COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE

ERIE CITY HALL
CITY COUNCIL CHAMBERS
ERIE, PENNSYLVANIA

AUGUST 26, 2008
10:00 a.m.

BEFORE:
HONORABLE ANTHONY M. DELUCA, CHAIRMAN
HONORABLE PATRICK J. HARKINS
HONORABLE NICK KOTIK
HONORABLE EDWARD P. WOJNAROSKI, SR.
HONORABLE BRAD ROAE
HONORABLE FLORINDO J. FABRIZIO

ALSO PRESENT:

HONORABLE THOMAS C. PETRONE, CHAIRMAN OF URBAN AFFAIRS COMMITTEE.

RICK SPEESE - EXECUTIVE DIRECTOR (D)

Reported by Janis L. Ferguson, RPR, CRR
Ferguson & Holdnack Reporting, Inc.

I N D E X

REPRESENTATIVE DeLUCA: Good morning, ladies and gentlemen. I want to call this meeting to order of the Insurance Committee today. And before I start out, I'd like the members of the committee to introduce themself; from my left to my right.

REPRESENTATIVE PETRONE: Thank you, Mr. Chairman. Representative Thomas Petrone, Democratic Chairman of the Urban Affairs Committee. Good morning.

REPRESENTATIVE HARKINS: Good morning, Mr. Chairman. Welcome to Erie.

REPRESENTATIVE DeLUCA: Thank you.

REPRESENTATIVE HARKINS: Pat Harkins, 1st District; Erie and Lawrence Park.

REPRESENTATIVE FABRIZIO: Flo Fabrizio, 2nd District; Erie, Summit, and Millcreek.

REPRESENTATIVE DeLUCA: I'm the Chairman of the Insurance Committee, and I'm from Allegheny County. And to my right is my executive director, Rick Speese.

REPRESENTATIVE KOTIK: Nick Kotik, 45th Legislative District, Allegheny County.

REPRESENTATIVE WOJNAROSKI: Ed Wojnaroski, Cameron County.

REPRESENTATIVE DeLUCA: As I say, good morning. And for the audience out there -- and I was asked by Paul Wagner with WICU Channel 12 in Erie, since this Bill passed

the House, why were we having these hearings. We are going to continue to have these hearings until we go back in September. And the reason, even though this Bill passed the House, is to try to prod the Senate into acting on healthcare.

As you know, healthcare is one of the most important issues out there facing the public, not only in Pennsylvania, but also throughout this nation. Both candidates for President are talking about healthcare. The people continue to lose their jobs, continue to lose their healthcare, and we intend to try to do something to put pressure on the Senate of Pennsylvania to come up with a compromise. And as the Chairman of this committee -- and it's a bipartisan committee; nine members on the committee -- we are willing to compromise on behalf of 12 million Pennsylvanians out there to come up with a plan that will enable them to have healthcare.

As I said, this hearing this morning on healthcare reform, Pennsylvania ABC plan is very important. First, I would like to thank Representative Fabrizio for being our gracious host this morning. And I also would like to thank the folks in Erie for allowing the committee to meet in this beautiful Erie City Council chambers.

As I look up at the board here, there's a familiar name that I had the privilege and honor of serving

with, Italo Cappabianca, and I understand that's his brother on Council. So it's always good to see his name. And certainly it brings back a lot of memories of my colleague that I served with.

As most of you know, this committee has held numerous hearings in the last two years throughout the length of Pennsylvania on the subject of healthcare reform. In fact, since the Governor announced his healthcare reform proposal a little over 18 months ago, this committee held 11 hearings on this proposal. We traveled throughout the state and heard testimony from a wide range of citizens and interested parties. We spent a good part of 2007 listening and learning from the people of Pennsylvania regarding the state of healthcare coverage in our Commonwealth.

Having gathered significant feedback from all corners of the state, we began to advance an aggressive healthcare policy agenda in the House.

Significant progress has been made in controlling costs by enacting the most comprehensive legislation in the country dealing with the prevention of healthcare-associated infections in our healthcare facilities. This legislation, signed by the Governor on July 20th, 2007, will save billions in wasted healthcare dollars by preventing hospital-acquired infections, and, more importantly, will save the lives of our fellow

citizens.

We also passed numerous measures which expanded the scope of practice for less expensive providers, such as physician assistants, nurse practitioners. We enacted a statewide smoking ban, and, most recently, mandating insurance coverage for the treatment of autism and colorectal cancer screening.

If we intend to see reform this fall, we need to encourage the discussions, as I stated, with our Senate counterparts immediately. The people of Pennsylvania expect us to work together to fashion a plan which encompasses the best ideas of both chambers.

As Chairman, I remain willing to meet anywhere, at any time, to discuss and negotiate compromise solutions in providing healthcare insurance to as many people as possible. We can do much if we have the will to tackle the problems head on.

Today, I urge my Senate colleagues to take up the issue, and let's meet the challenge together for the betterment of the people of the Pennsylvania -- of the Commonwealth of Pennsylvania.

So here we are today to keep the focus on the need expressed -- the needs expressed to us over and over again by Pennsylvanians of all political persuasions that they need action now to assist their fellow citizens in

becoming insured.

Today I look forward to hearing the testimony we will receive. I want to thank all those who will be testifying. I want you to be assured, we will take your thoughts and ideas to heart when we return to session in September.

With that, I will call our first witness to the table, Mr. George Hoover, Deputy Insurance Commissioner, Office of CHIP and adultBasic Coverage. Welcome, George.

MR. HOOVER: Thank you.

(Discussion held off the record.)

MR. HOOVER: Well, good morning. I am George Hoover. I'm the Deputy Commissioner for CHIP and adultBasic program in the Pennsylvania Insurance Department. And on behalf of the Insurance Commissioner, I would like to thank the committee members for the opportunity to come before you today to talk about access to healthcare in Pennsylvania.

I will speak briefly about the status of Governor Rendell's initiative, Prescription for Pennsylvania, PA Access to Basic Care, or ABC, which is a major component of the initiative, and a bit about small group health insurance reform.

In January of 2007, Governor Rendell stated that now is the time to provide affordable, quality healthcare to all Pennsylvanians and reform and repair our

broken healthcare system. To address these issues, the Governor announced the Prescription for Pennsylvania, an aggressive and comprehensive plan to reform Pennsylvania's healthcare system and reduce the number of uninsured adults. The Prescription for Pennsylvania is a set of integrated practical strategies for improving the healthcare of all Pennsylvanians, making the healthcare system more efficient and containing its costs, resulting in affordable, quality healthcare accessible to all Pennsylvanians.

The key is that it's a set of integrated strategies. Addressing one area alone may serve as a band-aid, but will not result in reform of the healthcare system.

We have reached many of the goals set forth in the Prescription for Pennsylvania. A brief summary of what we've accomplished follows:

For example, we've improved -- Pennsylvania has improved the access to healthcare by enabling certified registered nurse practitioners, nurse midwives, dental hygienists, physician assistants, respiratory care practitioners, and physical therapy assistants to practice to the full extent of their training and education through changes to the Scope of Practice.

Legislation to require infection prevention procedures and reporting of health-associated infections has

been enacted, and a public education campaign on infection prevention is underway.

The chronic care commission presented a strategic plan in February of 2008 to improve the delivery of healthcare to Pennsylvanians with a chronic illness. Regional rollouts of the plan started in May, with a statewide rollout incrementally throughout 2008.

A comprehensive indoor smoking ban barring smoking in most indoor places has been enacted and takes effect September 11, 2008.

The Office of Long-Term Care Living is working to increase the number of people using home and community-based services and establish a centralized resource center for information on planning, insurance, and application for services.

The Cover All Kids initiative to expand the Children's Health Insurance Program was successfully launched and is currently providing access to affordable, quality healthcare to over 174,000 children, which is an increase of over 20,000 children since the expansion of the program. Thank you to the Committee for all the assistance in expanding CHIP to include all of Pennsylvania's children.

While we have achieved much, there's still much to do. Two initiatives under the purview of the Insurance Department are Small Group Reform and Pennsylvania

Access to Basic Care.

As is evident from some of the accomplishments just mentioned, Pennsylvania is a national leader in addressing key cost drivers of medical inflation by focusing on reducing healthcare-acquired infections, managing chronic care conditions, and enhancing transparency of healthcare quality and cost comparisons. Insurance companies must be active participants in these cost-control initiatives so that groups of all sizes, not just large employers, achieve cost savings.

The reforms defined in House Bill 2005 give the Insurance Department the authority to make sure that insurance companies adopt the best practices for cost control for all consumers and pass on the resulting savings or cost containments for all businesses. All businesses need stable and predictable health insurance rates so that they can hire the most qualified and experienced workers without the fear of discriminatory rate hikes.

House Bill 2005 makes premiums more stable and predictable by limiting rating variations and prohibiting rating increases based upon pre-existing conditions, health status, and gender.

House Bill 2005 requires insurance companies to contain rates in the small group market by rating all small employers within rate bands that limit variations.

The most expensive policies may, at most, cost a third more than the average rate. The Bill increases the efficiency of health insurance operations by requiring insurance companies to spend 85 percent of what they collect in premiums from employers when paying for healthcare for those covered by their policies. It is time for Pennsylvania to join the 48 other states that have adopted small group health insurance reforms to protect small businesses.

