TRANSCRIPT OF PROCEEDINGS

- - - -

COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE

WILLIAM E. ANDERSON LIBRARY OF PENN HILLS

THE DELUCA ROOM

1037 STOTLER ROAD

PITTSBURGH, PA 15235

TUESDAY, JULY 20, 2010

JOINT PUBLIC HEARING WITH POLICY COMMITTEE ON HEALTH INSURANCE RATE INCREASES

BEFORE:

REPRESENTATIVE ANTHONY DELUCA, CHAIRMAN
REPRESENTATIVE RICHARD GRUCELA
REPRESENTATIVE TONY MELIO
REPRESENTATIVE FLORINDO FABRIZIO
REPRESENTATIVE NICK KOTIK
REPRESENTATIVE MARK LONGIETTI
REPRESENTATIVE SCOTT BOYD
REPRESENTATIVE MIKE STURLA
REPRESENTATIVE KEVIN MURPHY
REPRESENTATIVE HARRY READSHAW
REPRESENTATIVE DOM COSTA
REPRESENTATIVE BRAD ROAE
REPRESENTATIVE CURT SONNEY
REPRESENTATIVE ROB MATZIE
REPRESENTATIVE DANTE SANTONI
REPRESENTATIVE MATT SMITH
REPRESENTATIVE DAN FRANKEL
REPRESENTATIVE CHRIS SAINATO

Reported by Jean M. Bujdos, Court Reporter

TRANSCRIPT OF PROCEEDINGS

- - - -

INDEX

NAME:

TRANSCRIPT OF PROCEEDINGS

\- - - -

P R O C E E D I N G S

(10:02 o'clock a.m.)

REP. DeLUCA: Good morning, ladies and gentlemen. I hope you can hear us today. We have mics in this room, but I guess they weren't giving us everything in the room here, but I hope that you'll be able to hear us.

I'm calling this committee meeting to order. It's an Insurance Committee meeting along with the Policy Committee, and my good friend, Policy Committee Chairman Mike Sturla, is here to help out on this meeting today.

Before I start officially with the meeting, I would like to recognize a citizen who lives in the 32nd legislative district who certainly is a tribute to what we are trying to do with healthcare. As you know, we keep talking about healthcare, we talk about reducing the cost, we talk about preventive healthcare, and this individual is a testament to what you can do if you set your mind to it and today I'd like to recognize -- to acknowledge an outstanding accomplishment. Most people don't realize the importance of exercise.

The average American watches three and a half hours of television a day, which adds up to 56 days of

TRANSCRIPT OF PROCEEDINGS

- - - -

channel surfing a year. By the age of 65, that adds up to over nine years spent in front of a small screen. Becoming a strong and healthy individual can be attained through an exercise regimen. The great thing about exercise is that anyone can do it at any point in their lifetime. It doesn't matter if you're lifting weights, swimming, running or riding a bicycle. As we all know, exercise can improve our quality of life as well as longevity of life. As a culture, we must embrace healthy living and better ourselves inside and out through exercising of all kinds. And let me state, age doesn't matter. If you can dream it, you can do it.

I am joined here today by an astonishing woman who proves just that. Age wasn't a factor when she set out to complete a feat that would take her across the southern United States, a 3,000-mile journey, all while riding a bicycle. Joanne has completed a 3,000-mile journey across the southern tier of the United States as part of a bicycle tour for women. Her trip of 20 similar-aged women from the ages of 55 to 75 took several months, starting in San Diego on March 4th. Joanne Barry and her fellow riders paid visits to Arizona, New Mexico, Texas, Louisiana, Mississippi and Alabama before ending in St.

TRANSCRIPT OF PROCEEDINGS

\- - - -

Augustine, Florida on April 30th. Each day, the women would ride 60 to 100 miles, stopping at night and only take one day off a week. That sort of determination and ambition is commendable and inspiring. Joanne brings new meaning to the term exercising, and I find it to be greatly refreshing.

As an indication for the extreme efforts Joanne Barry put forth, I would like now to present her with a citation from the House of Representatives congratulating her on her triumph. Joanne, I would like to thank you for showing everyone what real ambition looks like and proving exercise at any age can be accomplished with practice and hard work. Your bicycling achievements will go down in the history books. Come on up, Joanne.

(Applause.)

REP. DeLUCA: We all congratulate you on such a fine achievement. Keep up the good work. You're certainly an inspiration for a lot of individuals out there. As we talk about healthcare, we talk about preventive care, I think you're an example of what healthcare can do. Thank you.

MS. BARRY: Thank you very much. I'm honored to be here. It was harder for me to come up here than it was to cycle through thousands of miles.

TRANSCRIPT OF PROCEEDINGS

\- - - -

It took a lot of nerve to get up here, but thank you again.

(Applause.)

REP. DeLUCA: Again, good morning and welcome to the Joint Hearing of the House Insurance Committee and House Majority Policy Committee on the impact of the recent increases in health premium rates in western Pennsylvania. Specifically, we are focusing on the impact of those rate hikes on small employers.

As background, I was initially approached by the Allegheny County Bar Association about the rate increases that were applied to small law offices and sole practitioners. These rate increases were double-digit increases with some reported in excess of 50 percent.

In scheduling this hearing, we learned that these increases were not restricted to the field of law but also apply to a wide range of small employers.

Several concerns have been brought to me and the Committee:

Are these rate increases reasonable, given the economic environment we live in today?

Are these rate increases merely an attempt to force bad risk off the books of certain insurers?

TRANSCRIPT OF PROCEEDINGS

- - - -

Are these rate increases fallouts from the new federal healthcare law and are there state legislative solutions that should be preserved?

It is these questions that prompted my calling for this hearing and inviting the individuals most affected by the rate hikes.

The agenda today includes the largest insurers in the commonwealth, as well as the individuals who are responsible for implementing the industry, the Insurance Commissioner. In addition, I have invited and we will hear from those individuals and employers who are being asked to pay substantially more for health insurance for their employees and families.

At the outset, I want to thank all of you who will participate here today. I know that there are burdens and costs to being here today, but the issues we will be considering are just too important to ignore.

Let me also say that the response to the scheduling of this hearing has been overwhelming, and I want to thank those individuals who took the time to submit written remarks for the record. I am sorry we couldn't fit everyone in, but the written submissions will be very helpful and they are appreciated.

Before I have my colleague, Mike Sturla, make

TRANSCRIPT OF PROCEEDINGS

\- - - -

a few statements, I want to thank the William Anderson Library for permitting us to come to this facility. I also want to thank the executive director who has been doing a fantastic job. As you can see, this is a library, the new library, about three and a half years old, that was put together in cooperation of the state, the municipal government and also from Mr. Anderson, who was an individual who lived in this community for years, was a builder, moved away, but he never forgot his community and he had a ten-year endowment to help pay for this, to help the merit council pay for it. And it's a facility, and we know how important libraries are, not only to ourselves, but also to our children, it's a facility that's well used, as any other library, and it's a tribute to this great community of ours, Penn Hills.

As I see, we have one of the councilmen, Dr. Kincaid, in the audience. I want to thank you, Doctor, for your vote to put this library in Penn Hills. As they say, Penn Hills is a very special community in the eastern suburbs.

Now I will turn it over to my good friend and Policy Committee chairman, Mike Sturla.

REP. STURLA: Thank you. Thank you, Chairman DeLuca. I just want to thank you for making sure that we had this hearing here today. This is an important issue that for all Democrats. And Chairman DeLuca has been championing the way on a lot of these insurance issues as chair of the Insurance Committee.

I kind of like to think we're tagging along today to be able to claim we're all looking at it, and it gives all the members that aren't on the Insurance Committee an opportunity to hear about this firsthand, also. So again, thank you and let's get -- I'll have some more questions as we get into this.

REP. DeLUCA: I also would like to have the members introduce themselves to my left. Rich.

REP. GRUCELA: Thank you, Mr. Chairman. Rich Grucela from Northampton County.

REP. MELIO: Tony Melio, Bucks County.

REP. KOTIK: Nick Kotik, Allegheny County.

REP. FABRIZIO: Flo Fabrizio, Erie County.

REP. LONGIETTI: Mark Longietti, Mercer County.

MS. McCORMAC: Kathy McCormac, House Insurance Committee.

REP. BOYD: Scott Boyd from Lancaster County and a good friend of Chairman DeLuca and

TRANSCRIPT OF PROCEEDINGS

- - - -

Chairman Sturla, and I just want to assure Chairman Sturla that Republicans care about healthcare too. We do care. We do care.

MR. McNULTY: Art McNulty, executive director, House Insurance Committee.

REP. DeLUCA: Representative Tony DeLuca. I have the honor of being the chairman of the Democratic Insurance Committee.

REP. STURLA: Representative Mike Sturla. I'm chair of the Democratic Policy Committee from Lancaster.

REP. PASHINSKI: Representative Eddie Day Pashinski, Luzerne County.

REP. TAYLOR: Rick Taylor, Montgomery County, right outside of Philadelphia.

REP. READSHAW: Harry Readshaw, Allegheny County.

REP. COSTA: Dom Costa, Allegheny County.

REP. ROAE: Brad Roae, Crawford County.

REP. SONNEY: Curt Sonney, Erie County.

REP. MATZIE: Rob Matzie, Beaver and Allegheny County.

REP. SMITH: Matt Smith, Allegheny County.

REP. DeLUCA: Thank you. I would be

remiss if I didn't say that the Insurance Committee has been one of the hardest working committees in Harrisburg, no disrespect to the Policy Committee, but it also has been working bipartisanly, as Representative Boyd has said. We couldn't ask for better members on the Committee, on the Republican side, too. They have done an excellent job in working bipartisanly for the issues that affect all of the Pennsylvanians out there and I want to commend them.

As you said, Scott, we work together, it's a Democratic issue, Republican, it's about the people, and we're out here to represent the people.

The first individuals to testify today would be Lisa Frank, come up here, she's a policy specialist and -- excuse me. I'm sorry, we're doing the wrong agenda. That's tomorrow. Excuse me.

Today we'll have Gary Hunt, Gary Hunt, Mark Vuono of the Allegheny County Bar Association. Come on up to the table. William Price of Price & Associates. Two more chairs, please.

And while these gentlemen are getting ready to testify, I want to thank PCN for the fine job they do in keeping the citizens of Pennsylvania aware of what's going on in our commonwealth. They do a fantastic job. And I want to thank them for coming out today to televise this meeting.

Welcome, gentlemen, and whoever wants to start first.

MR. HUNT: Good morning, Representative DeLuca.

I want to start by thanking the Committee for taking the time to hold this hearing and agreeing to the suggestion of the Allegheny County Bar Association that public hearings be held. I think it's a testament to your commitment to the citizens of Pennsylvania that you've come from all over the state to hear evidence on this important issue, and it is a very important issue.

My name is Gary Hunt, I'm the president of the Allegheny County Bar Association. I'm also a shareholder and a former managing partner of the law firm of Tucker Arensberg, P.C., so I know, I have very much real world experience on the impact of insurance premiums.

REP. DeLUCA: Pardon me, can you speak up a little bit? Unfortunately, we don't have any microphones in here and I think they can't hear you in the back.

MR. HUNT: Okay. As I said, I'm president of the Allegheny County Bar Association, I'm also a practicing lawyer and a former managing shareholder of Tucker Arensberg, a mid-sized law firm in Pittsburgh and in Harrisburg. I have real-world experience in that role of the impact of insurance premiums on the viability of any business.

The Allegheny County Bar Association is a membership organization with more than 6,300 members. More than 60 percent of those members are either sole practitioners or in a small law firm with six or fewer lawyers. This group of at least 3,700 lawyers in turn employs thousands of individuals as secretaries, paralegals and other clerical employees. I am, therefore, speaking not only for this group of lawyers but also for their families, their employees and their employees' families.

Furthermore, our membership provides legal services to thousands or even tens of thousands of small businesses that are the foundation of our local economy. These businesses employ tens, if not hundreds of thousands of individuals.

The Allegheny County Bar Association is very concerned with the impact that Highmark's dramatic rate increase in insurance premiums is having on its own members. But make no mistake about it, this is an issue that goes far beyond the impact on the members of the Allegheny County Bar Association and the individuals employed by those members.

The dramatic increase in health insurance premiums for Highmark is causing substantial hardship for all small business owners and associations and their employees and members.

The impact of these premium increases on the members of the Allegheny County Bar Association is typical of the impact on the hundreds of small businesses who also obtain their health insurance through programs sponsored by their business associations, whether it's the Chamber of Commerce, the Small Manufacturer's Council, the Medical Society or any of a number of other such associations that have provided group health insurance as a member benefit.

Therefore, when I tell you that the premiums for some of our members have increased by as much as 70 to 79 percent for the upcoming year, you must understand that a similar impact is being felt by many other small businesses throughout our community. The impact of these premium increases is all the greater because small business owners, whether they're a small law firm or a solo practitioner or a small manufacturer or a local hardware store or any of hundreds of other types of small business have few, if any, options for alternative health insurance.

The Allegheny County Bar Association requested public hearings on this issue, first because its own members were being dramatically impacted. But we requested the hearings also because these premium increases can have a dramatic impact on the entire business community. We all depend upon each other, and we all depend upon the financial health of every part of our economic engine.

The mechanism by which Highmark initiated these premium increases was simple. It moved all insured groups below a certain size into the for-profit arm of Highmark. By doing so, Highmark avoids much of the regulation and scrutiny to which such rate increases would otherwise be subject. Furthermore, this move frees Highmark's hand with respect to medical underwriting, however you want to define that term. With respect to the Allegheny County Bar Association membership, this means that rather than being able to spread the cost of group insurance across the entire membership, many of the small groups will be forced to pay premiums that make it impossible to maintain health insurance for themselves, their employees and their employees' families.

The situation is exacerbated because as we all know, it is impossible for a small group to negotiate with a large health insurance provider on rates. The rates are quoted and the insured has a take it or leave it choice.

We are asking the Insurance Department and the state legislature to step in and take a hard look at what is happening. We are also asking that a Public Advocate Division be created in the Pennsylvania Insurance Department, similar to the Public Advocates who protect utility consumers. This would ensure that the citizens of the Commonwealth of Pennsylvania are protected from any abusive practice of insurance companies. This type of oversight is working well for utilities and other industries.

I don't pretend to be an expert in this area and perhaps do not have all of the facts. However, the reality is that because Highmark has initiated these changes without any regulatory or legislative scrutiny, none of us, other than Highmark, have all the facts.

When it comes to something as vital as health insurance, not free health insurance, paid health insurance, aren't the citizens of Allegheny County entitled to have these facts? And isn't this particularly true for Highmark when Highmark was originally created to be the insurance provider of last resort. Thank you very much for your time.

(Applause.)

REP. DeLUCA: I have to recognize one of my other colleagues who came in, Chris Sainato from Lawrence County. Thank you.

MR. VUONO: I'm Mark Vuono. I'm a partner in the downtown law firm of Vuono & Gray. We've been practicing for over 55 years downtown and we focus our practice on representing small businesses. I'm here today, however, as the chairman of the Lawyer Insurance Committee of the Allegheny County Bar Association. I'll sit and stay close to the mic.

The function of the Lawyers Insurance Committee of our Bar Association is to review and endorse insurance products that are offered to our members. Our Lawyer Insurance Committee is volunteer attorneys who meet regularly to provide an important screening function for our members. As Gary mentioned, small businesses don't have the expertise or the time to devote to review insurance products and to negotiate with an insurance company, so our organization historically has provided that kind of a service, and although we review a number of different lines of insurance, health insurance is the key function of our committee, is to make sure that our members have available affordable and quality health insurance.

I've served on this committee continuously for about 25 years now. Nevertheless, like Mr. Hunt, I don't profess to be an expert in the health insurance industry. In that time though, our committee has learned a lot about how Highmark does business as we have done business. We have endorsed Highmark's products for over 40 years to our association, but there are a few things that I think it's important to bring to the attention of the Committee and to the public.

One reason that the Association has endorsed Highmark in the past is that it offered coverage to all of our members without regard to medical history or preexisting conditions. It was, as Gary said, the community insurer of last resort, offering coverage to all of our members and to the community at large. And in exchange for fulfilling that important role in the marketplace, Highmark and its predecessors have enjoyed a tax-exempt status that distinguished it from its competitors. Over the years, it has been able to leverage that status to become the dominant player in the marketplace in Allegheny County and has accumulated massive reserves under its not-for-profit umbrella.

In the past, going back ten, 15 years, Blue Cross and Blue Shield offered group coverage to our members based on the experience of the group as a whole. Each member of our organization paid the same price for coverage without regard to age, gender, medical condition or history. The risks were spread over the entire pool of the members of the Allegheny County Bar Association, just as if our sole practitioner members were employees in a large firm. Our committee received regular reports from Highmark on the claims experience of our group, the premiums that were paid by our group and the net profit that was generated.

In those days, we actually, on behalf of our employees, our members, rather, negotiated the rates with Highmark or Blue Cross/Blue Shield in those days. In fact, we were even able in good years, when we had good experience, we could carry over the so-called profits to reduce premiums in future years and so that was an important service that we were able to provide to our clients.

So you understand who we're talking about, we're not talking about the large law firms in town with over a hundred attorneys. We're talking about small group market, which consists of firms with from one to 50 employed individuals, and that's the same definition that applies not just to attorneys, but to any small businesses, whether, like Mr. Hunt said, through the Small Business Council, Medical Society, Chamber of Commerce or other groups. Mr. Hunt pointed out that over 60 percent of our members are small firms of one to six attorneys.

More importantly, within that group, 35 percent of our membership consists of sole practitioners, one attorney firms, and these are the ones who have been most dramatically affected by what's happened recently.

At one time, Highmark proposed to eliminate group coverage for sole practitioners. We went to the Insurance Commission and under some pressure, Highmark backed off and reluctantly, thus far, has continued to offer coverage to our sole practitioner members.

The first historical step away from this arrangement where we pooled all of our risks together within the association was the Blue Cross/Blue Shield decision a number of years ago to combine all of its association business into one pool, so we were combined with the High Tech Council, the Medical Society, the Dental Society into one big pool, which at the time, sounded good, right, a bigger pool, spread the risk, and it should result in lower overall rates.

The problem from our standpoint was that we could no longer monitor the experience of our own group. We didn't know if our group was being -- had a favorable experience or an unfavorable claims experience because we were pooled in with everyone else, so we lost a little bit of the function that we were able to provide for our members.

The next big step down the slippery slope of what's happened was the decision by Highmark to start using different rates for different law firms based on the average age. That was the first factor that differentiated the amount that people paid for their coverage. They put us into age bans, they took the average age of a firm and said if your average age is in the twenties, your rate is going to obviously be much lower than if your average age was in the fifties. Well, the average age factor was particularly burdensome for our sole practitioners, because, obviously, if you got one person covered, your average is how old you are, so our older sole practitioners were adversely affected by that step.

Later, Highmark began including other so-called demographic factors, such as occupation, doctors and lawyers might be rated differently, location and gender into their rating process. And the most significant one from our standpoint was that firm size was considered to be a demographic factor that had some impact, supposedly, on the rates that were being charged. I've never been able to understand personally how a sole practitioner is a greater health risk than if that same lawyer were practicing in a larger firm, but that was one of the factors that was taken into account.

Now, as these things happened with all these additional so-called demographic factors being taken into account, we completely lost the ability to protect our members and figure out how their rates -- it got to the point, as Gary said, this is the rate, take it or leave it. And when we would ask for explanation, the response was well, we can't tell you about your members' health condition, that would violate HIPAA and our rating policies are confidential proprietary business models that we are not willing to reveal.

Then, the next big step along the way was Highmark advised our committee that in addition to using the so-called demographic factors, which the Insurance Commission had authorized Highmark to use, they also began using computer-driven predictive modeling as part of the process. We didn't understand what that terminology meant. What we were told was that it took into account past procedures that had been received by a member and medications to predict with their health might be in the future. We didn't know how it worked, but it sure sounded like medically underwriting to us. But again, at that time, Highmark was taking the position, as they still do today, that they do not medically underwrite their premiums. How they distinguish medically underwriting from predictive modeling, we've never been able to understand.

We attempted, when we heard about this predictive modeling, we attempted to find out from the Insurance Commission or from the insurance department whether this was permissible. We were told that Highmark's filed rates only were based upon demographic factors, age and so forth, not on medical underwriting or predictive modeling, and we were never able to find anything in Highmark's public filings that authorized the so-called predictive modeling technique.

Before we were able to find the answers to these problems, though, Highmark again changed the rules of the game this past December, when they announced that they were planning to move all of their small group business, again, all their one to 50 size employer groups into their for-profit subsidiary. And the effect of that was to take that business outside of the scope of the regulations of the Insurance Commission and enable them to begin to use medical underwriting. There was also some concern at that time as to whether they would change the definition of small group to exclude sole practitioners. Thus far, they have not taken that step. They are, on the surface of things at least, continuing to insure our single-member sole practitioner firms. But I think we need to look beneath the surface to understand what's happening.

The insurance department did approve the transfer of the small group business over to the for-profit side of Highmark. That approval process resulted in a delay in the rates being released for our July 1 renewals. When those rates were released, however, the results were frankly shocking.

There's a chart in the materials that we've submitted on page 5 of the materials that outlines some of the effect of the rate increases, and in particular, the effect on our sole practitioners. The vast majority of our sole practitioners received rate increases of more than 20 percent, and there were nine firms that received a rate increase of more than 70 percent, 70 percent, from one year to the next.

One of our members who submitted written testimony is Mary Margaret Isabella, and I do implore you to look at her statement because she is at the point where she questions whether she's going to live to age 65 and be able to get to Medicare because of the fact that she can no longer afford health insurance coverage.

What it appears to us from these rate increases is that Highmark has singled out our sole practitioners for excessive rate increases so that they could accomplish indirectly what we think they tried to accomplish directly several years ago, and that was to exclude our sole practitioners.

In the marketplace, there are no alternative health insurers that are willing to provide group coverage to individuals. The other for-profit companies only offer coverage to groups of two to 50, not one to 50. So our members who cannot afford the premium increases have only the option of going to a direct pay based on their own medical history.

The insurance department's approval of this transfer has allowed Highmark's for-profit company to charge excessive premiums for health insurance, and it seems to us that the motive is, like I said, to exclude our sole practitioners.

When we met with Highmark to look at these rates, we got no explanation again, as in the past, of how they were determined because of HIPAA confidentiality and proprietary business models. Although Highmark claims that they are not medically underwriting, they do acknowledge that predictive modeling has entered into the formulation of these rates. We don't understand how that works, but we know the effect on our sole practitioner members.

You're going to hear from Mr. Price in a few moments about how this has affected him personally. He's one of our members, but it's not just lawyers that we're here to stand up for today or that we are asking the legislature to stand up for, it's individuals in small businesses generally. We are all in this game together, we all face the same problems.

TRANSCRIPT OF PROCEEDINGS

- - - -

The Bar Association historically has had this committee that's been able to study and understand this and work with Highmark and we felt it was critical to bring this to the attention of the Committee.

We're, therefore, asking for, because we can not solve this problem on behalf of our members any longer, we're turning to the legislature and to the insurance department to stand up for small business. We want to know why Highmark, having benefited from tax-exempt status over the years, should be permitted to walk away from its role as a community insurer of last resort for small business groups. Why should they be allowed to use an employee's medical history, by whatever label that attach to it, to make coverage prohibitively expensive and weed out the bad risks?

(Applause.)

MR. VUONO: Why can't our members or our committee receive any credible explanation of how our rates are being calculated?

We ask that you demand a plausible and documented explanation from Highmark for why coverage is being effectively denied to our members and our most vulnerable members, our small firms who are older and less healthy. We ask that you require the insurance department to create a public advocate to speak for our members and other small businesses in Allegheny County and throughout the commonwealth.

Thank you for your time.

(Applause.)

REP. DeLUCA: Thank you. I'm glad that, before we get to Mr. Price here, I'm glad you clarified to the audience that we're not just talking about the Bar Association. We are talking about other small groups. We're talking about businesses, small businesses, so I don't want the audience out there to think that we're only out here for the Bar Association and the legal profession. We're out here for everybody and certainly your testimony is why we have these hearings to try to determine what's going on out there. So I just want to make that clear to the public and to PCN that these hearings are not just pertaining to the Bar Association, this is happening to other small businesses out there, as I said, in my opening remarks. So I just want to make that clear that when you're talking, it was mostly Bar Association, I want to make that clear.

Mr. Price. Before you start, I just want to recognize Representative Matzie has joined us and Representative Frankel. You look like you could project, so I'm sure they could hear you out in the audience.

MR. PRICE: I'm one of the 35 percent of the attorneys in the Allegheny County Bar Association that are sole practitioners. I have a little tiny storefront office in Swissvale where I work mostly with the elderly and I write wills, I guess that's a plug. But I don't know, for some reason, sometimes I worry that Highmark just doesn't love lawyers anymore. I don't know what's happening, but I'm not here --

REP. DeLUCA: I don't think the insurance industry loves anybody out there the way rate increases are going on. I wouldn't say about lawyers, I think that we're talking about the general public, it's not just Highmark, it's everybody out there.

MR. PRICE: Exactly.

I'm not here today to complain about the general high cost of healthcare in America. My concern is about arbitrary, capricious and discriminatory pricing practices that Highmark is engaging in, and these practices are to the very real detriment of sole practitioners like myself and the Allegheny County Bar Association, and I believe that one of the things that Highmark is trying to do is to drive sole practitioners from the group. And it worked for me.

I was in the group for 26 years, in the Allegheny County Bar Association's plan, and the premiums became so outrageously expensive that a couple months ago, I went into Highmark's new walk-in storefront place on McKnight Road and I was able to purchase the insurance directly for my same family from the same insurance company, Highmark, and save about $4,000 a year. And the woman that waited on us told us that if it wasn't for some very minor preexisting conditions in our family, that we would have saved over $10,000 a year for our family.

What has happened in our group plan is what I refer as discriminatory slice and dice. You would think that another lawyer my exact same age in Allegheny County, in the same profession, in the same group plan would have the same premium that I would for my family, but I started talking with other attorneys around the county and I found out that is simply not true, that attorneys in groups of two or more had premiums that were substantially lower than the premiums that my family was charged.

Last year, to cover my wife and myself and our 14-year-old daughter, no optical coverage, no dental coverage, we had to take a $7,000 deductible to hold our premium down to $1,200 a month. That went up again this year, it went up to $1500 per month to cover my wife and my 14-year-old and myself on the Allegheny County Bar Association plan. And the only reason that I could get from Highmark, because I've been very vocal with Highmark in calling them and hounding them about this, is that they do not treat a 55-year-old lawyer in Swissvale the same as a 55-year-old lawyer in downtown Pittsburgh.

