

# PPACA AND PENNSYLVANIA: ONE YEAR OF BROKEN PROMISES

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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MARCH 23, 2011

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## **PPACA AND PENNSYLVANIA: ONE YEAR OF BROKEN PROMISES**

**WEDNESDAY, MARCH 23, 2011**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:15 a.m., in the Senate Majority Caucus Room, Pennsylvania State Capitol, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Member present: Representative Pitts.

Also present: Representative Glenn Thompson.

Staff present: Heidi Stirrup, Health Policy Coordinator; Ryan Long, Chief Counsel, Health; Paul Edattel, Professional Staff Member, Health; Debbee Keller, Press Secretary; Katie Novaria, Legislative Clerk; and Stacia Cardille, Democratic Counsel.

Mr. PITTS. The subcommittee will come to order.

I have with me seated at the dais Congressman G.T. Thompson. He is a Member from the 5th Congressional district of Pennsylvania and served as a hospital administrator for 28 years, so he has some expertise in the area of health care. He serves on the Education and Workforce Committee, which has co-jurisdiction with Energy and Commerce Committee, and one other committee, I guess it is, Ways and Means, on health care, primarily employer health plans, I believe. The chair will recognize himself for an opening statement for 5 minutes.

### **OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

First of all, let me say it is good to be back in Harrisburg. I spent more than 20 years here as a State representative, and I still have many fond memories and good friends from my time here.

On the 1-year anniversary of the Patient Protection and Affordable Care Act being signed into law, we are here today to examine the effects of the law, the effects it has already had and which it will have on the States, and we will hear how various provisions in the law are burdening businesses and employers, precisely at a time when we need them to be hiring new employees and creating jobs.

What we affectionately call Obamacare, its heaviest burden on the States is the Medicaid expansion. A May 2010 Kaiser Family Foundation report found that by the year 2019, Pennsylvania's Medicaid rolls may grow by an additional 682,880 people and may

cost the State an additional \$2.041 billion over the 2014–2019 time period.

Where is Pennsylvania supposed to come up with that \$2 billion? How much spending for education, transportation, and other priorities will have to be cut to come up with this money? Which taxes will need to be raised to pay for this expansion?

And, in the private sector, Obamacare levels taxes on virtually every sector of our economy. For businesses, the law raises the Medicare payroll tax by a total of \$210.2 billion. Employers will also be penalized for hiring new workers. They will pay a fine of \$2,000 for every full-time employee for whom they do not provide acceptable coverage, as defined by the government. Many employers will be forced to dump their employees into the exchanges, just to remain competitive. Employers will have to comply with thousands and thousands of pages of burdensome regulations. There is something like 6,500 already and many thousand more coming out in future years that will impose new mandates and responsibilities and new compliance costs on businesses, while driving up health insurance premiums and discouraging hiring.

So today, we will hear from representatives of the State and the private sector to get their perspective on what Obamacare means for them. I would again like to thank Governor Tom Corbett for kindly agreeing to share some opening remarks.

At this time I would like to welcome our distinguished witnesses, Secretary of Public Welfare Gary Alexander and State Insurance Commissioner Michael Consedine, on panel one. On panel two, we will have State Senator Pat Vance, chair of the Senate Public Health and Welfare Committee, and State Representative Matt Baker, chairman of the House Health Committee. And on panel three, we will hear from Gene Barr, Vice President of Government and Public Affairs for the Pennsylvania Chamber of Business and Industry, Kevin Shivers, Pennsylvania State Director with the NFIB, and Ann Daane, Vice President of North America Human Resources at Case New Holland.

And finally, I would like to thank Governor Corbett's office, both Senator Scarnati's and Dominic Pileggi's offices and Representative Matt Baker's office for their help with accommodations and making this hearing possible today.

[The prepared statement of Mr. Pitts follows:]

#### PREPARED STATEMENT OF HON. JOSEPH R. PITTS

It's good to be back in Harrisburg. I spent more than 20 years here as a state representative, and I still have many fond memories and good friends from my time here.

On the one-year anniversary of the Patient Protection and Affordable Care Act being signed into law, we are here to examine the effects that the law will have, and is already having, on states.

And, we will hear how various provisions in the law are burdening businesses and employers, precisely at a time when we need them to be hiring new employees and creating jobs.

Obamacare's heaviest burden on states is the Medicaid expansion.

A May 2010 Kaiser Family Foundation report found that by 2019, Pennsylvania's Medicaid rolls may grow by an additional 682,880 people and may cost the state an additional \$2.041 billion over the 2014–2019 time period.

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And, in the private sector, Obamacare levels destructive taxes on virtually every sector of our economy.

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So, today, we will hear from representatives of the state and the private sector to get their perspective on what Obamacare means for them.

I would again like to thank Governor Tom Corbett for kindly agreeing to share some opening remarks with us before our hearing got underway. Thank you, Governor.

I would also like to welcome our distinguished witnesses, Secretary of Public Welfare Gary Alexander, and State Insurance Commissioner Michael Consedine, on panel one.

On panel two, we will have State Senator Pat Vance, chair of the Senate Public Health and Welfare Committee, and State Representative Matt Baker, chairman of the House Health Committee.

And on panel three we will hear from Gene Barr, Vice President of Government and Public Affairs for the Pennsylvania Chamber of Business and Industry, Kevin Shivers, PA State Director with the NFIB, and Ann Daane (Day-nee), Vice President of North America Human Resources at Case New Holland.

Finally, I would like to thank Gov. Corbett’s office, Sen. Dominic Pileggi’s office, and Rep. Matt Baker’s office for their help with accommodations and making this hearing possible.

Mr. PITTS. So at this time we have our first panel seated. Each witness has prepared a written opening statement that will be placed in the record. Our first witness is Acting Secretary of Public Welfare Gary Alexander. Secretary Alexander oversees a department that provides services and support to more than 2.1 million low-income, elderly and disabled Pennsylvanians. Prior to being nominated as DPW Secretary earlier this year, Secretary Alexander served as the Rhode Island Secretary of Health and Human Services. He is widely recognized as a health care and program innovator, welfare reformer and management specialist.

Our second witness, Michael Consedine, was appointed by Governor Corbett to serve as Insurance Commissioner for the Pennsylvania Insurance Department pending senate confirmation. From 1995 to 1999, Commissioner Consedine served as Department Counsel for the Pennsylvania Insurance Department. From 1999 to January of 2011, he was in private practice where he was partner and vice chair of his firm’s insurance practice group.

Secretary Alexander, you will have 5 minutes to summarize your testimony. Before you do that, I would like to recognize Congressman G.T. Thompson for his opening statement.

Mr. THOMPSON. Thank you, Chairman, and thank you so much for not just convening this panel but thanks for the invitation to be able to join you and really to be here to address very important issues that we have.

**OPENING STATEMENT OF HON. GLENN THOMPSON, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

You know, when the President signed the Affordable Care Act into last March effectively immediately, States were strictly prohibited from making any changes to their Medicaid programs' eligibility standards, methodologies and/or procedures. And while I am not an official member of the Energy and Commerce Committee, my professional background is in health care, and as a member of the Education and Workforce Committee and specifically the Health Subcommittee, there is a shared jurisdiction with Energy and Commerce over many of these issues. This includes any changes that would identify and reduce waste, fraud and abuse in the system.

Many States such as Pennsylvania are generous with their Medicaid eligibility and surpass the mandatory federal guidelines, and as we know, currently many States are struggling to meet their fiscal obligations. States, unlike the Federal Government, are generally required to balance their budgets. It has become increasingly clear that drastic increases in State obligations will force significant tax increases or will result in cuts to vital programs to meet these new federally dictated obligations. Estimates suggest that Pennsylvania will see up to a 25 percent increase in Medicaid enrollment. During the years of 2014 to 2019, this will cost Pennsylvania alone over \$2 billion. Many States will experience similar, if not greater, funding burdens.

The Robert Wood Johnson Foundation estimates that 18.6 million new people will be eligible for Medicaid rolls nationally. Enrollment will be substantially higher in southern and western States. Several States will now have more than 10 percent of their population newly eligible and the national Medicaid roll will reach upwards of 80 million people. The bottom line: States simply cannot afford this dramatic cost.

Now, I am glad to have the opportunity to be here and look forward to receiving some further insights and feedback on the effect that the Affordable Care Act is having right here in the Commonwealth of Pennsylvania, and thanks again to the chairman for having us and thank you to all of our witnesses for being here today.

Mr. PITTS. Thank you, Congressman Thompson, for your opening statement.

Mr. Secretary, you are recognized.

**STATEMENTS OF GARY ALEXANDER, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE; AND MICHAEL CONSEDINE, ACTING INSURANCE COMMISSIONER, PENNSYLVANIA INSURANCE DEPARTMENT**

**STATEMENT OF GARY ALEXANDER**

Mr. ALEXANDER. Thank you very much. Chairman Pitts and members of the committee, I thank you for this opportunity to discuss Pennsylvania's medical assistance program, the challenges that we face because of these federal mandates and the issues that are arising because of the Affordable Care Act.