Equally important is to ensure that Pennsylvania families can afford health insurance. As I stated earlier, Pennsylvania successfully expanded its Children's Health Insurance Program to provide quality healthcare to all children. We have also been very fortunate in Pennsylvania to have the adultBasic program in Pennsylvania to provide a limited benefit health insurance product to low-income adults. However, the program quickly reached its funding limit, and a waiting list had to be created. The Prescription for Pennsylvania proposed the Cover All Pennsylvanians initiative as the next logical step in providing access to quality affordable healthcare to all Pennsylvanians. This initiative has since been modified and amended into Senate Bill 1137 by the House of Representatives and is now the PA Access to Basic Care program. This program addresses hundreds of thousands of uninsured adults in Pennsylvania that need access to the

healthcare system.

Data from the 2004 Health Insurance Status Survey conducted on behalf of the Pennsylvania Insurance Department indicates the following:

47 percent of the adult uninsured are between the ages of 19 and 34 years of age.

71 percent of the uninsured are employed.

75 percent of the employed uninsured work for private companies.

62 percent of the employed uninsured are in the service industry, and 21 percent are in retail.

77 percent earn less than 300 percent of the federal poverty level. Using the 2008 poverty level guidelines, that equates to about 31,000 for an individual or $63,600 for a family of four.

27 percent of the uninsured have been without insurance for at least five years.

70 percent of the uninsured list cost as the reason for not having health insurance.

Expanding access to appropriate care will, (A), include the quality of care that the Pennsylvanians receive and, (B), drive down the cost of healthcare for families and employers. PA ABC is an affordable healthcare plan for eligible uninsured adults and small businesses. PA ABC will provide access to healthcare coverage by creating

an affordable health insurance product for small businesses, low-wage employees, and uninsured self-employed, as well as other uninsured individuals through a combination of efforts.

Small businesses with two to 50 employees that are low-wage employers, where the average wage is not greater than 300 percent of the federal poverty level, which I said was currently 31,200 annually, and who enroll at least 50 percent of the eligible employees who work over 20 hours per week, will be entitled to participate in PA ABC. The employer will be required to pay 50 percent of the discounted premium for the enrolled employees or $150 a month, whichever is greater, and the enrolled employee will be responsible for the remainder of the discounted premium. This means that businesses will pay far less for employee healthcare because of the program and, thus, will be more willing to purchase coverage than is currently the case.

In dollars and cents, the estimated cost to provide the benefit is approximately $322 per enrollee per month. Employers that meet the eligibility requirements and choose to participate will pay approximately $161 -- as I said, 50 percent -- per enrolled employee per month in the first year. Employees who participate in PA ABC will pay the following:

There's no premium for individuals who have

no income greater than 150 percent of poverty, which would be 15,600, or 31,800 for a family of four.

The premium would be $40 a month for those individuals who had income greater than 150 percent of poverty level, no greater than 175, which is the $15,600 to $18,200 range for an individual, and 31,800 to 37,000 for a family of four.

$50 will be the income -- $50 for those with income greater than 175 percent of poverty, but no greater than 200 percent of poverty, which is between 18,000 and 20,800 for an individual, and 37 and 42 for a family of four.

Adults with income greater than 200 percent of poverty may purchase the benefit at the per-member, per-month rate negotiated by the Commonwealth, or, in the first year, $322 a month.

Employees of non-participating employers with incomes no greater than 200 percent of the federal poverty level who are uninsured because they cannot afford the premiums for private healthcare insurance offered by their employers may also apply and participate in PA ABC. The Commonwealth will determine if it's more cost-effective to pay for their employer-sponsored insurance or to have them participate in PA ABC. This will operate similarly to the Department of Public Welfare's existing and very successful

health insurance premium program.

Other individuals, including the self-employed, may also participate in PA ABC. Those with incomes no greater than 300 percent of the federal poverty level may apply for PA ABC and will pay premiums as outlined for the employees; again, depending on family income. If the uninsured individuals, including the self-employed, have income greater than 300 percent of poverty, they may also apply for PA ABC. However, they would pay the full monthly premiums and must show that private coverage would not exceed 10 percent of their household income or that the total cost of coverage for the individual is 150 percent of the premium. And that's sort of a mouthful there. So, in other words, they would have to prove to us that their income was no greater than -- or the premium was more than 10 percent of their income, or that they couldn't receive a program like ABC, a comparable program, for 150 percent of the premium costs.

Also, if the family was denied coverage or the person was denied coverage due to a pre-existing condition, they would not be disqualified from PA ABC.

To discourage employers from dropping their private insurance coverage just to participate in PA ABC, small, low-wage employers must not have offered health insurance coverage to their employees for the six months

preceding their application for participation in the program. To discourage individuals from doing the same, the applicant must have been uninsured for at least 180 days immediately preceding the date of application.

You know, for adultBasic right now, we have a 90-day requirement. But the Federal Government will be insisting on a 180-day requirement.

There are exceptions to the "go bare" periods to allow for individuals who have lost their health insurance coverage for reasons such as the loss of a job, divorce, for separation from a covered individual, the death of a spouse who was insured, or if the applicant is transferring from one government-subsidized health insurance program to another.

PA ABC, as currently drafted, will also provide for more than $2 million in care grants to eligible low-wage small businesses that currently offer health insurance to help them cover the rise in premiums.

PA ABC will replace the current state-funded and adultBasic program which provides a more limited benefit package. Like adultBasic, PA ABC is not an entitlement program and will be limited based upon available funding. PA ABC will operate similarly to managed care plans doing business in Pennsylvania. As with adultBasic, to ensure statewide coverage, the Blue Cross/Blue Shield plans will be

required to submit a proposal. The infusion of State funds from a number of sources will serve as the State match portion for accessing Federal Medicaid dollars, to both increase the number of individuals enrolled, as well as increase the benefits that are provided. The intent is to enroll approximately 111,000 individuals during the first year, and we anticipate that growing in the year 2012 to 2013 to about 265.

The healthcare benefit cost will total approximately 214 million in fiscal year 2008/2009. Of this, about 123.3 will be the cost to the State, mainly incorporating funding already allocated to the current adultBasic program. The remaining costs will be covered by a variety of revenue sources, including Federal Medicaid matching funds, enrollee, and small employer cost-sharing. Right now, the Federal Government reimburses us at 54 percent. For every dollar we spend on a Medicaid-type program, we get 54 cents back.

I just highlighted the cost of action, but what is the cost of inaction? For the sake of time, I'll not delve into the numerous studies on the uninsured that impact on billing through various stages of life without preventative visits, screenings, and early detection of high-cost and often life-threatening conditions.

However, if we were to leave the adult

program as it is today, it is estimated that by the end of this current fiscal year, we would be providing access to approximately only 40,000 people, and the wait list would be about 160,000 people. Without the ability to draw down total funding, the number of enrolled will continue to erode by approximately 1,000 enrollees per month, and the wait list will continue to grow five times faster.

Even more significant, according to a March 2008 Families USA report, two working-age Pennsylvanians die each day due to lack of health insurance, which was about 710 people in the year 2006. Between 2000 and 2006, the estimated number of adults between the ages of 25 and 64 years old in Pennsylvania who died because they did not have health insurance was more than 4,800 people.

My office responds to consumers inquiring both about the CHIP program and the adultBasic program. On more than one occasion over the past year we have had to write condolence letters to families of individuals waiting to be enrolled in the program. We are planning to have the PA ABC program begin by providing coverage to uninsured adults early in 2009, assuming timely passing of state legislation to implement the program and prompt approval by the Federal Government. The acquired waiver request was submitted to the Department of Health & Human Services at the Federal Government level on June 16th, 2008. We

continue to communicate with and work closely with the staff of the Center for Medicare and Medicaid Services regarding a waiver request. Negotiations continue to move forward.

PA ABC and Cover All Kids will make affordable health insurance available to the vast majority of uninsured Pennsylvanians. But this is only one piece of the puzzle. To affect true reform, you must address affordability, accessibility, and quality as equal parts of the plan.

As you continue to hold hearings regarding healthcare across the state, I'm certain that you will agree in this case, as the Governor stated; the cost of inaction will far outweigh those costs associated with the actions outlined in Prescription for Pennsylvanians.

Thank you for convening this hearing and allowing me the opportunity to speak about the uninsured, PA Access to Basic Care, and the Prescription for Pennsylvania. I'm available for any questions you may have.

REPRESENTATIVE DeLUCA: Thank you very much, George. You've done an excellent job in your testimony.

Before I ask you a question, I want to recognize one of our colleagues that just joined us, Brad Roae of -- Mercer County?

REPRESENTATIVE ROAE: Crawford County.

REPRESENTATIVE DeLUCA: Crawford County. Sorry.

Crawford County. Thank you for showing up.

George, you mentioned the fact about -- and the Governor has mentioned it too -- where the inaction would far outweigh the costs associated in connection without -- by action. Can you tell this committee how -- approximately what the savings would be if we adopt this program.

MR. HOOVER: Well --

REPRESENTATIVE DeLUCA: When I say what the savings would be, right now, what does it cost to every ratepayer in the Commonwealth of Pennsylvania for uncompensated care?

MR. HOOVER: About 6.25 percent of the premium that's in your insurance and my insurance is as a result of having to pay for the cost of uncompensated care. So that results in a figure that you and I pay on a monthly basis, or whoever pays for insurance.