They chop us all up into little tiny hundreds and hundreds of tiny sub groups that are each little office and although, and I can't explain this, because we haven't used our coverage in years, we've had this high deductible for a few years now, and of course you don't get medical coverage, you don't get medical treatment when you have a $7,000 deductible.

But they have this mysterious thing, if I could borrow something for the moment, I can't talk without having props, but if I could borrow this. This is Highmark's predictive modeling computer, and I don't know how it works, I don't know what's in it, I don't know what criteria they use. I've asked them what is it about my family that causes our rates to be so high, maybe something was put down in error in the medical record, how can I correct that?

But they tell me that this information is proprietary, that they don't want people to know what they're looking at that's causing this predictive modeling computer to spit out such a high premium for my family. All they tell me is oh, well, we looked at it and we did it correctly. Of course, that tells me nothing and since it's only my own family, I'm not asking for information about employees, I would know everything that's in there anyways, but for some reason, we're getting these ridiculously high premiums.

There's no checks and balances. The high priests, the high priests of Highmark work with this and then they give us these rates. For all I know, maybe I complain too much, maybe I made too many calls to Highmark, perhaps that's a reason why my premiums have went up nearly $4,000 this year. I don't know. But this concerns me because, you know, even with the federal government, the person can apply under the Freedom of Information Act and see all sorts of files about themselves, but Highmark won't explain what criteria is causing my family to pay substantially more than other attorneys that are demographically identical to ours.

Thank you.

TRANSCRIPT OF PROCEEDINGS

- - - -

(Applause.)

REP. DeLUCA: Thank you. Bill, I would be remiss if I didn't say you brought your prop up here, I could just picture the courtroom when you go up there and practice law.

MR. PRICE: I write wills.

REP. DeLUCA: I hope you don't use the props when you do the wills.

REP. STURLA: Actually, I think most of my questions will, after hearing this, will be reserved for Highmark when we hear from them. Thank you.

REP. DeLUCA: If I could, before we have the questions for these three gentlemen, if you could just stay here for a few minutes, PCN would like to take a little break, about five minutes, and we'll -- if you could stay here, we'd would appreciate that. Take about a five minute break for PCN.

(Recess.)

REP. DeLUCA: We're going to proceed. I'd like to recognize my colleague, Kevin Murphy has just shown up here today. Come on over. Dante Santoni is out there. Welcome. Okay.

From my left, is there any questions for this group? Representative Boyd.

TRANSCRIPT OF PROCEEDINGS

\- - - -

REP. BOYD: Thank you, Mr. Chairman. It's interesting, I'm a small business person myself, I have a small company, not a law firm, I'm not an attorney, but one of the things that some of us in Harrisburg had been advocating for the last number of years would be amending the state's constitution to provide for a capsule on non-economic damages. There's been a series of testimony limiting damages on, potentially heavy limits on damages would, in fact, lower the costs of healthcare ultimately and health insurance premiums. I'm kind of curious how the Bar Association would react to maybe a move like that from the general --

MR. HUNT: Well, as you may expect, with 6300 lawyers in the Bar Association, there are a number of them that maybe represent corporations or doctors on the defense side who might favor something like that, and a number of them who represent individuals who have suffered injuries as a result of malpractice who would be strongly opposed to something like that, and for that reason, the Bar Association feels it really can't take a position on that.

What I would say is what we're really talking about here is not the cost of medical malpractice insurance, but the cost of health insurance, and the notion that these two are directly related, I think is -- I don't believe it's accurate.

Highmark, on its non-profit side, has enormous reserves. The number of lawsuits filed on the malpractice side dropped by about a third over the last few years based upon -- due to the regulation instituted to control frivolous lawsuits. So I frankly don't think they're connected, and respectfully, I have to tell you that because of the diverse makeup of our association, I can't take a position on that.

REP. BOYD: I appreciate that, the honesty in your answer, and I thought it was very direct. One of the reasons I brought it up, to Chairman DeLuca's credit, we have been working bipartisanly, and whatever is done through the next balance of this session and in the next session to try and lower the cost of healthcare and then ultimately help insurance premiums is probably going to have to be a comprehensive package, it's more than just community rating or one or two. One thing this Committee has found out is, there is no silver bullet to this thing.

So we've been working hard together, and that's something that might be on the table, so if you get four other things that you're supportive of, I'm just asking you to have an open mind that there may be some additional things that the legal field isn't crazy about, but the insurance industry and the medical industry, the providers may be interested in.

If we work together that way, we're all willing to give something, I think we can get some positive change.

Thank you, Mr. Chairman.

REP. DeLUCA: Thank you. From my right, any other? Representative Pashinski.

REP. PASHINSKI: Thank you, Mr. Chairman, and thank you, gentlemen, for your testimony today.

Just to clarify, I want to make sure we have this straight here for the record, I believe this is Attorney Price?

MR. PRICE: Yes, sir.

REP. PASHINSKI: You have requested from the insurance that supports your healthcare, you have requested your own records to try to determine how your rate hike was determined; is that correct?

MR. PRICE: That's correct. I've personally contacted Highmark on a few different occasions to ask them, first of all, what criteria they're using and they won't even tell me that. And

I've asked them what in my medical records, because I barely used my healthcare for many years, but they refused, they completely stonewalled me, they won't give me any information at all.

REP. PASHINSKI: See, that's why I'm asking these questions. Has your usage changed that may justify them altering your rates?

MR. PRICE: I don't remember us ever hitting our deductible. The premiums that we've been paying the last several years that we've had this high deductible plan have been straight profit for them.

REP. PASHINSKI: Okay. And to clarify again, you then took it upon yourself to go in as a private citizen to the same company and request insurance, health insurance, from this company and you were quoted a price that was, I believe you said, $4,000 less than what you were being charged in this pool?

MR. PRICE: That's correct. And we're now insured under that plan and we've dropped out of the Bar Association plan after 26 years.

REP. PASHINSKI: So if the cry has been we have to bring more people in the pool to balance out the cost, how could that possibly be?

MR. VUONO: They're driving the people

out of the pool, out of our pool, by singling out that particular sole practitioner, the single member law firms.

REP. PASHINSKI: And to clarify once again for the record that your pool consisted of not only attorneys, but doctors and other professional people in similar --

MR. VUONO: For the past ten to 15 years, that's correct. Originally, we had our own separate pool and our rates were uniform within our pool. But the first step in that historical process was to combine us with all the other small group business, all the association business was combined into a single pool. And then at that step, we still, everybody had the same rates, then the demographic factors came and things got progressively foggier in terms of how our rates were calculated, so that to the point where, you know, his is the extreme case.

We don't want to know what his medical history is at the Bar Association. We want to know what are the factors that went into determining a rate for an unidentified individual. We just want to know how does this work.

REP. PASHINSKI: A set of something that's rather standardized, a formulary.

MR. VUONO: You would think. And then when we didn't get it from Highmark, we went to the insurance department to try to figure it out, and not all the rate filings are public and we were not able to get any credible explanation.

REP. PASHINSKI: Can I just follow up with it? Now Highmark is non-profit.

MR. VUONO: Well, they are --

REP. PASHINSKI: Well, I'll tell you where I'm going. A lot of the non-profit groups have developed ancillary companies that are for-profit. I'm trying to determine now, is your insurance policy covered by the non-profit Highmark or is it an ancillary company?

MR. VUONO: That's exactly what changed that has prompted all of this most recently, it has always been until June 30th of this year, through June 30th of this year, our coverage has been through the non-profit arm, but as of July 1, all of the small group business moved over to the for-profits subsidiary, and the effect of that is not just that it can become profitable, but it also changes the regulatory requirements that they're subject to.

MR. HUNT: And if I could make other point, Representative, and that is that although, I don't know this, because I'm certainly not familiar with Mr. Price's insurance program, but I suspect that the insurance that he was able to acquire was through the non-profit and that goes right to the heart of what we're talking about. Because the group program, small group programs were put into the for-profit, and they increased these rates dramatically, they're driving these people out of the group programs. And then he walks in through the door, and they say well, sure, we'll give you insurance through our for-profit or our non-profit, what's the result? All of these individuals are being driven out of the group plans.

MR. PRICE: I forgot to mention one very important factor for our family, now that we have this $4,000 cheaper policy, I don't have a $7,000 deductible anymore. I have a couple thousand dollar deductible.

REP. PASHINSKI: And it was extremely important, sir, that you said with my $7,000 deductible, I really don't get healthcare, because I can't afford it.

Thank you, Mr. Chairman. Thank you, gentlemen.

REP. DeLUCA: Thank you. Any other questions?

TRANSCRIPT OF PROCEEDINGS

- - - -

We want to thank you for your testimony today and certainly we'll be looking at this and getting a result of that.

MR. HUNT: Thank you for your time. We appreciate it.

REP. DeLUCA: Next panel will be the Small Manufacturing Association, Business Councils. William Snyder, Carolyn Franks and Bruce Rosen. Whenever you're ready.

MR. SNYDER: I'm William Snyder. I'm a CPA and I want to thank the Committee, Chairman DeLuca and the House Insurance Committee, Policy Committee for this opportunity.

Before I get started, I want to contrast the group sitting up here from the group that was here before. We represent small business, period. We don't represent one industry. I'm a CPA, Mr. Rosen is a broker and Mrs. Franks is in the auto repair industry. And so it's all different things. And by the way, I represent the largest company of the three up here. There's two in my company, the other ones are the small ones. So all I'm going to relate to you is what happens in a small business when we get these kinds of increases here.

I operate my business as a sole

proprietorship. As I said, I'm a CPA, and I have one full-time associate. I began my business in '98. At that time, I purchased health insurance through SMC Insurance Agency. Because I've had a number of health issues over the years, I've always bought the best coverage I could find and afford. I used Highmark, as most other people did around here, Blue Cross/Blue Shield and its predecessors. Until July 1, 2010, I've continuously used Highmark Blue Cross/Blue Shield. And I've had a prior business before becoming a CPA dating back to 1972, a restaurant, and I've used the same plan through the same agency, so it's been many, many years I've done that.

I've attached an Exhibit 1, marked Highmark Renewal Rates, and it shows my annual premiums from July 1, 2007 through June 30, 2011 through Highmark as projected. On that chart, I've had the same two individuals since 2007, myself and my associate, and my premium has increased 96.14 percent over four years.

As most small businesses, we're in competitive business environments. I have not raised my rates in four years, let alone doubled my rates over the last four years. Therefore, I had to absorb most of this premium increase from around 13,000 to 26,000, an increase I've absorbed or would have absorbed if I would have continued with this year's rate.

When I got my premiums for the current year, which starts July 1, 2010 through June 30, 2011, my premiums rose by $7,772.40 for two individuals, and this is single coverage, not family coverage for the two individuals. At that time, I was forced to seek some type of relief and I applied to other insurance companies through the SMC Insurance Agency at their suggestion to find another comprehensive affordable coverage.

Because of my health issues, I didn't think I could find anything else because all the other plans are medically underwritten, and to my surprise, UPMC Health Plan offered me coverage at less than I paid at last year's premiums. Even with the medical underwriting and my current health status, UPMC medically underwritten rates were significantly lower than Highmark's renewal premiums.

As a sole proprietor or as a shareholder in an S corporation or as a partner in a partnership, we are subject to self-employment tax on our health insurance premiums of 15.3 percent.

So my premium proposal from UPMC annually for myself is $9,110.52, but in reality, it's $10,504.42.

That's $1393.90 of self-employment tax that I pay on top of paying premiums, which everyone will agree, premiums are getting higher and higher and they're harder and harder to pay.

No one else in the country is paying this, only these groups, sole proprietors, share two percent or more owners, shareholders in S corporations and partners in partnerships that are paying this 15.3 percent. I realize it's not a state tax. But the point is, we're still coming across with this money, we're trying to show you what's happening, what this is doing. This is the second largest item in my budget after my wages, is my health insurance.

I'm a member of the SMC board of directors and I attended a meeting on March 11, 2010 where representatives of Highmark explained why their premiums were raised by such huge amounts. To my memory, it was approximately 32 percent across the board. It was explained by Highmark that they were -- they had switched from a non-profit to a for-profit entity and since they were a for-profit entity, they no longer had to abide by the minimums and maximums as they did as a non-profit entity.

My premiums increased 40 percent from last year, $19,203 to this year, $26,975.40. As I said,

TRANSCRIPT OF PROCEEDINGS

- - - -

$7,772.40 for two individuals. That's what forced me to look elsewhere.

The UPMC Plan that I found was $8,753.64 less than Highmark and the only thing I had to worry about was were my providers in UPMC plan. Fortunately they were. So I did change, and I had that option to change, not everybody had that, UPMC plans do not cover individuals, but they do cover a group of two and larger, so that was available to me.

As Highmark had told us at this SMC board of directors meeting that they want to position themselves under the new affordable healthcare legislation that was recently signed into law. The Highmark representatives also said that plans with one and two participants are larger users of health benefits.

Obviously, because of the dramatic rate increases, Highmark is trying to rid themselves of these plans. I was fortunate to find another option, although, I have to be careful and limit myself to UPMC providers, at least I found an option. If the UPMC plan was not available, I would have two choices, cut my standard of living by $8,000 or cut my employee's benefits or hours.

Since you cannot keep good employees unless you pay a competitive rate with competitive benefits, I risk losing somebody who greatly contributes to my organization. In other words, I would have been between a rock and a hard place.

(Applause.)

REP. DeLUCA: Thank you. Excellent testimony.

MS. FRANKS: I would also like to thank you for allowing us to testify.

My husband, Keith and I have been self-employed since 1990. We own Frank's Auto Service, an auto repair garage in Penn Hills. At one time, we had a successful business with several employees, a growing retirement fund, we were active, generous in our community. We pretty much had the American dream on the middle class level.

And I don't want to get down in the weeds with numbers, but some of these numbers are important, so I do want -- I ask your patience with this. In the year 2000, we were paying approximately $500 a month through the SMC for a Highmark HMO. Because I had a preexisting condition and children, again, we wanted a very high quality health insurance program or plan, which is why we went with that. By the year 2007, our premium had risen to $1500 a month. Then, the following year, it went up to 2,476 a month. That was a 64 percent increase in one year. Okay.

Obviously, at that point, we had to research other options. We looked at HSAs, wasn't going to work for us. We ended up opting for a high deductible PPO. The cost for that plan was $1,890, which was still almost a $400 increase, but now, we had a $2,000 deductible, higher out-of-pocket costs and less coverage, so we still were paying so much more and getting less, but that was the only plan we could find that would save us anything.

That plan this year in 2010 was slated to increase to $2,620 a month, which is $31,440 a year. That was a 37 percent increase over the previous year, but a 425 percent increase over the first year I quoted you, the year 2000, so in ten years, it was a 425 percent increase and a lesser plan. That also represented 40 percent of our income. We were panicked and we went to the SMC representative who informed us that now we could have options of other carriers.

We settled on UPMC PPO. We had to separate my husband and my -- this was a legitimate thing to do, we separated our two premiums out, and we now total, our premiums are only $1,280 a month. No deductible and pretty reasonable copays.

The last several years before we switched to this lesser plan -- well, first let me back up. Even though this is much, much better, it still represents $15,000 a year plus out-of-pocket costs, that is still 20 percent of our income. That is an annual minimum wage salary. That's several thousand dollars less than our mortgage. And we have no guarantee that that won't jump dramatically as other premiums have done for us in the past. So yes, it's much better, but okay.

Anyway, in the last several years, when our premiums were so dramatically high, we were reluctant to reinvest in our business or expand our business in any way. We talked about moving to a larger location, we talked about purchasing property, we talked about hiring more employees, but wouldn't do it. We were apprehensive because of the uncertainty of where our premiums could go and the anxiety already over this cost that was already so high. So all the talk about expanding and reinvesting was going nowhere.

As you all know who own businesses or who live in the real world, that's not your only expense that goes up, your utilities go up, your rent goes up, whatever.

- - - -

The other thing that I would really like to point out that disturbs me is that we were at one time very active in our community, we supported all the local, you know, things, the baseball people and the chamber and okay, but my husband, in order to make ends meet, had to start working an average of 55 to 65 hours a week, sometimes more, was totally unavailable to my family and was unavailable to do any community activities, lessened my ability to be involved in community activities, and we had no money to donate. We no longer could support the community that we had been involved with for all those years.

We had to dramatically decrease our retirement, the contributions to our retirement fund. We had to dramatically decrease the contributions to my children's college funds. At one point, we stopped contributing to either for several years. I don't know, I'm 50-some years old and I'm a little worried about retirement and my kids' college.

In the past two years, with my $2,000 deductible, I stopped pursuing health concerns, I just didn't go to find out if there was a problem, because I didn't want to pay the deductible. I mean, obviously had it been a crisis, I would have, but you know. I worry about my husband's health incessantly, he's working too many hours in a physically demanding job, he doesn't sleep, he lays awake at night and worries: Will he make enough next month to pay the premium? Will we be able to pay for our kids college? Will we have any money in our retirement funds? We're both in our fifties. So I worry about him, frankly, all the time.

Let me just ad lib here to say that he was not supposed to be still fixing cars at his age, we were going to expand and he would be managing, but healthcare costs just prohibited that expansion. I do contribute by working in a school district so that I can contribute to our family's expenses, but I have to work part time, I cannot go full time because my husband needs me to do the administrative tasks at the business, and somebody has to be around when you've got kids, and because he's always working, I try to be somewhat accessible to my children.

We have been actively lobbying for healthcare reform for the past several years and we will continue to do so. The anxiety and apprehension has not lessened. We still haven't planned to reinvest or expand, we still don't feel confident we could send our kids to college or have a secure retirement. This uncertainty continues because of the volatility of the insurance market and the lack of regulation.

We have begged and will continue to beg our legislators for fair and affordable access to healthcare for all of us in the middle class who work so hard and play by the rules.

Thank you.

MR. ROSEN: Good morning and thank you for the opportunity to let me speak in front of such a vast room and members of the -- the Congress and our Pennsylvania Legislature.

Carolyn actually has said many of the things that I would have said, so I'm not going to read the testimony that I have written out for you, hopefully you have it.

The reason I'm here is because when I was told that our insurance premium was going to increase by 73 percent, my pacemaker actually took a detour and that's probably -- you know, I've only had the pacemaker five and a half years, my wife happened to have breast cancer five years ago. In my testimony, I say in spite of that, I'm as healthy as a horse, and I'll challenge any of you to a game of tennis or squash and I'll prove that.

But I guess the bottom line is, I was asked to give you the details and I think the important thing is for me, which is self-interest, that my insurance is going from about $19,000 -- and when I say mine, my small company, $19,000 last year which ended June 30th, and effective July 1, just 20 days ago, I will have the pleasure, if I continue with the policy with Highmark, of paying $32,500, 32,243 to be exact, that includes the $1,000 deductible.

My wife is a psychiatric social worker and is here. That basically would be her salary, you know, of what she makes by performing the job that she does in a private practice.

Just as a quick prologue to these comments, I'd like you to know that for 18 years, I worked for some fairly large companies in the coal and in the steel business. I worked for a group that was covered by United Mine Workers plans and also by United Steelworker plans, so I was spoiled, we were spoiled, and when I left them in 2001 and formed my own business, I had the privilege of staying with their insurance for about a year, well, a couple years, and then on COBRA, which you're probably all familiar with, which carried me until 2005. Those premiums are like $900 a year, excuse me, $900 a month. Okay. You could do the math, but, you know, you get spoiled.

And then you enter the real world when you end up with a small business, as we have, and you realize that we're no longer -- for some reason, my health changed the day that I left and formed my own company. Now, I'm the same person I was the day before than when I then formed my own business and yet, my insurance literally went up 101 percent. And you can see it in the information I've listed.

But again, you know, I don't like to look back so much in history, but it's interesting that, you know, obviously the United Mine Workers and the Steelworkers, they should be very proud of the fact that they have wonderful insurance and it's such -- well, call it a perk or call it whatever you want, but it's a wonderful thing.

What I do want to do real quickly is read a letter to you and it's a very short letter. When I was so annoyed by the amount that my insurance was going to go up, I sent a letter figuring oh, maybe the Pennsylvania Insurance Department would help me and so it was sent, and I received a response from Roger Lisi, L-i-s-i, he's the Harrisburg regional manager, and basically what I told him is exactly what I just told you, that my insurance is going up 73 percent.

He said, Dear Mr. Rosen -- and I gave him the details. He said, thank you for your patience as we review your concerns and analyze the impact of Highmark's transition of a small employer group business to its for-profit subsidiary, Highmark Health Insurance Company, on your behalf or on your premium. Based on our review, it appears -- and if you can explain this after I read it, I'd be very happy. Based on our review, it appears that your premium increase is one that we cannot address under the current law. However, we did review the calculations used in your specific instance to confirm that the application was consistent with the methodology Highmark represented is being applied uniformly throughout the transition. That's gobbledegook to me, but maybe you guys figure it out.

As we have stated previously, Governor Rendell and Commissioner Ario have been strong advocates for legislation that would give the Insurance Commission rate review authority and specific standards for limiting rate increase and stopping other unfair rating practices. You can assist in this effort by contacting your local legislators and explain your situation and by giving us permission to share your story.

Well, you have my permission. So what are you -- what's going to be done? I mean, to me, this is -- I mean, really, this is pathetic.

(Applause.)

MR. ROSEN: So here we are. I hope this is not a waste of time.

REP. DeLUCA: It's not a waste of time, we wouldn't be here today. It's not a waste of time. This is not an easy issue that we can wave a magic wand and correct the situation.

As Representative Boyd says, there's a lot of moving factors here, we're trying to get a handle on it. We've been working on healthcare. I think what the Commissioner is saying, we're one of two states that don't have the authority for small group reform.

House Bill 746 has been lingering over in the Senate that this Committee passed bipartisanly and the House passed for over a year, it hasn't moved. We are working on it. It's not our fault that we can't move it out of the Senate. Unfortunately, there's two bodies out there, but this House bipartisanly and this Committee bipartisanly has moved small group reform to the Senate which would give the Commissioner the power. He'll be up here, if you can leave that letter right on that table there, he's the next one to testify, we'll have him give you an explanation of this letter.

TRANSCRIPT OF PROCEEDINGS

\- - - -

Let me say this to you, we talk about jobs, we talk about economic development, and now we have three business people there and you stated that you were going to expand, and because of the healthcare issue that you weren't going to expand, because you couldn't afford it. I think there's nobody up here that doesn't understand that small businesses is the backbone of this country, we need to try to keep it. Healthcare is a big part of what your expenses are and what you are able to -- some of you are working on marginal profits.

I was in small business, you don't make that much. It's between expanding or covering your employees and yourself, you have the option to expand. I understand that. That's what these hearings are about as far as you say -- we are working on it.

This is not an issue that we are just having a dog and pony show. This Committee doesn't work like that. I don't work like that. We try to get answers. I have a problem with some of these insurance carriers, and that is that there's no competition out there. We went to UPMC and UPMC is trying to break into the Highmark market, they had approximately 69 or 70 percent. You mentioned the fact that you don't know what your premiums are going to be once they get a market share, who knows, so we don't know that.

I find it ironic that we do so much advertising in healthcare, we had boxes in every stadium, I don't know what that has to do with healthcare. I don't know what a million dollar sign has to do with UPMC down in the town has to do about healthcare.

(Applause.)

REP. DeLUCA: The money we spend for this advertising, maybe it would be better to reduce our premiums instead of -- because there is no competition out there. The only competition out there is for the younger groups, the insurance carriers come in and cherry pick the younger individuals, and naturally when you're young, you have less health problems, so naturally, you can afford to have less premiums, because they certainly -- and you have the statistics on it. We need to get a handle on that.

It galls me when I start seeing all these fancy brochures when it comes to my house that entices me to -- well, it doesn't entice me, but certainly it costs a lot of money and I don't know how much benefit it does, because of the fact there's no competition out there. So I think that that's one of the things we need to look at. Any questions?

Representative Grucela.

REP. GRUCELA: Just a comment, Mr. Chairman. I can't help it, but you opened the door for me to make a comment on the fact that the legislation is in the Senate. I have been an advocate of the unicameral legislature since you talked about reform, so I would only say that my idea, would it come to fruition, that you'd have a part of the solution. Thank you.

REP. DeLUCA: And with all due respect, he's absolutely right, because the House does all the work, the other Senate, the Senate is like the country club over here, it doesn't do anything, in my opinion. I could take that to the Senate and let them know that.

Representative Pashinski.

REP. PASHINSKI: Thank you, Mr. Chairman. Only the chairman can be so frank on that.

But if I could just share one thing with you, first of all, to all of you that are here today, the chairman thanked all of you, let me reinforce that again.

The only lobby that is going to be large enough to make the changes in healthcare that we need is you. Your stories impact across all party lines.

This should never be a political issue, this is about the health and the welfare of Americans.

I'm going to use a term called an Active American Humanitarianism. And Active American Humanitarianism, you know what, maybe you shouldn't make 19 percent profit, maybe you should make two; maybe you shouldn't make 15 percent, maybe you should make two. Why? Because that $30,000 that you're paying, that could be going back into the economy and getting us out of this economic recession.

(Applause.)

REP. PASHINSKI: We're not talking about small money here, we're talking about hundreds of billions of dollars. And that Active American Humanitarianism should go out to everybody. That is those humongous companies that are so large it's very difficult, you know, in order to change, but as an American and we as Americans, we have to work together on this.

And again, what the chairman indicated, we passed that legislation out of the House. We can't get it out of the Senate. This is where you guys come in. So your testimony is absolutely critical to make sure that everyone out there knows these are the facts, and it's not one political group against another. These are the facts. These are human stories of people of all political divides.

Thank you very much for your testimony, you're going to help your own cause. Thank you.

(Applause.)

REP. DeLUCA: Thank you. Chairman Sturla.

REP. STURLA: Thank you. I appreciate your testimony, because what we've heard here is, you talked about 30 to a hundred percent increases in premiums, you talked about when you were able to finally figure out a different insurance company, you had to make sure that the doctors still fit into that category that you wanted, so you were limited as to which insurance companies you might even be able to go with so that you could keep your doctor.

You talked about, you know, $7,000 deductibles, those kinds of things, and when I look at the recent debate that there has been on healthcare in the last couple of years, people were basically in the streets chanting about the fact that they didn't want a government-run health plan.