Given your time constraints, I will get straight to the point, two points actually. Number one, Pennsylvania's Medicaid program as currently structured is unsustainable, inefficient, bureaucratic and not focused on performance and outcomes. Federal mandates are largely responsible because Medicaid is a program that pays for volume and not value. Number two, the federal health care law will make this problem even worse for consumers and taxpayers. Adding more people to a broken system is a terrible idea no matter how much money Washington wants to throw at it.

Pennsylvania's Medicaid rolls already are heading toward a cliff of fiscal instability, and this will clearly plunge us over the edge if this law is not stopped. The federal health care law requires State Medicaid programs to cover every adult who earns up to 133 percent of the federal poverty level or 138 percent if we use this new code from the IRS.

The expansion will bring nearly 1 million new additional Pennsylvanians onto the Medicaid rolls. That is in addition to the more than 2.2 million on our rolls today. The Pennsylvania Department of Public Welfare's overall Medicaid budget, the amount spent from both State and federal dollars is already growing at nearly 12 percent annually and is expected to exceed \$18.3 billion in the current fiscal year. That is a 97 percent increase from the \$9.3 billion budget of a decade ago.

Pennsylvania already spends more of its general fund revenues on Medicaid than all but two States in the Nation with about 30 percent of it going towards Medicaid. If we continue on this path, the State will use about 60 percent of its budget on Medicaid alone by fiscal 2019, leaving less money for other vital services. If the federal health care law is implemented as currently planned, this already unsustainable spending pattern will get much worse. Contrary to what some in Washington think, the new law will not be entirely financed by the Federal Government. Even with the enhanced funding for certain expansion populations, the law will cost the Commonwealth taxpayers more than \$11.4 billion over the first full decade of implementation. This is totally unsustainable.

Certainly, a safety net is important for our most vulnerable citizens so if Medicaid is to remain economically viable, where does that leave us for options? The most obvious and viable option is to give States complete flexibility to design and manage a Medicaid program that allows us to improve outcomes and bring more value to taxpayers and beneficiaries. We need to make this a health program and not a benefit program. For Pennsylvania, this solution would be a boom for innovation, efficiency and, most of all, a healthier and more productive citizenry. Our current Medicaid program is an inefficient hodgepodge of command and control top-down processes from afar. Very few of our current programs nationally reward or even encourage prevention, wellness and disease management and people in this Nation on the welfare system are discouraged from working.

Administratively, the program is equally broken. Operating multiple waivers across multiple populations is archaic, siloed and prevents integrated health care. Bureaucrats in Baltimore don't manage and don't administer programs and certainly don't have to balance a budget. We do.

Public welfare reform presents us with a great opportunity to use the resources within our Commonwealth to transform the structure and operations of the public health system without needless federal intervention and with the best interests of Pennsylvanians in mind instead of being distracted by the interest of federal bureaucrats.

Permit me to outline a few of the reforms that Pennsylvania and other States can do on their own without the heavy hand of Washington. We can promote improved care management through quality outcomes, wellness and prevention and new provider markets that drive nutrition and personal responsibility into the programs. We can focus on data-driven consistent management and decision-making from measured quality outcomes. We can examine new initiatives such as healthy choice accounts for families structured to promote personal responsibility and incentivize preventive care. We can provide care coordination and management for all beneficiaries through mandatory enrollment in a primary care coordination model, a managed care plan or a healthy choice option. We can implement smart purchasing techniques and strategies and fair share initiatives which empower Medicaid recipients to make cost-conscious decisions about their medical care and competitive and selective contracting to ensure purchases are made at the best competitive prices.

Mr. Chairman, as we Americans have given trillions of dollars to government entitlements with the poorest of outcomes, we ask that Washington get off of our backs. It is time that State governors, State legislators and others have their chance. Washington has already had theirs. We have firsthand experience managing our own programs; Washington does not. We know how to balance budgets; Washington does not. Pennsylvania is ready and able to bring innovative policy solutions to actively address Medicaid's unsustainable growth. The States can and should be the originators of policies and best benefits their own diverse populations and demographic realities. It is time we realize the "Washington knows best" mentality is counterproductive to innovation within States.

Thank you for allowing me to speak today.

[The prepared statement of Mr. Alexander follows:]

The Committee on Energy and Commerce, Subcommittee on Health  
Statement of Acting Department of Public Welfare Secretary Gary Alexander  
Harrisburg, Pennsylvania  
March 23, 2011

Chairman Pitts, Ranking Member Pallone, and members of the committee, I thank you for this opportunity to discuss Pennsylvania's Medical Assistance program, the challenges it already faces due to burdensome federal mandates and the even greater – arguably insurmountable – issues that will arise due to the Patient and Protection and Affordable Care Act (PPACA), more commonly known as federal healthcare reform.

Given your time constraints, I'll get straight to the point – two points, actually:

1. Pennsylvania's Medicaid program, as currently structured, is unsustainable, inefficient, bureaucratic and not focused on performance and outcomes. Federal mandates are largely responsible because Medicaid is program that pays for volume, not value.
2. The federal healthcare law will make this problem even worse for consumers and taxpayers. Adding more people to a broken system is NOT a good idea, no matter how much money Washington wants to throw at it.

Pennsylvania's Medicaid rolls, already heading towards a cliff of fiscal instability, will clearly plunge over the edge if federal regulations are not eased. And that includes putting the brakes on this healthcare reform law.

The federal healthcare law requires state Medicaid programs to begin, in 2014, covering every adult who earns up to 133 percent of the federal poverty level. It is estimated that the 2014 expansion will bring more than 750,000 additional Pennsylvanians onto the Medicaid rolls – that is in addition to the more than 2.2 million on our Medicaid rolls today. By 2019, that expansion is expected to add more than 891,000 people to our Medicaid rolls.

To help you understand where we're headed, let me summarize where we are now.

The Pennsylvania Department of Public Welfare's overall Medicaid budget – the amount spent from both state and federal dollars - is growing at nearly 12 percent annually, and is expected to exceed \$18.3 billion in the current fiscal year - a 97 percent increase from the \$9.3 billion budget of a decade ago.

The state's share of Medicaid funding has doubled in the same period, ballooning to more than \$6.7 billion slated for fiscal year 2011-2012, compared to \$3.3 billion a decade ago. Pennsylvania already spends more of its General Fund revenues on Medicaid than all but two states (Illinois and Missouri), with about 30 percent of it going towards Medicaid. If we continue

on this path, DPW will use about 60 percent of its budget on Medicaid alone by fiscal 2019-20 leaving less money for other important services.

If the federal healthcare law is implemented as currently planned, this already unsustainable spending pattern will get exponentially worse.

Contrary to what some in Washington think, the new law will not be entirely financed by the federal government. Even with the enhanced funding for certain expansion populations, the law will cost commonwealth taxpayers more than \$11.4 billion over the first full decade of implementation.

Under the new law, the federal government will pay the full cost for new enrollees for the first three years, but the amount the feds pay will fall after that – leaving the states to pick up the balance. What this means is Pennsylvania and other states will be facing a repeat of the so-called “stimulus cliff,” a scenario where federal funding evaporates and leaves states to pick up where Washington left off.

Certainly, a safety net is important, so if Medicaid is to remain *and* remain economically viable, where does that leave us in terms of options?

The most obvious and viable option is to give each state the flexibility to design and manage a Medicaid program that allows us to improve outcomes and bring more value to taxpayers and beneficiaries.

For Pennsylvania, this solution would be a boon for innovation, efficiency, and most important of all, a healthier and more productive citizenry.

Our current Medicaid program is an inefficient hodgepodge of processes that too often are disconnected from one another. Very few of our current programs reward – or even aggressively encourage - prevention, wellness, and disease management, and people are discouraged from working.

Public welfare reform presents us with a great opportunity to use the resources within our commonwealth to transform the structure and operations of the public health system without needless federal intervention and with the best interests of Pennsylvanians in mind, instead of being distracted by the interest of federal bureaucrats.

Permit me to outline a few of the reforms that Pennsylvania and other states can do on their own - without the heavy hand of Washington:

- We can promote Improved Care Management as measured by the reduction in Medicaid and SCHIP costs through quality outcomes, wellness, prevention, new provider markets, nutrition, and personal responsibility.

- We can focus on data-driven, consistent management and decision-making from measured quality outcomes.
- We can examine new initiatives – such as Healthy Choice Accounts for families structured to promote personal responsibility and preventive care.
- We can provide care coordination and management for all beneficiaries through mandatory enrollment in a primary care coordination model (PCCM), a managed care plan, or a Choice Option (such as a self-directed account or voucher system), promoting reduced use of costly services.
- We can implement smart purchasing techniques such as Fair Share Initiatives, which empower MA recipients to make cost-conscious decisions about their medical care, and competitive and selective contracting to ensure purchases are made at the best competitive prices.

Mr. Chairman, we as Americans have given trillions of dollars to government entitlements with the poorest of outcomes. Washington has had its chance and we have seen the results. It's time that states – governors, state legislators and others – have their chance. We have the first-hand experience managing our programs - Washington does not. We know how to balance budgets - Washington does not.

Pennsylvania is ready and able to bring innovative policy solutions to actively address Medicaid's unsustainable growth. The states can, and should, be the originators of policies that best benefit their own diverse populations and demographic realities. It time we realize the "Washington knows best" mentality is not only not working, it's flat-out counterproductive to innovation within states.