REPRESENTATIVE DeLUCA: I don't think the public realizes that they are paying for the uninsured already. I really don't believe that they -- nobody says how much of their premium goes to paying for the uninsured. I think we need to get that out there a little bit more, so people realize that there is no free lunch out there, and that we, as ratepayers, are paying for the uninsured out there, and that's why it's important that we adopt this type of

program.

And I just want to say, to the Governor's credit, bringing this up to the forefront, especially in his -- in his winding years, as he recognizes he can't run anymore, so his, certainly, being an active participant in this program certainly has helped.

And I also want to state the fact that to his credit, he was willing to compromise. I know we met with his staff many a times to talk about what we could pass and what we couldn't pass, and, as you know, his first plan was to cover all Pennsylvanians with a 3 percent payroll tax, and he was very adamant to that. But as you know, the legislature would not go along with that, and he realized that he had to compromise. And to his credit, he did compromise. Certainly, the $42 million wasn't in his plan either that he provided to small businesses. So I just wanted to state that for the record.

Any questions from my left?

REPRESENTATIVE PETRONE: No, thank you.

REPRESENTATIVE DeLUCA: How about my right? Representative Brad Roae.

REPRESENTATIVE ROAE: Thank you, Mr. Chairman. And thank you for your testimony. I just did some quick math here. When you look at the money the State would be paying and the money the Federal Government would be

paying --

MR. HOOVER: Yes.

REPRESENTATIVE ROAE: -- it works out to about $1900 a year per person. Is that correct?

MR. HOOVER: 1900 -- the benefit is going to be about $322 a month. So -- and that would be -- that would be times 12. But then you take out the Federal share, which would be 54 percent. Now, if individuals have earnings of their own, they would pay part of it.

REPRESENTATIVE ROAE: Well, what I meant, the State would be paying $123 million a year --

MR. HOOVER: Right.

REPRESENTATIVE ROAE: -- to cover 111,000 people.

MR. HOOVER: Okay. Yeah.

REPRESENTATIVE ROAE: And then the Federal Government would be paying -- the number is here someplace. When you do the math out, it works out to about $1900 a year per person. And doesn't health insurance usually cost, you know, 10 or $12,000 a year per person?

MR. HOOVER: Well, it usually costs more than that, unless you're buying it as part of a group pool. And, also, the way that we would get insurers to participate in the program, which are already calling us, because they are interested, waiting for the program to occur, we'd be -- what we'd be doing would be called Medicaid rate banding,

where we decide what the premium level was that was affordable.

Now, we've also had Mercer, who is a very well-known nationally -- actuarial group help us with these numbers, and they have told us, even though they don't certify right at this point that they are actuarially sound, they say that that premium of 322 a month follows all actuarial principles. And when the final rate is set, they will certify that.

We are only able to get Federal funding from the Federal Government if we have a premium that is certifiable. So I guess to your point, that even though that seems cheap, those numbers are valid numbers, and part of it's based upon the large pool of people that we'll be insuring.

REPRESENTATIVE ROAE: And then when you project the numbers out, the cost to Pennsylvania taxpayers would be about 293 million by the year 2012, if you figure out the cost per person. You know, if 111,000 people, compared to 265,000 people. And I think it's well-intentioned to try to help people get coverage. I think it's a noble goal that, you know, everybody that wants health insurance, to have it. But just from a fiscal point of view, where would you anticipate that we would come up with $293 million in the State budget that's already strained with what we're already

spending on all the different, you know, Medical Assistance programs, you know, medical care for prison inmates; all the other different welfare programs that we have. You know, currently about, you know, one-third of the State budget is aid for low-income people, which I think is good; we should help people.

MR. HOOVER: Sure.

REPRESENTATIVE ROAE: At some point we have to cut a line and say, you know, we can't use all of the State resources. You know, we still have to have roads, we still have to have education, we still have to have, you know, other Government functions.

At what point do we decide that we can only spend so much, you know, to help people?

MR. HOOVER: Well, to get the money for the 265,000 people, you're probably aware that when the Governor talked about that, the sources of funding that he used were the two current sources that we have right now in adultBasic, which is tobacco dollars and the money from the Blues which come in from their charity; what's called the community health reinvestment dollar. So we have those two sources.

There would also be additional sources of tobacco uncompensated care dollars that we would use. In the year five, that number would be $11 million. There's

also a disproportionate share of hospital money that's going out to hospitals. In other words, hospitals right now are serving the uninsured. They have to when people show up on their door. As we insure more and more people, what we'll find is there will be less people that will need to go to a hospital to receive that treatment, because they will have received care. So we'll be using monies from -- that are now paid to hospitals for uncompensated care.

We'd also use some money from the healthcare prevention -- healthcare providers retention account. And I think that number, in the year five, is about $24 million.

So when you add all those numbers together -- and I didn't give you the exact totals of those, but I would be happy to do so -- that's where the funding would come from in a five-year period.

REPRESENTATIVE ROAE: All right. Thank you, sir.

REPRESENTATIVE DeLUCA: Any other questions? Representative Kotik.

REPRESENTATIVE KOTIK: Thank you, Mr. Hoover, for your testimony today.

This plan that you've outlined today, this kind of assumes that the Federal Government is going to do anything -- or do nothing. Is that correct? In other words, any plan that we eventually come up with in Pennsylvania has to have a Federal component.

MR. HOOVER: Right.

REPRESENTATIVE KOTIK: And as the Chairman indicated in his opening remarks, I'm sure that there's going to have to be a meshing of the two plans at some time in the future if the Federal Government decides to step to the plate and really participate in healthcare.

So this plan just assumes that funding -- Pennsylvania going alone, with some help from the Federal Government, without a substantial infusion of new Federal dollars.

MR. HOOVER: Yeah. I mean, who knows what the future holds. But we've been meeting with the current Administration very closely for about a six-month period. And I actually have a letter here I'd be happy to give you that they wrote back to us to say that things are going very well for Pennsylvania.

I think waiting for a Federal solution, a long-term Federal solution, like some type of universal plan, I mean, that's going to take, even a new President, who is well intending, probably two or three years to put something that large in place. And we think that folks have waited too long already in Pennsylvania, and we believe that we're very close to being able to get their approval.

They, however, cannot give us approval and their funding until we have State legislation. The Senate

has to act. And we're working with the Federal Government, assuming that the Senate is going to approve the Bill that's in front of them. If it needs to be adjusted -- if it is adjusted and then goes back to the House, what it's actually -- the plan in Pennsylvania, we'll have to go back and adjust the information that we've given to the Federal Government.

But, I mean, in the short term, the Feds say, we don't have a solution; we'll work with states on their own solution. Maybe a new President will come up with a Federal solution. But we don't want to wait that two or three years from where we're at right now.

REPRESENTATIVE KOTIK: No, I agree with that. My only point is that when we talk about prescription drugs, Pennsylvania was the leader with the expansion of the PACE program, and consequently, then, the Feds came into the picture, and we've kind of meshed the two programs together. And, hopefully, down the road, if we implement this program, the Federal Government will see the program and implement it and give us more assistance to kind of lighten the burden on Pennsylvania taxpayers.

MR. HOOVER: I mean, we would hope so. When this program gets approved, we'll get 54 cents back for every dollar we spend. So over half of the cost will be borne by the Federal Government.

REPRESENTATIVE KOTIK: Thank you.

REPRESENTATIVE DeLUCA: Let me also state in response to Representative Roae's question about where the money is coming from, one of the things you should put down there, there are -- there are other avenues for revenue too. You might -- there are a lot of us in the House who certainly believe that we can cut the four caucuses' legislative appropriations 20 percent, which is a substantial amount of money that can go into these programs. And there are other programs that we're looking at too.

So, I mean, there are monies available, and I would rather use that money for healthcare to insure Pennsylvanians out there than anything else.

MR. HOOVER: Thank you -- thank you very much for that offer.

REPRESENTATIVE DeLUCA: Well, there are certainly members in the House -- both sides of the aisle will agree with that 20 percent cut.

Thank you very much for your testimony.

The next individual to testify is Andy Glass.

MR. GLASS: Good morning. Thank you.

REPRESENTATIVE DeLUCA: Okay. Are we ready, Andy?

MR. GLASS: I'm ready.

REPRESENTATIVE DeLUCA: All right. Go ahead.

MR. GLASS: Good morning. My name is Andy Glass,

and I'm the director of the Erie County Department of Health. I appreciate this opportunity to talk with your committee today about healthcare reform in Pennsylvania.

I don't know anyone who doesn't support the idea of healthcare reform in some way. Today, millions of Americans and hundreds of thousands of Pennsylvanians lack access to medical care. In Erie County alone, the Governor's office estimates that more than 11,000 people currently lack access to care. And as director of the County Health Department, I know the real number is even higher.

Healthcare reform can take many forms. Without getting into specifics or endorsements, Governor Rendell's Prescription for Pennsylvania proposal has many outstanding qualities. So does Access to Basic Care program, or ABC, that the House passed in March. Both could enhance access to care for hundreds of thousands of Pennsylvanians by making health insurance more affordable.

But if our core objective is to provide care for those who can't get it today, insurance isn't the only way to achieve that. If we want, we can simply provide care, insurance or not. Senator Erickson's Community-Based Healthcare Act, SB 5, would provide grants to community clinics to help serve those who lack access to care. Representative John Evans, who represents my own home county

of Erie, as well as neighboring Crawford County, has proposed HB 1824, which proposes much the same thing. Just like the Prescription for Pennsylvania and ABC proposals, these programs would enhance access to care for possibly hundreds of thousands of Pennsylvanians.