The only government-run health plan that there currently is is called Medicare and it's got about a three percent operating overhead. You can choose whatever doctor you want, you're guaranteed coverage, and that's the bad thing that people were protesting against, and then I hear these kinds of stories and I go, I don't understand why there's not the same outrage in the street. I think we're starting to see a little bit of it here, but when you all are talking about a 40 or 50 percent increase and not being able to even use your insurance that you paid for, because you have a $7,000 deductible and having to worry about which doctor you're able to go to, I start to wonder where the balance is here, what is it that we're going to do here.

And so I appreciate you bringing this information to us, because it arms us with information when people say we don't want you to do the adultBasic plan, we don't want you to do something else, we just want to have it be the free market system. Well, you just told me that the free market system, as it will, is killing you, it's killing you. And there's a point where either we got to figure out how to make that free market system work, by a consumer advocate or something else, or we got to figure out a different system. Because this is unsustainable.

(Applause.)

REP. DeLUCA: Thank you, Chairman.

Representative Boyd.

REP. BOYD: If I can ask a quick question, Carolyn -- is that okay if I call you Carolyn?

MS. FRANKS: Yes, it is.

REP. BOYD: In your testimony, you mentioned that after you panicked, you were told by an SMC representative that you can choose from different carriers and you specifically mentioned that something changed. What changed that gave you the ability to go from, what gave you the ability to go to UPMC then PPO? You said something changed. What changed, do you know offhand?

MS. FRANKS: You mean in my personal situation or with the SMC?

REP. BOYD: With SMC.

MS. FRANKS: I cannot answer that question. I was told I had further options, which we had not had in the past, but I cannot tell you why.

REP. BOYD: Okay. It would be nice if we could find that out at some point, Mr. Chairman.

REP. DeLUCA: If you could get that information, relay that information, we'd appreciate that. Any other questions?

Let me also state the fact that, you know, even though we are the representatives up here, we try to do our best, we're trying to get legislation passed, the public also has a role to play because our newspapers and our news media out there doesn't seem to cover this type of situation. If there was an elected official who happened to do something wrong, this place would be with helicopters, TV cameras and everybody else would be here.

This is a critical thing for people, it's not only the small business people, it's the people that don't have -- the uninsured, the uninsured people out there who can't afford any insurance because of the fact that they're -- some of them are making just a little bit more than minimum wage and they don't qualify. It has to be -- you need to put this out there to the public, to the news media and let them know what's going on, how it's affecting the businesses you have.

It's nice to send us letters and that, but you also need to get out there and talk to the newspapers, talk to the editorial boards. We need your help. That's what I'm trying to say. We need your help to help us, and nobody, no small businesses, like Representative Boyd, he's in a small business, and I was in years ago. Unfortunately, healthcare wasn't that high at that time, so we understand your plight and your -- we're looking to work for you.

MR. SNYDER: Is the news media here today?

REP. DeLUCA: Yes, the news media is here today, and that's why we had the hearings. The hearings bring out the news media.

We also need to -- when you're done out here, you also need to continue, you just don't have a hearing here and one story in the paper. It has to be a continuous thing. I say that to a lot of groups, because we just leave these hearings, and even though they get one-day coverage, PCN does a tremendous job, of all the people out there that are going to be watching this program to get that message out, because healthcare resonates with a lot of people, they know that their healthcare has gone up, the deductibles have gone up, the copays and everything else, so it's costing them a lot more money out of their pocket. The rates go up and also the copays go up, so it's a double hit.

We are working on it. As I said, we sent a bill over there into the Senate a year ago to address the situation. We're looking to work with them, we're looking to work with them, if they don't like it, send us something back. Tell us what they don't like about House Bill 746, we work together, we need to work together.

This stuff, partisanship, out there doesn't serve any of the citizens in Pennsylvania, that's from the national level down to the state level. It's time that we all understand that we are elected by all the people regardless of whether you're a Democrat, Republican, non-partisan, whatever you want to call it, we represent -- once we're elected, we should drop the party label and work for the people. That's the way I feel.

Again, I want to thank you for your testimony and certainly I look forward to your ideas on how we can change the situation.

(Applause.)

REP. DeLUCA: Next, we're going to bring up the insurance commissioner, Mr. Ario, and they left that correspondence for you so that you can look at it and maybe you might want to give them a response to what your staff is saying there.

Welcome, Commissioner, you certainly -- I have to say working with you has been an honor, you certainly had the citizens of Pennsylvania, as one of the few insurance commissioners, at heart. I want to commend you for that, you've been doing a tremendous job, it's not an easy job, and I just want to commend you for what you've been doing.

MR. ARIO: Thank you, Mr. Chairman, thank you, members of the Committee. It has a been a great partnership, I wish we could get the Senate into that partnership and have real health reform here in Pennsylvania.

I came here three years ago to be commissioner primarily to fight for healthcare reform, so it pains me to be in this room today and say that we have not gotten that job done. We just have hit gridlock, as it's been said repeatedly here, between the House and the Senate, so we just haven't gotten that job done.

We have made some progress: We said no to a consolidation, I think, that would have made things worse for consumers in this state. We passed some minor reforms, extended COBRA coverage, extended coverage to dependents, but the core issue of whether insurance companies should be able to look at you and say if you've got health problems, we're going to charge you a lot more money for insurance or we're going to drive you out of the market entirely, that needs to end. It needs to end now and that's why I'm here today to support that.

TRANSCRIPT OF PROCEEDINGS

\- - - -

I always have a mixed reaction when I listen to the stories that we hear today and we hear many more in our office. On the one hand, they pain me because there shouldn't be that situation. On the other, I'm inspired because when I go back to Harrisburg, I hear a lot of people say well, where are the problems? There aren't too many problems in healthcare, are there? And they just don't see the problems that are out there.

So this inspires me, too, to come here today and see that there are people demonstrating those problems and I couldn't agree more with what's been said this morning about how, in order to get this done, people have to continue to fight. It can't be done just by you at that table, it can't be done just by me at this table, there's a real fight going on out there for this whole country.

There are people who say that health reform that didn't pass federally ought to be rolled back, have too much government and that we ought to eliminate those. Those will make things worse, we need those reforms and I am here happy to tell you today, that in 2014, because of what the federal government did this year, this discrimination against people who are sick and charging people more money simply because they have healthcare costs is perverse, it's against health policy. The people who most need coverage are the people who have the health problems, and instead, the companies compete for all the people that don't need the care and don't compete for the people who actually need the product. And that will end in 2014 if it's not repealed. It's a fight. Again, people are saying they should repeal it, but we will get there.

What I want to talk about some today is what's going to happen between now and 2014, because as you point out, between now and 2014, Pennsylvania still sits with some of the weakest laws in the country.

I hate the language of this letter, Bruce, Gary, William, Mark, Carolyn, Bruce, another William, I hate that we have to write letters like this. We will go back and try to improve on the language, we don't need to have as technical an explanation of the issues, but the bottom line is, until the law changes, we can't force companies to practice their business different than they practice it today. So these kinds of things that people have testified on today, sometimes we look into the details and sometimes we find out that the companies didn't follow their own rules. That's what Roger is trying to say here, even though we don't have the authority to stop them, we can see if they didn't follow their own rules, and if they didn't, sometimes we can help consumers with the situation. But if they followed their own rules, which they get to set for themselves under the current law, we can't stop these kinds of practices. We did add the language in these letters, I know it's small talk for somebody who's suffering, but that's exactly the kind of person who needs to get out and tell their story to this Committee.

I commend the people who came here today, I know it's not easy to come and tell some of these very personal stories, but those are necessary parts of the reform effort that we have here. So that's what we're going to fight for.

I'm going to talk a little bit about a report that we released today, but frankly, it's a lot of technical gobbledegook about how we're trying to reform the market. It still basically comes down to the fact that it ought not to be legal for insurance companies to price insurance higher simply because somebody is sick. Again, that's going to be the law of the land in 2014. We ought to get there before 2014 in this state.

But we did an investigation to look at exactly the details of how that's done in the marketplace today and we did it because we have a long-standing concern with these practices, as you've said repeatedly, and I won't go into any more detail about it. House Bill 746, most of the problems that we're talking about today would be gone. So this group has done its work, it's up to the Senate to do its work.

So we took a look at what exactly does happen in the market absent those reforms and one of the practices we saw that we really don't like is the use of medical questionnaires, individual medical questionnaires in the business environment. And these questionnaires, probably a lot of people in this audience have seen them and had to fill them out, they're pretty invasive, they ask a lot of detailed questions and they not only end up hurting you on your insurance if you happen to answer any of the questions wrong about past claims, they can hurt on your insurance even if you have no claims yet, because they might show a diagnosis that somebody's computer program is going to show tomorrow will lead to claims. So they're not used just to penalize people for past claims, they're used to penalize people because their predictive models suggest that they might have some claims in the future if they have a certain diagnosis.

This is the kind of thing that will end, again, in 2014 and ought to end a lot sooner.

What we found in our study was that seven of the nine largest insurers in the state use those questionnaires. The only two who don't are ironically the carrier who is kind of on the hot seat today, Highmark, and I wouldn't let them off the hot seat, but I would say to you that they're one of two carriers that's not using the most invasive technology today and that they've agreed with us, under some pressure in the negotiation, not to use those questionnaires at least into the next administration, we can't control them after that.

So there is the potential for the situation with Highmark to get worse relating to those questionnaires, and they'll come up and tell you, if all the other companies that they're competing with get to use them and get to find out who's got expensive claims and push those people to the side or charge them a lot more money, then they're likely to do it, too. So their solution is the one I agree with, which is everybody ought to be prohibited from using those questionnaires, but I'll let them speak for themselves on that. So that's what we found, seven of the nine used it.

TRANSCRIPT OF PROCEEDINGS

\- - - -

Carriers like to say, well, gee, when you look into the details, not that many people are punished by these questionnaires, and the numbers we found them at, 12 percent, so about one out of eight people are punished by these or adversely affected by these questionnaires. So you say, well, that's not big a deal, 88 percent of the people are okay. Well, 12 percent of Pennsylvania is like a million people, so it's a lot of people.

And the question is, why is that fair? We do not allow large businesses to say gee, we've got a couple people who got cancer last year, let's kick them out of our insurance pool, use the questionnaire, and charge them in a separate -- it doesn't happen in the large business world. Why do we allow it in small business because one person out of two happens to have a claim, essentially segregate them out. So a small number of people, but a very big impact, and they're the people that most need the coverage. So it's just not acceptable and we need to make it end.

Now to Highmark in particular and then I'll take questions. Highmark, in spite of the fact of not using these questionnaires, they have done what all the other carriers in the market have done, which is get out from underneath -- we have a little shred of regulatory authority over certain non-profits and HMOs, the Blues have been busy getting out from underneath that coverage, so that they can be under the same kind of freedom from regulation as the commercial carriers are. Highmark was the last to do this and they did it this year. We had no authority to stop it. We've got proposals in the legislature, too, to close that loophole to stop that, but we don't have the authority right now to stop that. So they move that business, they're outside of our regulation, and that's even without questionnaires there are a lot of complaints.

In fact, Highmark has got more complaints than any other carrier in the last year with us, but again, it's mostly because everybody else is already rejecting all of the bad risks or charging them way up, and Highmark was kind of the only game in town, and now they're kind of starting to do the same thing as all the other carriers. So we have no good solutions for a lot of people in this market.

The right solution is something like Senate Bill 746, but we, in the meantime, will continue to keep the heat on Highmark, we will locate every one of those complaints, we'll do what we can, and then most importantly, from my perspective, I mean, fighting for healthcare reform has been my professional dedication for 15 years. I'm on my way to D.C. from here to fight again on some of those federal issues, because the implementation of that federal bill, there's a lot at stake in how that's done and it needs to be done in the right way, so that by 2014, nobody can tell the kind of stories that people told today.

But in the meantime, we need to try to change the situation here in Pennsylvania and I'm happy that you're holding this hearing and I really, really -- my hat's off to all the people who came here today to testify, because it is, you're right, the media doesn't cover this, they cover a scandal or something much more readily than they'll cover these kinds of stories. But if you just keep pounding it in day after day, eventually some of this will sink in. We just have to hope and will continue to struggle.

So with that, thanks for the opportunity and I'm happy to answer questions.

REP. DeLUCA: Thank you, Commissioner. You certainly have done a good job.

As you know, the high risk pool is supposed to be in place. Can you tell us when the application for the high risk pool coverage will be available?

MR. ARIO: Yes. I'm happy to report that

we will be taking applications for the high risk pool as of August 2nd, so we got a couple more weeks here. We have the Attorney General doing his due diligence under the laws, take a look at our contract and had a few questions and going back and forth for a few days, lost a week or two of time here answering questions, but the Attorney General did eventually sign off this week on the high risk pool, and so we will be taking applications as of August 2nd, and I think the coverage is likely to take effect around September 1st. I don't think we have that date for sure at this point. Highmark, by the way, will be the contractee for that coverage.

Now, on that, I have to hasten to add, again, it's a band-aid that will cover about 5,000 people with preexisting conditions who have been out of insurance for six months, so there's a Catch 22 here. If you really need coverage and you've been struggling to pay for it, you're not eligible, but if you didn't have coverage, those are the people who are eligible, we think we'll cover about 5,000 of them.

I think there's probably at least a hundred thousand people, maybe a couple hundred thousand who would qualify under the terms of this agreement. There's a million people uninsured in Pennsylvania, but this will provide real coverage and real needed service to about 5,000 Pennsylvanians over the next few years until, again, we get to the federal reforms in 2014.

REP. DeLUCA: How will this 5,000 that's going to be covered --

MR. ARIO: First come/first serve. I may do this, I just got this word this morning, but we'll be announcing that start date, we've already had some publicity out on the program in general. We had predicted an earlier date until we ran into this little snafu with the Attorney General on the contract and that put us back a little bit, but we will be again, publicizing. There will be a web page, Pennsylvania Fair Care it's called. Google the Pennsylvania Insurance Department and you'll find information about the high risk pool and how to apply. There will be, in the next few days, a lot more detail coming forward.

Somebody is showing me a BlackBerry. Somebody is saying that there's some technical issues that we still have to handle on the pool, so I don't know the answer to your question, but we're taking applications August 4th, but the pool will be up and running.

REP. STURLA: He said the 2nd. Now wait.

TRANSCRIPT OF PROCEEDINGS

- - - -

REP. DeLUCA: We want to make sure we get that information out to the public.

Also, Commissioner, we've been studying for several months and conducting an examination of the Pennsylvania healthcare insurance market to gauge the competitiveness out there. I know that has focused on the Blues, but also, did that focus on the small group markets?

MR. ARIO: Yes. Thank you for that question, because there's a paragraph in my testimony about this. We ran into some snags here, too.

The laws of this country are not that favorable to the public, they're more favorable to the insurance industry, frankly, on many of these areas, and so as we were trying to start these investigations, Highmark said well, we don't think you have the legal right to do this, they took us to Court. I think we would have won eventually, but we were hung up in the courts, but I'm happy to say that set of issues have settled out, too, now, and we are again moving forward on those examinations. They are changing focus. When we started them, we were looking at things like the Blues licensing system and how that worked. Now, because of health reform has really changed the world, the federal health reform, it is a major accomplishment.

It seems kind of a downer because of all the trouble we're still in, but we are -- there's sunshine at the end of the tunnel here with federal health reform, and so we've shifted those studies of the four different marketplaces; the four, basically Pittsburgh, Philadelphia, central PA, northeast PA into more focused on what is necessary to set the right conditions in those marketplaces, so when we have these insurance exchanges in 2014, and no more discrimination based on health status, will we have the right competitive situation.

You're absolutely right, some of the kinds of ways in which money is used today suggests maybe there's not as much competition as there should be. The exchanges, we hope, will bring some new competitive blood into those marketplaces. We have a hearing on Friday, some of the national carriers that haven't played in the small group market, like Cigna, are going to come and talk about how they may start playing in that marketplace under reform, because it will be a more competitive marketplace for them. So what used to be exams are now studies looking at competitive conditions in relation to the health reforms as of 2014.

TRANSCRIPT OF PROCEEDINGS

- - - -

REP. DeLUCA: The other thing I would like you to explain to the public is the fact that we are one of the two states that are against small group health --

MR. ARIO: Yes, that's correct. I was just astonished when I got here in 2007, because I was looking more at the consolidation and the Governor, by the way, had a very good comprehensive health reform package back then. Parts of that package have passed into law, some of the cost control measures, like hospital infections and so forth, but some of the core provisions that had to do with ending health discrimination against people that have health conditions did not, did not pass. And so when I got here, I looked and saw why would we not have health reform in this state, like 48 other states have, and the basic answer is why we haven't gotten to this, because in the '90s, when most states were doing that, these things tend to happen in waves of reform, the Blue Cross and Blue Shield companies here in Pennsylvania, which have always been dominant, were basically community rating or doing adjusted community rating, things that were pretty close to what other states were having to pass laws to get all the insurance companies to do.

So the commercial carriers basically got to skate because the argument was well, we don't need laws like this in Pennsylvania, because the Blues are there, the community rate and the pool for everybody and the commercial carriers can meanwhile go ahead and cherry pick the market and so forth. That was the kind of theory that, one, Mr. Marshall is very adept at arguing this particular theory, but it was very predictable, but over time, if somebody over here can cherry pick the best risk and somebody over here is taking everybody, these guys are going to figure out a way to compete with these guys over here, and so now you have all the Blues creating their for-profit subsidiaries and competing with the commercial carriers to cherry pick the best business, to keep their pools over here for people who are sick. Well, guess what, the costs are five and ten times as much as they are over here. It's a bad system. It will change in 2014. It ought to change earlier.

REP. DeLUCA: Now, do you have more authority for the non-profits than you do for the for-profits?

MR. ARIO: Correct. We have authority over the Blues and their non-profit manifestation and we have authority over HMOs in the small group market.

TRANSCRIPT OF PROCEEDINGS

- - - -

We do not have authority over the for-profit subsidiaries or the Blues or over the commercial carriers.

We also, in the individual market, which is a much tougher marketplace, we have authority over everybody, but in that marketplace, until we have the notion that everybody needs to have insurance, that's a very difficult marketplace to change, because if you, today in that marketplace, if you say to people, you could come in to the market whenever you want and we won't penalize you at all if you're sick, then you would have people say, well, then, why would I buy insurance before I get sick. It's like trying to sell somebody flood insurance and saying, you could buy it the day after the flood for the same price as the day before, people tend not to buy it until the day after the flood. So it doesn't work in the individual market without the mandate, but when we have the mandate in 2014, then we'll have reform in that market, too.

REP. DeLUCA: So let me understand this, Commissioner, if you had a bill like 746 that's over in the Senate, you would be able to maybe scrutinize these raises a little bit more than we're hearing today from some of these carriers?

TRANSCRIPT OF PROCEEDINGS

- - - -

MR. ARIO: We already -- a lot of the work goes on behind the scenes, every one of the Blue Cross/Blue Shield plans, for instance, filed rate increases with us in the individual market where we do have authority over them back in the summer and they all had rate increases of 20 percent plus on some of their products. Part of it is instead having a rate increase for everybody that's the same, equal, you know, that would be like medical trend, that would be understandable, they have 30 percent for this little sliver, ten percent for this sliver, 58 percent for this sliver, it's all sliced and diced in that sort of way.

So we've looked at those and we said you know what, we're not giving you any of those increases over ten percent until you explain to us exactly how you sliced this piece over here and this piece over here and by the time we were done talking to them, they said well, we'll just take those ten percent increases. So that's what happened in the individual market with them this summer.

And that's basically, by the way, what's happening around the country when companies come in and say I need a 40 percent rate increase. They're not trying to get 40 percent for everybody, no company gets that big a rate increase, but they're getting it for certain little segments of the market over here, all of which is going to complicate reform in 2014 when they do have to spread the costs across everybody at a equal --

REP. DeLUCA: Chairman Sturla.

REP. STURLA: Just a couple of quick comments. You know, when you read the letter, it seems to me that basically what you're saying is, the company is pillaging consistent with the manner that they said they were going to pillage and basically you have no control over that at this point in time, correct?

MR. ARIO: Correct.

REP. STURLA: And that gets to the next point, that there's this mantra out there now that seems to be that regulation is what's killing us, that's what's costing us all the money, and yet, you seem to be saying that the fact that you can't regulate is what's costing these people all this money. In fact, regulation in this particular instance anyway is good for the consumer.

MR. ARIO: Absolutely. This notion that if we could just deregulate everything that we would be in nirvana, if that were the case, the advice to the developing countries in Africa and elsewhere would be easy, get rid of your government and then everything will go just hunky-dory. It doesn't work the way. Actually, the way in which an economy produces well and succeeds is to have very complicated rules and regulations.

Every big industrial country has extremely complicated laws, and guess who uses most of the lawyers? The businesses use most of the lawyers to make those laws and to protect themselves. Getting rid of the laws doesn't work. If it did, then the most successful countries tend to be the ones that have no government. And it works the opposite way. So yes, you're absolutely right, some of these need to be effectively regulated, not stupidly regulated, but effectively regulated.

REP. STURLA: Thanks.

REP. DeLUCA: Representative Kotik.

REP. KOTIK: Thank you, Mr. Chairman. Commissioner Ario, thank you for your testimony.

I'd just like to get some clarification on the program dealing with preexisting conditions. Now, the money that we're saving from the federal government, how long will that last?

MR. ARIO: We hope it will last all the

way to 2014, but we don't know that. The actuaries have looked at what they think it will cost, the premiums on that program are 280 bucks a month, or 282, something in that range, and so they predicted how much of a subsidy there will be and then the 5,000 number they used is what we think today will be how many people we can serve in any given month, and that that would make the money last until 2014. But if it turns out either costs are cheaper or costs are more expensive, we might have to adjust those numbers. We're trying to have the money last until 2014. Some people predict the money will run out sooner, and this is a limited program and so if the money does run out, then there will be another gap in service before 2014.

REP. KOTIK: So you have no assurances from the federal government that they're going to up some more money when this original money runs out?

MR. ARIO: No. The only assurance we have from the federal government is that we are not going to be required to put state money in to fill any shortfall, that the program may terminate, but there will be no obligation on the state to provide money for this program. There are people who think, depending on how elections come out and that sort of thing, that if there's a shortfall, we're moving towards reform, people will get the idea, just like people now do, seriously, people who are in Medicare say keep the government off my Medicare, because once they have it, they think they're entitled to it, and people may get a sense of entitlement to someone's healthcare and then they may push harder and we may have more money for these programs before 2014, but that would depend on an act of Congress.

REP. KOTIK: So wouldn't it be wiser for us on the state level to plan for the contingency that in the event that the money does run out prior to 2014, that we step in, because I can't see leaving 5,000, or whatever the number of people, hanging because of the fact that the money runs out. I've introduced legislation to set up our own pool, working with Chairman DeLuca and Art McNulty, the executive director, to plan for that contingency in the event the federal money is exhausted prior to 2014.

MR. ARIO: I think it's a farsighted thing to look at and to do, yes. As you know, we're still struggling with how to fund the adultBasic program on a go-forward basis, but yes, when you have those kinds of programs, you should be planning to have for contingencies and one of them might be that we would need some money. Again, the state is not --

so it's not misconstrued here, the state is not going to be required to do any of what you suggest, but it is certainly an opportunity that the state could provide or be planning for and providing for.

REP. KOTIK: Thank you very much. Thank you, Mr. Chairman.

REP. DeLUCA: Thank you, Representative Kotik. Representative Boyd.

REP. BOYD: Thank you, Mr. Chairman. Commissioner, good to see you. I have a number of questions for you.

And I guess the first question I want to ask is: The two panels that were here in the beginning prior to you who testified, particularly, the ones that mentioned their specific increases in premiums that they were facing, exactly how does 746 change that?

MR. ARIO: First of all, it says health status cannot be used at all in the pricing of insurance. So any of those increases that relate to somebody's husband has cancer or somebody had an expensive claim last year, whatever, none of that kind of information can be used at all in the pricing of insurance. So it would eliminate that, that part of it, immediately.

And then secondly, the next biggest factor in insurance pricing is age, which I'm getting painfully aware of as I age up, but 20 year olds are a lot cheaper in general than 60 year olds in terms of healthcare costs, so you get a lot of age discrimination in healthcare costs, too. And discrimination is not necessarily a bad word in insurance, but it is discrimination between people based on age. The bill says two to one, we can only charge people who are 60 twice as much as 20. Insurance companies today, they charge them like six times as much, so that would also be eliminated. You notice there are people that are 20 who have serious health problems, but the people today, I better not -- I was going to say more like my age, but I better be careful because I don't remember everybody that was up here.

REP. BOYD: I appreciate what you're saying. The reason I ask is specifically, Mr. Price, who was the attorney, he said I have no idea, nothing has changed in my life, his family, and there weren't any preexisting conditions, it's just that his premiums went up and it was a renewal of the policy, it wasn't a new policy.

Ms. Franks, Franks Auto Service, and I want to know, what's in 746 that would have precluded those premiums for those people that didn't appear to have any substantive life changes, their premiums just went up?

MR. ARIO: My guess is, it's those questionnaires, Representative, that have some information in them that even though they don't show a claim yet, have a predictive possibility, based on what was answered on that questionnaire, that claims are going to go up in the future. Insurance companies aren't stupid, they don't just go around raising rates just with no basis for it, they do have a basis and it's going to be that they think there's something in the record, again, if the laws don't prohibit it, they think there's something in the record that this person is maybe going to cost me money and I don't want to spread that cost across everybody, I want to keep that person out of my pool. That's what goes on.

One thing, though, that you and I probably could agree on, would be the transparency issue. It would be a much better world, and we're fighting for this, too, this is also in 746, and the federal government, by the way, has some new authority on this area and we're going to see more, is the system ought to be more transparent. You ought to be able to go up on the web page and figure out exactly what it is that you're being charged for, what factors play into it and so forth. And those efforts, we just pursued a million dollar grant from the federal government to open up that process.

Our process is much more open today than it was when I got here three years ago. It needs to be a lot more open than it is today, so we're going to continue to make it more transparent and then people could go up and answer that question very specifically.

REP. BOYD: Again, I'm kind of coming back to the individuals who testified, and the reason I'm doing that is because we're focusing a lot on House Bill 746 and, you know, encouraging, and I'm using the word graciously, encouraging our brethren in the other side of the building to take up 746. I'm one that believes that 746 is not the silver bullet and I just want to be clear in saying that I don't know that these people on their policy renewals, and they're probably still in the room, had to answer another set of questionnaires about what changed for them when their policy expired.

MR. ARIO: I could tell you this, I don't remember all the numbers, but any number that's over

15 percent, that is not because the carrier is collecting more than 15 percent from every single policyholder, not because they're spreading their increased costs across everybody. It's because they're singling out certain people over here to charge them more. That's what 746 gets at, so it does solve that particular problem.