Thank you for allowing me to share my views on this extremely important issue, and I'd be happy to take any questions.

###

Mr. PITTS. Thank you, Mr. Secretary.

Mr. Commissioner, you are recognized for your opening statement at this time.

#### **STATEMENT OF MICHAEL CONSEDINE**

Mr. CONSEDINE. Good morning, Chairman Pitts and distinguished members of the committee. My name is Michael Consedine and I am Pennsylvania's Acting Insurance Commissioner.

As you know, this is the first anniversary of the federal Affordable Care Act. As Pennsylvania's chief regulator of the insurance industry, I appreciate the opportunity to share with you our efforts over the last year to navigate this new law, our view on its impact on consumers, both individual and business, and on our State and the challenges we face as we move forward. But first, because as Chairman Pitts knows, Pennsylvania is unlike many other States, please allow me to provide a brief snapshot of Pennsylvania's health care marketplace.

While there are more than 100 carriers licensed to write health insurance in our State, the marketplace is in fact dominated by nine carriers with two groups sharing over 50 percent of the market. Moreover, Pennsylvania's population is diverse. We have both urban and rural areas. We are often considered a State with large businesses due in part to our urban concentrations but much of our population is employed by small businesses. It is in this unique and in many respects challenging marketplace that we are dealing with the implementation of the Affordable Care Act.

If the Act was designed to serve as a roadmap to affordable and accessible health insurance for Pennsylvanians, I will tell you that thus far it has been a path marked by lack of clear direction and troubling indications for the road ahead. I recognize that some journeys do start out that way and still one proceeds undaunted by the twists and turns ahead.

One of the first requirements we dealt with under the act was the creation of the so-called high-risk plan designed to act as a stopgap measure for uninsured Americans until the act takes full effect in 2014. It was a significant undertaking to create a new program in a very short timeframe but we made it to this first mile marker. As of March 1, 2011, we have 2,684 enrollees receiving coverage and care. Ironically, this makes Pennsylvania one of the more successful programs in the country in terms of its participation.

Several provisions of the Affordable Care Act have become effective and several additional provisions will become effective in 2011. These requirements primarily deal with policy design and required coverages. Compliance with these provisions required Pennsylvania to develop new systems and procedures, all within associated cost to the State to ensure compliance, and it was at this point in our journey that we first saw troubling signs for the road ahead.

While from a consumer perspective there are additional benefits as a result of these forms, these federally mandated coverage changes resulted in premium increases of up to 9 percent, this on top of already significant premium increases being seen by Pennsylvania businesses and consumers. Therefore, it is important to

stress that the initial reforms have caused an increase in premiums, not a decrease.

The Affordable Care Act also provided for several grants from the Federal Government to the States as a way to help States navigate the path to health care implementation. The first, already mentioned, was PA Fair Care. We next intend to utilize the consumer assistance grant in making health insurance understandable to consumers. I am not sure any of us here or even in Washington truly understand the act, in part because it is still evolving and changing. So educating everyday Pennsylvanians about the new law is a challenge. To use the journey analogy, how can a State effectively give directions to consumers when the destination itself is still moving?

There is also an exchange planning grant. The formation of a health insurance exchange market in each State by 2014, really 2013, is one of the act's landmark provisions. If the States does not set up an exchange, the State's exchange will be run at the federal level. Implementation of an exchange is no small endeavor. In some respects, it represents the point of no return in the implementation of the act because of the time and resources that States will need to expend in creating this new enterprise. Also, the Affordable Care Act sets various aggressive timeline for exchange implementation. As with other areas of the law, here we are also awaiting clear direction from HHS on key components of the exchange including the design of the essential benefit package.

Governor Corbett has tasked the Insurance Department as the lead agency in the Commonwealth to study implementation of the health care exchange. We intend to look very carefully at what type of an exchange, if any, Pennsylvania should implement before taking that very significant step.

Overall, Mr. Chairman, we are concerned that the road to implementation of the act is a toll road. As noted earlier, the immediate insurance reforms imposed by the Affordable Care Act added to the cost of coverage by mandating required benefits or expanded coverage. Additionally, the act imposes a toll on the insurance regulators' already strained resources. There is no money in the act to help fund the increased workload associated with reviewing the act nor is there any money to fund the enforcement efforts that States will need to undertake to ensure industry compliance. Again, this is a toll that States are expected to pay out of already strained budgets.

As Governor Corbett noted in his remarks, the act does not go far enough in addressing the cost drivers of health insurance. If the ultimate objective of our journey of reform is affordable care, we question whether the Affordable Care Act is a clear roadmap or still an uncharted course.

So Pennsylvania, like many States, stands here today 1 year after the Affordable Care Act enactment at a crossroads. We could proceed down one path towards full implementation of the law, expending substantial time and limited State resources and funds in doing so, possibly only to find that the path is closed by virtue of legal or legislative challenges to the current version of the act. We could also choose a path to full resistance of the act. However, we risk that our journey ends in federal regulation of Pennsylvania's

health insurance market. We continue to hope that with your hope, Mr. Chairman, members of the committee and Governor Corbett, that we might be able to forge another path, one that results in a clear roadmap that delivers us to the destination we all seek: health care reform that truly addresses the issues of affordability and accessibility in a fiscally sound manner.

Thank you, and we would be happy to answer any questions that you have.

[The prepared statement of Mr. Consedine follows:]

**The Committee on Energy and Commerce, Subcommittee on Health  
Statement Summary**

**Michael F. Consedine, Acting Insurance Commissioner**

The first anniversary of the federal Affordable Care Act (“ACA”) provides a point-in-time snapshot of what it has taken to understand and implement the immediate reforms of this new law in Pennsylvania, what it will take to navigate its further implementation, and its impact and cost to business, the consumer and government.

- Pennsylvania’s marketplace is unique in terms of population and health-care carriers.
- Pennsylvania has received four HHS grants to offer a high risk plan, review health trends and rating, provide for consumer assistance, and analyze health exchanges.
- Implementation of ACA has thus far been a toll-road for Pennsylvania both in terms of increased premiums for consumers and unfunded mandates on state agencies.
- Clear and consistent direction from HHS is lacking which further undermines our ability to create and manage a new health insurance market place.
- Our desire is to look at what is needed to get us to the destination we all seek – health-care reform that truly addresses the issues of affordability and accessibility in a fiscally sound manner.

**The Committee on Energy and Commerce, Subcommittee on Health**

**Statement of Michael F. Consedine,**

**Pennsylvania's Acting Insurance Commissioner**

Harrisburg, Pennsylvania

March 23, 2011

Good Morning Chairman Pitts, Ranking Member Pallone, and distinguished members of the Committee. My name is Michael Consedine and I am Pennsylvania's acting Insurance Commissioner.

As you know, this is the first anniversary of the federal Affordable Care Act or "ACA." As Pennsylvania's chief regulator of the insurance industry, I appreciate the opportunity to share with you our efforts over the last year to navigate this new law; our view on its impact on our consumers, both individual and business, and on our state; and the challenges we face as we move forward.

But first, because, as Chairman Pitts knows, Pennsylvania is unlike many other states, allow me to provide a snapshot of Pennsylvania's health insurance marketplace. Our market is distinctive in many respects and is a good example of

why increased flexibility for states in implementing health care reform is going to be crucial to any hope of addressing the issue of affordable and accessible health insurance. While there are more than one hundred carriers licensed to write health insurance in our state, the marketplace is in fact dominated by nine carriers: two groups share over 50 percent of the market, five groups each maintain close to 5 percent of the market, and two groups each have about 2.5 percent of the market. Moreover, Pennsylvania's population is diverse. We have urban areas, but we have significant rural regions. We're often considered a state with large businesses, due in part to the urban concentrations; but much of our population is employed by small businesses.

It is in this unique, and in many respects challenging, marketplace, that we are dealing with implementation of the Affordable Care Act. If the Act was designed to serve as a roadmap to affordable and accessible health insurance for Pennsylvanians, I will tell you that thus far the path has been marked by a lack of clear direction and troubling indications of the terrain ahead. I recognize that some journeys do start out that way, and still one proceeds undaunted by the twists and turns ahead. But I feel it is very important to share the Insurance Department's journey over the last year and provide our thoughts on some of the challenges we see down the road for Pennsylvania.

Taking the First Step – Implementing a High Risk Plan

One of the first requirements we dealt with under ACA was the creation of a so-called state “high risk plan.” These plans or pools were designed to act as a stop gap measure for uninsured Americans until the Act takes full effect in 2014. HHS had initially projected that over 350,000 participants would be enrolled nationwide by 2014. As has been widely reported, the actual numbers indicate the program has gotten off to a slow start with just over 12,000 enrollees across the country at the current time.

While neither HHS, nor any state, quite hit the mark of establishing a pool within 90 days of enactment, Pennsylvania met its obligation on time to form its plan, and by October was enrolling individuals in the program we titled “PA Fair Care.” It was a significant undertaking to create a new program in the short time frame required, but we made it to this first mile marker. At the current time, PA Fair Care has enabled 3,211 different individuals to have insurance. However, it should be noted that some of that number were enrolled for only a month or two before dropping coverage. As of March 1, 2011, we have 2,684 enrollees receiving coverage and care. This makes Pennsylvania one of the more successful programs in the country in terms of participation.