But, again, there are many ways to achieve that basic objective of delivering care for those in need. Many of us in Erie, for example, are very excited about Representative Pallone's HB 2625, which would create a new Access to Community-Based Care and Extended Safety-Net Services program. Through this program, which Mr. Pallone refers to as "County Access", county governments would be empowered to create community-based partnerships to facilitate access to care and address health-related issues for the uninsured and underinsured.

Many of us in Erie are talking about County Access and are excited about its potential. When I say "many of us", I'm referring to more than just people in county government. I'm also talking about local government, hospitals, community clinics and providers, health planning organizations, community groups, health advocates, local foundations, colleges and universities, and more. These groups and others would work together to create a program developed by our county and for our county under the guidance of the enabling legislation.

At the heart of County Access are three primary components; access to care, case management, and accountability for outcomes. Together they offer the promise of meaningful healthcare reform.

First, the basic idea underlying County Access is that instead of spending more money to merely provide insurance to the uninsured, we reach out to them and provide the care that they need. After all, health insurance doesn't stitch wounds, quiet coughs, or diagnose underlying medical problems. Actual healthcare does those things. So through County Access, we would reach out to the uninsured and deliver the care that they need.

Second, County Access includes a strong case management component. Participants would have a case manager responsible for ensuring that they receive the care they need and maintain the care that is offered. This person would coordinate care not only among different medical specialists and facilities, but also among social service organizations whose assistance might be needed to help ensure participants' well-being.

We've been hearing a lot lately about managing chronic medical conditions, and that would be a central part of the County Access program. The experts tell us that people with chronic medical conditions like asthma and diabetes account for a significant portion of our

healthcare expenditures, and especially a significant portion of all hospitalizations. They all tell us that with appropriate disease management, many of those hospitalizations can be avoided. For this reason, disease management is a major component of the County Access program.

The third major component of County Access is accountability for outcomes. Under this program, we'd measure outcomes and be accountable for them. Those same experts have been telling us that when public dollars are used to pay for healthcare, the public sector needs to ensure that it is getting its money's worth. That's exactly what would happen under County Access. Before we even start, we'd assess a participating community's overall health status. Then, after the program is launched, we'd periodically reassess that health status.

In this manner, we'd be able to see if our efforts are actually making a difference, actually improving the health of the community we're serving. That's a level of accountability that would be without precedent in Pennsylvania.

The private sector doesn't do this, Medical Assistance doesn't do this, CHIP doesn't do this, and adultBasic doesn't do this. Under County Access, we definitely would do it. We would be accountable for our

program's performance.

When you think about it, County Access is like a combination of the insurance-based principles underlying Prescription for Pennsylvania and ABC and the community clinic orientation of the Erickson and Evans Bills. We wouldn't be offering the insurance of Prescription for Pennsylvania or ABC, but we'd be offering much the same services as these programs. We would be offering the clinic-based services envisioned by the Erickson and Evans Bills, but we'd do it without the entire health insurance component.

More than any approach I've seen, County Access brings together the key components of a successful delivery program: Outreach, chronic condition and case management, health and wellness education, alternatives to emergency rooms, and links to other services. Most important, it offers the promise of timely, quality, accessible care to the people that have no such access today. That would be true reform.

What the Pallone Bill proposes is a new approach to care, as far as I know. I encourage you to consider the program as a piece of healthcare reform. If legislation is not enacted, I would suggest you try this approach in a few different kinds of counties across the state. I know we're extremely enthusiastic about it in Erie

County and would welcome an opportunity to take this responsibility and help blaze a trail for others to follow. We already have the critical mass to move forward. We've gained the support of the public sector, hospitals, community groups, clinics, advocates, academic institutions, and others. The delivery system is interested and involved.

Nationally, healthcare reform has been elusive. It first emerged as a major political issue right here in Pennsylvania in 1991 during the Senate race between former Governor Dick Thornburgh and Harris Wofford. It was a major issue again in the Presidential campaign of 1992 and again in the current campaign.

Since that time, the consensus seems to be that we're probably never going to have one major society-altering healthcare reform program. Instead, we're more likely to see incremental reform, bits and pieces here and there, some at the State level, some in Washington.

We see examples of this in the addition of the Medicare prescription drug benefit in Massachusetts' mandatory health insurance program, in major Medicaid eligibility expansions in Kansas, in the use of executive orders to mandate access to certain medical tests for women in Illinois, in Minnesota's recently enacted law that expands access to care for children, makes health insurance more affordable for the uninsured, and helps businesses make

health insurance available to their employees and others.

Prescription for Pennsylvania fits in along these lines. Parts of it have already been implemented, parts of it haven't. ABC may surpass Prescription for Pennsylvania as the State's primary approach to enhancing access to care insurance or it may not.

My point is that if we wait for that one great fix, we may never stop waiting. The Pallone Bill offers enormous potential. It is an experiment to be sure, but a moderately priced experiment that is worth undertaking.

As you consider healthcare reform in Pennsylvania, I urge you to remain open to the possibilities offered by a non-insurance-oriented approach and give serious consideration to the Pallone Bill and the County Access program and the promise of reform it offers. Thank you.

REPRESENTATIVE DeLUCA: Thank you, Anthony. And certainly -- I thank you for your testimony. You certainly brought up very some good points here; that I intend to send your testimony over to the Senate.

And I want to commend your Representative, John Evans, who was the leader in that House Bill 1824. He was at the forefront. And also the fact that he is willing to work with Representative Pallone, because both Bills in

combination go together, and, as you know, we did pass them Bills in the House, and they are over at the Senate. And I think your testimony is testimony that -- something that they need to act on along with ABC.

But, again, I want to thank -- personally thank Representative John Evans for his hard work he did on that piece of legislation.

Any questions from the left here? Representative Petrone?

REPRESENTATIVE PETRONE: When my colleagues are finished, I do have some questions for you, Mr. Glass.

MR. GLASS: Okay.

REPRESENTATIVE PETRONE: I'll be last. I want to ask him about some problems that I've been aware of for more than 25 years that has affected the beaches in Erie. I worked with the Fish Commission and the Conservation Committee to help clean up Presque Isle, and the Sons of Erie. And we read a lot about the pollution that's occurring. And, of course, this is a danger to public health, is it not?

MR. GLASS: It's of concern.

REPRESENTATIVE PETRONE: Okay. I've been coming here for 60 years or more, and I'm just wondering about the progress being made or lack of it. Because we did, 25 years ago, put our best foot forward to try to help a great deal,

and we saw some new successes. That's just my own personal --

REPRESENTATIVE DeLUCA: Thank you for your personal comments.

REPRESENTATIVE PETRONE: If I'm allowed. We can talk privately, maybe.

MR. GLASS: I'd really appreciate the opportunity to do that, publicly or privately.

REPRESENTATIVE DeLUCA: Thank you. Thank you, Representative Petrone for bringing it up, and I'm sure Mr. Glass would, in private, certainly want to talk to you, or in public. Thank you very much.

MR. GLASS: Thank you.

REPRESENTATIVE DeLUCA: The next individual to testify is Steve Fisher, President, and Dan Severo, Legislative Chair, NWPAHU.

MR. FISHER: Good morning. As you can see, I'm here by myself. Dan Severo actually had to take care of a health insurance renewal this morning that he couldn't get out of.

And before I get started, I do want to say that I appreciate the comments that Mr. Glass just made. That's the type of thinking that we need to have discussed throughout, over and above insurance companies and everything else. So that is greatly appreciated.

REPRESENTATIVE WOJNAROSKI: Mr. Chairman, Committee members, ladies and gentlemen, I am Steve Fisher. I'm the president of the Northwest Pennsylvania Association of Health Underwriters. Our association is made up of insurance producers who specialize in meeting individual and business needs for health insurance. We do appreciate your holding this meeting in Erie and allowing me to testify.

You will find that I'm giving a very abbreviated version of the testimony that you have in front of you, because that would take me 20, 25 minutes.

I believe that our current system does have some problems. However, I believe that it is bruised and not broken. And I think it would be a mistake to try and replace it with something entirely new. Other states have tried that and are now correcting the new problems that have resulted as they've made those changes.

We're also in the middle of a Presidential campaign, as it's been mentioned, that promises to provide us with a better healthcare system. The question is, do we really want to make a major change right now if we might have to evolve into a national program in the near future.

REPRESENTATIVE WOJNAROSKI: Much has been written on crippling health insurance premiums and blaming the insurance industry for the number of uninsured citizens. As legislators, you hear what I hear, and that's that insurance

premiums are expensive; that they're too high. The pressure is on you to react and solve the problem, but we just want to make sure that you solve the right problem.

I support the employer-based system, but I also recognize that employees have been insulated from the true healthcare costs. I've seen this over the years. In my opinion, we need to focus more on the cost of healthcare and the utilization of care, as these are two of the main factors that are driving the premiums.

I do give credit to Governor Rendell for addressing these issues; things such as the hospital-acquired infections. Again, they are part of the big problem out there. If we can control those, we can reduce the costs. However, there are many other factors that still need to be addressed. I simply ask that as you look at any health reform proposal, you ask yourself this question: Will this reduce cost in an intangible way.

It's important for us to understand that health care costs are not high because insurance premiums are high. In fact, it's just the opposite. Insurance premiums are high because the cost of healthcare is high. And the only thing that the two have in common is that one pays for the other. Unless we can find a way to control escalating healthcare costs, we will not be able to provide affordable health insurance under either private sector or a

government-run program.