There are other things that you and I could dispute about the bill, whether it will control overall costs and so forth, but any time you see 20 and 30 percent rate increases, those will not happen in a world in which the costs are spread evenly across large populations.

REP. BOYD: So the renewal rates that were discussed in the room, you're absolutely certain if 746 passed, that those renewal rates could not take place, that there could not be a renewal rate for someone and their premium go up more than 15 percent?

MR. ARIO: There would be extremely rare situations where, say, if a business has only four, 20-year-old employees today, and tomorrow they have only four 60-year-olds and even under the reforms, because they do allow some differentiation of rate, you could have jumps that might be like 20 percent. You wouldn't have anything like 50 percent like we have now or 80 percent and some people, I think, testified to more than a hundred percent, but you could have some significant jumps, because it does allow a rating based on age, and the federal reform would allow rating based on age.

But anybody who did have a connection between their health premium, and usually most people do, and I thought most people testified had some notion of the connection between their health status and their premium. Those things are affected by -- would be affected by something like 746. And again, remember 746, that's going to be the law of the land under the federal reform in 2014.

REP. BOYD: Right, 746 as it currently exists, I imagine based on that, that passed prior to the federal bill passing, so there's going to need to be some changes to 746 to bring that.

MR. ARIO: It's only necessary between now and 2014. After 2014, the federal reforms will supercede it.

REP. BOYD: Right, but assuming that we're making some headway with our friends across the building, to get 746 run, it's going to need to be amended to come into compliance with the federal bill.

MR. ARIO: It might make sense, we

wouldn't have to do it, we could have different rules between now and 2014, but I think your point is well taken, and it might make sense to try to conform them, two to one rate band on ages. The further bill says three to one, so you can charge older people three times as much as younger people. Those are kind of tough policies. One that's not tough for me is whether you should be able to penalize people because they get cancer --

REP. BOYD: And I'm not questioning that, I'm focusing -- I didn't hear the people in the room say -- I heard them say nothing changed in my life, I went from today and my premium -- my business's premiums, we just got a renewal rate, it's up 27 percent and nothing has changed. So the question becomes, under 746, can I tell my staff, can I tell my 60,000 people that if we pass 746 that we can guarantee premiums will not increase more than 15 percent annually?

MR. ARIO: Again, it depends on if you have complete community rating, medical trend should never be more than 15 percent. We've had medical trend, the average increase in health spending has been in the six, seven, eight percent range for the last several years. It's not a good situation. You have eight percent times ten years, you've doubled your rate. So that still is a significant increase, but you talk about 20, that is not because the company is charging everybody.

I'll give you the numbers on Highmark's most recent set of increases. They answered some questions for us, five percent of the people paid more than -- had a 50 percent increase or more; ten percent had a decrease in rates. They said if they had done the average, it would have been somewhere in the teens. So that's an example of where, you know, if you slice and dice, you get different, you get extremes. Whereas, if you spread, you get a lower rate.

REP. BOYD: I'm glad that you brought that up, because again, for the folks in the room, it's important to recognize that, and I'll piggyback on something that Representative Sturla said, basically the net effect of 746 is to sort of spread this load, that's what it does, it spreads the load, and so if you are a small group that has specific people that are -- their premiums are lower, they're probably going to be paying higher. That's the net effect of this, is that it's going to spread things out, particularly for a guy like myself who's now crested the half-century mark and I'm on the upswing.

Of course, my 23-year-old son, it's actually going to increase probably the premium that's being charged to his company where he works, because it's going to be doing this spreading out.

And Representative Sturla's comment that regulation controls costs, I would at least offer that there's some other viewpoints and one of those viewpoints is, the competition is absolutely in transparency, giving these folks in the room the ability to shop among a dozen insurers instead of one or two and, you know, you know I was a massive advocate of allowing Capital Blue Cross to write statewide when the merger was proposed.

So I'm suggesting that 746 is a part of the package, but I still think I would like to see these people be able to buy insurance across state lines. That's a bill that we had talked about in the House. So that if there's an insurer that's offering a product over in Ohio and it's a competitive product and they can buy it here, why shouldn't they be allowed to do that?

MR. ARIO: Anybody that wants to sell their product in Pennsylvania can do so, they just have to comply with our consumer protection laws. And so if you say you want a company in Ohio to be able to sell here without any consumer protection, the question is what do you exactly mean by that, do you mean that they don't have to pay claims, they shouldn't be subject to any regulation if they refuse to pay claims, or what level of consumer protection do you want to cut them out of that applies to other companies in Pennsylvania?

But any company that wants to comply with our consumer protection laws already can sell in Pennsylvania and most of them do. Aetna is in almost every state. United is in almost every state. So the question is whether they get to -- the out-of-state companies get to comply with a lesser set of laws than the in-state companies, and you may be advocating that, it's a hard question about which consumer protection laws shouldn't apply to the Ohio company that do apply to the Pennsylvania company.

REP. BOYD: Well, there's other issues that go along with that and it's the mandate moratoriums, every time we put another mandate on, potentially we're increasing the potential cost. So, again, the point that I'm trying to get at is for people to understand what the net effect of these bills do. All right. They're going to increase premiums for some people, they'll decrease premiums for other people, they will have a stabilizing impact, and I think that's absolutely true. As a business person, I don't like unpredictable costs, but I also don't necessarily believe that government regulation is the only way to control costs.

There was an article that just came out not too long ago on the ten items that are cheaper now than they were 20 years ago, and I can guarantee you that every one of them is not a regulated item, the market forces do help drive costs down. Competition is a good thing, transparency is a good thing. So anything in these regulations that, in my opinion, that facilitate and enhance a competitive marketplace are positive reforms as well, not just --

MR. ARIO: I do not disagree, broad strokes, with the notion that we want to combine competition with regulation in an effective manner. The federal reform is a not single-payer system that wipes out all competition, it also wasn't a let it rip in the marketplace with no regulation. It's a delicate balancing of those two things that will get us the best results. Many of your points are well taken, I would agree with much of what you said, not all of it, though.

REP. DeLUCA: Commissioner, you're going

to have to stay here to lobby a couple of people. The reporter needs a break and there is a -- there's a Mercury Mariner that's blocking the driveway.

(Recess.)

REP. DeLUCA: Representative Longietti, you're next.

REP. LONGIETTI: Thank you, Mr. Chairman. I'll be brief. Thank you.

We've heard some terminology today, medical underwriting, computer predictive modeling, questionnaires, assisting computer predictive modeling. I have a two-part question. One is, can you distinguish between those, is there a difference between medical underwriting and computer predictive modeling with or without questionnaires; and No. 2, I think it was indicated that Highmark doesn't use questionnaires, but they do computer predictive modeling. What information would they be including in their modeling, age, gender, past claims, is there something else -- if you have -- but first off, is there a distinction between medical underwriting and --

MR. ARIO: Yes, there's a distinction. I'm going to try to stay out of the weeds here, because we can get very nerdish and very complicated very quickly, but basically medical underwriting means that you're using medical information to decide -- technically, underwriting means to decide whether you're going to take the risk or not, but the term has come to be used in this state to also mean how much you're going to price the insurance. That would technically be medical rating, not medical underwriting, but it refers to the use of medical information of some sort to either decide yes or no on the risk or to price the risk.

Computer predictive modeling can use any number of factors, it could be medical, but it could also be age and demographics, type of business. I think all insurers today in the small group market use what are called SIC codes to determine what kind of industry it is, those sort of things. So computer modeling can be done on any number of variables, it's not necessarily the type of medical variables.

REP. LONGIETTI: So with computer predictive modeling, particularly I'm thinking to the questionnaires, I'm assuming they're asking some medical information, perhaps, family history?

MR. ARIO: So they're probably all both medical underwriting and predictive modeling together.

REP. LONGIETTI: So in other words, with

TRANSCRIPT OF PROCEEDINGS

\- - - -

the computer predictive modeling, why can we not say that they cannot use medical information as part of their modeling, if you're saying we really don't permit medical underwriting or medical ratings.

MR. ARIO: Well, today we do permit medical underwriting and rating. Those models won't be usable for those purposes after 2014.

There's an argument, by the way, today that some of the questioning is illegal under federal law that prohibits people from being punished because of their genetic, your DNA basically, and so some of these questions may arguably be getting at questions that are essentially punishing people because they have a certain genetic makeup, and the question gets at that, and that is prohibited now because, guess what? If people knew they were going to be punished on their healthcare for their genetic makeup, people probably wouldn't want to find out too much about their makeup. So there are laws on some of these issues --

Healthcare is just different than other things. If I'm, you know, a driver who has had a great driving record for ten, 20 years, and all of a sudden, I have three bad claims, in a year, three accidents, say, I expect to pay more for my insurance,

TRANSCRIPT OF PROCEEDINGS

- - - -

I think most people do, but you ask somebody who has paid on a healthcare policy for ten, 20 years and now they get cancer, should they be punished on their health premium for that, most people would say no. So healthcare, use of health information is different than kind of predictive modeling might be in other forms of insurance.

REP. LONGIETTI: It's my understanding that Highmark claims that they don't medical underwrite, they don't medically rate.

MR. ARIO: That's correct.

REP. LONGIETTI: Yet, they do use computer predictive modeling to price out their plan or to determine whether somebody is going to be declined. Is there a difference? Are they using medical information, do we know that? Is there a way for us to know whether or not they're using medical information?

MR. ARIO: There's going to be a very fine line here, you're correct. I think you should ask these questions to Highmark, but I think what they'll probably tell you generally is we don't use these questionnaires on the front end when we do business, but yes, but when we have -- it comes to renewal of a current client, we look at their claims experience, which is really a form of looking at their medical experience and so they do use that information at renewal time.

REP. LONGIETTI: So the lines seem pretty blurred at this point?

MR. ARIO: Yes. Once we reform market in 2014, it's going to be a whole lot simpler to buying insurance. In Massachusetts, where you have the exchanges, people can buy insurance within 20 minutes on the web site, because you don't have to go through all these medical questions and details about your health history, because they can't be used to price the insurance, so it simplifies the whole process, makes it more efficient, makes it more competitive. It's very good for Representative Boyd and the competition advocates to streamline the process.

REP. LONGIETTI: Thank you. Thank you very much.

MR. ARIO: Thank you.

REP. DeLUCA: Representative Frankel.

REP. FRANKEL: Thank you, Mr. Chairman. Thank you, Commissioner, for being here today.

One of the things that we've heard from some of the testimony this morning was that folks are being really forced into policy options that contain very high deductibles, very high copayments and as a result, I think Ms. Franks and Mr. Price both expressed the fact that they try not to utilize their insurance until there's something catastrophic that takes place.

I'm wondering, because, you know, we've talked about the cost that drives the healthcare system is sometimes the overutilization of the healthcare system by individuals, but this, on the other hand, as folks are forced into these high deductible programs, seems to me could exacerbate costs within the healthcare system as people don't seek preventive care, don't go to seek interventions when something strikes them as not being right early, and then you're faced with chronic illness or a catastrophic health instance. Any sense of that type of thing taking place out there?

MR. ARIO: Representative Frankel, very good question. You're drilling into one of the -- the kind of the complex issues here, and the federal reform on this tries to strike a balance, there's certain kinds of preventive services have to be available with no cost sharing, because we definitely know that they promote health, and we want everybody to get those preventive services and not be an incentive to maybe avoid them, because there's a high copay on them.

On the other hand, we're not going to solve our healthcare problems if we don't have as a general matter, consumers have, quote/unquote, more skin in the game, as the insurers like to say. So the use of higher cost sharing is generally a good thing within reason. It's helped drive the people away from brand name drugs into prescription drugs that do just as good. The drug companies are very good about advertising and making people think they need brand names when, in fact, the science says the generic does just as good a job. Pure pricing works to send people the right way, you're not going to force people away from the brand, but they'll just pay more if they want to use them.

So when is it something that ought to be no copays, like preventive service versus a significant copay to use a brand name drug, where do you draw those lines? There are a lot of experts who are looking at that, those issues will be part of defining the essential benefit plan under the federal law, but I do think -- a little known fact about the federal bill, is it allows for wellness incentives of up to 35 percent. So we made reference to people who smoke, they can be charged a lot more for insurance because that causes health problems. All those sorts of incentives should be built into our system.

Premiums are a particularly poor way to do that, actually, because they punish people for things that they have no control over, like a genetic disease, and they don't reward you for quitting smoking because it doesn't show up for years. So wellness incentives actually does -- could be it.

REP. FRANKEL: I think skin in the game is important, but a several thousand dollars deductible is a different issue, that's more than the skin in the game for a lot of people. So there needs to be a balance.

MR. ARIO: Yeah, and under the federal reforms, again, the companies have to offer -- if they're going to offer those in the market, they have to also offer richer benefit plans, so there's choice for people. It will cost you more if you want the richer benefit, but it should be available to you.

REP. FRANKEL: Thank you.

REP. DeLUCA: Representative Pashinski.

REP. PASHINSKI: Thank you, Mr. Chairman. Mr. Secretary, I have three short things here.

First of all, as we've discussed this and in

TRANSCRIPT OF PROCEEDINGS

- - - -

our plight to try to balance all the things that we need to do, for the record, could you prioritize what you believe needs to be done in some kind of an order to help balance this system so that the insurers can still stay in business and make somewhat of a profit, and yet reduce those premiums or at least control those premium costs so it doesn't put everybody else out of business?

MR. ARIO: Well, the first thing you have to do is what Massachusetts did and what every other country in the world has done, is to get everybody in the system. So coverage has to be the first thing and the way we do it in our system, unless we're going to have a single payer, if you're going to have competitive insurance companies, then you have to say if insurance companies have to take everybody, then everybody has to take up an offer, everybody has to participate, there's no dues, union dues and whatever, you have to have that. Romney called it personal responsibility. Obamacare was Romneycare before it was Obamacare, but that notion of getting everybody in in Massachusetts shows you can do it, you can get 97, 98, whatever, it's America, whatever you get, you can't get hundred percent of the people doing the same thing on anything, so 97, 98, that's pretty good.

TRANSCRIPT OF PROCEEDINGS

- - - -

Once you have that, then you can have much more rational discussion of how to control costs. As long as there are people outside of that system, that conversation never works, because it's a balloon, you squeeze here and the balloon opens up over here, and you got cost shifts going in different directions, and all it is is a huge equity argument about whose back are we saving money on. And so the idea of save money in the system by kicking people out of the system, it doesn't work very well, and it's not fair, and so forth.

So now you got everyone in the system, then you do have to do cost control and this is why I'm defending insurance, the principal cost drivers are not with the insurance companies, we take all the profits of all of the insurance companies and all of the earnings of the non-profit insurance companies and all the executive compensation, all that, and it would pay for a couple days worth of healthcare per year.

So it's a factor that you need to squeeze on, just like you squeeze on every other factor, but the costs are in the delivery system and that's where you have to get at things and there, the first thing you have to do is, it's not rocket science, you have to stop paying fee for service medicine. If you pay people for volume in business, you get what you pay for, you're going to get volume. So you have to change the system.

Some people talk about the ways in which they experimented in combining the costs so that you don't pay for the heart surgery once when you come in and then if you get a complication, they actually benefit, because they get to charge you again. It ought to be one price and bundled payments and ultimately global payments. That needs to all happen on steroids in our system and the federal bill is set up to do all of that. It does have that, it's all done in pilot programs, it's going to have to be ratcheted up, but it's there, use of higher quality medicine and then these wellness incentives.

So cost control is absolutely essential. Every other country in the world, first they got everybody in and then they controlled the cost. The idea that in America we can't do that and the idea that people say, well, it's just common sense if you cover more people, it's going to cost more. No, it's not common sense, because look at the record, every other country in the world covers everybody and pays less than us. Dah? I mean you think it would be something that people would say gee, if that's the record of every single country, maybe there is a connection here, but in this country people still fight about that.

REP. PASHINSKI: And I appreciate that and that needs to be said many times over. So every time I see you, I'm going to ask you that question.

MR. ARIO: I'll try to get shorter and shorter with my description of it.

REP. PASHINSKI: The second thing is, do you agree that we should be able to have, with all the information we have, with all the data that we've collected over the years, the cost of different kinds of procedures that there should be a standardized rating set of formulas so that you should have some idea of what to charge?

MR. ARIO: Yes, I don't think you could get to, you know, bill charges in the sense of that we have workers' comp for everything, I think you want the competition thing in there and you want transparency as part of it, but we should definitely make issue of the fact that in this part of the country, it costs three times as much for the same kind of situation. It's interesting, usually, those things, medicine is complicated, but usually, back surgeries seem to be more expensive in particular areas, probably because there's more utilization of back surgery, and it's probably because there happen to be more back surgeons in that part of the world. You know, so supply drives demand and so forth. So you do need to, I think, get rid of some of these disparities and there's things in this bill that do that as well, but you'll never be completely rid of them.

REP. PASHINSKI: I understand there are various parts of the country demand a different charge, but there should be a -- I was thinking about the gentleman that testified earlier where he couldn't get the insurance company to define for he and his family why the insurance costs were going through the roof, because they wouldn't allow him to have the information by which they would be developing that premium. And my point here is that I believe we do have enough information, we've done a bazillion operations and procedures, we should have a pretty standard idea of what it would cost. It would vary slightly from region to region, state to state, but there should be some kind of basic formula that you work with.

MR. ARIO: And people want standardization. We talk about choice, people want choices, but every kind of marketing research that's done on this shows that people want a reasonable number of choices, but then at some level, too many choices become disempowering and confusing to people, so it's hitting the sweet spot, enough choices to give people a choice, but also not so many, such a proliferation of non-standardized this or that that you can't -- it's too hard to figure out.

REP. PASHINSKI: And I appreciate that. And the very last thing I'm going to ask you, you developed a ceiling level of ten percent, when the insurance companies requested rates well beyond the ten percent, 30, 40 percent that were the non-profits, that you have some ability to control, you put a ceiling rate at ten percent which they ended up accepting. Why would it be ten percent, why not five?

MR. ARIO: First of all, we didn't put an absolute ceiling, we just said if you want to get more than that, then you need to show us the whole book and show us that the whole book of business actually is over ten percent and that it's not -- the reason these rate increases are over ten percent is not because you're discriminating against this group over here versus this group, it's because everything is more expensive. The reason we chose ten is because, as I said before, medical inflation is over five, so ten was a little generous actually because medical inflation may be six or seven. I think as we get more and more transparency in the marketplace, these things will be, you know, the margins will be tighter and tighter probably. Health insurance is still -- the stock market and companies that are on the stock market is still doing well, but they're probably going to have narrower margins in the future than they've had in the past.

REP. PASHINSKI: Thank you. I appreciate it.

REP. DeLUCA: Just one question, Commissioner. You mentioned the fact that, I think it's one -- Representative Frankel -- that we need to have everybody in the system. I think, if I'm not mistaken, doesn't uncompensated care to the uninsured cost us about nine percent in our premiums, the nine to ten percent of our premiums, does that play a part in our premiums?

MR. ARIO: Yes. Mr. Chairman, you're absolutely right, the nine percent, seven percent, whatever that number is is calculated in different ways. America is too generous a country in the end to say sorry, you don't have insurance, you'll die on the street out here. It happens, but it doesn't happen with a lot of frequency. Most of the time, people end up in an emergency room at the expense of and to the continuum when they can't get their care earlier, and so forth, and we have laws that say you can't just kick people out of the emergency room, you have to stabilize them. And so that does end up costing a fair amount of money for the hospital system, and then of course, they have to charge other payers to make up for those costs and so that ends up being a load on everybody's premium.

REP. DeLUCA: And as we continue to increase the individuals without healthcare, that means we continue to increase our premiums because, in fact, we are paying for it, the ones who have healthcare, there's no free lunch out there. We are paying for them people that are uninsured. A lot of people don't understand, but some of these uninsured people go to the emergency room, they're paying their premiums, because they raise the price of the hospitals.

MR. ARIO: Yes, you're absolutely right. And for a number of -- that's one very important thing, there's a whole litany of reasons why you will not ever have an effective rational healthcare system until you have everybody a part of that system. Again, that's -- there's no other country that doesn't achieve that in the industrial world.

REP. DeLUCA: I just want to say something, just on behalf of my good friend, Representative Boyd, and maybe I could be wrong, but I haven't seen deregulation benefit anybody as far as cost in the last ten or 15 years. Deregulated the airline industry, our costs went up; telephone industry, our costs went up. I don't know where we get this stuff, the trucking industry, we got trucks going out there with unsafe tires, so not to take -- but if deregulation helps, I'm all for it.

Thank you, Mr. Commissioner. Representative Roae.

REP. ROAE: Thank you, Mr. Chairman, and thank you, Commissioner.

Sometimes when you look at things like how expensive property taxes are, everybody wants to look at what you can do to better fund schools, nobody ever wants to look at the cost of schools. Well, with health insurance, it's kind of the same thing. Everybody always talks about how to cut the cost of healthcare and what you pay in premiums and I think a lot of it has to do with things that we do for ourselves. For example, what percentage of healthcare costs do you think could be attributed to people being overweight, drinking too much, smoking too much, not wearing seat belts, you know, having unprotected sex, the things that increase the cost, regardless of whether we have the government paying for healthcare or individual plans or the bill that we're talking about here today, it seems like probably a third or a half of the costs are a hundred percent avoidable.

Do you have any figures on that, sir?

MR. ARIO: I think it's a very good question, works in with several of my answers earlier, the notion of wellness incentives. I think it is very important to address these behavioral issues.

There's no question about that, the ones you ticked off, I won't get your whole list, but just take smoking, obesity and drug abuse, alcohol and drug abuse, those three things, if we could get a better handle on those behaviors, we could save substantial amounts of money.

I've seen presentations where medical personnel have pointed out that we are in danger of actually going backwards on health in our country because of the games that we make, and we do -- part of the reason our system is as expensive as it is, because the drugs that we use today are so much better than the drugs we used only ten years ago and 20 years ago, so there are improvements in health, but all of that technical improvement that we make is in danger of being overrun by the behavioral deterioration. I mean, you go into any other country in the world and look around and go, Americans really are obese. I mean, they are.

And so all of those things I think have to be addressed and part of a good health reform is to say we're going to give people targeted incentives to engage in the healthy behavior. So you take a medical questionnaire, get a break on your healthcare, if you actually achieve weight loss, you get a break on your healthcare. Those are things that should be part of the system and they are in some of the leading companies and they achieve pretty amazing successes with that.

Again, the insurance companies will say well, the way to do that is premiums. Premiums are a very poor way to do it. They penalize people for things they have no control over and they don't reward things that people have a lot of control over, that should happen, like quitting smoking. So you want something that's targeted and I think your point is well taken and then, you know, you get to the end of the list and you start saying which things is the government going to be involved in and which aren't they.

REP. ROAE: It just seems like most of the argument that takes place on our national and state level, there's so much money that has to get paid, everybody is fighting over how you divide out the total cost that needs to be paid, and I think the argument should be more of how to reduce that overall cost and just things that we do ourselves.

If somebody gets struck by lighting or if somebody gets hit by a drunk driver, something like that, they don't really have control over that, but we can all control what we eat, what we smoke, what we drink, and I think any kind of a solution at a state or national level is going to have to involve all the people in the country taking more responsibility on their own behavior. Thank you, sir.

MR. ARIO: Point well taken.

REP. DeLUCA: Thank you, Commissioner. As always, thank you for your excellent testimony and being willing to come out here and certainly answer the questions.

MR. ARIO: I just feel like I'm preaching to the choir here, because you guys have done your

TRANSCRIPT OF PROCEEDINGS

- - - -

work, you just need to get the Senate to do its work.

REP. DeLUCA: Well, we appreciate that very much. Thank you.

(Applause.)

REP. DeLUCA: Next panel would be James Fawcett, the senior vice president, Small Group and Individual Market; Mike Warfel, vice president, government affairs for Highmark. Welcome both of you, gentlemen.

You heard the testimony out there, you heard the complaints from some of the small business people, hopefully you can answer some of their concerns as to why their insurance has gone up so tremendously high.

MR. FAWCETT: Thank you, Mr. Chairman. If you don't mind, I'd like to read my prepared testimony first and then we'll, of course, have open dialogue.

REP. DeLUCA: Certainly.

MR. FAWCETT: Good afternoon. My name is Jim Fawcett and I am senior vice president at Highmark, Inc. My responsibilities include marketing insurance products to small employers and individuals in the western and central part of the state. With me today is Mike Warfel, Highmark's vice president of government affairs.

TRANSCRIPT OF PROCEEDINGS

- - - -

I would like to thank Chairman DeLuca and members of the Committee for the opportunity to appear here today.

I'm here to discuss some of the problems with the small employer insurance market in Pennsylvania that have contributed to higher health insurance rates for small businesses. Let me begin by quoting some comments from a few years ago about health insurance and small employers: "Talk to small business owners in Pennsylvania, and two messages come through loud and clear. First, they want stability in health insurance costs, so they no longer face the sudden and significant rate increases due to unforeseen events, such as an employee being diagnosed with cancer or a dependent giving birth to a seriously ill newborn.

Second, they want an insurance system that is fair and just. One that does not encourage insurance companies to avoid covering workers with chronic medical conditions, while targeting only those companies with workers in the best of health. They want rules and regulations that move the state toward restoring the true purpose of health insurance, spreading the health risks and costs so that all workers at small companies share the responsibility of covering the cost of services of workers in poorer health.

These words were part of testimony Highmark presented at a legislative hearing almost five years ago. At the time, we called for enactment of legislation to reform small group health insurance. We urged the General Assembly to impose a ban on the use of medical screening questionnaires to set insurance rates. This would have eliminated the "pay your own freight" mentality that undermines the whole notion of health insurance for small employers in the Commonwealth.

We called for a requirement that all insurers follow the same rules in setting rates for small employers. Uniform regulation of rate-setting for small employers would remove the unfair practices in the market that de facto permit commercial insurance carriers to deny healthcare coverage to those small employers who need it most.

Unfortunately, the state is no further along in helping small employers obtain affordable health insurance than we were five years ago. Pennsylvania stands alone as the only state that has not passed legislation to improve the small employer insurance market. The state continues to have a different set of rating regulations for non-profit insurers and commercial carriers.

I bring up this bit of history because we find it ironic that Highmark is the only health insurance company represented here today to explain the reasons for higher insurance premiums. It is particularly disappointing for us because for more than seven years, Highmark has strongly championed legislation that would help stabilize the cost of small group health insurance for small employers and provide more insurance choices for all small employers, not just small business owners with healthy employees.

It is also worth noting that in this current environment, Highmark has supported greater state regulation of our own industry for the overall public good, while our competitors in the commercial insurance industry have fought against small group reform legislation.