Thoroughfare of Immediate Insurance Reforms

Several provisions of the Affordable Care Act have become effective and several additional provisions will become effective in 2011. These are the “immediate” insurance reforms that took effect for plan years beginning on or after September 23, 2010, including:

- Prohibition of lifetime benefit limits;
- Restrictions on annual benefit limits;
- Prohibition of rescissions;
- Extension of dependent coverage up to age 26; and
- Prohibition of pre-existing condition exclusions for children.

Compliance with ACA required Pennsylvania to develop new systems and procedures – all with an associated cost to the state – to ensure compliance. And it was also at this point in our journey that we first saw troubling signs for the road ahead. While from a consumer perspective there are additional benefits as a result of these reforms, these ACA-mandated coverage changes resulted in premium increases of up to 9 percent – this on top of already significant premium

increases being seen by Pennsylvania businesses and consumers. Therefore, it is important to stress that the initial reforms have caused an increase in premiums and not a decrease.

#### Planning for the Road Ahead

ACA also provided for several grants from the federal government to the states as a way to help states navigate the path to implementation. The first, as already mentioned, is funding PA Fair Care. Two other grants are allowing Pennsylvania to study the market and enhance its regulatory processes and to further educate consumers, and another is allowing for planning for implementation of an exchange.

The first of these is a **rate review grant**. This \$1 million grant is allowing the Department to perform an analysis of gaps in the Department's regulatory authority over rates, and to develop a data base for rate review and comparison. While no determination has been made as yet as to whether the Department will seek (through state legislation) to increase its authority to review rates, we expect that the work performed under this grant will make the rate review process more transparent, to the benefit of consumers.

The second grant is a **consumer assistance grant**. While this \$1.4 million grant has not yet been appropriated by the state legislature due to the timing of the grant award in the state budget cycle, we anticipate that this grant will assist us in making health insurance understandable to consumers. I'm not sure any of us here or in Washington understand ACA, in part because it is still evolving and changing, so educating everyday Pennsylvanians about the new law is a challenge. While this grant will be helpful in advising consumers on ACA, we are concerned about our ability to properly advise on a law that is still in flux and about which the rules are being still being written. To use the journey analogy, how can a state effectively give directions to consumers when the destination itself is still moving?

Finally, there is the **exchange planning grant**. The formation of a health insurance exchange or market in each state by 2014, really by 2013, is one of ACA's landmark provisions. If the state does not set up an exchange, the state's exchange will be run at the federal level.

Implementation of an exchange is no small endeavor – in some respects it represents the “point of no return” in the implementation of ACA because of the time and resources that states will need to expend in creating this new

enterprise. Also, ACA sets a very aggressive timeline for exchange implementation. As with other areas of the law, here we are also awaiting clear direction from HHS on key components of the exchange, including the design of the “essential benefit package.”

Governor Corbett has tasked the Insurance Department as the lead agency in the Commonwealth to study implementation of a health insurance exchange. The \$1 million exchange planning grant will be used to fund background research and analysis to set the stage for informed decisions regarding formation of an exchange. We intend to look very carefully at what type of an exchange, if any, Pennsylvania should implement before taking that very significant step on the road to ACA implementation.

I'd like to further touch on two points that I've referenced elsewhere in my testimony – the cost of implementation and the uncertainty.

#### The “Tolls” on the Road Ahead

The road to Affordable Care Act implementation is a toll-road.

As noted earlier, the immediate insurance reforms imposed by ACA added to the cost of coverage by mandating required benefits or expanding coverage.

Whether the “essential benefit package” to be defined by ACA further contributes to costs for states is unknown at this time. If for example, the essential benefit package does not include certain benefits such as autism coverage, then the state must determine whether it will provide those benefits at its own cost, out of its already strained budget.

Additionally, ACA imposes a toll on insurance regulators’ already strained resources. There is no money in ACA to help fund the increased work load associated with reviewing new products and rates required under the Act. Nor is there any money to fund the enforcement efforts that states will need to undertake to ensure industry compliance. Again, this is a toll that states are expected to pay out of already strained budgets.

As Governor Corbett noted in his remarks, ACA also does not go far enough in addressing the cost drivers of health insurance. These include: medical needs of an aging population; cost of new technologies; consumer and treatment demand; provider consolidation; cost shifting from public to private payers; lifestyle changes to unhealthy behavior; and defensive medicine.

Beyond these factors is the unknown of how new elements injected into the health insurance marketplace by ACA will affect insurance pricing. Many

questions arise here. Will the individual mandate trigger adverse selection? Will the expansion of the small group market from groups of 1-50 to 1-100 prompt healthy small groups to self-insure, leaving the insured marketplace to the older and sicker population, making insurance more expensive for those left in the marketplace? Will smaller insurers simply flee the market to avoid the hassle of compliance, further undermining competition and potentially driving up cost?

If the ultimate objective of our journey to healthcare reform is affordable care – we question whether ACA is a clear roadmap or a still uncharted course.

In addition to the financial toll of healthcare reform, we also find ourselves without clear direction on many key points. I think even HHS would agree that there are many critical components of ACA that have yet to be firmly defined and this has led to a general atmosphere of uncertainty and confusion for the states and consumers.

For example, ACA charges HHS with promulgating a significant number of regulations, in an area that, quite frankly, it has not regulated to-date. Insurance has been a state-regulated industry since its inception in this country. For HHS to now step in and write regulations is no small task, nor does the volume of regulations to be issued ease the challenge. The National Association of

Insurance Commissioners has been providing input, but it is a process that is not as simple as many would wish. Let me provide a quick example. HHS is currently in the process of finalizing regulations related to Rate Increase Disclosure and Review. Final regulations are not expected for several more weeks, if not months, but unless Pennsylvania enacts legislation almost immediately to provide the Insurance Department with additional rate review authority, HHS will assume certain rate review functions for Pennsylvania this July.

You can readily see our dilemma. How do we fashion appropriate legislation when we don't yet know what the final regulations will require? This is one area where we hope that HHS will delay implementation of the regulations in order to provide us with some opportunity to review the final regulations and determine the best course of action for Pennsylvania.

There are also grants HHS is to issue for which consumers are still waiting. For example, the Department has fielded inquiries from small businesses about the grants that are to be issued (under section 10408 of ACA) to "small businesses to provide comprehensive workplace wellness programs." The funding of this grant program was authorized for fiscal years 2011-2015. While fiscal year 2011 began last October, small businesses are still waiting.

In order to successfully traverse health-care implementation, states need clear guidance and direction. Right now, we do not really have a working compass or a precise map and yet we've been told that time is of the essence. This is not the best of environments in which to make sound, well-informed judgments.

#### Critical Crossroads

So Pennsylvania, like many states, stands here today one year after the Affordable Care Act's enactment, at a crossroads. We could proceed down a path towards full implementation of the Act – expending substantial time and limited state resources and funds in doing so – possibly only later to find that the path is closed by virtue of legal or legislative challenges to the current version of the law. We could also choose a path of full resistance to implementation but risk that we end the journey with federal regulation of Pennsylvania's health insurance market. We continue to hope that together with your help Mr. Chairman, members of the Committee and Governor Corbett, we might be able to forge another path – one that results in a clear roadmap that delivers us to the destination we all seek – health care reform that truly addresses the issues of affordability and accessibility in a fiscally sound manner.

Thank you. I would be happy to take your questions.

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Mr. PITTS. The chair thanks the gentleman. The chair now recognizes himself for questioning.

Secretary Alexander, can you describe your experience in dealing with the CMS bureaucracy in your attempts to be granted Medicaid waivers? Do you find the CMS bureaucracy helpful and cooperative? Do you find their decision-making process timely? Do you find the actions of the CMS bureaucracy to be burdensome? Would you please elaborate?

Mr. ALEXANDER. Thank you, Mr. Chairman. Certainly, the citizens that work at CMS are fine people. Many of them have grown up in the bureaucratic abyss of Washington or Baltimore. What I would say essentially is that the CMS process is heavily bureaucratic, it is not timely, it is very burdensome and archaic. Sometimes approval for just a routine question can take months and reams of paperwork from the State. The federal establishment keeps adding more and more employees. We here at the State level keep decreasing our employees. We cannot continue to mirror our operations here like the federal establishment.

I will just give you an example of something recent. South Carolina is trying to amend one of their home and community-based waivers, and because they made a mistake and added one or two sentences that shouldn't have been in the application, the application then got put to the bottom of the pile again and they are going to have to wait another few months. Now, when States are trying to balance their budgets, this is extremely troublesome. Generally what happens is, States want to make changes to their programs. They petition CMS. It takes months and months. The legislature will then pass a bill in June or July and then it takes us months and months and months, sometimes 12, 18 months or 2 years to get a decision out of Baltimore. This leads us to have deficits in our own budgets. All of this can't continue. We are operating multiple waivers across multiple programs. It is very disjointed and disorganized. So I guess the short answer is, it needs to be overhauled.