New oral oncology drugs are a perfect example of this. We live in a society that wants the newest and the best drugs, and we want them covered by insurance. It's reported that the potential cost for these new drugs will range from 10 to $40,000 per month. No plan will remain affordable if we don't first bring these costs under control. We also have the new bioengineer drugs that can perform magic, but they can cost from 2 to $3,000 per month. And the tab for these specialty drugs is predicted to grow from nearly 59 billion in 2008 to 98 billion in 2011.

These are just a couple of examples as to how healthcare costs are driving up premiums. Other states have tried to budget the healthcare expenses, and they have consistently found themselves with shortfalls at the end of the year. The cause was generally found to be higher utilization than expected, which everybody has predicted, and also it's the rising healthcare costs. I do not see how the proposed ABC plan addresses either one of these factors.

I'd like to address a neighboring state that's done some things. New Jersey introduced health insurance reform to create programs to guarantee access to health coverage for both individuals and small employers in the two to 50 range. These plans were issued regardless of health status, age, claims history, or any other risk

factor, and some of the key results of this reform, including five standard plans, community rating, affordability, pre-existing condition limitations, and a 75 percent minimum loss ratio. We're looking at 85. 22 carriers were writing business in New Jersey when the reform was introduced. Now there are only seven writing individual medical coverage, and only four of those are offering PPO plans, and most people cannot afford the 2008 premiums.

The annual premium for a family with a $2,500 deductible PPO plan with coinsurance ranges from a little over $34,000 a year to $148,500 per year.

Now, even though these rates have been approved by the New Jersey Department of Insurance, and they've been justified based on loss ratios, I personally don't consider them to be affordable. And, again, I'd like to know how Pennsylvania will avoid ending up with similar results under the ABC plan.

Some people claim that Access to Basic Care is not an entitlement program. Technically, that may be true, but if you have the Government design the program, use public money to pay for it, and you rhetorically tell everyone that it's their right to have it, what else are they going to think?

Finally, I want to address a concern that I have that's a personal concern regarding these discount

plans. I refer to them as the good until Friday only plans, because generally when you see the faxes and e-mails, they say the offers are only good until Friday. Unfortunately, many individuals have fallen prey to these plans and canceled legitimate coverage, only to find that the coverage was not anywhere near what they had before.

It is time to have an open discussion about the real cost of healthcare, and before we commit any taxpayer dollars on that, such as Access to Basic Care, the Pennsylvania Association of Health Underwriters welcomes the opportunity to work with you in trying to come up with some solutions that make sense for everybody. And, again, thank you for providing me with this opportunity to testify before you.

REPRESENTATIVE DeLUCA: Thank you, Steve. And, certainly, we look forward to working with you. This committee looks forward to working with you.

You made the comment that "on the national level in the near future". Let's be realistic. On both sides, the parties, the Democrats and the Republicans, even though they are talking about healthcare, I don't believe I'll see that in the near future. So it behooves us -- if we wait for the near future, maybe that 5 and 6 percent that we're all paying on our premiums might go up to 10 percent, and that doesn't control costs for uncompensated care if we

wait for the Federal Government to act. And, you know, it sounds good on the TV's and that there, talking, and it brings it out to the public, but I think the states have a role to play in providing healthcare and not just waiting till our friends in Washington decide they are going to give us healthcare. Even though the Presidential candidates are talking about it, it still has to go through the Congress and the Senate.

But I was very -- we had a discussion last night with Erie Insurance, and I was very impressed with some of the comments coming from an individual, Gary Veschecco, who is the vice president, along with his counsel. It seems to me they are on to something.

They initiated a wellness program, and -- for all their employees. I don't know; I think it was every month or every other month they do blood testing, they do blood pressure, they do the screening of the arteries and that there. And they found it beneficial and worth their while to pay for that. And I'm wondering how we can get the business community to initiate some type of program for their employees out there, because they actually think they are saving money by doing this. And Erie Insurance is certainly a big company, and they have found it to be very beneficial in preventing lost work days, having a healthier employee workforce.

So, I mean, how do we get the business community to start recognizing that they have a part to play with their employees? In the long run, it would save them a tremendous amount of money in lost wages, productibility if they keep their workers healthy. I mean, how do we do that?

MR. FISHER: I agree fully with you. I have been trying to promote wellness to clients for years. Part of the problem is, Erie Insurance is a very large corporation. I'm sure they are self-funded. And when they see savings, it comes directly to them.

When you look at the small employers, they don't see that savings for a long period of time. The insurance companies are not willing to give them full credit for it.

We have a mobile society. Part of it is you might have a employee that goes through a wellness program, then goes to work down the road for a competitor, leaves your employment, and you replace them with somebody that comes in that's obese, that's a smoker. So the insurance companies aren't willing to take on that risk.

A big part of it is the personal responsibility. I'm from down in Meadville, and we have a company down there called Mind/Body Wellness that has program. And if you have Highmark, you can attend many of those programs for free. We encourage our Highmark clients

to do that. Do you know what percentage of the people generally participate? Probably less than 1 percent, because it's the inconvenience, it's at night, and at night their kids have soccer or Little League or dance or something else. And there has to be some rationale for the employees to participate in it.

Some employers have done that. They've said, you know what, we're going to have drawings for prizes. We'll give away a weekend stay someplace or gift cards, gas cards, anything. But a lot of the employers, again, are saying, I'm spending this money; what am I getting in return. In reality, they're not seeing anything from the carriers.

Dan Edgar is an agent here, and he'd probably attest to the same with his clients. The small employers are not being rewarded by their carriers. They're looking at it, but, again, they don't see anything in short-term. It's a long-term picture. And if the employees will stay at that place, then the employers might be willing. But you have to have the personal commitment, and we're not seeing that out there from the individuals yet.

REPRESENTATIVE DeLUCA: Wouldn't it benefit the carriers too if they would give some incentive to their -- to their policy holders --

MR. FISHER: Yes.

REPRESENTATIVE DeLUCA: -- to initiate those programs?

MR. FISHER: Yes. And some of them have screening programs you can go on-line and look at. And, again, you know, they're trying to get the programs -- if you look at the seniors, what's benefited there with the Silver Sneakers people that are participating in that and helping with their wellness tremendously.

REPRESENTATIVE DeLUCA: And they have done that very well; the Silver Sneakers.

MR. FISHER: Sure. They also have more time available to do it.

REPRESENTATIVE DeLUCA: That's true.

MR. FISHER: Yeah, than the typical family does today.

And the other problem is employers are putting together wellness packages; some of them have, but they are introducing them to their employees. And what we've said is we encourage you to introduce it to the whole family and bring it -- make it a family picnic or a family event; a health fair that you bring the family members in. Because, quite frankly -- and I'm not stereotyping anybody. But from what I've seen over the years is you have an employee meeting, tell the employee about it. Not a whole lot of that information goes home to the spouse. And it's

usually the spouse that's taking care of the kids, that are taking them to the doctors, that are preparing the meals that the family is having, et cetera. So it has to be a family unit that you're getting involved in this wellness program, if you want it to work correctly.

REPRESENTATIVE DeLUCA: Good point. Any questions from the right? Representative Roae?

REPRESENTATIVE ROAE: Thank you, Mr. Chairman. I worked at Erie Insurance for 14 years. I worked there from 1992 till 2006, right before I got elected. And they do a wonderful job to encourage a healthy lifestyle. They have programs, you know, to help people lose weight, quit smoking, you know, cholesterol testing, all kinds of good things like that.

What I saw as a employee, if things are convenient, employees participate. There's programs at work for -- there's programs you can do right at work. You know, people will do it. If stuck after work, people don't want to stay. And it is harder for smaller companies to do something like that. If you only have, you know, five people that work someplace, you can't have, you know, your whole work force in a meeting at the same time.

But as far as your actual testimony, I think a good point that you had is we have to look at the costs of the health insurance -- or, excuse me, the cost of

healthcare. Under the Governor's plan, I think it's well intentioned, but even by 2012, it would cover 265,000 people that currently don't have insurance. That would only be about a third of the people that are currently uninsured. I just read a press release from the Governor that he put out a few months ago, and I think it was around 700 or 800,000 people in Pennsylvania are uninsured. So even, you know, four years from now, we're only going to be at covering 35 percent of those people.

If we do something to control the costs of the health insurance -- excuse me -- the cost of the healthcare, you know, regardless of whether somebody has insurance, they might not have to pay premiums as high. The people that are covered by Medicare, Medicaid, if those costs are lower, taxpayers will save money there. It seems like lowering the cost of healthcare could help a hundred percent of the population, whereas making healthcare -- basically giving free healthcare to people that don't have insurance is only going to help a third of the people, and it's not going to help, you know, 95 percent of the population that already has health insurance in Pennsylvania.

Could you expand more on what would lower the cost of healthcare.

MR. FISHER: Part of it is things, again, like

what Andy Glass was talking about. People that are not abusing the healthcare system. There's a lot of people that have health insurance that are going in there unnecessarily for things.

We brought a lot of this on ourselves. I mean, back in 1986, I was involved with one of the first PPO's in this area, and we introduced $5 co-pays. We saw utilization go through the roof over the next couple of years because it was so easy for people to go for $5. And when you changed it to $20, people started screaming about it, but they started thinking, and they weren't going in unnecessarily. When you put on the co-pays for the ER's, originally $50, then a hundred, and some are higher than that, you're seeing that people aren't going to the emergency room unnecessarily, which is, again, a big part of the cost that's there.