For more than seven years, Highmark has urged the General Assembly to establish fairer market rules built around a single, uniform method of setting rates that applies to all insurance carriers. We have listed all of our testimony and public comments at the end of my remarks. We see no valid policy reason why Pennsylvania should have different sets of rating rules for different types of insurers. Despite our best efforts to raise awareness about the urgent need for small group reform, state government action on this critical issue remains elusive.

Make no mistake, the state's broken small group health insurance market is not the only reason why health insurance premiums continue to increase, sometimes at unacceptable levels. Ever-rising medical costs is a major driver of higher health insurance costs. In fact, for every dollar of insurance premiums that Highmark receives, 90 cents is used to pay for medical care our members receive.

The combination of increasing medical costs, a fragile economy and the state's current unworkable group health insurance market are forcing more small employers to drop coverage altogether, further swelling the ranks of the state's uninsured population.

Highmark understands that the premium increases represent a burden for many small companies and organizations, although our average rate increases for the July 2010 period have been consistent with the small employer premiums of other health insurers.

In fact, approximately 70 percent of our small group members in Pennsylvania work for employers who received a rate increase of ten percent or less.

Almost ten percent of our members are employed by small groups that actually received a rate decrease. As you are hearing today, some of our small group members, representing less than five percent, received rate increases well above this average.

To a large extent, the larger rate increases were the result of a change made in July in the way we offered small group insurance products to operate under the same set of regulatory rules as other insurance companies do in the state.

We took this step now to remain a viable option for Pennsylvania small employers, as we have been for decades. For example, Highmark had three consecutive years of net membership losses in the small employer insurance market, dropping from 333,000 members in 2007 to 269,000 in 2009. During this same period, Highmark has lost more than $72 million on this book of business.

In light of this challenging business environment, Highmark faced difficult choices. We could abandon a line of business that was not sustainable over the long term. This was an unacceptable path given our tradition of serving the small employer market. Or we could remain a viable option for Pennsylvania small employers leading up to the introduction of the state-based purchasing exchanges in 2014.

We have chosen the latter course, to reinforce our commitment to serving the small employer market in Pennsylvania.

The changes Highmark has implemented will allow the company to compete fairly against for-profit health insurers that currently have virtually no rate regulation on how they price their insurance products for small companies.

At the same time, we are taking steps to identify opportunities for many small employers to lower the cost of their health benefits through changes in benefit design. Unlike most mid- and large-size employers, a significant portion of Highmark's small employer customers still offer "Cadillac" benefit programs with virtually no cost sharing by employees.

We are working cooperatively with producers and associations to encourage small employers to offer health benefit programs that include varying levels of coinsurance and deductibles, and high-deductible health plans, to help control their costs. Specifically, all of Highmark's small group customers may select alternative coverage options, with lower rates. In addition, our wide range of non-group individual products is another insurance option that is available to the self-employed and other small employers.

We are also sustaining and building upon programs to control rising medical and drug costs. Our efforts to control rising healthcare costs and improve the quality of care are built around trying to reduce the unwarranted differences in how patients are treated for the same medical condition. Highmark's focus is on helping to ensure that medical care for our members is consistent with proven evidence-based guidelines.

In closing, let me reiterate that we continue to urge the General Assembly to pass small group reform legislation. We believe small group insurance reform must stabilize small employer health insurance premiums by banning medical underwriting, creating uniform rating rules for all insurers and restoring the true purpose of health insurance, which is spreading health risks and health costs across a large community.

The new federal healthcare reform law reflects these basic insurance market principles, which Highmark has advocated for years. We believe that

Pennsylvania should not simply wait until 2014 for insurance reform to take effect. During this interim period, small employers in the state should not lose virtually all health insurance choices or be forced to cut back or drop coverage because one employee becomes seriously ill or because they employ older workers.

We thank you for this opportunity to express Highmark's views on this important issue. We welcome your questions.

REP. DeLUCA: Thank you for your testimony, certainly you heard the Commissioner gave you a nice plug here pertaining to some of the other commercial insurers.

On page 8 in closing, you reiterate that we continue to urge the General Assembly to pass small group reform. We believe small group insurance reform must stabilize small employer health insurance premiums. Yet, I understand that you are not -- Highmark is not in favor of House Bill 1746, am I correct?

MR. FAWCETT: There's two of us here, so he's going to handle the policy questions and I'll handle the business questions.

REP. DeLUCA: You're also not in favor of Senator White's bill, 1189. Now, I understand there's two bills here. I understand that, you know, sometimes we get caught up in not wanting -- the stakeholders don't want to give and take, can't be all winners in some of this legislation. Some have to -- some take a little bit, some take -- everybody has to take a little hit sometimes, but there are two bills that you evidently don't like, and there's small group reform that we believe will stabilize the market and do exactly what you do, but you're not in favor.

MR. WARFEL: Sure. Let me try to address your concerns, Representative.

First of all, as Jim said in his testimony, I think it's ironic that we're sitting here today, you and the other members of this Committee know that we have long fought for small group reform.

Now, let me make it clear, what we've been for is nearly precisely what the federal healthcare reform law will bring in 2014. Basically it's saying to every player in the marketplace, you're all going to operate the same way. You heard the Commissioner testify today that Pennsylvania is one of only two states that has failed to pass small group reform over the past number of years. So I think if I was sitting in your position at this point, and I think the Commissioner in the dialogue you had with him pretty much sets up this issue in terms of which pathway is this Committee, is this General Assembly going to take between now and 2014. So you have several choices, Chairman DeLuca.

First, it is clear, it is concrete clear that come 2014, the market is going to act like Highmark has advocated for for more than seven years, and that is that everyone is going approach the marketplace the same way: You will not use medical underwriting, there will be guaranteed issue in the individual and small group marketplace. And we're proud to say that that is what we have been fighting for for years. And some of you have supported that with Representative Schroder's legislation. So I think clearly in 2014, the market is going to equalize and that everyone is going to be the same.

The question, and I think really the charge that you heard from the Commissioner today is, should we wait until 2014 to see this uniformity come. We're saying, Jim and I, and our company is saying, we think that you should act before 2014, and that's a policy question you're all going to have to consider, but the folks sitting behind us are saying we can't wait, and we understand the rates that some of these folks are getting, it's not sustainable and it's not defensible.

TRANSCRIPT OF PROCEEDINGS

- - - -

We understand that, but the pressures that we're seeing from our competitors, who aren't forced to file their rates, who aren't forced to share their forms with the insurance department as the executive director and former general counsel at the department knows, what do you want this company to do? When you look at the losses over the past three years that Mr. Fawcett has shared with you, when you look at the -- not in terms of cost, meaning in terms of premium losses, that is what we're paying versus what we're taking in, when you look at the shrinking number of customers that we had, some of you have worked in insurance. You got to have competitively priced products in the marketplace.

So this is the challenge that we find, just like you find here. Are you going to wait until 2014 or are we going to see reform come about sooner? So to get to your point, but I thought it was important, Chairman DeLuca, to sort of set the table here and tell a story, because we're obviously disappointed that we're the only insurer sitting here today, but felt that it was important out of respect to you to be here and that's why we're here, Chairman Sturla.

So we articulated on June 22, 2009 our specific problems with House Bill 746. We did it in committee before you passed that bill. There are a plethora of reasons of why we don't like 746, but I think if I was in your position, and you know it's coming in 2014, why would you take this state and the insurers and the customers in one direction when you know that come 2014, there is a uniform pathway that all the insurers are going to be taking. So to me, 746 is definitely incongruent with what the federal law is calling for.

It actually sets up, if you look at the bill, seven purchasing regions across the commonwealth. Well, I don't know how administratively that would work, I don't know the kind of confusion it would create for our customers, and for Jim and his team who are in the small marketplace, it obviously is going to provide a number of challenges for them.

It also, and I quickly reviewed the bill, has a hard ten percent rate cap. No exceptions. Well, what happens when you look at medical trends that the Commissioner has articulated are probably exceeding that in some years, so then you may be forced to make creative prices in terms of availability, because insurers are not going to be in the business to lose money indefinitely. At some point over time, you have peaks and valleys in terms of the premiums that are coming in and your expenditures.

So I would say to you those were some of the more significant concerns. One of the things we do like in the bill, it has medical loss ratio with minimal requirements, actually stronger than the federal act, for small groups. As Art knows, it's 80 percent in the federal law. In 746, it actually has an 85 percent minimum loss ratio for small groups.

To Representative Boyd's point earlier talking about small employer purchasing groups, it actually calls for that, I think that may have been your amendment, Representative Boyd, I'm not certain of that. I know my recollection is that there were some amendments that were offered, either in committee or on the floor.

And then lastly, one of the things that concerns us, but clearly hits on the theme that Representative Frankel mentioned, we very much value encouraging our customers to be engaged in wellness and healthy behaviors. A plug for the company, we pay our employees $350 a year if they perform an annual survey, if they complete an annual health assessment, which is looking at their dietary intake, regular exercise, do they pursue risky behaviors and that's all collated. And they also have to participate in two educational activities. If they complete that process, they receive a check from Highmark less taxes $350. So we actually do value, Representative Roae, and we bring that to our customers through healthy lifestyles. That's a long-winded answer, Chairman DeLuca, but I think tries to tackle some of the questions that are part of your primary question.

REP. DeLUCA: Mike, I also mentioned, I understand you had problems with 746, but Senate Bill 1189, it has little changes than 746. Now, no other insurance carrier has said they're against these bills. They haven't complained to our committee or said anything about it, but I understand both of these individual bills, there's got to be a common ground where we could come to some type of consensus that you're talking about, forget about 2014, this bill became, I mean, came out of the House long before 2014, out of the federal government, way before 2014, before the Obama administration passed that piece of legislation. So I mean, it's not like we're waiting for Obama to address that. But anyhow, we would hope that maybe there's got to be a common ground where we could come together. None of these bills are in concrete. If there's something that benefits you, it benefits the small business community, then let's work on it. That's all I'm saying to you.

The other thing, Mike, you mentioned the fact that you lost the book of business here. Yet, I read in the paper that your surplus has gone from 3.0 billion to 3.5 billion, and it's just the middle of the month here. I mean, if you're losing money, how is the surplus growing, is that from your investments or what?

MR. FAWCETT: Roughly, and we've said 90 percent of the dollars paid to Highmark go to direct reimbursement to providers for care, 90 cents comes to us, and one cent, we have a one cent, one percent margin, our margin is one percent, but what I want to remind everybody is, yes, our reserves are large, but our obligations are large. If you divided our reserves by every one of our medical members, it would be $750. That doesn't even pay for an emergency room visit. So our margins -- and we really welcome the idea of publishing medical loss ratios and being transparent about it. I don't think anybody in the industry has margins as low as ours.

REP. DeLUCA: But I guess I don't understand if you're losing all this money how you can still grow your surplus. I guess that's a little mind boggling to me. I was in business, if I lost money, my surplus -- my bank account doesn't grow.

MR. FAWCETT: Last year we posted our annual report, which is public, of course, over half of our monies were made through for-profit subsidiary companies in the dental, vision and casualty areas, as well as we do make money in some other markets, but without a doubt, our dental and vision companies are performing admirably, they contribute to our bottom line, as well as investments.

REP. DeLUCA: Let me also ask you, you mentioned the fact earlier that none of the other insurers are here, I think what we heard from is the fact that, I guess the fact that they're not here is because of the fact the individuals who are complaining are complaining about Highmark who they were insured with, where they took out of the non-profit and put them in for-profit and the rates have gone up 50 to 60 percent. Why was that necessary to do?

MR. FAWCETT: Without a doubt, the biggest impact on any of our customers was that for decades, our age banning has been suppressed by regulation, and that's why there's been a lot of talk about individuals being able to get something lower somewhere else. Well, the whole idea, the larger the community risk hold, the better. What happens in those smallest of individual group markets is someone will go off and be medically underwritten, because they're the healthiest and then others will go into group programs, and as the one gentleman indicated this morning, there is a subsidized guaranteed issue individual product that we're required to have that doesn't use any age banning at all, so when we went with HHIC, which is our downstream subsidiary for this, the No. 1 driver of the serious rate increases was the age factor which was capped and is now at a level that we went out and looked at what's consistent in other states that have regulatory reform, we went with the model and are consistent with that.

So I say comfortably that the average increase was around 15 percent. The most common cause for a big increase was the artificial capping that had been done on age and is now up to a more industry standard.

REP. DeLUCA: Let me just digress a little bit. Business is going down, I think you're saying you lost a book of business.

MR. FAWCETT: We've had substantial membership losses.

REP. DeLUCA: Memberships went down. What we have heard on the state level from the citizens out there is the fact that we need to live within our means and we need to start cutting back on the state level, as far as expenditures. What I don't understand is in a situation with non-profits, why haven't we tried to -- since rates are going to keep going up, put businesses out of business because they can't afford it, why haven't we looked at trying to cut back on some of the costs that's not related to the healthcare, but tell me, does your advertising budget bring more people into the system, have you found that to be beneficial to you, say, like you had 70 percent of the market, does all this advertising bring in two to three percent more to your market? How does that work? I guess I'd just like to know how the sky boxes, all these fancy brochures, does that create a market for you to bring more customers in to you, since there isn't that much competition in western Pennsylvania?

MR. WARFEL: Let me offer several comments, Representative DeLuca. First, let's just go with the notion that Highmark is a charity. We did that, I think, with the other Blue plans, with the House Insurance Committee a couple of months ago when we were talking about the community health reinvestment, an issue. Highmark over the past five years has paid $700 million in federal, state and local taxes. So let's be clear, Highmark is not a charity. We lost our federal tax exempt status in 1986 and we pay substantial taxes, and I think the community needs to appreciate, both communities need to appreciate we're not a charity, we are not for-profit.

Second, I'm advised that in the past five years, Highmark has made more than $750 million in community contributions.

Thirdly, we testified, I testified before your committee a couple of weeks ago in Harrisburg when I indicated that in the past five years, Highmark has given the state in cash more than 300 million to help you support the adultBasic program. So be fair here, Chairman DeLuca.

REP. DeLUCA: I just asked you a question, I didn't say you were a charity.

MR. WARFEL: I want to be clear with the community about what it is that the company is trying to do, to meet its not-for-profit mission, and I would say to you that those numbers I just shared with you, we're trying to do that.

Now, as to the advertising budget, I'm not in a position to know here today what we spent on

TRANSCRIPT OF PROCEEDINGS

- - - -

advertising, but what I do know is that Jim and his team and the rest of the folks that market Highmark products are competing for healthy risk in the marketplace, because our commercial competitors are sure as heck competing for that healthy risk. And so that's the differentiator for us, is trying to maintain the social mission perspective, which clearly I demonstrated to you we continue to pursue, but Jim still needs to have products in the marketplace that meet the needs of our members. Not only that, our commercial competitors are not required to file their rates with the insurance department, not required to file their forms with the insurance department, shadow prices in the marketplace, et cetera.

So that's the reason, I think, Chairman DeLuca, that you find the need for us to continue to promote ourselves in the form of advertising that you see, not only in western Pennsylvania, but in central Pennsylvania as well.

REP. DeLUCA: In other words, and I understand what you're saying, I understand you're not a charity. In other words, what I hear you saying also is the fact that that's why you switched some of these people to the for-profit, because you want to compete with the other ones; is that correct?

TRANSCRIPT OF PROCEEDINGS

- - - -

MR. WARFEL: Yeah, I think that's a very -- absolutely. I think that for Jim who has a responsibility for the small group marketplace across the entire Highmark region, he needed to have products that he could offer in the marketplace that people wanted.

MR. FAWCETT: And if I could add to that, the competition from my perspective was fierce. I know I've heard a lot that there isn't a lot of competition, but to be very clear, it's fierce for those good risk businesses that remain with Highmark that we needed to maintain to be competitive. By doing this, we're also paying an additional two percent premium tax now that we didn't have to before, but that's the way the law works.

But the one thing that hasn't been addressed, and I believe it was Commissioner Ario had talked about earlier, that he believes that roughly ten percent of Pennsylvanians are excluded because of evidence of insurability of medical underwriting. Although they're ten percent of the people, they may account for upwards of 50 to 60 percent of the total cost.

So what happens to us is, there is no randomness, we always keep the higher risk, we always lose the better risk when the carriers are medically writing against us. So the key was to get into a rating environment where we can be more competitive, do something. As I mentioned, we make sure ten percent of the population received a rate decrease, because we so desperately need to keep them.

MR. WARFEL: And I think just to add on to that, Chairman DeLuca, the Committee needs to appreciate, come 2014, all insurers that are in operation at that time will be subjected to fairly substantial excise taxes. This is part of how the federal government is going to pay for the subsidies that will become available for individuals who access care through the exchanges and to pay for the tax credits that small businesses will be able to enjoy in exchange for 2014.

We're still calculating, because there's still a lack of clarity in terms of how much that's going to mean for Highmark, but I'm comfortable in saying it's going to be probably 150 to 200 million dollars per year just for Highmark. Now, that actually exceeded our entire net last year, I think our net was about 187 million. So you could see that's also the pressure that the company finds itself under as we're preparing for 2014, some additional costs that will not be tax deductible.

This is to help everyone, Commissioner Ario talked about in order for healthcare really to work, everybody has to be in the system. Well, if everyone has to be in the system, some people can't afford the system, you're hearing that today. So how are we going to deal with all that and these excise taxes on insurance, on durable medical equipment manufacturers, on pharmacies just to name a few, as to how we're going to pay for that. And if they're individuals, an additional Medicare hospital tax that they'll be paying.

REP. DeLUCA: Thank you. Chairman Sturla.

REP. STURLA: So I guess what I'm hearing here, and this gives me a slightly different perspective than when we started out this morning, essentially what you're saying is that the non-regulated market that's out there came in, over a period of time cherry picked your business and said, you know what, there's a small business that's got really low risk, they got all 22 year olds working for them, we'll take them. There's somebody else, we'll take them and we'll take them, and you're left with a pool that is relatively costly, and even though there

- - - -

are individual people who came and testified today, look, I'm a great risk, they're in part of that pool that overall is a higher risk pool than the ones that were cherry picked off of you and now you have to go compete. I mean, is that --

MR. FAWCETT: That's how it works. You will find that for a producer, there are some trade associations represented here today and producers in the room, if an employer wants to get a Highmark Blue Cross/Blue Shield quote today, they could go on line, enter all the census, you'll get a rate, that's it. If they enroll that way, that's the binding rate.

What happens in the industry is, they walk into that same producer of that same trade association and they'll enter into the demographic data into the commercial carriers and they will get an illustrative rate, but the fact of the matter is, employees have to fill out individual statements of health or give release that we permit you to go in five days to look at our health status, so there is no randomness, it will always predict, it will always bring in sure fire good risk, or maybe they'll rate them up a little bit, because they learned there's something moderate out there, but if there really is somebody out there that is tragically ill, the commercial carriers magically will make sure that their rate is substantially higher than Highmark's. That's the way it works.

MR. WARFEL: I think it's important to amplify Jim's point. We're not suggesting that the commercial insurers aren't writing a rate, the rate is written so high that they're not going to take it, and so by that fact, they're going to stay with us.

REP. STURLA: So I mean, the cherry picking has already occurred, you've got what's left and understandably somebody else could go out and find something else cheaper if they're part of that pool that's existing if they have no history. I mean, the reason that the people that testified could go find cheaper rates was because they were the ones that could have been cherry picked but weren't.

MR. FAWCETT: Right. And my guess is, and I have no idea at this point, but we may have done an actuarial estimate based on age and when we pushed that age up, that that individual was probably much healthier and we missed.

Now, the other gentleman actually went to a Highmark guarantee issue subsidized product and that really pushes to our point earlier, that all of this fragmentation that exists out there, we really need to get back to community-type rating and get large risk pools with even rules for everybody.

REP. STURLA: Given that, and you said you have some concerns with 746, if 746 were consistent with the federal laws going to come in place in 2014, would you then support that type of legislation just getting us here quicker instead of --

MR. WARFEL: Yes.

REP. STURLA: Ultimately that's what we should be looking at.

MR. WARFEL: It's the point I made earlier, Representative Sturla. Why take -- we already have one of the most perverse small group markets in the country. By your own Commissioner's admittance, I think when he first came to Pennsylvania, he said, my God, we didn't fix this, we've been there in the trenches working with you and you and you to try to do that, and we've not been successful. And I understand that there are some nuances here, so I'm thinking, what is the pathway to get us to 2014. It seems to me illogical to move another completely different direction yet and have the industry and the customer sitting behind us move another direction come 2014. That's very disruptive, I don't understand why you would want to do that.

So you're saying take 2014, adopt it earlier, which you can do, as a state legislature, make it consistent with the federal laws, and yes, we would support that.

REP. STURLA: One final on a much lighter point to Representative Roae's point. You know, if somebody is slightly overweight, has a few drinks, comes home and has sex, smokes a cigarette, how do we regulate that person in the future, any suggestions?

MR. FAWCETT: Well, in the future, it won't be regulated at all, with the exception of tobacco. It was mentioned by the Commissioner today that age banning will be allowed under federal reform at a one to three ratio. There's an additional 1 to 1.5, so if you are looking at tobacco use, if you are old and smoke, it may actually get worse, so get rid of the tobacco products.

REP. DeLUCA: Representative Boyd.

REP. BOYD: Thank you, Mr. Chairman. I appreciate the testimony.

You made a comment that, I think it was a response to a question that you had some -- lifted the age bans, I think was your terminology, and you said when that happened, that's when the rates went up. Who lifted the age bans, what was lifted? Was it something the Commissioner did? Was there a filing, what happened?

MR. FAWCETT: And I apologize, stop me if I get too technical.

As the Commissioner indicated, he has rate regulatory authority over not-for-profit and HMOs, which by the way, if you go to the marketplace right now and try to get an HMO, nobody is quoting it, because it's so highly regulated.

Under the regulation as to not-for-profit, we had an upper limit of 1.5 for our age rating. When we went to the for-profit downstream subsidiary and moved those same business, any employer, any employer that had an average age that in the marketplace should have been as high as a 2.5, literally we divide the two, that drives a 67 percent increase. That's why I said with great certainty that the vast majority of those horrific rate increases that were mentioned here were driven by the artificial capping of the rate portion of our demographic rating under the not-for-profit, that went out to a 2.5 ratio, and I apologize for being technical, but I want to be transparent on it, it drove up to 67 percent of that increase.

MR. WARFEL: So it was our movement from the not-for-profit to the for-profit, which I want to make it clear, with no relief in sight, a shrinking book of business, substantial losses, Scott, you're a business person, you understand that over time, you got to change something or it's just not going to work. So we said, Jim and the senior management team said we've got to do something differently, so we moved HHIC and that's why we've launched that.

REP. BOYD: So I get my mind around what transpired, you guys traditionally put small groups through your not-for-profit book of business and so if I, my company, when I got prices on insurance, I would go with my agent and I would get a price from, you know, in my area, Capital and Highmark and Health Assurance, I think, or somebody like that, the other companies that write business. You're saying that when I was -- you were competing with for-profit companies in those areas, they would look at my demographic and age, and I had mainly guys, because it's a manufacturing company, and they were all pretty young, so the rates that I got from them, because they could do this experience rating and demographic rating, they were giving me lower premiums than you guys could. Is that fair, am I portraying it accurately?

MR. FAWCETT: The only thing I would add to that is the critical component in acquiring a new

TRANSCRIPT OF PROCEEDINGS

- - - -

quote, and this gets to your question earlier, sir, where I don't understand medical underwriting against risk modeling.

In our terminology, medical underwriting is when a business goes out to obtain quotes. What I would suggest, probably the bigger factor when you went to market to figure out what Capital, HealthAssurance, Geisinger or whoever you went out to, is you either had to have each employee sign and fill out a medical questionnaire or they had to sign a statement that allowed the carrier to go out and buy drug data or something to establish the health status. That by far drives ultimately the final rate that you get from our competitors. So the demographics will be there for a basis, they'll get real aggressive, but they can rest under the old saying hey, that's an illustrative rate. Until we find out for sure how good or bad your risk is, we may rate it up a little bit or a lot.

REP. BOYD: Well, typically, what every business does is when they get their annual renewal of the premium, if it's in their mind reasonable, which is a few percent up to five or seven percent, they probably renew automatically, because they really don't like messing with trying to find insurance, it's a hassle, but when we get the 20 some odd percent premium increase, you immediately, my direction to the CEO is (A) go shopping and (B) look at what changes we can make to the policy to drive the cost down. I mean, everybody functions the same way.

So when we start shopping, what you're saying is that when I do that, I'm an attractive product, because of the young work force, so on and so forth, and some of the independents cherry pick. I mean, I want to be very direct with what you're saying, they cherry pick and so you lose my business, I go with them, and so that's when you say you're losing a book of business, people like me were leaving and going elsewhere. So corporately, you made a decision that said we can't continue to be required to be as on our not-for-profit side of the business, the insurer of last resort, you can't turn anybody down and have expensive individuals and expensive groups in an unhealthy book of business, is that fair way of saying it? And so what you did is, to attract people like me back, you put that into your for-profit side and now eventually what you're thinking is young companies, people young are going to come back and you're going to be competitively priced in that marketplace, but the people who were with you when you were not-for-profit in that conversion are getting whacked? Is that a fair analysis? I mean, I think these guys want to know what the heck happened, and they're like me. I mean, make it simple.

MR. FAWCETT: Because we're not medical underwriting in the marketplace, the move to go downstream with our existing block was to protect what we had, and as I had testified, 70 percent of our customers we had, we were able to charge a ten percent or less and even ten percent of them got a rate decrease, because we felt if we didn't take that step, those were the ones that when they went to market were going to get rates that were lower, and by the way, they were going to get shadow priced anyway.

The one thing we really look forward to is what other commercial carriers think. When we represented here today over the last three years, our medical loss ratio, regardless of what the rates are, 90 cents are going out, we have a 90 percent medical loss ratio. We really have no idea what the commercial carriers are and we look forward to that, but I would agree the only thing that we haven't done is enabled us to be more competitive in acquiring business right now, because we're still doing the book rate adjusted by demographics.

TRANSCRIPT OF PROCEEDINGS

- - - -

REP. BOYD: So I can be clear on that, what you're saying is, is of the people that got shifted from the not-for-profit to the new for-profit company, of that hundred percent of those total people, 70 percent actually had their rates drop?

MR. FAWCETT: Ten percent or less.

REP. BOYD: Ten percent or less, but there's a smaller group that went way up.

MR. FAWCETT: Five percent, that's correct.

REP. BOYD: And they're all in the room.

MR. WARFEL: That's right. I mean, we don't get letters thanking us for ten percent reductions, Representative.