Mr. PITTS. Thank you. Mr. Secretary, in what they call reforming the Nation's health care system, the President and the previous Congress decided on a plan that significantly expanded the Medicaid program. In fact, the Administration's Chief Actuary believes the plan will expand the Nation's Medicaid rolls by 20 million people. Do you believe that reforming the Nation's health care system is accomplished by expanding the Medicaid program by nearly 30 percent?

Mr. ALEXANDER. The Medicaid program is singularly the most broken program in Washington. None of us would sit around and create a health care program with outcomes or outcome-based measures and created the way the Medicaid program is currently structured. It is going to be a disaster for the States to continue down this road and to add all of these people to the rolls.

Mr. PITTS. Mr. Secretary, do you believe that PPACA's maintenance of effort requirement hinders States from implemented program integrity measures to root out fraud and waste and abuse in Medicaid?

Mr. ALEXANDER. It does. It also inhibits States from saving money when we are on a financial cliff, and for our hands to be tied like that under the current structure where we have no flexi-

bility in the program at all is disastrous. We cannot tailor benefits. We cannot structure benefit packages for certain populations. It is a one-size-fits-all program, and that type of a program invites fraud, waste and abuse.

Mr. PITTS. Finally, Mr. Secretary, the CHIP program, the expansion of the State Children's Health Insurance program, signed into law in 2009, provided bonus payments to States for adopting administrative changes such as eliminating asset tests and in-person interviews to verify Medicaid eligibility. Do you believe this bonus payment system promotes fraud and abuse?

Mr. ALEXANDER. It certainly does because any time we are inviting things like express-lane eligibility or presumptive eligibility in trying to have recipients access these programs in an expedited manner, we here on the State level have a lack of staff to begin with so all of those items would invite fraud, waste and abuse in the system.

Mr. PITTS. Thank you.

Commissioner, in your testimony you described the uncertainty facing States as they decide whether to create an exchange. Can you explain in further detail how PPACA imposes both a financial and administrative hardship on States that choose to set up an exchange?

Mr. CONSEDINE. I would be happy to, Mr. Chairman. The system in terms of what an exchange looks like, how it operates is still dependent on significant guidance from the Federal Government, even on such things as simple matters of the technology involved, the computer language that the State system is going to use to communicate with the federal system. You know, while the law provides for grants to help studies for implementation of the act and does provide more substantial grants to other States for early innovator approaches, it really still doesn't address the long-term maintenance costs associated with setting up and running an exchange long term, and again, there is still so much that needs to be decided in terms of how these exchanges operate and what is going to be acceptable to the Federal Government and what is not going to be acceptable, and that is, as I mentioned in my remarks, sort of the atmosphere of uncertainty that the States and businesses and everybody are dealing with is how do you set up an exchange or how do you build something, and essentially what we are doing with an exchange is building something, but we don't have any blueprints to use at this point so we are just—you can't build effectively a sound structure when you don't have blueprints, and we are waiting for that, and until we have those, it is a loss of money and time and resources for States and all of those are very precious resources at this point.

Mr. PITTS. Thank you. Commissioner, in your testimony you cite defensive medicine resulting from frivolous lawsuits as one of the drivers of health care costs. Do you believe PPACA credibly addressed the issue of medical liability reform?

Mr. CONSEDINE. I do not. I am quite clear that I believe that is one of the major failings with the Affordable Care Act is it really does not address the cost drivers of health insurance. I mean, one of the things we really want as part of reform is affordability, and the act does not go nearly as far as it could in addressing afford-

ability and certainly the defensive medicine is a significant factor that really is not addressed to any great degree as part of the reform.

Mr. PITTS. Thank you. The chair recognizes the gentleman, Congressman Thompson, for questioning.

Mr. THOMPSON. Thank you, Chairman.

Thank you, Mr. Secretary, Mr. Commissioner, for participating in the panel and for your leadership here in the Keystone State. We very much appreciate it.

Mr. Secretary, in my opening statement I mentioned the maintenance of effort provisions that prohibit States from altering their Medicaid programs, the way their Medicaid programs are administered, and this includes cleaning up waste, fraud and abuse in the system.

Mr. THOMPSON. My question is, has Pennsylvania identified areas in the system that could be improved but are being held back because of the maintenance of effort provisions?

Mr. ALEXANDER. Well, certainly the biggest problem we have with the maintenance of effort provisions is really, we have to maintain all of the eligibility levels that we have as of a certain date, which was about a year ago. The other part of this step I think we all seem to forget and it is sort of in the details, always the devil is in the details, is that if somebody—if we try to change a benefit, not an eligibility category but a benefit and it results in anybody losing eligibility, the State will be penalized. So the reason why that is detrimental, of course, is of a State tries to innovate and create benefit packages that are tailored and targeted to certain populations so that they don't have to give those benefits across all of the populations, which we really can't do anyway, but if we tinker with the benefit and it results in the loss of eligibility, the States will be penalized and in fact if we turn the clock back to when the stimulus was first given to the States, that was a huge problem because certain States already had some innovation in the pipeline, and when the new Administration came in, that all came to a halt.

Now, of course, when you have to—any time you are administering a program this large, this fast with all of these onerous rules and regulations, it is going to be very difficult to root out all of the waste, fraud and abuse, and certainly those MOE requirements would keep us down the same path so that we certainly couldn't clean up as much as we should.

Mr. THOMPSON. Certainly I am of the belief that States are laboratories of innovation, and certainly based on your testimony from both you gentlemen, you talked about very innovative ways to meet needs, and this is a question, just follow-up. If the maintenance of effort provision were obviously repealed or at least delayed for a certain period of time, could there be some savings realized?

Mr. ALEXANDER. Absolutely because it would give the States the flexibility to eliminate some higher-end populations, and if you are looking at States that are more lucrative in their Medicaid benefit, then obviously those are the types of States that would be able to eliminate certain eligibility categories. Certainly that is not the goal, but when you are in dire straits and you have to balance a budget and your State is on a cliff, you better do everything hu-

manly possible, and for governors, it is a huge burden to have those MOE requirements. Those MOE requirements should have never been put in even with the federal stimulus. They were detrimental because it is obviously a cliff. We got all that federal stimulus money and now it is ending and we never made the hard choices and the difficult choices, and now we have to make those.

Mr. THOMPSON. Mr. Secretary, the new law creates a trillion-dollar entitlement program, expands Medicaid, imposes new taxes and regulatory burdens on American employers and workers. In your view, does the new law control and reduce the trend of increasing public health expenditures in Pennsylvania?

Mr. ALEXANDER. Absolutely not. Have we ever seen anywhere the costs in Medicaid ever come down, ever? The biggest part of this law is the expansion in Medicaid, and that is going to be to the detriment of the States. Expanding Medicaid is no way to give universal health care.

Mr. THOMPSON. Mr. Commissioner, supporters of the health care law claim that new insurance exchanges will give small employers the same leverage as large employers. Will the new exchanges work or are there too many unresolved questions regarding their structure and are there any problems you anticipate?

Mr. CONSEDINE. We just don't know. At this point we really don't have any other models that we can look at and say one way or the other they work well or they don't work well. I mean, we have seen Massachusetts as an example of an existing health care exchange and certainly in that case it hasn't lived up to its promises in terms of certainly affordability. Access may have been improved but not significantly, and the affordability issue continues.

There are a lot of questions that are still unresolved. For example, what is going to constitute sort of the essential benefits package that is going to be required under the exchange? You know, what is going to be covered under that and what is not? I mean, there are a lot of what we call sort of additional mandated benefits that are provided under most health insurance policies. Autism is a good example. If that is not part of the essential benefits package that is yet to be developed at the federal level and the States want to provide that as part of our essential benefits package here, we can do that but that is going to substantially add to the cost and that is a cost that is in that case borne by the State, and again, that is one of those big issues that we don't know yet what direction they are going. Hopefully sometime this summer we will have a better sense but there are still a lot more questions that need to be answered before we can give any sound guidance on how this is going to work and if it is going to work well.

Mr. THOMPSON. I mean, there are ideas that we had worked on, a bill specifically, Putting Patients First Act, that was introduced in July 2009 and it had some parts of it that were totally ignored with the President's health care bill that was signed, so I want to share some of those and get your opinions on them. Would ideas like cross-State purchasing and permitting employers to pool their resources to increase bargaining power with insurance companies help begin the process of controlling and lowering health care costs here in the Commonwealth?

Mr. CONSEDINE. Well, certainly that type of buying power on a pooled basis has been shown to be an effective way to lower premium costs, and again, that is not something you see in this act. You know, I think there are a lot of great ideas that were out there but did not find their way into the reform law that we are dealing with, and that is one of the issues we have is we are sort of stuck with what we have and there is still a great deal of questions on what we are going to do with it and how it is going to work with the States but we would certainly like the opportunity to go back to the drawing board and come up with something that works for the country and especially works for Pennsylvania.

Mr. THOMPSON. Great. Thank you.

Mr. PITTS. The chair thanks the gentleman.

Mr. Secretary, what do the words "independence" and "self-sufficiency" mean to you? The Medicaid Act says that we are to furnish services to families and individuals to gain independence and self-sufficiency, and that doesn't sound like a lifetime of benefits to me. Do you think the current regulations give States the ability to operate a program that instills self-sufficiency and independence?