So it's helping people to think twice. You're seeing the high deductible programs. Many of the employers have put in plans now with $1250 deductibles. They still have office co-pays, because, again, most people are only going to use it there, but it's a $20 or $40 co-pay, so they are thinking twice, but they're not abusing the other -- you know, before they go in and have an MRI, they're asking to see, is an x-ray pertinent, will that take care of the problem first. So it's just how -- how we use

the care as consumers is a big part of it.

The care that's gets written off. I've seen a tremendous amount of that with my clients still that have insurance, but the employer has gone to a $1250 deductible. Some of these people don't have the money. I have seen the letters they've got where they're still paying the doctors and hospitals $10 a month until it's paid off. So even though they're covered, they really don't have full coverage for what their needs might be.

When you were asking about wellness, you know, one area that I think that we need to look at wellness is on the care that we're giving to the public. I mean, how many of the people that are accessing CHIP or adultBasic or any other program are going in for wellness preventive care? And if they were doing that, we might be able to reduce a lot of it. If they were better educated on not going into the emergency room, again, as an example.

But it's even things like -- and I'm not picking on Meadville Medical Center. It's just one -- one example. They just built a new cancer center there. A lot of people are questioning why they needed a $12 million cancer center, when the Regional Cancer Center in Erie has a location there, they have location here, Sandy Lake, which is two exits south on 79 has a cancer center, you have the big one in Pittsburgh. Spending $12 million for a local

cancer center has to add cost to the Meadville community.

When they built the new hospital out in Venango County, that had to add cost. They merged two to control costs, but then they built this brand new one that was probably three times what was originally forecasted for the cost. That's healthcare cost.

We don't have CON's anymore. I remember the days when I used to go to Harrisburg with our hospital group to argue CON's. That had an impact to some extent. But everybody debates, you know, are they going to say no, because then they're going to say no when I want one.

So -- but there's a lot of duplication of service that's out there, but, again, it's because we're in a society that we want to be able to get the cancer care locally, we want to be able to get the MRI locally. We don't want to have to drive 20 minutes. That's inconvenient for us with our schedules today. So we're paying for that inconvenience.

REPRESENTATIVE ROAE: All right. Thank you. Don't we have a committee meeting coming up on CON in a couple weeks down in Harrisburg? I think it's about a week from today or two weeks from today, I think.

(Discussion held off the record.)

REPRESENTATIVE ROAE: A week from tomorrow. All right, thank you.

REPRESENTATIVE DeLUCA: Any other questions?

REPRESENTATIVE PETRONE: Mr. Fisher, your indications of not implementing preventative healthcare fully and wellness programs on large scale by companies, by people that have insurance, if this is done in a much better fashion, could it be a big factor in controlling or reducing the cost of insurance?

MR. FISHER: Absolutely. I'll use myself as an example. I'm one that seldom ever goes to the doctor. It's about every five to seven years, and when I go, it's usually a nuclear stress test, because they thought I might have had a heart attack. It runs in my family.

Most recently I went, and I ended up going in for a cardiac cath. It was a $19,000 bill. I haven't got the doctor's side of it yet. Of course, the insurance only paid $3,000 something. But in a case like that, if I would have been following regular procedures on that, maybe it wouldn't have been necessary for me to have that cath. You know, they found some blockages and it was necessary for treatment, but I might have been able to avoid that, which is a large bill, just by having smaller preventive visits throughout the year. I preach it to people. I watch what I do. I'm heavier than I should be. I have been working at it, but it doesn't help.

We all do need to go more often. And in my

case, it's because of the family scare that I went, and that's when they found it. But if everybody would do that more often, we would be able to reduce the cost of care considerably, and I think you'd save a tremendous amount of dollars on that. I would like to see employers encourage it, but, again, right now there's no incentive for them.

When we talk to them about it, we say it can help them not only in healthcare on the long-run, but on the short-term, maybe on Worker's Comp., on absenteeism, on things along those lines, which do have a cost for them, but they have a hard time measuring it; to see if I spend this $3 on preventive, what am I getting in return, immediately, not long-term.

REPRESENTATIVE PETRONE: Thank you.

REPRESENTATIVE DeLUCA: Steve, that was very good testimony. And I think you hit the nail on the head. I had said it in previous hearings. We have a lot of duplication of services. To me, I still don't understand why every hospital has to have a heart unit. Very expensive. And I want to emphasize again, the healthcare is a business. It's the only business I know that nobody makes any money, though. Okay? The providers say, we don't make any money, the hospitals don't make any money, the doctors don't make any money, and yet healthcare continues to go up, and nobody makes any money. It's amazing. And I just don't know how

that business -- any business like that, nobody makes any money and the price continues to go up.

So, I mean -- but I think you have hit it on the head. And I think Representative Roae said the fact that we need to look at Certificate of Need again. And we tried to look at that four or five, six years and couldn't get it. You don't need to be a brain surgeon to know that. If we want to bring down costs, we can't continue to build facilities out there. Independent MRI facilities. I mean, where are we going? You know, a lot of these facilities are owned by professionals, and as you know yourself, when you start one and start two in the Medicare program, that's why you had it, because they were prescribing 10 to 15 to one because they own the facilities.

So, again, I want to thank you for your testimony. It's interesting.

MR. FISHER: Thank you.

REPRESENTATIVE DeLUCA: The next individual to testify is Diana Ames, and she's the director of the Erie Coalition to End Homelessness.

MR. SPEESE: Mr. Chairman, Jonathan is going to go next.

REPRESENTATIVE DeLUCA: Pardon me?

MR. SPEESE: Jonathan is going to go next. She's not here yet.

REPRESENTATIVE DeLUCA: Oh, she's not here yet? Okay. Jonathan Greer is the vice president of the Insurance Federation, standing in for Stan Marshall.

(Discussion held off the record.)

REPRESENTATIVE DeLUCA: He's got a good guy to stand in for him. That's all I can say.

MR. GREER: Thank you, Mr. Chairman.

REPRESENTATIVE DeLUCA: You're welcome.

MR. GREER: I'll try to be as brief as possible.

Thank you for the opportunity to speak today on the Pennsylvania Access to Care, PA ABC proposal, and healthcare reform generally. I am Jonathan Greer, vice president of the Insurance Federation of Pennsylvania. We're a non-profit trade association representing commercial insurers in all lines of insurance. Our members include many of the large national health insurers and some of the few remaining small local health insurers, but not the Blues.

Too often the discussion of healthcare and providing health insurance to the uninsured overlooks the fundamental issue of first determining who these people are and why they are inunsured in the first place. To that end, the Insurance Department in 2005 published a state-specific study of the uninsured population, because previous information derived from Census Bureau statistics was deemed

unreliable.

The Insurance Department's findings confirmed for Pennsylvania what is true across the country. The majority of the adult uninsured population is between the ages of 18 and 34, and the leading reason they lack coverage is because it is too expensive. Another reason is that many of these young, healthy individuals feel the immortality of youth, and, therefore, don't see the value in paying for insurance they think they don't need.

The study also found that 92 percent of the State's population has some type of coverage, a far better percentage than most other states in the national average, and one that presents the chance to work on what works.

We in the insurance business realize, as all of you do, that the cost of healthcare and insurance is an ongoing struggle for everyone; the insureds who are struggling to afford coverage, as well as the uninsured who can't afford coverage now. We are all aware of the problem of medical inflation and the need to contain costs. Whatever you do to help the uninsured should not come at the expense of those who currently buy insurance or are struggling to maintain coverage. Yes, subsidies will be needed to help the uninsured, but those with coverage also need relief and shouldn't be the source of new subsidies for others.

While limited in its scope, we think the current adultBasic plan does a good job of balancing the needs of the uninsured population without supplanting or creating added expense for those with private insurance; what we in the health insurance arena refer to as "crowd-out".

As we understand it, the PA ABC plan in Senate Bill 1137 expands the adultBasic program to cover additional individuals already on the adultBasic waiting list and provides fully subsidized care to individuals earning less than 150 percent of the federal poverty level, with cost sharing increasing up to 200 percent of the federal poverty level.

It goes past the adultBasic program by providing additional cost-sharing arrangements to individuals above 200 percent of the federal poverty level and allowing individuals above 300 percent to buy into the program if they can demonstrate an inability to purchase private insurance, including those individuals with pre-existing conditions. Employers are also eligible to enroll their employees in the program, and the benefit package is dramatically increased to provide both prescription drug coverage and behavioral health services.

The financial sustainability of this program, its effect on the private market, and the State's ability to

administer it should all be considered as you consider this proposal. The national landscape is littered with expanded forms of public healthcare that have far outgrown their projected costs. Tennessee's ill-fated TennCare comes to mind, as does Massachusetts Romneycare that is still trying to get off the ground.

An example of some of the questions in the ABC plan: The idea of adding prescription drug coverage and behavioral health services to the adultBasic benefit package is well-intentioned, but these are two of the most expensive and highly utilized benefits in today's private market. Maybe you need to do this to qualify for Federal funding, but make sure that funding is there first, because otherwise the State will be left with a hefty bill.

Another example is the plan's opening up this benefit package to employers, which, we believe, invites crowd-out and maybe some needless subsidies and administrative complexities. This may sound a bit too much like "learn to walk, then run", but I don't think employers need a Government insurance program; they need Government to help make the private market more competitive and less expensive.