REP. BOYD: I will make it a point to send you, if you can get my premiums down ten percent. Thanks.

REP. DeLUCA: Any other questions? Mike or Jim, let me ask you, I'm just a little confused as I went over Mr. Price's testimony here, why would he be able to go to your organization and pay $4,000 cheaper and lower deductibles than going through the Bar Association?

MR. FAWCETT: I can answer that. And this gets at the core of the question of many of the

Allegheny County Bar representatives, why would one individual make a difference on a loan if they were in a law firm versus them, what happens is, individuals have to go out and they shop, they select what's best for them. So there's really three avenues for individuals in the marketplace, one is and the best prices always come in medically underwritten policies, individual policies. Commercial carriers offer them. By the way, we offer them as well, but you really have to be healthy to get into those. The next best has historically been, if you were a sole business owner, you could come into a trade association and enjoy group type rating, even though you're an individual. What has happened, particularly as we've gone into rating formulas that are more consistent with the marketplace, the age now drives such a wide disparity in rates that these individual group policies through the trade associations now actually may be higher than the guaranteed individual product that we still offer under our not-for-profit brand, which has two significant differences; No. 1, it is absolutely subsidized, it loses money, and that's part of our community mission. And secondly, there's no age banning at all, so it's one rate for everybody, it is the true community rate product.

TRANSCRIPT OF PROCEEDINGS

- - - -

So what has been difficult for us in many of the complaints we've received, and we value our relationships with our trade association partners, is unfortunately, many options, the best choice for that individual is to leave the group plan and to purchase our individual guaranteed issue policy, which is purposely subsidized. And some of that is just a market rationalization that's occurring, it's occurring because the marketplace is so fragmented.

REP. DeLUCA: And that would be because their experience rate would be -- you take the whole experience rate into the association?

MR. FAWCETT: Well, all of our associations, all small businesses for Highmark that are two to 50 or an association of 1 to 50 are in one large gigantic risk pool for western Pennsylvania, and we have another large risk pool in central Pennsylvania. So you take them out of that risk pool and put them into the separate risk pool, which the insurance commissioner alluded to earlier, where there's all these little filings that come in and then that is our guaranteed issue, so they do move from the group market to the individual guaranteed issue market.

REP. DeLUCA: Thank you. Any other

questions? Thank you very much.

The next individual to testify is Ron Baker, Human Resource Director for the Cambria County Commissioners & Cambria County Healthcare Committee. Thank you for waiting. I know we're behind schedule, but I want to thank you for taking your time to come here.

MR. BAKER: Thank you, Mr. Chairman. Thank you very much. I'd like to thank the Committee for holding these hearings today.

I'm here on behalf of the Cambria County Commissioners in Cambria County, central Pennsylvania, and here to talk about the recent rate hikes with Highmark. Actually, I didn't mind, Mr. Chairman, waiting that long, because it was good that I heard some of the comments that came from previous testimony, because I do have some remarks about those, too.

First of all, I would like to recognize here in the room with me today are representatives from 11 townships and boroughs that are in central Pennsylvania, as well as six union representatives and the executive director of AFSCME, District Council 13 who are also here, not only supporting the statement but helped to write the statement and with the concurrence of the Cambria County Commissioners and the Cambria County Healthcare Committee and the seven or eight townships and boroughs that are represented today that are impacted by small group rate increases, I'd like to thank this Committee once again for holding this hearing.

I'll move forward, Mr. Chairman, if it's okay with you to read my testimony and then to insert certain things thereafter.

Thank you, Mr. Chairman, for allowing us to make this brief presentation to you today concerning the issues that we, as taxpayers in the Commonwealth and local government officials have been attempting to address as far back as 2008. Quite frankly, our issues with Highmark, Inc. reached their pinnacle this year. But you are aware that these types of issues on healthcare costs and how the state handles insurance carriers, especially Highmark, Inc., and these are by no means new events; but in our estimation, just a sad ongoing saga of what seems to have no one with the authority to initiate meaningful change and willing to address the issues.

Here with me today, as I said, are the 11 members of the townships and boroughs, the business managers of AFSCME, PSSU Local 668 and its business

TRANSCRIPT OF PROCEEDINGS

\- - - -

agent and representatives of other labor unions.

For those of you who do not know about our struggles with Highmark, you may wonder about what connections we all have when it comes to unions, managers of local government as well as townships and borough managers. It is specifically geared to this question today which is the recent rate hikes by Highmark. When we say recent, these local governments have been living it for years. We just want to define for our understanding and for the Committee what recent we're talking about here today.

Mr. Chairman, the recent rate increase of Highmark and the escalating healthcare premiums have gone beyond the realm of acceptable with nowhere for these and other small governments to turn.

Mr. Chairman, I am sure that the nowhere to turn scenario might raise some skepticism from the state and quite possibly by several if not all of the members of this Committee. However, it is a true and accurate statement.

Mr. Chairman, as hard as it may be to hear, the insurance industry in Pennsylvania is a glowing example of no place to turn for small business persons, employers and employees and individuals seeking coverage. Highmark sets the rules and the PA legislature and all its subordinate departments follow those that they have set.

In November of 2008, Cambria County created a healthcare consortium along with ten townships and boroughs under Section 2307 of the 2001 state-enacted Inter-Governmental Cooperation Act, and that's under Title 53. As a matter of fact, when there was a comment earlier about legislation and I do -- I am very happy that the House has moved a bill to the Senate, but there is an enactment in place right now that allows small local governments to ban together their resources, including setting up group rates on healthcare, that isn't in place and, as you will see through the testimony, Highmark, even though they make the comment, the larger the community risk pool the better, have absolutely said that our consortium is without legal standing and failed to recognize it into the next year.

In November of 2008, Cambria County created a healthcare consortium along with ten townships and boroughs under that section of the Act, its purpose was to legally, under a consortium health group structure, rescue these struggling townships and boroughs from financial ruin as they tried to pay for health benefits for their several employees at rates they could no longer sustain. Mr. Chairman, they were at a crossroads. Do they water down benefits to a meaningless level in order to offset the cost of these outrageous premium increases? Do they eliminate the benefit altogether in order to keep employees on the job, or do they lay off some employes so that those that remained could continue to have meaningful coverage? None of the options were good. So beginning in January of 2009, after extensive discussion with Highmark in the latter months of 2008, and the legal concurrence of these local governments, we initiated the Cambria County Healthcare Consortium under Section 2037 of that Act with the advice of our solicitor.

Highmark covered the consortium, which included Cambria County employees and 40 or so other employees from ten townships and boroughs for all of 2009. However, in January of 2010, Highmark abruptly announced that it would not continue to cover the consortium in 2011. At first, Highmark claimed they were not even aware of its existence at all, but, Mr. Chairman, and also included in the packet that I've given to the stenographer here, we had ample documentation that they not only knew, but actively participated in the process of administratively establishing the group. Why did they cover it then and not now? Because we had left them in 2008 to go with UPMC, and in our opinion, to include the consortium under our plan was a small price for them to pay for them to agree to recapture our business in 2009. They knew it was part of our group and never objected or raised any particular concern. They now may claim risk and they may cite regulations, but they have covered Cambria County's own independent local government authorities under our Subgroup 40 for over a decade. Employees of our authorities are not county employees either. Their argument that covered lives under the plan must be linked to employees of the employer doesn't work when it comes to recognizing the consortium.

Mr. Chairman, it's not about HIPAA, insurance regulations or risk as they now profess. It's about not having the unilateral unquestioned right to quote whatever rates they desire whenever they decide, in small groups. The vast majority of these represented small local government groups were experiencing monthly premium rate increases hundreds and thousands of dollars above the larger groups with nearly identical coverage.

And that is the first part of the exhibit,

TRANSCRIPT OF PROCEEDINGS

- - - -

which shows you between 35 to 110 percent difference in the rate structures with essentially the same or less coverage, and that was a 2008 rate compared to the county's 2009 rate. I submit to the Committee this analysis of Highmark's rates associated with our consortium members prior to them joining the consortium in 2009. This sampling of nine of these local governments shows the wide disparity on rates in small versus large groups.

Mr. Chairman, we believe that this outline is but a microcosm of what is occurring out there. I will not take the time to cover the analysis, but for some of these small group government rates were over 100 percent as I said before, and that was before the creation of HHCI (sic), before the creation of HHCI. Please keep in mind when reviewing our data that we are comparing the 2008 rates on the quoted coverage for similar coverage to the County's 2009 rates. This makes these results even more staggering in these small groups that could not afford to pay the 2008 rates, let alone what they would have experienced in a 2009 rate increase when it was applied, or let alone what they would be subjected to right now under HHCI's rate schedule.

Mr. Chairman, every avenue of redress on this issue, including the Pennsylvania Department of Insurance has been for naught. Numerous of our state legislators bemoan the fact that they cannot dictate that Highmark recognizes our consortium even though it's a legal avenue for local governments and their entities under the law.

Mr. Chairman, we thank you for opening this meeting to the public. More of these should occur so that healthcare consumers can speak about their personal experiences and the anxiety they experience in trying to balance a budget where there is no cap on what these carriers may charge.

But, quite honestly, and you have to understand, based on the frustration the Cambria County Commissioners, this healthcare committee and these townships and boroughs have been through for six months, with all due respect, this hearing, we are hopeful, but it comes with a sense of little or no real hope of arriving at a resolution to this terrible crisis because we have already written scores of letters, spent countless hours on the telephone with the Pennsylvania Insurance Department in offices with our legislators, but to no avail. We have stacks of letters that are two feet high and conversations of countless hours on the phone, both to the insurance department and to our legislative offices. One thing is clear from our experience and our perspective, however, Highmark sets the rules and everyone in this extensive chain of state authority on all levels simply abides by its terms.

Why can Highmark scoff at the law and refuse to abide by the terms of the state-enacted Intergovernmental Cooperation Act of 2001? Because they believe, as they well should, that they do not have to.

Why does Highmark believe they can increase rates as they please on a take-it or leave-it basis, or to quote someone before, a slice and dice type basis that impacts employers, employees, small and large businesses without any oversight from the state? Because that is the way it's been, that's the way it's always been, they know they can, and no one has ever stopped them.

Mr. Chairman, and you mentioned this earlier, Representative DeLuca, according to an April 2010 Post Gazette article, Highmark holds 3.4 billion dollars in excess income. They can't call it profit, it's excess income, it's surplus income or whatever, but, Mr. Chairman, that's well above ten percent of the recently passed state budget needed to run the entire commonwealth for an entire year. I'm sure that it falls within the generous Risk Based Capital ratio standards that have been set by the Pennsylvania Insurance Department with the carrier. However, does anyone really analyze what goes into the RBC ratio formula for this carrier? Does anyone outside the agency really analyze the RBC formula and its respective parts? Do they ever question the carrier's data?

Why do PA healthcare consumers get lip service when it comes to complaints? Because we believe, based on our numerous phone calls, based on our numerous inquiries, that the Pennsylvania Insurance Department is an advocate for the industry, not the overseer of the industry. So I would ask: Who is the advocate for the Pennsylvania taxpayer when it comes to healthcare rates?

Mr. Chairman, Cambria County and its townships and boroughs in its consortium have hit a brick wall on all levels of state government. As we stand here today, Highmark has put the edict down that says that this consortium must go away by the end of the year 2011, much in conflict with the statement that was made by Mr. Fawcett earlier that says the larger the community risk pool, the better.

TRANSCRIPT OF PROCEEDINGS

\- - - -

The unfortunate thing is that this wall was built brick by brick with the full understanding by the state, state insurance department and the state legislature that no one controls this industry and it maneuvers in its own sphere and without much regard to taxpayers or the communities. Yes, and we spoke about this earlier, they will claim they give millions back to the community, Mr. Chairman, but compare the cost of their so-called philanthropy with the amount of their holdings and the picture becomes clearer. Besides, should they not be required to do so since they hold a coveted non-profit status with the state? Heard a lot of testimony earlier about two percent on premiums of 6 billion dollars in premiums received is about 120 million dollars, that's nothing to sneeze at, either.

This state and the nation have never recovered from the 2008 downturn in the economy. Pennsylvania's unemployment and underemployment rate is at a record high with those lucky enough to be employed living with stagnant wages or reduced earnings. Local governments, who derive their operating revenue from real estate and occupational taxes are in a dilemma in most areas.

This state is swimming in red ink, desperately trying to figure out how to pay the bills. None of the choices to bridge the fiscal gap on any level are easy and most deal with the unfortunate knowledge that any remedy will largely impact the lives of those who can least afford it. State employees, commonwealth taxpayers, local governments, small businesses, and consumers of much needed state funded services.

Yet, with all this, Highmark operates as if these communities, local governments, the state, the counties, and employers in general, are flush with cash, when in reality they have been reduced in many cases to fiscal rubble in the market decline of 2008. The individual taxpayer can only sit back and hope for better days when their personal savings may crawl back to their previous values. Government investments, as you all know, also took a proportioned hit. Yet these corporations continue their double-digit rate increases year after year as the rest of the world is just expected to somehow absorb it.

It has been and will continue to be a one-sided balancing act where carriers like Highmark put on their community economic blinders and operate as if they are the first to be paid and everyone and everything else can just adjust to the increase. This state has allowed this culture to flourish at the expense of taxpayers, businesses and local governments that can no longer afford to meet these financial hurdles.

We are all at a crossroads, Mr. Chairman. All those entities listed above have reduced employee benefits in one way or another or required those that can least afford it to pay more so that they can balance their own checkbooks. However, in our opinion, this industry now is at the best place ever, higher rates than ever before and less risk against its sponsored plans than ever before, the perfect storm. Unfortunately, those who are sinking are commonwealth taxpayers.

Mr. Chairman, this is a state recognized non-profit corporation who is setting the rules. Their product is an essential service and one that consumers must have. I know we will hear about free markets and competition and taking our business elsewhere if we don't like it, but in these rural counties, competition is virtually non-existent. Highmark and its Blues cousins operating in the state even set their own boundaries via their national Blue Cross/Blue Shield association. There is not even competition between the three other Blues carriers and Highmark when it comes to groups domiciled in their

- - - -

corporately set sales areas. They ban competition internally and taxpayers pay for it. They set it up that way and this state has done nothing about it but acquiesce to their plans.

Mr. Chairman, look for yourself on any Blues website or call them as we have done in the last week on numerous occasions seeking alternative quotes for coverage. They will outwardly proclaim the boundaries of their coverage areas. They'll quite frankly tell you, we're sorry, we're northeast Blue, we can't quote a bid in Cambria County; we're sorry, we're Capital Blue, that's outside of our marketing area. They outwardly proclaim these boundaries, however, and they will not quote small or larger groups outside their corporately established marketing boundaries.

Yet, their behavior, in our opinion, is duplicitous because when it benefits any one of them, they cross their own self-imposed boundaries. Case in point; Highmark on June 17, 2010 announced it has recently secured the PPO business from Capital Blue for state employees covered under the Pennsylvania Employees Benefit Trust Fund or PEBTF. This trust is located in the Capital Blue marketing area in Harrisburg, not in western Pennsylvania. How is it that Highmark crossed over their association's own self-proclaimed boundary to compete with its sister Blues company when local governments cannot get a quote on coverage for any Blue's plan, except for one that controls their area?

You see, Mr. Chairman, they do what they want when it suits them, and when it doesn't, they invoke their own internal rules as a reason why they can't. It's a facade and nothing more than a state-sanctioned regionalized monopoly that drives costs through the roof because the industry itself has stymied competition. Yet, Mr. Chairman, as they continue to evoke their standard line about their association's set market areas. Highmark itself, in its 2009 annual report touts, among its 4 million members in the commonwealth, nearly one million are in the central PA/Lehigh Valley area, 355,000 in the northeastern Pennsylvania area and over 200,000 in southeastern PA. So, Mr. Chairman and Committee, which is it? Is Highmark or Capital limited by a marketing region or not? Is Highmark truly competitive or not? We've seen the answer from our own experience. This Committee should look into Highmark's marketing practices, which leave smaller employers disadvantaged, and subject to no access to competitive pricing as larger employers may access.

Mr. Chairman, taxpayers have had to tighten their belts and run household budgets on less and less; why should Highmark not at least be empathetic to this economic calamity? At the end of this year, as you know, rate caps on electricity will expire and taxpayers will have to absorb those costs. Where does it all end? Is the final chapter one that requires less and less people covered by health insurance while corporations like Highmark continue to hold billions in excess income? In their own 2009 annual report, Highmark's board chairman speaks about the economy wherein he states, "Meanwhile, the ripple effects persist from the most severe economic downturn since the Great Depression. Job losses across American business and government at all levels have led to declining membership for many health insurance companies and increasing pressure to hold down costs." Yet, Mr. Chairman, you can see no dip whatsoever in the rates of this carrier during the "most severe economic downturn since the Great Depression." Just an acknowledgment that job losses have led to declines in "membership" for many of their health plans.

Mr. Chairman, they doubled their profits in 2009 from 2008 while they admittedly, in their own reports, lost about 100,000 covered members. Rate increases on those that remained had to account for a substantial way they covered their revenue shortfalls. Having nearly 100,000 less members and doubling their gains in one year from the previous speaks volumes about the financial health of a carrier who has never slowed down on its rate increases even during dire times.

Mr. Chairman, this Committee needs to know that while we may appear to be just a few disgruntled ordinary taxpaying, working people from some rural Pennsylvania county, we believe this feeling is widespread across this state. It would behoove this Committee to seek out the voices of other local governments, businesses, et cetera, who have the same problems. Then, and only then, will the true impact of these ridiculous rate increases be truly known. Taxpayers continue to pay the bills, while corporations like Highmark get top class treatment from our legislators, as well as through agencies and departments of this state that are responsible for their oversight. What is the answer? Well, from this group of ordinary taxpayers, it seems fairly simple and straightforward, which we know the issues aren't simple and straightforward.

If you are a non-profit insurer in this state,

- - - -

you should at least be required to abide by all legislative enactments in this state, including the creations of consortiums in healthcare so that small local governments and businesses can benefit from larger group pooled rates. That enactment has been in place since 2001. So when they talk about larger communities for risk pools, it is here, we have the enactment, the legislature saw fit to do it and they refused to agree to acknowledge it.

They should be obligated to file their corporate information in an area readily accessible to the taxpaying public and not on some convoluted state website hosted by the Pennsylvania Insurance Department that has most taxpayers throwing up their hands in frustration.

We do not guide or create state policy, Mr. Chairman, but if it were up to us, this state should not permit any carrier to set their own rules on sales areas governed by their own corporate association at the expense of competition. If they want to be a non-profit, then require them to compete and have this state require adequate and meaningful oversight ensuring that they are operating as independent companies as they do so. We always hear competition is good, but as a state we do not require

TRANSCRIPT OF PROCEEDINGS

- - - -

these insurers to win contracts based on price, service or efficiency. They get them because there's no meaningful competition in many of these areas. Thus, in most cases, they set the rates they want, where they want, and upon whom the decide.

This Committee should spearhead legislative efforts to change the culture of the Pennsylvania Insurance Department, and I'm sure Commissioner Ario is doing everything he can to change that culture, but that culture doesn't get changed in three years when it's been established and in place for many, many years.

This Committee, Mr. Chairman, if it proves impossible to give the Pennsylvania Insurance Department the adequate tools to oversee the industry or to change the culture of the industry, it is this spokesman's belief, based on discussions with the county commissioners, that the Pennsylvania Insurance Department should be abolished and savings should come as tax relief for Pennsylvania taxpayers. Right now, we believe the department puts the industry at the top of the list and taxpayers, local governments, employers and all others are a distant second.

Case in point on that, we filed on February 23rd of this year, a right to know request to the state. We asked them specifically why we couldn't get a quote from Capital Blue or Northeastern Blue or Independence Blue as some competitive type play to offset what these small governments are going through, and they clearly, and it's in the information that I've given you today, say we do not control it, Highmark's national association sets the boundaries for its marketing areas. In a business like this, with four Blues across the state, they put the barriers up where they want, they let the barriers down when they decide.

Mr. Chairman, we all know that healthcare is not free. But this Committee and this state must at least attempt to make the playing field somewhat level. These tremendous rate increases by a corporation that holds over 3 billion dollars in "excess income" or "surplus reserves" or whatever they want to call it is putting people out of work or reducing their levels of coverage and currently and sadly there is no one to turn to at present for relief.

Mr. Chairman, these leaders of local government gathered here today don't get paid big salaries. These are community people that devote countless volunteer hours to make sure that basic services in their townships and boroughs are provided to those that live within their boundaries. Mr. Chairman, in our area, there are slots for township and borough positions that no one is running for because so much needs done with so little financial resources to cover the need. These folks are not lawyers and they are not people with prominent elected positions. They are grass roots community heroes that get the work done. You know the difficult work they do and you know their financial limitations. They need your help and the help of this state legislature to ensure that this ever rising unchecked cost of healthcare coverage does not continue to erode their already tenuous financial position. County governments need the same help.

Our consortium did that. It was legal and is legal, just unrecognized by this carrier. Not because it's a bad idea. As a matter of fact, it is a good legally appropriate state created opportunity for small groups. Our own medical loss ratio never moved its needle in 2009 due to their inclusion. So much for the risk argument from Highmark. The carrier's unspoken reasons to abolish it is because it limits their ability to charge what they want on whomever they please, especially in small groups.

TRANSCRIPT OF PROCEEDINGS

- - - -

On behalf of the Cambria County Commissioners; P.J. Stevens, Milan Gjurich, and Salvatore Valenty; the Cambria County Healthcare Committee; and the leaders of our townships and boroughs, we want to thank this entire Committee for holding this hearing. I provide to you and I have already my statement and all the backup material, Mr. Chairman. Thank you very much.

(Applause.)

REP. DeLUCA: Thank you. Any questions? Representative Boyd.

REP. BOYD: Thank you, Mr. Chairman.

Just a couple things for some clarification and I'm going to look to some of the other experts that are on the panel. The national association that, I'll use the term loosely, governs the Blues, what that association or what's done there is it has to do with the brand and the trademark of the Blues. So Capital can sell outside of their geographic area, they just can't market as Capital Blue Cross. It has to do with trademark issues that have been upheld federally in court, so for the state --

Well, I just want to clarify, because you made some pretty strong statements that we should disband the insurance department and we should eliminate or stop that practice, we can't. Legally, if we would try and pass a law that and, in fact, I was the architect of an amendment when Capital or when Highmark was trying to merge with IBC. I actually had a law drafted that would have provided that Capital would have sold statewide and was clearly told that while it was a very unique idea and very, very strategic in pointing out that creating a bigger Blue would eliminate competition and make things worse. I legally can't violate federal trade or -- yeah, federal trademark law at the state level. It would have been overturned in court.

So while people want us to do some things at the state level, we can't do that, legally we can't.

MR. BAKER: Let me clarify one thing about the Pennsylvania Insurance Commission first and then I'll move on to the other thing.

The statement of the Committee was that if the Pennsylvania Insurance Committee doesn't have the teeth to do it or the authority to do it, then why have it. That was the statement that was made here.

On the other side, when you talk about trademarks and brands and whatever, then I guess I would ask for clarification from the Committee or maybe we can get some clarification as to how Highmark can go in and bid on the PEBTF contract in Harrisburg outside their domiciled marketing area.

REP. BOYD: Actually, Highmark, the only place where Blues compete in the state is in central Pennsylvania and it had to do with restructuring of a corporate entity that it was a part of the breakup of -- formation of Highmark, but it was agreed to by the association and it provided -- hey, and you can lobby the association, I think they're located in Chicago and say we want the four Blues in Pennsylvania to compete.

MR. BAKER: Representative, I don't have any umbrage with that, other than to say, here again, that is, quite frankly, another example as to how the corporate dynamics and the corporate structure dictate the rules of the road when it comes to marketing insurance in the state of Pennsylvania. Whether you can change it or not, it just shows you that the corporation's internal rules or the national association's internal rules have actually hamstrung the state legislature in providing competition across the state.

REP. BOYD: And I'm not disagreeing with that, but understand that it's federal court rulings defining then federal law and there's some states that

TRANSCRIPT OF PROCEEDINGS

- - - -

have decided we're not going to be compliant with federal law. We did that back in the 1860s, that didn't work out.

MR. BAKER: Well, then, if the insurance carriers then really espouse the fact that competition is good, then I would imagine that those barriers should be brought down by the national Blue Cross/Blue Shield Association so all Pennsylvanians could benefit from competitive pricing.

REP. BOYD: And some of us, I personally would agree. I would love to see all four Blues and the people who represent the Blues that are in the room know that I advocated this, to allow the Blues to sell in multiple jurisdictions.

What I'm saying is, there's some things that we can do, House Bill 786 -- 746, that's a positive or a piece of legislation that we can actually do, the things that -- the control regulation oversight of the Blues association, the national association, we simply don't have the authority to do.

MR. BAKER: I appreciate that, Mr. Representative, and like I said, I mean, that's just another example. I mean, on one hand, they want to talk about competition with their competitors. On the other hand, they have a sister Blues company who, quite frankly, I mean, I will tell you, I think it advantages them to have a charter that sets up certain segmented areas and counties within the commonwealth so that you can decide to cross when you want and you can decide to put the shield up whenever you don't.

REP. BOYD: And I don't necessarily disagree with anything that you're saying. I think what we want to be about here is to try and talk about what we can do.

MR. BAKER: I understand.

REP. BOYD: And your discussion about the intergovernmental affair agreement, did you guys retain an attorney and consider suing over that issue?

MR. BAKER: Our county solicitor actually was the one that brought it to us, it was Section 2307, and it's provided in the information. The municipality must give us some authority to operate on their behalf, so there was resolutions that were passed and then there was some discussion back and forth, well, should it have been an ordinance, should it have been a resolution, back and forth, whatever. But ultimately, when it came down to us delivering those resolutions on June 9th to Highmark via Senator Wozniak's office, they made it clear to us it didn't matter whether it was a resolution, it didn't matter whether it was an ordinance, it didn't matter what it was, they are not going to cover the consortium past December 31st of 2010. Had a meeting on May 20th with the Highmark representatives, and without completely going out there on it, I mean, the words back to us were, well, what if everybody decided to do this? Well, quite frankly, if everybody decided to do it, I think it would be a pretty good idea, I mean, you could follow the same premise that Mr. Fawcett indicated by saying a larger community risk pool benefits consumers, which it does.

One particular township and borough around here, the gentleman is sitting right behind me, saved $69,000 on 12 employees in one year, three mills of taxes, so people continued to work, people continued to have great healthcare coverage. No harm, no foul. Until January 1st of this year when they decided not to do it any longer.