Mr. ALEXANDER. Absolutely not. We promote in this program and all of the other programs dependency and not self-sufficiency and self-reliance. Clearly, the Medicaid Act spells it out and it tells us that we are to furnish services so that individuals and families can gain or retain independence and self-sufficiency. Obviously we know we have very vulnerable citizens that may need care for a lifetime, and that is why we are here. But the vast majority of our beneficiaries or recipients could be moved more quickly off of the program and the current system does not allow us to do that.

Mr. PITTS. If we eliminate the maintenance of effort requirement, then would you have the flexibility to achieve that purpose?

Mr. ALEXANDER. Well, if we remove the maintenance of effort requirement, all that would enable us to do is to eliminate eligibility categories. If we are truly going to focus on work and employment, then we need to retool all of the federal entitlement programs to focus on that. Even the disabled population will tell you that they would like to go to work. There are many barriers in the federal entitlement programs, especially the Social Security program. This is why it is so disorganized. We are dealing with multiple programs, multiple federal agencies, multiple bureaucrats and it is not integrated. If we were to eliminate barriers in some of these programs, it would make it much easier for even our disabled population to go to work. We should be here to empower them and give them the tools to do this, not put barriers in front of them. So what I would say to you is, the federal programs do not promote self-sufficiency and reliance and independence; they promote dependency.

Mr. PITTS. Thank you.

Commissioner, cost shifting occurs when hospitals and doctors receive reimbursement rates from Medicare and Medicaid that are lower than the cost of providing care. In order to break even, providers, hospitals and physicians compensate for these unpaid costs by increasing how much they charge other patients, especially those that are privately insured or paid out of pocket. You cite cost shifting in your testimony as a driver of health care costs. I am concerned that this effect is going to get worse under Obamacare,

which forces nearly 20 million people into a Medicaid program that typically providers even less than Medicare. Obamacare increases medical costs for private payers by expanding the government programs and reducing payment rates. In addition, because Obamacare did not properly handle the issue of provider reimbursement under Medicare, doctors are faced with the added pressure of finding revenue elsewhere. Do you believe the expansions of Medicaid in your State will shift costs to private payers and ultimately increase premiums for privately insured individuals? If so, why?

Mr. CONSEDINE. I absolutely do, and I would be interested to hear Secretary Alexander's views on this as well. We are certainly concerned about the cost shifting on the Medicaid side. We are also concerned about it on the exchange side. Again, what we have seen in the Massachusetts example is that costs went up and in fact that is due in large part because of the cost-shifting issues that you cite as well as adverse selection. So it continues to be an area that we are very concerned about, and again, I think highlights one of our main problems with the Affordable Care Act is, it doesn't really address the cost side.

Mr. PITTS. Mr. Secretary?

Mr. ALEXANDER. Mr. Chairman, the hospitals in Pennsylvania stand to lose hundreds of millions of dollars in disproportionate share payments to hospitals. The premise behind the federal health care law is that by providing everybody with insurance that the hospitals will need much less in disproportionate share payments. If we look at the one example that we have, which is Massachusetts, Massachusetts openly admits that their uncompensated care is going sky high. So if the federal health care law is based on the Massachusetts model, if that is how we are modeling this, we are going to be in serious trouble, and in fact, Pennsylvania's hospitals will be in serious trouble with that reduction in disproportionate share payments. All of this is a cost shift, and we are operating a system where we have all of these onerous, very onerous federal mandates, rules and regulations and we see that we don't have enough money to pay certain providers. We don't have enough to pay doctors adequately and we don't have enough money to pay hospitals adequately. So we keep putting more and more mandates on the system and there is no money. The only way out is flexibility. We have to lift a lot of these mandates that actually just don't make any sense, and if we have that ability, we could tailor programs here appropriately and use the money more wisely even across all of the programs, not just Medicaid. So if we had that flexibility, I think it would make it much easier for us.

Mr. PITTS. Thank you. The chair recognizes Mr. Thompson for additional questions.

Mr. THOMPSON. Thank you, Chairman.

You talked about hospitals and specifically rural hospitals. That is the world I came out of. I spent 28 years there, and I am still trying to figure out how I got in Congress, but it was a great learning experience working in health care in a world of regulations and looking what mandates and unfunded mandated and regulations, the impact that it has on our health care system, and you gentlemen have both referenced in terms of hospitals. Now, in Pennsyl-

vania we have a lot of hospitals and they are a site of providing care. Given the fact that the President's health care bill expands Medicaid's rolls by about 18 million, I think it what was projected, Pennsylvania somewhere under a million more people enrolled in medical assistance, and medical assistance paying—and I am not sure about specifically—well, my experience in Pennsylvania, medical assistance pays somewhere about 40 to 60 cents on every dollar of cost that a hospital or physician has. Based on your professional experiences and your leadership roles here, is that good news or bad news for the future of specifically rural hospitals and underserved urban hospitals?

Mr. ALEXANDER. I would say obviously not. I think in Pennsylvania, because of the ruralness of the State, we have to be very conscious for access purposes, and currently the reimbursement rates because of this perverse system that we are operating between State and Federal Government, does not lend itself to be able to even increase rates adequately. We here at the State level are operating multiple programs across multiple federal agencies. It is very, very disorganized. If States should be left alone to create programs that are tailored to their own citizens and if we were able to do that, we would even be able to take less money from the Federal Government. Maybe some States would put money into health care. Maybe some States would put more money into nutritional services. Maybe some States would put more money into employment. The bottom line is, is if we had that flexibility, we could use federal money and State money much more wisely so that rural hospitals or even in the inner city where they are dying for more money would be able to have some relief.

Mr. CONSEDINE. The only other observation I would make is one of our concerns looking down the road is, we see already sort of a consolidation trend occurring not only on the insurance side where you have either health insurance companies that are either getting out of the market altogether or they are consolidating, the view being that you almost are going to have to survive this new environment under the Affordable Care Act. The same thing is going to happen on the hospital side too where you have the larger hospital chains potentially acquiring rural hospitals and smaller hospitals, and long term as they look at, you know, what hospitals are more profitable, which are not, there is a risk that some of those rural hospitals just go away. And again, for a State like ours where we have large swaths of the State that are served by one rural hospital, that is a concern to us.

Mr. THOMPSON. I want to follow up on one point you made in terms of what is the likelihood that some rural hospitals may go away, may close. I have never been one for health care reform, and I have spent my entire professional career in terms of health care refinement and improvement, and one of the principles obviously of that is access, and given this medical assistance expansion, and I am not sure what the portion of the half a trillion dollars of Medicare cuts will hit hospitals here in Pennsylvania but it will be significant, certainly the bureaucracy costs that are layered on, now we have over 100 new bureaucracies. I remember the costs when HIPAA was implemented, my hospitals and the amount of people that had to be hired that really don't do any direct patient care but

that was to be in compliance, those compliance costs. Given all that, is there a likelihood in Pennsylvania if this bill goes unchecked and all parts of it are implemented that we will see hospitals, some hospitals close in Pennsylvania, and isn't that completely opposite of expanding access to care?

Mr. ALEXANDER. I would say yes. Hospitals right now are—we have hospitals in this State that are on the brink, and I have seen it in other States where they are just barely making it. Any more federal top-down heavy-handed rules and regulations and laws from Washington are not going to solve the problem, and I like what you just said. We should be using refinement rather than reform because that is exactly—we have a lot of hardworking people in our hospitals and our nursing homes and our health care providers have been doing an excellent job. It is the government that puts roadblocks in the way. So not only does Washington have to get off of our backs but we at the State level in some respects have to be cognizant of what is going on in the counties and in our local hospitals.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

The committee received a letter earlier this year from 33 governors and governors-elect asking for the additional flexibility that you have talked about. Sort of the theme in this testimony, and the committee is committed to provide States with the flexibility they need. If you have any suggestions that you have where Congress can help lift the mandates to provide this flexibility, we would welcome them.

This has been excellent testimony. We thank you for your input. We look forward to continuing to work with you. This is our first field hearing, so you are guinea pigs for us in a way. We thank you for your excellent input. At this time the chair will excuse panel one and call forward the second panel.

For our second panel, we will hear from two of Pennsylvania's senior legislators, two former colleagues and good friends. Senator Patricia Vance is the only member of the legislature who is a professional nurse. Prior to her election to the Senate, she served 14 years in the Pennsylvania House. In the Senate, Senator Vance chairs the Public Health and Welfare Committee.

Our second witness, Matt Baker, was recently elected to his 10th term in the House of Representative. Representative Baker serves as chairman of the House Health Committee for the 2011–12 session.

Welcome. We have your written testimony in the record. You are now recognized for opening statement. Senator Vance, you are recognized for your statement.

**STATEMENTS OF PENNSYLVANIA STATE SENATOR PATRICIA VANCE, SENATE PUBLIC HEALTH AND WELFARE COMMITTEE; AND PENNSYLVANIA STATE REPRESENTATIVE MATTHEW BAKER, CHAIR, PENNSYLVANIA HOUSE HEALTH COMMITTEE**

**STATEMENT OF PATRICIA VANCE**

Ms. VANCE. Good morning, Chairman Pitts, Congressman Thompson. We are delighted to have you here with us today to talk about the impact of the Patient Protection and Affordable Care Act.