A third example, and one that's confused us, is the ABC program's intent to provide immediate coverage to individuals with pre-existing conditions. That's a very

expensive proposition. It is also, we believe, counterproductive. The goal should be to get people covered before they need the coverage. If we wait until we -- if we wait until we get sick to buy insurance, I can assure you the price won't be $320 a month.

We're also concerned that the administrative complexity of the ABC program in Senate Bill 1137 will make it needlessly expensive and bureaucratic. As a former employee of the Insurance Department and someone who was there when the adultBasic program started, I had great respect for its abilities and commitment to the program, but I am also not sure the Department is equipped to constantly track income levels of this expanded population, which is the key to determining who gets what subsidy. That's especially true when you include employers, with subsidies varying with each employee.

That's not to suggest that PA ABC or a program like it shouldn't be undertaken, but it does mean that we need to realize the financial impact the current proposal will have on all of us and the practical problems of administering this program, and they need to be addressed at the outset.

There has been a lot of discussion on how this program will be funded. Much of this has centered on the decision to co-mingle this program with the Mcare

abatement program and for surplus funds in the provider retention account to be a major funding source for PA ABC. Also under discussion were/are increased tobacco taxes, existing tobacco settlement funds, and uncommitted Federal money.

Whatever the financial sources are for this program or one like it, they should be both secure and sustainable. Healthcare, whether it is funded through private insurance, Medicaid, CHIP, adultBasic, et cetera, has been and will likely continue to be subject to medical inflation. Because of this, we think any expanded form of publicly-funded healthcare should be entered into with great care and with the acknowledgment that its costs will increase over time.

In some recent hearings, we've heard some proponents of the ABC program say it should be accompanied by the insurance, quote, reforms the house passed in House Bill 2005; the elimination of medical underwriting in the small group and individual markets, prior approval of all health insurance rates, and a prohibition of pre-existing condition exclusions and limitations in all health insurance. The suggestion has been that those reforms go hand in glove with the ABC program; that they will make the program work better.

We don't get that connection. We're ready,

willing, and able to debate the merits of those measures, because we have some very strong opinions and, more important, experience on whether they raise or lower costs, raise or lower the number of uninsured, and raise or lower competition and choice in the market. But whatever they do, they are distinct from the merits of the ABC program, which is targeted at those unable to afford the private market.

Because others have brought in these insurance measures to the dialogue on the ABC Program, we want to clarify a few things we've heard. You know our views on rating restrictions. Whatever you do, don't eliminate competition, because a private monopoly in health insurance won't help anybody but the monopolist.

We've also heard that all health insurance rates should, like auto insurance rates, be subject to prior approval. First, individual health rates are subject to prior approval. Second, group property/casualty rates are less regulated than group health rates. There is no rate regulation of large group property/casualty rates, and small group property/casualty rates are filed and given same-day approval.

The reality is that the Department does as much or more health rate regulation than it does for auto insurance rates. As we've seen in every line of insurance, more competition, not more Government bureaucracy, is the

best way of holding down rates.

We've also heard that pre-existing condition exclusions and limitations should be outlawed. As I mentioned earlier, that would mean an individual wouldn't need to purchase health insurance, unless and until they get sick. Whatever that is, it's not insurance. You can't purchase a homeowner's policy after you've had a fire, you can't purchase auto insurance after you've been in an accident, and you can't purchase life insurance after you die. This issue has largely been addressed through an 11-year-old Federal law that created the concepts of credible coverage and portability when an individual leaves one policy to get into another. It may also merit consideration of a health risk pool for the exceptional cases.

We do see merit in some other healthcare reforms you are considering. These include extending COBRA benefits to the employees of small businesses, non-payment for medical errors, and extending dependent coverage for adult children up to the age of 30. We also see merit in much of the ABC proposal, but with the concluding observation that it would be better to make it more targeted to those most in need of financial subsidies, rather than an alternative for all income levels.

Thank you again for the opportunity to be

here, and I'm happy to answer any questions.

REPRESENTATIVE DeLUCA: Thank you. As you know, this committee is willing to work with you and your organization to come up with some type of proposal that would be beneficial to the citizens in the Commonwealth of Pennsylvania.

Let me just say -- and we keep throwing out the -- and I understand the 92 percent is only 8 percent. Have you done a study on if we didn't have the two Government programs, how many people would be uninsured?

MR. GREER: I can consult the Insurance Department study --

REPRESENTATIVE DeLUCA: I would appreciate if you could do that. Because when we talk about the 8 percent, we're including in there the people on Medicaid, the 92 percent -- we're including the people on Medicaid, we're also including the elderly with Medicare.

MR. GREER: Right.

REPRESENTATIVE DeLUCA: So if we didn't have the two Government programs, I'm just wondering what the rate of uninsured would be in the Commonwealth of Pennsylvania and what the cost of healthcare would be for the individuals who have to buy healthcare.

MR. GREER: Well, part of the reason --

REPRESENTATIVE DeLUCA: Not the Government

programs.

MR. GREER: Part of the reason those two programs were created before I was born in the 60's was because it wasn't available to them. No one was writing for older people, and poor people weren't buying insurance because they couldn't afford it. So there was a -- there was a lack of coverage generally available for them. So in that -- in that vacuum, the Federal Government stepped in and created both. Previously, they weren't -- there was no coverage available to them.

REPRESENTATIVE DeLUCA: But the public got their, say, 8 percent uninsured. They really don't understand. They say 92 percent have insurance. Well, they think that insurance is all private coverage.

MR. GREER: No, no, no. It's all forms of coverage.

REPRESENTATIVE DeLUCA: I'm not saying you. The public doesn't have it in mind that we have two Government programs out there, and that 92 percent would be a lot less without that two Government programs. And probably a lot of people would not be able to have any healthcare.

So I just wanted to bring that to a point. I have said that to some of the labor people too that keep bringing up only 8 percent. Thank God for them two Government programs, because the fact is, I'm just afraid

how many people would not be able to have any healthcare on the private market and how many small businesses would lose their business because they would have to pay for healthcare.

MR. GREER: And that doesn't -- and for those people who are in the 8 percent now -- I don't want to diminish -- if you're in that 8 percent, being uninsured is a burden, and I don't want to diminish that fact by suggesting --

REPRESENTATIVE DeLUCA: Yeah. That's -- I just want to bring that up to you; the fact that even with the young people in that category there, everybody is young and feels they are indestructible, and even if they had the opportunity to buy it at a cheaper price, they wouldn't buy it anyhow, because it's like more for a job. When you're young, you don't care about benefits until you get older. You want the pay coming in your pocket. So, I mean, that's the way it is. That's human nature.

Do you have any questions? To the left? To the right? Representative Roae?

REPRESENTATIVE ROAE: More of a comment than a question. I was dickering around on the Internet, doing a lot bit of research to prepare for the meeting, and what I found is on a national level for 2006, the website I was at said something like 17.9 percent of the non-elderly U.S.

population does not have health insurance. But, you know, Pennsylvania, the numbers I looked at it was more like 6 percent, based on the Gottleib (phonetic) numbers. Seven hundred and some thousand got health insurance for about 12 and a half million. And so I think we're already doing a lot here in Pennsylvania, compared to what other states are doing, you know, to help our uninsured people. And I think we should continue to do that. I think it's important that we help people, you know, that need help; you know, people that are making an effort. But, again, I get concerned when I look at the fiscal impact of things. And it's very well intentioned to try to help everybody, but I don't know that, you know, we can -- I looked it up. Only 42,000 people are buying adultBasic right now. You know, we have 700 and some thousand uninsured people, and about 42,000 of them are buying adultBasic, and maybe that's all that can afford it. I don't know. Maybe some of the people in that 700,000 without insurance, you know, maybe they could pay the 300 bucks or whatever it is to be on the waiting list. Maybe they could pay that, and they are choosing not to.

What's your observations as far as, you know, of all the uninsured people, you know, are all of them destitute and none of them could afford it? Could half of them afford it? Have you ever seen any numbers or anything?

MR. GREER: Well, to your first point,

Pennsylvania is a national leader in terms of our insured rate, and we are certainly a leader as it relates to a state of our size, a state of our diversity, and a state with the population that we do have. So that, we should all be commended for that. To have a 92 percent insured rate, however -- whatever forms it takes, is a worthy accomplishment.

In terms of the people who make up that 767,000 adult uninsured population, that's -- that's prior to the age of enrolling in Medicare.

I can only go off on what I presented today, which is the vast majority of those people are young in Pennsylvania. And why that they are uninsured, now the Department study says that the leading reason is, it's too costly. Well, that's -- that's a question; okay, what is more important, a flat-screen TV or cable or health insurance if you're 20 years old. It's a question of what's important to them.

The other thing is, if you're 20 years old, you're making less than somebody who's 60 years old. So it's a percentage -- as a percentage of your income, you can understand while a young people who is seemingly healthy and maybe has healthcare -- has a health component to their auto policy -- so if they're are in an accident, they'll be covered there -- you can maybe understand why they don't see

the need for it. I think part of it is we often say -- you know, educate, don't mandate. You know, if you have to -- you have to tell people the reasons why it's important, and you have to instill in them that it's -- it is important to have coverage, even if you are healthy, to stay healthy. So it's something that you don't show up in a emergency room, that you don't wait till something develops into a chronic illness that could have been taken care of very early on.