REP. BOYD: So are you guys considering litigation?

MR. BAKER: We have not. We have tried to do a legislative option, we have tried to seek help via legislators, we're still in that particular process. One thing we did not want to do, I mean, we felt that there might be a way to work it out with

Highmark. In the meantime, we did not want to go out publicly and do this or do that in hopes of resolution, but quite frankly, here we are today. We have a definite problem with it. We may seek that alternative.

REP. BOYD: Thank you, Mr. Chairman.

REP. DeLUCA: Any other questions? Let me just say, Mr. Baker, that as far as the insurance department, they are self-sufficient, they bring in more money than they pay out in employees, so I just want to bring that out to you.

Secondly, as Representative Boyd has said, there are certain things we can't do, and I don't want to just stick up for the insurance carriers here, but this is a multi-facet problem until we get our handle -- it's not just the insurance carriers, the rates and all that. Until we get our handle on the cost of healthcare, we could talk about something, and what we're talking about is exorbitant rate increases. We also need to get our handle on the cost of healthcare.

Let me give you an example. I find it ironic that we have a hospital system who's building a new hospital a mile away from another hospital. That certainly doesn't reduce cost. So I mean, we need to start looking at that kind of stuff. You know, you're not going to, just by saying by reducing healthcare premiums, you don't reduce the healthcare cost. Nobody is in there to lose money. As a Commissioner, you also have to understand there are other aspects in government that you have to look at. It's not just cut and dry.

MR. BAKER: Representative DeLuca, I totally understand that. I will tell you where the rubber meets the road, however, as you well know with everybody from a local township and borough to a small employer, where the rubber meets the road is the premium they pay every month. The big picture, I understand. You guys deal with the big picture, but I'm telling you it ultimately filters down to one place. They may be the insurer of last resort, there's a payer of last resort and it's the person that makes out the check or the employer that makes out the check for those insurance premiums every particular month.

REP. DeLUCA: And I understand that, and I also understand that we also need to get a handle on healthcare costs.

MR. BAKER: I agree. Thank you, sir.

REP. DeLUCA: Thank you. Thank you for

TRANSCRIPT OF PROCEEDINGS

- - - -

taking the time and staying here all day.

(Applause.)

REP. DeLUCA: The next panel, we have Sharon Ward, director, Pennsylvania Budget and Policy Center; Joyce Kane, owner and president of Cybertary Pittsburgh.

MS. WARD: Thanks very much for the opportunity to speak. I'm Sharon Ward, director of the Pennsylvania Budget and Policy Center. Thank you very much, Chairman, for allowing us the opportunity to speak today.

You have my written testimony, but what I think I'm going to do is depart from that. My testimony is only two pages, so I promise you, I'll be brief. And I think I'm just going to respond to some of the comments and testimony that we've heard this morning and to address some highlights.

So first let me start, very briefly, with our own personal story. Our business, which is located in Harrisburg, have been through what many of the businesses you're hearing today are experiencing. We had a 46 percent rate increase with Capital Blue Cross a year and a half ago, and what was that related to? Clearly related to issues of medical underwriting.

When we started, as the Insurance Commissioner has mentioned, we got a very favorable and very nice rate and our insurance broker warned us that the problem with the Blues was always in the renewal, and that was, in fact, the case. Our insurance premium increased by 46 percent. We had one staff member whose wife had a baby, we now pay $21,000 for that single employee and his premium went up by about $10,000 that one year. And two people in our organization turned 50, I won't you tell you who they are, but they did. And between the age rating and the medical underwriting, our premiums went up very significantly.

So let me get to back to we're hearing today among other small businesses that are located here in the Highmark area. First, I want to respond to some of the comments that were made by the Highmark representatives, and again, go back to some reality to all of this. We are in an environment of federal healthcare reform, which now has to be implemented and will be implemented in different ways in the states, but it's important to remember that the four Blues in the state have almost 70 percent of the covered lives in the state and they will be the big beneficiaries of federal healthcare reform, 32 million more people will be able to purchase health insurance, and that is why you did not have insurance companies, durable medical equipment providers, drug companies or hospitals opposing federal healthcare reform, because they understand their business is expanding exponentially.

Let me also say that the people, the insurers that will have to make the most changes will be the commercial insurers and not the Blues. The commercial insurers will be the ones that have to more significantly change the way they operate than the Blues do.

Let me respond to the comment that Highmark is not a charity. Highmark is a charity, Highmark was a charity. The Blues were chartered under state law. What we have seen in Pennsylvania is, in fact, a conversion from non-profit to for-profit organizations without the opportunity of legislative oversight of that, or without the opportunity of other states that have, which is to take back some of the surpluses, some of the -- some of the public funds involved in those charities. Right now, Highmark has 37 separate subsidiaries. They have one non-profit, the rest of their business is done through for-profit subsidiaries.

Now, addressing the issue of competition and risk. You cannot have 70 percent of the covered lives in the state and have 100 percent of the riskiest patients, it just doesn't happen that way. They have a variety of risk within those risk pools. So to make the comment that they have completely and all of the high risk patients is simply -- or lives is simple not the case.

Now, it's clear to say that the commercial carriers in the state have gotten away with murder and they have, but again, the commercial carriers will be the ones that have to make the biggest changes.

What I think we have here with respect to what Highmark is doing moving this book of business into a for-profit subsidiary is, in fact, the response to federal healthcare reform. This is not the last time you will see this, this is the first time you will see this, and that is the reason that one of the first things that Congress did in the timeline of federal healthcare reform was to acknowledge that states don't have the means, don't have the authority across the board, they don't have the resources to adequately review and regulate insurance companies.

Now, this year, and actually, just this month, there was the Department of Health and Human Services issued a grant opportunity, every state gets a million dollars a year for the next three years to improve the capacity of the insurance department to be able to go toe to toe with the insurance companies and have the resources and the actuaries that they need in order to be able to review rates adequately. What we don't have in Pennsylvania is the authority of the Insurance Commissioner to be able to review and to approve rates.

I can tell you, and I appreciate the fact that this Committee has voted out House Bill 746. I want to remind you all that the issue of small business rate regulation is an issue of Representative Schroder and Senator Wonderling when he was in the Senate. This is a bipartisan issue, small businesses really do need help in addressing these issues.

So what needs to be done? We need more, we need greater authority for the insurance department, not less authority for the insurance department. There's three years before the federal law kicks in. When that occurs, both the Secretary of Health and Human Services and each state insurance commissioner is going to have much greater authority to review and approve rates. We need to do that now. We passed a bill once, pass another bill and pass another bill and pass another bill until the Senate finally gets the message.

TRANSCRIPT OF PROCEEDINGS

- - - -

I can tell you that the movement of states before federal healthcare reform was towards rate approval. There are 28 states that currently require rate approval by the insurance commissioner, five states in 2009 alone enacted rate approval. I can also tell you in Colorado, in six months, in the first six months after they enacted a rate approval law, 50 percent of the rate hikes that were requested by the insurance companies were either denied or withdrawn.

So what we have here is, we simply have a lack of an authority. There's nothing wrong -- well, there's nothing wrong with these companies making profits, but it's really important to understand just what this means to these folks and to other small businesses.

Let me also point out that I really hope that we can get over the battle between the Blues and the commercial insurers. I don't think people in the audience understand how much of a problem that is in Harrisburg. I would say in Harrisburg poor people constantly come to lobby, the poorest people who come to Harrisburg to lobby are hospitals, nursing homes and insurance companies. If we walk the halls in Harrisburg, you would think all of our insurance companies are really just about to go under and I can assure they are not. So there are a couple of things that you could do and then I'll turn this over to my colleague.

There are -- the General Assembly both -- right now before federal reform takes effect, you should enact a law that would give the insurance commissioner rate review authority and the authority to deny rates, but it's very important the way that law is written, structured, the feds will create something, Pennsylvania, there will be a lot of discretions, and Pennsylvania will need to enact legislation and have the capacity and the ability to be able to go beyond what the feds require.

So we just ask you to do five things, give the insurance commissioner the authority to review and approve rates, create standards to determine whether these rate increases are justified. Again, the reporting on the medical loss ratios will begin this year. Next year, after that information is presented, the rebates that will come when insurers do not meet the medical loss ratios will begin, so it is conceivable that within the next year the commercial insurers are going to have to change their medical loss ratios or begin giving rebates to their customers.

We need to have a clear and transparent process for rate review and approval. We need to have informed consumer input into the rate review processes. It's very hard to get consumers, but we think that's very important, and it's important that you ensure that the million dollars, I'm sure Joel Ario would say is not enough, the insurance department has to have adequate capacity to independently review rate requests in a timely manner. So I will leave it that.

I do want to reiterate the issue that has been raised several times with respect to Highmark and its profits. Between 2005 and 2009, although their profits have declined with the recession, they're rebounding, their surpluses have increased from 2.8 billion dollars in 2005 to 3.4 billion dollars today.

I also want to point out that much of the impetus around the strong rate review has been because of the commercial insurers and to point out to you that in 2009, the nation's five largest health insurance companies, commercials, WellPoint, United, Cigna, Aetna and Humana had combined profits of 12.2 billion and those profits were up 56 percent from 2008. So while the rest of us have been struggling, the insurance carriers apparently have not been.

Finally, there was another person who was supposed to be on our panel, Cal Schuchman, who's a consumer who actually wanted to talk about adultBasic, he had to go to work. I just wanted to urge you that one piece of unfinished business is funding adultBasic through to 2014 and I hope that you'll take up that piece of legislation soon. I'll turn it over to my colleague.

REP. DeLUCA: You're next.

MS. KANE: I'm next and I promise I will be very brief. Good afternoon. My name is Joyce Kane, I'm the owner and president of Cybertary Pittsburgh, which is a small business, actually, a micro business, that offers administrative support services to other business owners, professionals and individuals. We incorporated in June of 2009, launched our business in September of 2009 and currently have two employees, myself and my husband.

I was laid off from my corporate position in October of 2008. I had COBRA benefits from that time, which represented an outlay of $472 per month until December of 2009. At that time, I was notified that my COBRA premiums would increase by 286 percent to over $1300 monthly, and funding income from unemployment and savings could not sustain that increase. I sought coverage alternatives from sources other than COBRA. Fortunately, through contacts that I've met in marketing my business, I had some options to consider, although those options were limited at best.

For example, I worked through a broker who proposed plans from three different carriers, as well as a chamber affiliated entity that offered policies through their collective bargaining power. Those plans ranged from a low of $566 a month to a high of 2033, a delta of 119 to 431 percent respectively over the cost of the COBRA coverage that I had had.

In addition to the cost differences, of course, we don't have to elaborate, but monthly premiums, there were significant differences in lifetime maximum coverage, deductibility, coverage for in-network, out-of-network providers, prescription guidelines, co-insurance, et cetera, and there was also some underwriting issues associated with those.

From my research, the Patient Protection Affordable Care Act appears to have limited impact for small business owners such as myself, in either a positive or a negative direction. Assuming the provisions as currently interpreted carry through, eligibility for coverage through state insurance pools or exchanges may increase options for healthcare coverage that are better than what I'm able to source on my own; however, the other provision such as eligibility for individual tax credits to help offset the cost of premiums are so restricted to employers that are -- have 25 FTEs or less and whose salaries are under 25,000, to employers with up to 50 employees and/or salaries of 50,000. Those percentage phase outs of those credits are for the owners. In addition, owners of C corporations are ineligible. I have to be incorporated as a C corporation for a number of reasons, including the way I was able to fund my business. Of course, there has to be taxable income against which credits would apply, and for those of us who do not have taxable income, again, it's a moot point.

So in my case and the other small business owners who are struggling to stay in business, these qualifications render the positive impact of these provisions untenable.

The one area that would potentially benefit business owners in circumstances near that of my company is the insurance reform protection that would prevent rejections and discriminatory pricing of insurance coverage, preexisting conditions, age, health status and other factors. Small business owners are looking for consumer protection that would enable the insurance commissioner to have the power to review and disapprove rates and to enact rate reforms at the state level. Thank you for the opportunity to address the panel.

REP. DeLUCA: Thank you both for being here and thank you for taking the time to wait.

Let me ask you, Sharon, one of your five points is the fact that you provide the informed consumer input into the rate process. Would you be in favor of a consumer advocate?

MS. WARD: Yeah, that's a good model.

REP. DeLUCA: Is that a good model?

MS. WARD: Uh-huh.

REP. DeLUCA: And if you are in favor of it, who would you say would have to pay for the consumer advocate?

MS. WARD: It should certainly be a public sector position. There are two options, I guess. One would be, it should be paid for out of the public, or the second, it should be paid for by the insurance companies, by the people who are regulated. I would say either one of those would be acceptable

TRANSCRIPT OF PROCEEDINGS

\- - - -

options.

REP. DeLUCA: You know their response would be that they're going to have to raise the rates to do that?

MS. WARD: They have to raise the rates to do everything, don't they?

REP. DeLUCA: I just want to bring that up. I think it's a good idea, but unfortunately, we did have a bill up there and that was one of the concerns, whether we duplicate the insurance department and the fact that who would pay for it and so that any time you have something like that, they always -- the insurance carriers always say we're going to have to raise the rates.

MS. WARD: I don't know if the applications, if the federal law allows some of the federal funds to be used for an office of consumer advocate.

REP. DeLUCA: That might be a good point for us to look at. We'll certainly take a look at that. Representative has a question.

REP. PASHINSKI: I apologize for missing part of your testimony there. Let's talk about this consumer advocate thing, because there's -- people don't want to increase their government bureaucracy,

TRANSCRIPT OF PROCEEDINGS

- - - -

and that's one of the arguments, create this other group that's going to supposedly take care of this, but the problem is, you know, again who is going to pay for it. There's been controversy regarding that and some people have suggested that if the insurance department that we have were given adequate funds that could set up that particular part of their duties within the insurance department. Do you have any feelings about that?

MS. WARD: Well, a couple of things. Let me first say that -- let's address the issue of bureaucracy and regulation. I think that what Commissioner Ario said and what we see in a number of areas, and I know Representative Boyd will have to jump in on this one, is in order to hold government accountable for these expenditure of public dollars, we need the money to do that and in order to ensure that all both private business and the public adequately serves the people who are paying the freight, we've got to pay for that. I don't like to think of it as a bureaucracy, I like to think of it as consumer regulation and consumer protection is to protect consumers. Who's looking out for them really, somebody -- and I know many of you are in many instances, but you're fighting in this instance very large, very well-financed insurance companies. You need someone with the skills or an office with the skills to do that. You need the capacity.

There are a variety of ways to have informed public input, I mean, just at the very beginning you've got to make sure that the rate information is available on line, you've got to make sure that people can access it, you have to make sure that there's a public notice about refilings and rate increases and then finally, putting somebody in there. You know, I can't answer the question about how it works in other states, I would be happy to get that information to you, but my understanding is that the consumer offices tend to be outside of the regulatory department.

REP. PASHINSKI: Well, that's my concern as well. This group has to be insulated from any kind of influence, government or private, and the mechanism to do that and the finance is what the profits, I think everyone is crying out for transparency, but I think what we're trying to do here is just to create a balance.

Again, nobody wants to put these companies out of business, that's not the point. But the fact of the matter is, this cost is just unsustainable and the cost of healthcare, not just the insurance guys, the cost of health delivery is really sucking out all the money that would be going back into the economy, which would then bring us out of this recession.

So I would ask you, if you would, if it's at all possible, you know, to make your suggestions to me in writing or to the Chairman, to the Committee, because I think this is one way that we can help balance the powers.

MS. WARD: That's true. I'm happy to do that.

REP. DeLUCA: Chairman Sturla.

REP. STURLA: Just one question or comment about consumer advocacy. Do we know in other states, I don't know the exact figures, but I think we're talking about a multi-billion dollar industry here and maybe a multi-thousand dollar consumer advocate, so I mean, we're really talking about even tens of cents on the dollar in terms of costs involved to make sure that we might get tens of dollars back in return, because somebody actually advocated for the consumers.

MS. WARD: Yeah, I don't think the cost would be prohibitive, I think the costs all covered by would be very, very minimal.

REP. STURLA: Thank you.

TRANSCRIPT OF PROCEEDINGS

- - - -

REP. DeLUCA: Very good. Thank you again for your testimony.

The last individuals to testify, Patrick Reidy, president and founder of The Parkridge Group; and Sandra Fox, president and co-chair Western Pennsylvania Coalition for Single Payer Healthcare. Welcome.

MR. REIDY: Thank you for having me. Thank you for the patience.

I appreciate the opportunity to be here. I'll be brief.

REP. DeLUCA: Pat, let me just say to you, over the years since I've come to be the chairman, there's a lot of committees that only give people a certain amount of time. I think the best thing to do is hear from the constituents out here and that's why we have these hearings, and to limit people to speak doesn't do us any good. That's one of the reasons. I apologize for you waiting here that long, but that's the way we operate this Committee.

MR. REIDY: I find it all very interesting and I appreciate it. So a brief introduction. My name is Pat Reidy. My wife, Mykie, is here with me. We have two sons who are college age. We've made western Pennsylvania our home for 22 years. I'm an attorney, I practice a little bit of law, but I have my financial planning practice. I worked for a large corporation for a number of years.

What brought me here, we had Blue Cross insurance through that corporation and as the industry changed and HMOs came up, the plans changed pretty much every year, co-payments, co-insurance, deductibles. One of my sons has diabetes, was diagnosed at the age of nine, developed quite a bad infection when he was in high school. Managing the insurance, the copays, the deductibles, the bills for me was probably a ten- to 12-hour a week job, because he was so involved in the healthcare business. If it took me that much time, it probably took all of the providers an aggregate ten times that amount of time, and by the time they finally got that my last dollar and 20 cents, we spent more in postage and paper.

And I'll submit to this Committee and to Highmark that policies with deductibles and co-payments and co-insurance, maybe not the co-payments, those are easy, but the others are ridiculous, they're a waste of time and money and those policies should not exist. I think they were designed to help large corporations and medium-sized ones who pay the premiums for their employees to keep those premiums low, but it just shifted across the line, they wound up increasing overall costs for us, and so proposal one, if there's a way to do away with those, they make no sense.

A little bit of the story with my son and his illness. We spent the better part of two years in multiple surgeries here in Pittsburgh with UPMC-based physicians, all very well and patient, very good at what they did, they couldn't fix his illness, they didn't have the skill set. We have a PPO plan through Highmark that allowed us to go out of Pittsburgh. It took us, the initiative of my wife and I, they asked the doctors what about this guy in Atlanta who specializes in this, and when we finally got to him, my son was almost dead, and this guy fixed him immediately, because he had the skill set.

Now, we never brought any suits or anything else, but I did some inquiring of the doctors here, and the big medical providers, UPMC in particular, has a contract with all of these physicians that allows them, mandates that they not refer out of network if they think there's somebody in network that can do that job. I don't know if they thought that or if they just didn't think beyond the box, but large corporate providers with the economy in scale, and I understand they can save costs, but I think they do a disservice to the consumers in many ways.

One of those is limiting the physician's ability to practice in the patient's best interest. We were fortunate. We had the options and we used them, but for health insurance companies and for -- well, it's pretty much the insurance providers not to allow choice, I think is wrong. You should be able to go where you can get the best care. I'm not going to do it for a broken arm, but certainly for something that requires a specialist that might not be here, we should all have that option.

So my son is well. He's in college. My small business is composed of me and a partner. I turned 50 this year. Our rates went from $1700 a month to about $2800 a month as of July 1, pretty big increase. We have a Cadillac plan. We now have a Cadillac plan that under the new healthcare federal law would be taxed, because the premium is so high. I understand a little bit more about why our rates have gone up, probably age-based, but I think also because we use a lot of insurance.

So I filed a complaint with the insurance commission when it went up, because I felt what Highmark did was probably perfectly legal, but not right. I got the same letter back that we had read here, the same letter, complained about the Senate, you guys may like it, the Senate may not. I also called my Congressman Matt Smith who got me here today, who's been very sympathetic and helpful and is just a good representative, I appreciate it. I called State Senator Pippy's office and wrote a letter. I didn't hear anything back for a month, so I called again, I got a note back, an e-mail back from someone on his staff saying that there is legislative action has been taken in the Senate and they'd fill me in soon. That was about 30 days ago, so I don't know what's happened, but no one has gotten back to me.

I got in touch with my federal representative, Tim Murphy. A month later, someone on his staff got back and said they were going to take this up in Washington. Neither of my U.S. senators returned calls or e-mails or written letters. I think probably because they're busy, but I'm not sure, maybe they're not well, so I was tickled with Matt Smith for getting me in here, I wanted to tell the story.

After the insurance department complaint, a Highmark representative called me, her name was -- and I'm just paraphrasing this speech, because it's too long, but Shirley, Shirley Stein, Highmark small group marketing, very pleasant, very interested, helpful. She asked me why I filed a complaint. She wasn't kidding. So a long conversation later left me wondering why, if Highmark wanted to be competitive in the market, they increased rates and provide a few more options.

If I want to be competitive in my business, I usually lower rates and do more. So the Highmark explanation was, it might be helpful today, they don't want to be competitive in the market and providing insurance to sick people, they want to be competitive in providing insurance to people who aren't going to use it, and that's understandable. So Shirley was great and she offered a whole lot of different options. I could lower my premiums by $1000 a month if I took a $10,000 deductible and limited lifetime benefits and higher copays.

Small business, pretty much operating as a partnership, aside from the federal Medicare tax, premiums are deductibles just like out-of-pockets would be through an HSA, so it makes no difference to me. These plans were great, but they don't work, and with sons in college who are not in this particular network, other plans aren't going to work where the network is limited, and I'm not going to subject my family to that, because we have a son alive today because we had a choice. So out-of-network copays of 50 percent don't work for me, I could easily be bankrupt. It's cheaper for me to spend 3,000 a month.

The problem with me spending 3,000 a month, which I'm doing right now, is my partner just left the plan, he's still a partner, but his wife got a job at Pitt, she's got UPMC coverage for $300 a month, it was a good business decision for him. So Audrey Winchell, (phonetic) as you may know, runs the Pittsburgh Technology Council, Audrey called because she wanted to make sure that her people had done a good job communicating what happened, giving me options, saw that I had filed a complaint with the insurance department, and she sympathized and said they -- basically the Tech Council, which I don't know how many lives they have under insurance, they have no leverage with any of the insurance companies, but especially with Highmark. Highmark controls the market, they set the rates, there is no competition to speak of in western Pennsylvania. That's a problem. I told Audrey that I appreciated the call and that her next call to me was probably going to happen in a couple months because now that I'm a group of one, I don't have any options for group insurance and I don't

TRANSCRIPT OF PROCEEDINGS

- - - -

know whether Highmark -- well, I'll keep going on Highmark, HHIC is going to cancel the coverage because it's no longer a group, it's individual. And there are no individual plans to cover what my family needs than Highmark, and that's of course, not our coverage.

I don't mind paying the out-of-pocket and the rest, I think it's a waste and really against policy, but the worst part about it is, if I do hire somebody else to come to work for me, if I hire somebody's son or daughter who's in their twenties, they'd pay my rate. They're going to pay if they have a family, $3,000 a month, and that's just wrong. They wouldn't do it, I'd give them money, they'd buy insurance elsewhere. So my group goes away, because it's a group of one, it doesn't work.

So what do you do as legislators? Some suggestions. Mr. DeLuca has raised the point many times, Mr. Boyd as well today, that the underlying problem is not Highmark. It's easy to vilify them, and I don't want to do that, I understand what they're doing and why they're doing it. The cost of health insurance is high. So what do we do? The big standardized rates that are coming are great, why is it 2014, what are they thinking about here in Washington? If you're going to make a change in the law and it's worth making, why don't you make it happen this year or January 1 next year?

So can we as a state do something? I thought the Cambria County issue was interesting. Why not a group pool, why not standardize rates, do you have that legislative authority? This is what the rates should be. Maybe you do it based on ages, so the young people, healthy people don't have to pay more. I'm more than happy to pay my way, but standardizing rates, making a big pool is a good idea, standardizing how the insurance companies bill and how the various providers bill, one code for one service, great idea, take a lot of costs out of the system, get rid of these co-pays -- I'm sorry, the co-insurance and deductible plans, they make no sense, absolutely none.

The anti-trust laws, I'm not that much of an expert in them, but one company that owns 70 percent of the market is not a monopoly? Most industries it is. Who's in charge of enforcing those? I think there ought to be a ban. Lawyers have all kinds of great rules that they can't be subjected to non-compete clauses, right, because our interest always has to be our clients. Why don't doctors have the same clauses? They should. They should be able to go to whatever hospital or whatever practice they want to, why should they have to refer within network. I think as a legislative body, those are issues that probably can be legislature and maybe ought to be legislature.

I'm not even going to talk about tort reform. We heard a little bit about that, I know there are two sides to that equation, probably something that can be done to make it a little more reasonable than it is.

I would say to the direct issue at hand is if there's no legislative option, to talk to Highmark and ask them to roll these rate increases back, I think there probably is a legal option. I'm, again, not a litigator, but I suspect that the biggest increases from this change -- while Shirley Stein at Highmark told me or while the insurance commission or department told me that they did nothing illegal, I think they did.

I think if you look at who's paying the higher rates right now, the substantially higher rates, a disproportion would impact those of us a little longer tooth, so age protected under the federal and state laws. I bet you a disproportion would impact those with disabilities that are protected under federal and state laws and I bet you there could be a very successful lawsuit. The problem with bringing a lawsuit like that is the cost of doing it. So I'm sorry to those of the lawyers who left early because I would have enlisted some of their services, but I think this could be a Tom Corbett or Attorney General suit, it ought to be brought to his attention. I ask for your help in doing that, I'm preparing a white paper that I'm going to send to him to say bring the suit. Now, the gentleman is running for governor, it may not be politically correct at this point in time, and I appreciate that, but if he doesn't, then who does?

I spent the month of June on healthcare, I spent the month of June on looking at other options, talking to a lot of people and making a lot of phone calls, some people didn't get back to me, a lot of others did. I spent the month of June getting all the healthcare things that I put off for years, taking care, I don't like to go to doctors, I have nothing against them, most of them are very nice people. When you turn 50, you're supposed to have a colonoscopy and I told Shirley Stein at Highmark, you realize June is going to be the most expensive month you've ever had. She wasn't amused.

Where do we go from here? I don't think there are going to be any options for my family to buy insurance in this commonwealth if the technology council at Highmark comes back to me and says you can't have a group of one. A high risk pool isn't going to work for me. We need to have insurance. I can't go uninsured for six months, I have a kid with diabetes that costs a thousand, $1500 a month to take care of him, I'm not going to leave him uninsured. How can you do that? So I'll join the Romney crowd and move to Massachusetts, leave the commonwealth, close the business. That's not a good option. That's not a good option for either of us.