As you said, my name is Pat Vance. I am one of the 50 senators in the Pennsylvania Senate and chair of the Public Health and Welfare Committee. Before serving in the legislature, I was both a geriatric and a pediatric nurse, so I hit both ends of life's spectrum, but my health care background really gives me a unique perspective on the medical and legislative impacts of this federal health care proposal.

Now that a year has passed since this legislation was signed into law, it is time to evaluate some of the consequences and rethink the direction we are headed.

First, insurance premiums have increased dramatically over the past year. Last August, the California Department of Insurance approved an average rate increase of 14 percent for Anthem Blue Cross and Blue Shield of California increased its rates in October 2010, January 2011 and is posed for a third rate hike this spring. For some individual policyholders, this cumulative increase could be as high as 86 percent. Mennonite Mutual Aid Association in Kansas increased its rates 4 percent recently to pay for provisions that were required in this federal health care law.

In Pennsylvania, Blue Cross of Northeastern Pennsylvania increased rates 9.9 to 15 percent as of January 1, 2011. These rate increases far outpaced the Consumer Price Index, which as you all probably know went up 1.6 percent before seasonal adjustments during the year-end January 2011 according to the United States Department of Labor. Now does not seem to be the time to further burden taxpayers. The economy is still in pretty dire straits. As of January 2011, Pennsylvania's seasonally adjusted unemployment rate is 8.2 percent, slightly better than the United States, which is 9 percent. Gasoline prices have been surging lately due to all the problems in the Middle East and employers have frozen wages during the past few years, and by all indications wages will continue to stagnate. Americans are really struggling. We hear from them every day in the office.

The federal health care law will only add to the average resident's financial stress with excise taxes on high-cost plans, increases on taxes on earned and unearned income, and penalties on uninsured individuals. On top of this, the federal health care bill will most likely increase the deficit through Medicaid expansion and increase subsidy costs as insurance premiums continue to rise. The voters have called on government to exercise fiscal restraint and it is irresponsible for all of us to leave a legacy of debt on our children and our grandchildren. We are really only kicking the can down the road and making things tougher for them.

Finally, employers will struggle with mandates required under the federal law, which will ultimately reduce their willingness to hire new employees. Under the law, employers have lost their flexibility, and that is a word we need to talk about a lot. We need more flexibility in choosing benefits for their employees. In Massachusetts, we have seen employers drop coverage and pay the fines, which they have determined to be cheaper. This defeats the goal of having more Americans covered by health insurance. Now is the time to step back and reexamine the federal health care law, the good and the bad.

In closing, thank you for this opportunity to testify on the impact of this law on the citizens of Pennsylvania, and I look forward to taking any of your questions.

[The prepared statement of Ms. Vance follows:]

**Testimony on the Impact of the Patient Protection and Affordable Care Act on States**

**Submitted by Pennsylvania Senator Patricia H. Vance**

**Before the U.S. House Energy and Commerce Subcommittee on Health  
Harrisburg, Pennsylvania  
March 23, 2011**

Good morning, Chairman Pitts and members of the House Energy and Commerce Subcommittee on Health. Thank you for this opportunity to present testimony regarding the impact of the Patient Protection and Affordable Care Act (PPACA) on states.

My name is Patricia Vance. I am one of 50 senators in the Pennsylvania Senate and chair of Senate Public Health and Welfare Committee. My committee has oversight of both the Pennsylvania Department of Health and Department of Public Welfare.

Before serving in the Pennsylvania Legislature, I was a geriatric and pediatric nurse. My healthcare background gives me a unique perspective regarding the medical and legislative impacts of the PPACA.

Now that a year has passed since this legislation was signed into law, it is time to evaluate some of its consequences and rethink the direction we are headed.

First, insurance premiums have increased dramatically over the past year. Last August the California Department of Insurance approved an average rate increase of 14 percent for Anthem Blue Cross. Blue Shield of California increased its rates in October 2010, January 2011 and is poised for a third rate hike this spring. For some individual policyholders this cumulative increase could be as high as 86 percent. Mennonite Mutual Aid Association in Kansas increased rates 4 percent recently to pay for provisions required in the PPACA. In Pennsylvania, Blue Cross of Northeastern Pennsylvania increased rates 9.9 to 15 percent as of January 1, 2011. These rate increases far outpace the Consumer Price Index, which went up 1.6 percent before seasonal adjustment during the year ending January 2011, according to the United States Department of Labor.

Now is not the time to further burden taxpayers. The economy is still in dire straits. As of January 2011, Pennsylvania's seasonally adjusted unemployment rate was 8.2 percent. The United States' rate was 9 percent. Gasoline prices have been surging lately due to the unrest in the Middle East. Employers have frozen wages during the past few years and by all indications, wages will continue to stagnate. Americans are struggling. The PPACA will only add to the average resident's financial stress with excise taxes on high-cost plans, increases in taxes on earned and unearned income and penalties on uninsured individuals.

On top of this the PPACA will most likely increase the deficit through Medicaid expansion and increased subsidy costs as insurance premiums continue to climb. The voters have called on government to exercise fiscal restraint, and it is irresponsible to leave a legacy of debt to our

children and grandchildren. We will only be kicking the can down the road and making things tougher for them.

Finally, employers will struggle with mandates required under PPACA, which will ultimately reduce their willingness to hire new employees. Under the law, employers have lost their flexibility in choosing benefits for their employees. In Massachusetts, we have seen employers drop coverage and pay fines, which are cheaper. This defeats the goal of having more Americans covered by health insurance.

Now is the time to step back and re-examine the PPACA. In closing, thank you for this opportunity to testify on the impact of this law. I will take any questions you have at this time.

Mr. PITTS. The chair thanks the gentlelady.  
Representative Baker, you are recognized for your opening statement.

#### **STATEMENT OF MATTHEW BAKER**

Mr. BAKER. Good morning, Mr. Chairman and committee members. Thank you for the opportunity to comment on the impact the federal health care law has upon Pennsylvania.

As the majority chairman of the House Health Committee, I have many concerns that the federal law will result in unsustainable growth in Medicaid costs, higher taxes, loss of liberty and freedom in choosing one's health insurance, being mandated to buy insurance or face fines or penalties by the IRS that has already been deemed unconstitutional and will likely be decided by the United States Supreme Court on appeal.

The federal takeover of health insurance regulation and, indeed, one-sixth of our national economy, will have serious and costly impacts to Pennsylvania's taxpayers, businesses and State budgets and constitutes a significant usurpation by the Federal Government of longstanding State authority over health insurance regulations.

Due to strong public opposition to the federal law, I have introduced House Bill 42 along with 41 other States called the Health Care Freedom Act that protects two essential rights: to participate or not in any health care system, and prohibits the government from imposing fines or penalties in that decision; and two, protects the right of individual to purchase, and the right of doctors to provide, lawful medical services without a government fine or penalty.

According to the American Legislative Exchange Council (ALEC), the federal health care law will cost \$1.5 trillion over the next 10 years, adding billions of dollars to Pennsylvania's budget shortfall. The Heritage Foundation estimates Pennsylvania's Medicaid costs to increase by nearly \$1 billion from 2014 to 2020 as a result of new Medicaid mandates. Eligibility for Medicaid would increase in 2014 by half a million people, growing Medicaid enrollment by 18 percent to over 3 million people in Pennsylvania. In other words, in 2014 one in four Pennsylvanians walking around in our great Keystone State would be on public welfare at greater taxpayer expense here in Pennsylvania.

A May 2010 Kaiser Foundation report found that by 2019, Pennsylvania's Medicaid rolls may grow by nearly 700,000 people and may cost our State an additional \$2 billion over the 2014–2019 time frame. Under the new law, Medicaid coverage will extend not only to those who are currently uninsured or whose incomes are below 133 percent of the federal poverty level but will also sweep into the program several million more nationally below that income threshold who are currently covered by private employer-sponsored coverage or individual coverage. The crowding out or displacement of private coverage will most likely occur among people who work for businesses with fewer than 50 employees.

Pennsylvania Medicaid consumes 31 percent of the entire State budget. Additional mandates under the federal law are estimated to increase exponentially by nearly \$1 billion on top of this growth. Pennsylvania's Medicaid budget is growing at nearly 12 percent a

year while revenues have grown just 3 percent. The unsustainable, unaffordable and unavoidable growth will continue as long as inflexible federal rules mandate State policies. I believe Pennsylvania should request a waiver of the Medicaid mandates that I believe bind States' controls, particularly given the maintenance of effort effects on needed cost control measures in the midst of Pennsylvania's \$4 billion budget deficit.

According to the Heritage Foundation/Lewin data, there would be dire consequences for patients, doctors and hospitals in Pennsylvania. They estimate 51 percent of privately insured Pennsylvania residents would transition out of private insurance. Fifty-nine percent of Pennsylvania's residents with employer-based coverage would lose their current insurance. Eighty percent of Pennsylvania's residents in a health insurance exchange would end up in a public plan. Thirty-two percent of the uninsured would still lack coverage.