So I think the goal should be to target the people who are the vast majority of the uninsured and to demonstrate to them, you know, why it is important. And I think HSA has done a good part in terms of lowering the cost for those individuals.

When we are doing the debate on that, we consulted one of our companies, and the cost for a 25-year-old with a thousand dollar deductible for an HSA was truly insignificant. It was something like $60 a month. So just to try to do those consumer-oriented policies, I think, will go a long way to making that segment of the population see the value and be able to obtain health insurance. That's my opinion.

REPRESENTATIVE ROAE: Okay, thank you. Just one other quick question. Have you seen numbers as far as, you know, what do our lifestyle choices do to the cost of healthcare? Things like being overweight, you know,

smoking, excessive alcohol use. It seems like those things, you know, really cause heart disease, you know, high blood pressure, cholesterol, heart attacks, all of those things, and I think to a certain extent, you know, as individuals, without any Government action, you know, collectively as a society, we could probably, you know, get the cost of healthcare down -- I don't know if the number is 10 percent, 20 percent, 50 percent. I don't know what it is. Have you guys done any study or seen any numbers or anything?

MR. GREER: Well, I don't know -- I can't quote you numbers, but I can tell you, without any question, that lifestyle habits have a contributing factor to the healthcare premiums. So if you smoke, if you're overweight, you don't exercise, all of those things have a contributing factor. And that's part of the reason we have such a concern with childhood obesity; because that child will live with that for the remainder of their life if they don't grow out of it. So that's -- and the diabetes or whatever that goes with it.

That, to bring up an issue that we brought up in our testimony, is a great fallacy in having restrictions on health status in determining a rate. Because if you can't consider health status, and the consumer knows that, there is no incentive to lose weight, there is no incentive to quit smoking, there is no incentive to exercise more,

because I'm going to be paying the same rate as somebody who does that. So there is no reason -- financially, there's no reason for me to improve my lifestyle if it doesn't improve my rates, so.

REPRESENTATIVE ROAE: All right, thank you.

REPRESENTATIVE DeLUCA: Representative Kotik.

REPRESENTATIVE KOTIK: Thank you, Mr. Chairman.

As we discuss all these issues about healthcare, it really brings back a problem with me, because, you know, on a State level, it seems to me that the Federal Government is abandoning its role of a partnership. It's more like it's your problem, it's not our problem anymore. And I think we have to look at how we spend our dollars, and we have to be very realistic. And I think we have to do some tough -- make some tough decisions.

And one of the decisions that has always bugged me is this long-term care. Because we see it more and more. And one of the big issues for me is what I call asset diversion. We're being required to pick up more and more of the care of the elderly in our nursing homes here in this Commonwealth, and more and more people are diverting their assets and saying, let the State pay. Well, who is the State? The State is the taxpayers.

So the more money we have to dedicate to taking care of our elderly -- because people don't want to

step to the plate. And I have a mom in an assisted living facility right now, and we're paying. We're not on the State bill. We're paying for my mom to be in a nursing home. And there is no free lunch. And it all plays into the monies we have available for the whole healthcare picture.

So there's some things I think we have to look at, and we have to make some tough decisions that I think are going to be very unpopular politically. Very unpopular. But I don't know where we're going if we don't do it. If we don't do it, these costs are going to continue to explode. I mean, there's going to be no end to this. And I think we just have to bite the bullet.

And I think one of the components, from my perspective, in the whole healthcare picture is long-term care. That has to be a mandatory thing, like auto insurance, as far as I'm concerned. Because, otherwise, the taxpayers will continue to pay to pick up this whole burden. So we've got to make these tough decisions.

MR. GREER: I'd be happy to talk to you off-line about that. As the Committee knows, we're working on implementing the long-term care partnership program, to induce people to buy private insurance, to avoid them going on Medicaid.

So I'd be happy -- we could talk at length

about that.

REPRESENTATIVE KOTIK: Thank you, Mr. Chairman.

REPRESENTATIVE DeLUCA: Any questions from the left?

(No response.)

REPRESENTATIVE DeLUCA: John, just one last question. If we didn't mandate auto insurance, would auto insurance be as cheap as it is right now?

MR. GREER: If we didn't mandate?

REPRESENTATIVE DeLUCA: Yeah.

MR. GREER: I don't know the answer to the question, because we mandate it now.

REPRESENTATIVE DeLUCA: I know.

MR. GREER: But we have thousands and thousands and thousands of uninsured drivers.

REPRESENTATIVE DeLUCA: But would the uninsured go up as far as people not having insurance, if we didn't mandate car insurance?

MR. GREER: Hard to say. I don't think so. I think --

REPRESENTATIVE DeLUCA: You don't think so?

MR. GREER: No. I think that if -- we have a law that requires you to have that insurance, and there are a lot of people that don't have that insurance.

REPRESENTATIVE DeLUCA: That's in certain parts of

the state.

MR. GREER: More than others, certainly. And I think that most people see the value in auto insurance. Because, you know, the physical accident of one car hitting another is something that everybody can associate with.

For a 20-year-old having a life-threatening illness, that's a pretty abstract thought, you know, for some of them, so.

REPRESENTATIVE DeLUCA: Again, I want to thank you for your testimony, and certainly we'll be looking for your work.

(Discussion held off the record.)

(Recess held from 11:30 a.m. till 11:42 a.m.)

REPRESENTATIVE DeLUCA: I'll call this hearing back to order. Our last testifier has joined us; Diana Ames, who is the director of the Erie Coalition to End Homelessness.

Diana, welcome.

MS. AMES: Good morning. And, first of all, thank you very much for this opportunity. I really appreciate it.

It's not always important that one experience what one advocates for, but it's not a hindrance either. I am the director of our state's homeless coalition. I'm also the co-chair of the Erie County, Pennsylvania Access to Basic Care Coalition.

I'm formerly homeless myself, and as of March 2007, without health insurance, as my husband's company, GAF, went out, we lost -- they went out of business after over 120 years in Erie. Being homeless felt much more traumatic than a lack of health insurance.

That was until September 1st of 2007, when I fell at home, and I broke my foot, ankle, and leg. Four days in the hospital, a two-hour surgery that listed over five, a team of orthopedic specialists, residents, clinic visits, and the list goes on. When I left Hamot in September -- I think it was the 26th, the bills were just under 40,000. It will be a year and another month, and the bills are over 65,000, and I still have no health insurance.

I'm unable to secure affordable health insurance because I have a couple of pre-existing conditions. One is asthma that I've had my entire life, and for the most part has been under control. I have -- I did have a couple of asthma attacks that caused me to be hospitalized. Because of that, they gave me steroidal treatments. Because of that, my weight ballooned, and that weight gain caused my blood pressure, both of which are treatable when I take medication. Without health insurance, I cannot afford a medication. So it becomes a Catch 22.

What I have to ask you is what is so criminal about common illnesses like high blood pressure and asthma?

There's a lot of people -- there's millions of people that have it. And, sadly, there will people that die from that.

It's been almost -- it's been over a year that my husband has been out of work. We have tried to secure health insurance. Part of the problem is my asthma and my high blood pressure. The other part of the problem is my husband's age. He's 58. I'm 64. I've got another year, I think, before I can get on Medicaid -- I'm sorry, Medicare. Medicare. So that kind of leaves us out there, in case -- who knows what will happen.

I don't have a magic answer, but I will tell you that it bothers me a great deal that there are individuals out there that are just like me, that choose not to say anything, because it's -- it's shameful that you can't take care of yourself or your family. We're very lucky that the kids are gone. We've got six kids. I don't know what we would do if we had kids. We would really be in trouble. It's only been recently that the CHIPS program has been able to put kids on. Prior to that, there was a huge waiting list. You know, we have to do something, and something has to be done quickly.

I just saw some stats of several months ago about two people a day that die in Pennsylvania from treatable illnesses and diseases. That's wrong on every level. That's so wrong. It should not happen in this

state. It should not happen in this nation. We are supposed to be living in one of the wealthiest nations of the planet, and people are dying from things like this?

I just had a call the other day from somebody who saw me on TV one of the 85 times and said, do you have an answer; my mother has cancer. She fought it, and now it's back, but she doesn't have insurance, and nobody will take care of her. And she lives in Erie County. I get calls from out of my own county. And I have nothing to say to them. Nothing at all. If you don't qualify for Medical Assistance, you're up a creek. You have nothing. You hope for the best, which is what we did. We hoped that things would just move along until Ron got a job or I did, and we got insurance. We weren't that lucky. And there's a whole bunch of us out there that aren't that lucky. We have to do something.

I listened to Senator Kennedy's speech last night, and I could not believe that I was hearing the same thing when his brother John spoke. And he's right. He advocates for healthcare at the national level. We need decent quality healthcare for everybody. It's a fundamental right -- he's right -- not a privilege. That should not even be an issue. It's like eating, a place to live. We have to do something.

Thank you. I hope I didn't overstay my

welcome.

REPRESENTATIVE DeLUCA: It did actually very good. We appreciate you taking the time.

Any questions from the left? From the right?

(No response.)

REPRESENTATIVE DeLUCA: Well, we want to thank you for taking your time to come here. We certainly understand that. I think all of us here understand the importance of that.

REPRESENTATIVE FABRIZIO: Keep up the fight.

REPRESENTATIVE DeLUCA: As Representative Fabrizio said, keep up the fight.

Ladies and gentlemen, this meeting is now adjourned. Thank you.

(Hearing concluded at 11:48 a.m.)