So I'm a little disappointed and I'm a little frustrated and I'm a little tired and I really regret having to take a month out of what's usually a pretty productive time of year to waste, and that's what it is.

Some of the options that were offered through UPMC and others, the technology council, would be okay, if we all lived in western Pennsylvania and my kids didn't move around and if we didn't have chronic illnesses that cost a lot of money, but we do. We also have a lot of options, I'll go out and make enough money to afford this, but I guarantee you that if it's 3,000 a month this year, it will be 5 next year. I have a very strong impression that Highmark does not want to insure some people, they don't want me as a customer, nor should they, I'm a lousy risk. I'm not, my family is, but I'm not going to leave them hanging. So at some point, my kid is going to grow up, maybe they'll get jobs, maybe they'll run for the legislature, I don't know. I wish you luck.

REP. DeLUCA: Certainly that's why we have these hearings, to hear your comments and certainly when we take this back to our colleges to discuss your comments along with the rest of the comments to see what we can do. If we had a magic wand, as I said before, we would wave it. Unfortunately, we don't have that, we don't have the luxury of just -- it takes higher than two votes in the house, 26 in the Senate. It takes a --

MR. REIDY: Do you have any influence with the Attorney General?

REP. DeLUCA: Do I have any influence with the Attorney General? Does anybody else have? Just as much as you would have.

REP. BOYD: Most of us don't.

REP. DeLUCA: I would imagine with all the Bar Association, all their expertise, I see a lot of these advertising on television about come see me and we'll get you money and get in an accident, the money that we would be saving, it would be beneficial for them if you thought -- I mean, with your information you have, to have them file a lawsuit. After all, there's a lot of things that they can do that's not going to cost them, I mean, going together, it's not going to cost them the labor part of it, like the average citizen.

MR. REIDY: The risk of these suits under the federal law, you know what I found, is if you lose, you have to pay the other side's costs and I'm sure they're not going to show up with one lawyer in brown shoes.

REP. DeLUCA: I would hope we have enough expertise in the Bar Association to counteract that.

MR. REIDY: Thanks for the opportunity to testify.

MS. FOX: I assume you each have a copy of my testimony or no?

REP. DeLUCA: Yes.

MS. FOX: Thank you for the opportunity to testify. My name is Sandra Fox. I appreciated hearing your testimony, Patrick, and that's why I do what I do.

I'm a volunteer of Squirrel Hill in Representative Frankel's district. I am self-employed

TRANSCRIPT OF PROCEEDINGS

- - - -

and I also volunteer as president/co-chair of the Western Pennsylvania Coalition for Single-Payer Healthcare.

My husband and I purchased insurance directly through a Highmark conversion plan, Keystone Blue HMO, offered to former members of Pittsburgh Center for the Arts, before that organization gave up administering group health insurance years ago. Our last invoice, dated June 25th of this year, indicates that the Pennsylvania Insurance Department approved a rate change that will become effective October 1st of this year. Your August statement for October coverage will reflect this rate change. The amount of that rate increase became apparent last week when a letter was received from Highmark with a bold headline reading, "This is a one-time offer. Please respond by July 30, 2010."

The letter opened with "Keystone Health Plan West is pleased to inform you that you can purchase prescription drug coverage as an added benefit to your Keystone Health Plan West HMO program. This is your only opportunity to add prescription drug coverage to your Keystone program."

Never mind that it was Highmark that stripped us of a better prescription drug benefit years before

TRANSCRIPT OF PROCEEDINGS

- - - -

without offering us a choice, and over the years, added a deductible and raised copays and premiums under this conversion plan.

So now, we have a two-week window in which to decide to either pay 16 percent more or 35 percent more for coverage beginning October 1st.

After hearing all the testimony today, I realized boy, we're lucky, right? Only 16 or 35 percent more, but you could say my experience has fed my passion for HR 676 which is the legislation in the US Congress that would create a single-payer, not-for-profit, Improved Medicare for All system of healthcare. But I also know that in our America, I am one of the lucky ones in that I have health insurance and am, so far, not declaring bankruptcy.

Herein lies the moral outrage for me. The ability to receive healthcare should not be a matter of lucky circumstance. While the new federal legislation, the Patient Protection and Affordable Care Act (PPACA) potentially opens the doorway to 30 million people in 2014, it leaves 20 million on the other side of the door.

What's more, many of the new insurance subscribers will not be able to use their health insurance due to out-of-pocket costs for co-pays or deductibles they cannot afford to meet, which we talked about today.

Meanwhile, in addition to the future windfall from 30 million new customers, the insurance industry is considering the following creative ways to continue their billion-dollar profits: (1) Reduce choice.

A front page headline in this past Sunday's NY Times read "Insurers Push plans that limit health choices." Apparently, our country's biggest insurers are busy promoting plans to small businesses that offer lower premiums in exchange for tighter restrictions on who the patient can see and what hospital they go to.

And listening to Patrick's testimony, I'm reminded, and hopefully all of us here are, about the importance of choice, and I wonder about the ten percent of people who received lower premiums from Highmark and was that because that they now have high deductible plans or what, I don't know, or less choice.

No. 2, another way to increase or maintain profits. Look for loopholes in the new federal law. PPACA requires insurers to spend 80 percent in the small business and individual market and 85 percent in the large group market on patient care (otherwise

TRANSCRIPT OF PROCEEDINGS

- - - -

known as you know as the Medical Loss Ratio.) However, the wording of the new law allows for "health quality improvements" to be part of patient care, creating a loophole for insurers to reclassify certain administrative costs as patient care. According to Consumer Watchdog, a law firm representing United HealthCare sent a letter to the National Association of Insurance Commissioners (NAIC) seeking to "include whole categories of claims administration and legal costs as patient care."

Evidently, the NAIC is tasked with making recommendations to Health and Human Services on implementation of the new health law.

Meanwhile, the industry has many friends who are in charge of overseeing healthcare reform. According to Consumer Watchdog, "top officials of the NAIC have long had revolving-door employment relationships with the insurance industry."

Furthermore, the Obama administration has just hired Liz Fowler to join the Office of Consumer Information and Insurance Oversight (OCIIO) at Health and Human Services. In 2006, Fowler was hired as vice president of Public Policy at WellPoint, our country's largest insurer, before she left to help draft the new healthcare bill as chief health counsel to finance

TRANSCRIPT OF PROCEEDINGS

- - - -

Committee Chairman Senator Max Baucus. So, we have the new healthcare law was written by someone who was an executive in the health insurance industry. Once again, we have a case of the "fox guarding the hen house." Would we consider hiring Don Blankenship to become the next director of the Occupational Safety and Health Administration? This is an outrage.

Because of the vague wording in what constitutes "patient care" and the lack of enforcement power in the law, we can expect the industry to offer little change in their degree of transparency and the continued spending of billions of our premium dollars on marketing, claims denials, lobbying and executive compensation.

Three, another way insurance companies will continue to make their profits, by increasing premiums. PPACA does not prevent insurance companies from engaging in double-digit increases in premiums. While insurers are required to post justifications for rate hikes on their website, neither the state nor the federal government is granted enforcement power to say no.

So, what do we propose the state insurance committee do? These are our recommendations:

(1) Support the passage of single-payer

legislation in the state, HB 1660 in the House, SB 400 in the Senate, entitled the Family and Business Healthcare Security Act and get the private insurance industry and profits out of healthcare.

(2) Support the funding for an economic feasibility study for HB 1660/SB 400.

(3) Support the federal single-payer improved Medicare for All bill in the US House, HR 676, which would save an annual $400 billion in administrative overhead and profit and redirect those funds to improve Medicare and expand it to everyone.

(4) Introduce legislation in the State House to give enforcement power, real enforcement power, to the insurance commissioner to: (a) demand real transparency in the expenses of the insurance industry; (b) require insurance companies to notify its subscribers of proposed rate increases; (c) require public hearings to review all proposed rate hikes; (d) to deny rate increases; (e) to end the discriminatory practice of medical underwriting in advance of the 2014 date in PPACA; (f) to make cherry picking illegal; (g) to require a much lower administrative overhead than the 15 to 20 percent allowed under federal law and closer to Medicare's administrative overhead of 3 to 4 percent, and to make

the administrative overhead consistent across individual, small and large groups; (h) to conduct audits of insurance companies to check for compliance; (i) to levy hefty fines against insurance companies out of compliance with new regulations; (j) to require citizen representation, with no ties to the insurance industry, on an oversight review board that has decision-making power within the Office of the Insurance Commissioner, otherwise referred to here today as the patient advocate, consumer advocate; (k) to disallow employment within the Office of the Insurance Commissioner of any one with past or present ties to the insurance industry, which would represent a conflict of interest; (l) to increase funding to the Office of the Insurance Commissioner to allow for adequate oversight of the insurance industry and enforcement of violations.

Joel Ario, who spoke earlier, acknowledged in June that his office and that of Health and Human Services have "no teeth" when it comes to regulation and enforcement of the insurance industry, and that all either office can do under current state and new federal legislation is to "shine a public spotlight" on the wrongdoing. This was during a panel discussion last month in Washington D.C. That is a tragic state of affairs and one I hope that you will do your part to correct. Thank you again for the opportunity to speak.

REP. DeLUCA: Thank you. Are there any questions? Chairman Sturla.

REP. STURLA: Thank you. Ultimately it goes to this notion of a single-payer system, but just to Mr. Reidy's point, I have a son who was born with some health issues also and he's now 16 and he has used more healthcare dollars than my wife, myself and my 20-year-old daughter combined, 130 years of health experience has not equaled to what his costs are at age 16. Not because he smokes or drinks or practices unsafe sex or any of those factors that you normally think of as behaviors that cost people more, it's because he had some health issues he was born with and that's where I think, you know, short of a single-payer plan, community rating looks beyond all that and says we're all in the same pool and, you know, I've always viewed this insurance as like I pay for life insurance, I really don't want to go collect it, you know, I am willing to pay for health insurance and my benefit of having to pay health insurance premiums and never have to use it is unhealthy, that's an okay result for me. I'm all right with the fact

TRANSCRIPT OF PROCEEDINGS

- - - -

that I pay health insurance premiums and never have to collect on that, but the day that I'm not healthy, I want to make sure that it's there, and if I can't guarantee that as a legislator, then something is wrong with the way that we administer this system. Because if it's just for -- if health insurance is just for healthy people, if this is a survival of the fittest model where those that can get by without the health insurance get the health insurance and those that can't, don't, there's something radically wrong with that system, and I think it's incumbent upon us to figure out how to change that system, to make it work.

MS. FOX: And to make it moral.

REP. DeLUCA: Representative Pashinski.

REP. PASHINSKI: Thank you, Mr. Chairman. First of all, to Mr. and Mrs. Reidy, thank goodness, and we're all very grateful that your son has recovered and found the right kind of doctor that could take care of him and to have your son so fortunate that he has a mom and dad that have the wherewithal and the financial capabilities to provide the care needed. You know, there are millions of other people out there that don't have that.

I think we're all victims here, we're all victims of a system that has gone wild and it's a matter of everyone trying to protect their own turf. Insurance companies are trying to protect their business, their turf, providing insurance for people that need it, and yet not going in the red or having another company take over and value, the doctors are trying to survive by the way they process their patients, volume, rather than what the Insurance Commissioner Ario talked about in bundling and so on. The people that provide the equipment and the supplies are making large sums of money on something that is something that we must have. Healthcare is no different than water or heat.

The point that the chairman made earlier was that we're all a part of this together and I think that, again, these hearings help us try to move the political agenda, the legislative agenda, but your roles can't just stop here with your testimony, and Chairman DeLuca made a recommendation that you have an organization which you can reach out to that has significant influence, you know, the profession that you're in, you need to gather your troops, and not that we're going to go into a fight, but the realization that we're all the same rats in the same sinking ship, we better all come together. And we can do our part legislatively, but we can only get it to a certain point, and this is where the public, when I mentioned earlier to you, you are the largest lobbying group and you're going to be the ones that's really going to shape this legislation. Thank God the oil spill, it appears, has ended. Now we can come back and focus on healthcare. Just because the feds passed that piece of legislation, it was a major step forward, it is not the end, it's just the beginning.

So to all of you that are here today, to those of you fighting for this, fairness and balance, you know, my hat's off to you, but we have to come together as Americans so that we can all sit down and understand their plight as well as we can understand that story and yours and yours and everybody else's. There is a solution, but it's certainly not going to be easy. Everybody has to give.

I think, again, Chairman DeLuca said it best, you have to give before you get, you can't continue to operate the same business model in 2007 here in 2010. It is a completely different business model and everybody is trying to protect theirself, less business, therefore, raise the price just to stay in, so we can provide the dividend or the capital for the investor.

TRANSCRIPT OF PROCEEDINGS

- - - -

Well, we're in a financial war, we're in the fight of our lives. We're all going to have to start working together and being very honest with each other and hopefully that dialogue will take place on a regular basis so that we all can survive. I mean, I could spend more time with you afterwards.

REP. DeLUCA: Representative Roae.

REP. ROAE: Thank you, Mr. Chairman, and thank you for your testimony. It's been my experience that people who push for the single-payer system are very sincere, they're very, you know, concerned about the issue and they really want to do the right thing, so I thank you for your advocacy for that cause that you believe in.

Now, on the other hand, people who have reservations about that, they're also very sincere about the concerns that are there, and I'm actually one of those people, but what I think a lot of people get concerned with with single-payer is: When you look at the federal government, the 13 trillion-dollar debt that we have; when you look at Medicare, it's going to be insolvent in eight years; when you look at social security, it's going to be insolvent in 2037; when the general accounting office, just like the postal service, is on the verge of insolvency; when you look at all these things that the federal government runs, they can't really run a big program without screwing it up. What confidence do you have that they'd be able to run the healthcare system better than they've been running the federal budget and social security and Medicare, the postal service, and any other major government program? Is there some indication that they would do a better job running that than they have run everything else?

MS. FOX: Many people are very happy with their Medicare and many people look forward to age 65 when they can go on Medicare and if you have traditional Medicare rather than Medicare Advantage program, in fact, you have the most choice than you probably had before with any insurance, private insurance carrier. Medicare has the lowest administrative rates, it's three to four percent, so when you talk about financial problems, under a Medicare for All system, we would save enormous sums of money because of the administrative overhead and because of the fact that it is not-for-profit, rather than a for-profit model and it takes out the middleman. So I don't buy that in terms of Medicare.

There have been studies done, many studies done, I should have brought the 12 page PDF file that

TRANSCRIPT OF PROCEEDINGS

- - - -

I have of states across the country, as well as studies on a national level that have all said the same thing, that under a single-payer Medicare for All system or under a state single-payer system, we would save billions of dollars. So I don't buy it.

REP. ROAE: Are you concerned that Medicare will be insolvent in eight years and are you concerned that if the federal government had a Medicare system for all 300 million of us that that wouldn't also become insolvent?

MR. REIDY: Sandra, do you mind if I take this one? Go ahead.

MS. FOX: If I could respond first. I don't believe that it will be insolvent and also, I'm very disappointed in the new national healthcare law that President Obama negotiated away the power to negotiate lower prices with the pharmaceutical industry by accepting a deal essentially for their endorsement of the plan.

There are things that can be done, there are reforms that still can be made and need to be made in order to reduce the cost of Medicare.

MR. REIDY: I understand that Medicare is a lot like the small group business that Highmark is looking to exit, at least the sick part of it, because they have a selection for people over age 65, they disproportionately use healthcare. Medicare's problems are an adverse selection problem and a funding problem. If you put 300 million people into the plan and they pay premiums, some reasonable basis, the funding problem will go away and the overhead costs that we now spend on all of the different codes and payments and the like would go away. I would submit without being able to even count that many zeros that the savings would more than cover, it would end the insolvency.

REP. ROAE: I guess when I look at the social security system, every single person, the entire country for the last, whenever they passed that 70 or 80 years ago, most people have been in the social security system. They knew we were all going to turn 65 some day, and like I said, that's going to be insolvent and I hope what you're saying is right, if it would ever come to that, I hope that it would work out, but it just seems like after decades and decades of deficits after, you know, massive insolvency in these major government programs, I really think there's a lot of concern with having the single-payer system run by the government.

And I still think the big emphasis should be on everybody focusing on how to get the cost of healthcare down rather than fight for who's going to pay for it. And I admire you for your advocacy, I think it's great that you're pushing for what you believe in, but I really think that it's such a divisive issue, I don't know how much headway you could get made for a single-payer. If all that energy were used to reduce the cost of healthcare, I just think that might be a better way to make sure that more people can have insurance coverage, we can improve the quality of healthcare in the country.

MS. REIDY: Can I add something?

REP. DeLUCA: Absolutely.

MS. REIDY: My name is Mykie Reidy, my husband gave testimony and mentioned that our son has been sick for most of his life and recently had a life-threatening event that went on for about three years.

You keep mentioning all these things that people can do to improve their health and lower the cost of healthcare and that is true, and it's true for people for whom their medical issues are related to their lifestyle, but my son didn't do anything to get diabetes when he was nine years old, and he didn't do anything to develop a life-threatening infection when he was 15 that kept him from being able to go to school for three years and require that he have five painful surgeries and miss pretty much his entire adolescence and suffer just unbearable pain for three years of his life that took him another three years to recover from.

There are many, many people who have illnesses and disabilities that have absolutely nothing to do with how they live and you can't just say that the cost of healthcare is just because of people's irresponsibility. There's many, many people who are -- I mean, I was the most diligent mother you can imagine, I fed my children the healthiest diet, I made everything from scratch, I gave him only organic food and still, my child got sick.

REP. ROAE: Right. I'm glad your child is okay. If I misspoke earlier, I apologize.

What I was getting at earlier was, people who cause damage to themselves in a good system should be paying more. If somebody chooses to smoke, if they choose to be overweight, if they choose to use drugs, they should pay more for health insurance than somebody that chooses to exercise, chooses to not smoke and chooses to maintain a healthy weight. And there's certainly people that access medical care through no fault of their own. And I think those people, they should not be penalized if they didn't do anything to cause it.

Now, if somebody smokes five packs a day, they're probably going to get sick more often, they should probably be paying more. I didn't mean to say that all healthcare is because of habits, it's not, probably half of it probably is. When you look at those things that are caused by our behaviors, so alcohol abuse, smoking abuse, things like that.

And one other note, again, I'm glad your son is okay. In a system like Canada, where there's a single-payer healthcare system, they probably would not have approved sending somebody 400, 500 miles away to a specialist doctor, that doesn't happen when there's a single payer, everything is rationed and it's very limited on the type of care that could be obtained.

MS. FOX: I just want to share a story in response to your last comment, Representative Roae, is that my mother-in-law who passed away last year needed surgery, she was from Beckley, West Virginia, she was on traditional Medicare and there was no doctor in her area that could provide the kind of surgery she needed for her cancer, and her doctors told her to come to

TRANSCRIPT OF PROCEEDINGS

- - - -

Pittsburgh where her son, my husband, is, and she had the surgery at Shadyside Hospital and it was completely paid for by traditional Medicare.

So you know, I think that we need to use examples of how successful traditional Medicare has been in this country in saving the lives of many people or at least prolonging their lives and getting them the surgery they need.

REP. DeLUCA: Chairman Sturla.

REP. STURLA: Just a couple comments. My sense is that the reason Medicare is in trouble is not because it's a bad system, it's because we've gone and raided funds there for years, we've said it is the provider of -- once said, the last resort, because it's, you turn 65, there you are, and you can go out and buy other insurances if you want to and some people do who can afford additional insurance beyond that, but it's there as that provider of last resort.

Social security being the other government-run program, we have stolen billions of dollars from the social security trust fund to balance budgets for years, which is why the social security system is in the trouble it's in and, you know, the best thing we can do to extend the life of social security is to increase the minimum wage, because all wages that are paid at minimum wage actually are taxed for social security.

If I increase the profits of an insurance exec who's making more than $90,000 a year and I up his salary, I don't do anything to extend the life of social security, because those benefits aren't taxed for social security. So the best thing I can do is to do things at the lower end of the scale as opposed to the upper end of the scale. So there's a lot of things we can do to make sure that those government programs actually work better. It has very little to do with denying people benefits, it has more to do with the way we administer those programs and who we get to pay for those programs along the way.

REP. DeLUCA: I want to thank you. Representative Boyd.

REP. BOYD: There's a couple quick points that need to be made. You brought up House Bill 1660. House Bill 1660 in it has a ten percent payroll tax and a three and a half percent increase in income taxes. It is a 52 billion dollar tax bill. That's double, almost double our current budget, so that is something that this legislature does not consider lightly. I mean, we, this past budget session, couldn't get enough votes out of the House with the governor strong arming to even put a tax on the Marcellus Shale gas or to tax tobacco products.

MS. FOX: I understand it would be a tough sell.

REP. BOYD: Okay. Well, I just wanted to bring that up, because it's good to advocate for that single-payer system, but we got to know a price tag, and that relates to what was brought up about Medicare, and one of the points that most people don't grasp about Medicare and Medicaid to a greater degree is one of the reasons that they continue to function the way they do is that there is a hidden private sector cost shift in both of those programs; the reimbursement rates that Medicare pays the providers does not even come close to matching the cost for medical procedures that they provide.

In other words, that cancer treatment, the surgery that your mother-in-law received, I can assure you that the cost that that hospital provided, that it costs them to do that procedure, they didn't meet, it exceeded what the Medicare reimbursement rate was. And one of the reasons all of our health insurance premiums continue to go up is very, very quietly underneath the system in these negotiated rates that are not transparent, and one of the things that

Chairman DeLuca and I want to get is transparency, is that what the providers are charging the private paying people is to make up that cost loss. They absolutely do. So there's a hidden shift that nobody sees.

So under the current environment, one of the things that we could do to help the private pay people is simply get Medicare's reimbursement rates and Medicaid's reimbursements rates up to the level they need to be to simply meet the cost of providing those services, because -- and here's the really, in my opinion, the sinister part of it, we want to provide the social programs to meet the needs of people, we really do, but we really don't want to pay for them. We have this aversion to saying House Bill 1660 is going to cost you 52 billion dollars, Pennsylvanians, are you on board? A ten percent payroll tax, what impact would that have on your business? What impact would that have on the small businesses out there, plus the three and a half percent income tax?

Some people are going to say I can absorb it, and other businesses are going to say, I'm out of here and I'm going to another state.

MS. FOX: I will just add that most businesses pay more than ten percent of their payroll on health insurance benefits if they're able to pay it at all. For them, it would be a dramatic savings. You know, I pay about 60 percent of my income for healthcare premiums and out-of-pocket costs right now. That's likely to go up, actually, as my income goes down because of the recession. So for me to pay, you know, three and a half percent, or I'm self-employed, so I add ten percent, my God, that's a lot of money that I would save, plus under the single-payer system, there are no premiums, there are no copays, there are no deductibles, there are no out-of-pocket costs.

So what you need to do, I say it's a tough sell only because people don't know the facts, and that's where public advocates come in, like me and many, many others throughout the country in educating people about single-payer and the fact that you can have guaranteed health security regardless of your ability to pay and circumstance. Everybody is lucky.

REP. BOYD: And I understand what you're saying, I hear you, and then there's a whole series of other businesses out there, sole proprietors, entrepreneurs, whose wife may work for a school district and the husband is covered, or vice versa, the husband works for a school district or works someplace and is covered and so they aren't -- they

- - - -

don't have health insurance, a lot of small businesses that are functioning, providing jobs, they aren't paying any health insurance premiums because their spouse or somebody is covering, they have family coverage elsewhere. All of a sudden, they're going to get hit with a ten percent payroll tax and the average small business, average small business, in the state of -- actually, nationally, their margin is roughly three percent. I can get you the statistics from the National Federation of Independent Business, I'd be happy to provide that. The bottom line is, you increase income taxes three and a half percent and you hit businesses with a ten percent payroll tax -- and by the way, 1660 is structured that it's a hundred percent paid for by the company, there's no employee -- at least social security has the integrity to split it.

MS. FOX: Well, three percent is paid by the individual.

REP. BOYD: Well, unless you're an S corp or a pass-through corporation and then you're paying 13.

MS. FOX: Again, that's a big difference for me, from 60 percent to 13 percent. Believe me, I would welcome that.

TRANSCRIPT OF PROCEEDINGS

\- - - -

REP. DeLUCA: Okay. Chairman Sturla.

REP. STURLA: House Resolution 732 would look at the cost of a single-payer plan, so you could actually then talk about what the cost is now in the state of Pennsylvania in its entirety for providing health insurance at a private level versus a single-payer plan, so hopefully we can get that house resolution passed, just to give the folks an analysis, so that we're talking about the same, the same analysis, as opposed to one person's analysis versus another.

REP. DeLUCA: Again, I want to thank you. I want to thank you for taking the time to come here and stay here for the meeting.

MS. FOX: Thank you so much for having us here.

REP. DeLUCA: Thank you. On behalf of myself and Chairman Sturla and the Committee, I want to thank every one who has participated in today's hearing.

I personally thought the testimony was outstanding and has provided the Committee with a number of thoughts on what our next steps should be. This Committee will work with all the stakeholders and the administration to develop the right approach on

TRANSCRIPT OF PROCEEDINGS

- - - -

how to best resolve issues that were raised here today.

I also, again, want to thank all the members who came, it was a great turnout, some of the members had to leave because they had other commitments, but I want to thank them. I have always thought, I'm sure Representative -- all the Committee has always thought and Chairman Sturla has always thought that there's no better alternatives to understanding all sides to an issue than attending a public hearing where all parties have the opportunity to demonstrate their perspective. This hearing is yet another example of how important the public hearing process is.

Just for a reminder to the public out there, tomorrow we will be having at the University of Pittsburgh the second in our series of hearings on the Pennsylvania implementation of the Patient Protection and Affordability Care. We will be at Room 548 of the William Pitt Union, student center of the University of Pittsburgh. For the members, there will be parking in Soldiers and Sailors parking garage, which is right across the street.

The hearing will focus on providers reimbursement in the context of the federal healthcare reform with an idea to making sure that adequate

TRANSCRIPT OF PROCEEDINGS

- - - -

quality healthcare is available to all our citizens. The meeting will start at 10:00 tomorrow morning.

Again, I want to thank you and I want to thank the Committee. This meeting is now adjourned.

(Hearing concluded at 3:44 o'clock p.m.)

- - -

- - - -

C E R T I F I C A T I O N

I hereby certify that the foregoing transcript is a true record of the testimony of the witnesses.

____

Jean M. Bujdos

Court Reporter