It is my understanding that the federal law raises taxes by almost \$500 billion, or a half a trillion dollars over 10 years. The largest portion of tax increases will fall upon small business owners, reducing capital, limiting economic growth and hiring and probably loss of jobs and reduction of hours and wages. The employer mandate will impose a tax of \$2,000 per employer on employers with more than 50 employees that do not provide health insurance. The federal law will also tax employers that offer health coverage unaffordable by the government. These new taxes on employers will reduce employment or be passed on to workers in the form of lower wages or reduced hours. New and increased Medicare taxes will impact our small businesses. Over time, higher payroll taxes will decrease wages for their employees.

While I believe there may be some good intentions with the federal health care act, in part, to support, I believe the federal health care act has to be reformed to better serve Pennsylvania citizens. In addition to constricting economic growth and reducing employment, the health care act will dramatically increase spending and health care as well as the cost of health coverage. Newer and higher taxes on small businesses and workers will impede job creation and economic growth that they can ill afford during a time when our economy struggles. With most States faced with deep budgetary deficits, the federal health law adds conservatively over \$118 billion that the federal health law will cost taxpayers through 2023. These are taxes that can be avoided and should be avoided if proper changes are made to the federal law.

In conclusion, it is my hope and the hope of the majority of the citizens that Congress will enact a new health care bill that will reduce health care costs, spending and taxes as well as the cost of health insurance coverage in a way that will do no harm to our fragile economy or to our taxpayers already overburdened by taxes, credit and debt. Let us work together in a shared vision to find solutions for health care reform that are innovative, private sector, market-driven, affordable, accessible and based on patients' needs and choices.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Baker follows:]

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*House of Representatives*  
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Harrisburg

**CHAIRMAN, HEALTH COMMITTEE**  
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DIABETES  
LUPUS

**APPOINTMENTS**  
STATE SYSTEM OF HIGHER EDUCATION  
BOARD OF GOVERNORS  
HEALTH CAREERS LEADERSHIP COUNCIL  
CAPITOL PRESERVATION COMMITTEE

**TESTIMONY ON THE IMPACT OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE  
CARE ACT (PPACA) UPON PENNSYLVANIA**

**REPRESENTATIVE MATTHEW E. BAKER, MAJORITY CHAIRMAN, HOUSE HEALTH COMMITTEE**

**CONGRESSIONAL HEARING**

**MARCH 23, 2011**

Good morning, Mr. Chairman and Committee members. Thank you for the opportunity to comment on the impact that the federal health care law has upon Pennsylvania.

As the Majority Chairman of the House Health Committee, I have many concerns that the (PPACA) federal law will result in unsustainable growth in Medicaid costs, higher taxes, loss of liberty and freedom in choosing one's health insurance, being mandated to buy insurance or face fines or penalties by the IRS that has already been deemed unconstitutional and will likely be decided by the U. S. Supreme Court upon appeal.

The federal takeover of health insurance regulation and, indeed, one-sixth of our national economy will have serious and costly impacts to Pennsylvania's taxpayers, businesses, and state budgets and constitutes a significant usurpation by the federal government of longstanding state authority over health insurance regulations.

Due to strong public opposition to the federal law, I have introduced House Bill 42 along with 41 other states called the Health Care Freedom Act that protects two essential rights: 1) to participate or not in any health care system and prohibits the government from imposing fines or penalties in that decision; and 2) protects the right of individuals to

purchase, and the right of doctors to provide, lawful medical services without a government fine or penalty.

According to the American Legislative Exchange Council (ALEC), the federal health care law will cost \$1.5 trillion over the next ten years, adding billions of dollars to Pennsylvania's budget shortfall. The Heritage Foundation estimates Pennsylvania's Medicaid costs to increase by nearly \$1 billion (\$841 million) from 2014 to 2020 as a result of new Medicaid mandates. Eligibility for Medicaid would increase in 2014 by 453,749, growing Medicaid enrollment by 18 percent to 3,036,729. In other words, in 2014 one in four Pennsylvanians would be on public welfare at a greater taxpayer expense here in Pennsylvania.

A May 2010 Kaiser Foundation report found that by 2019 Pennsylvania's Medicaid rolls may grow by nearly 700,000 people (682,880) and may cost our state an additional \$2 billion over the 2014-2019 time frame.

"Crowdout" effects:

Under the new law, Medicaid coverage will extend not only to those who are currently uninsured and whose incomes are below 133 percent of the federal poverty level, but will also sweep into the program several million more nationally below that income threshold who are currently covered by private, employer-sponsored coverage or individual coverage. The "crowding out" or displacement of private coverage will most likely occur among people who work for businesses with fewer than 50 employees.

Pennsylvania Medicaid consumes 31 percent of the state's budget. Additional mandates under the federal law are estimated to increase exponentially by nearly \$1 billion on top of this growth. Pennsylvania's Medicaid budget is growing at nearly 12 percent a year while revenues have grown just 3 percent. This unsustainable, unaffordable, and unavoidable growth will continue as long as inflexible federal rules mandate state policies. I believe Pennsylvania should request a waiver of the Medicaid mandates that I believe bind states' control, particularly given the Maintenance of Effort (MOE) effects on needed cost control measures in the midst of Pennsylvania's \$4 billion budget deficit.

According to the Heritage Foundation/Lewin data, there would be dire consequences for patients, doctors, and hospitals in Pennsylvania. They estimate that:

- 51 percent of privately insured Pennsylvania residents would transition out of private insurance
- 59 percent of Pennsylvania residents with employer-based coverage would lose their current insurance
- 80 percent of Pennsylvania residents in a health insurance exchange would end up in the public plan
- 32 percent of the uninsured would still lack coverage

Taxes:

It is my understanding that the federal law raises taxes by almost \$500 billion (one-half trillion dollars) over ten years. The largest portion of tax increases will fall upon small business owners, reducing capital, limiting economic growth and hiring, and probably loss of jobs and reduction of hours and wages.

The employer mandate will impose a tax of \$2,000 per employee on employers with more than 50 employees that do not provide health insurance. The federal law will also tax employers that offer health coverage "unaffordable" by the government. These new taxes on employers will reduce employment or may be passed on to workers in the form of lower wages or reduced hours.

New and increased Medicare taxes will impact our small businesses. Over time, higher payroll taxes will decrease wages for their employees.

While I believe there may have been some good intentions with the federal health care act, in part, to support, I believe the federal health care act has to be reformed to better serve Pennsylvania citizens. In addition to constricting economic growth and reducing employment, the health care act will dramatically increase spending in health care as well as the cost of health coverage. New and higher taxes on small businesses and workers will impede job creation and economic growth that they can ill afford during a time our economy struggles. With most states faced with deep budgetary deficits, the federal health law adds conservatively over \$118 billion that PPACA will cost state taxpayers through 2023. These

are taxes that can be avoided and should be avoided if proper changes are made to the federal law.

It is my hope and the hope of the majority of citizens that Congress will enact a new health care bill that will reduce health care costs, spending, and taxes, as well as the cost of health insurance coverage in a way that will “do no harm” to our fragile economy or to our taxpayers already overburdened by taxes, credit, and debt. Let us work together in a shared vision to find solutions for health care reform that are innovative, private sector, market driven, affordable, accessible, and based on patients’ needs and choices.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes himself for questioning.

Senator Vance, as a health care provider, you do have a unique perspective in this debate. Section 1311(h) of the new health care law gives the Secretary of HHS the power by regulation to determine which health care providers private insurers are allowed to contract with. Do you think it is appropriate for the HHS Secretary to have this power?

Ms. VANCE. I think one of the problems with federal health care law is how much power it does give to the Secretary. It is undefined. Even someone who may think this is a wonderful law is unable to ascertain what exactly will be done because there is so much uncertainty. There is very little actually written into the law and too much power given. So do I think that power should be there? No. It has to be—first of all, I am not sure I like the idea that they would dictate which health care professionals could be hired, number one, but number two, for it to be so nebulous does not benefit anyone.

Mr. PITTS. Senator, would you support federal legislation to repeal the Medicaid maintenance of effort requirement in the new health reform law?

Ms. VANCE. I never liked the maintenance of effort and I am not sure that we even need to have a law passed to do that. In fact, if the Federal Government was accessible to a waiver from the States, I think it could be done without legislation.

Mr. PITTS. Representative Baker, you mentioned that many individuals that have private insurance now may end up on Medicaid. Section 1413 of PPACA actually states that if an individual applies to buy a private insurance policy in the exchange and is found eligible for Medicaid, that person must be enrolled into public program and cannot buy a private plan. Do you think most Americans know this provision was included in the health care law? Do you think that individuals should have the right to buy private coverage if they want rather than be enrolled in Medicaid?

Mr. BAKER. Very good question, Mr. Chairman. I don't think the average American really understands the full import of this 2,000- or 3,000-page document. In fact, the former Speaker of your House said you had to pass it in order to understand what it is in it, so it seems to me not even many Members of Congress understood the federal law and its full import. You are absolutely right in terms of the minimal coverage requirements in health insurance, the mandates, the migration of millions more Americans going into Medicaid, growing Medicaid costs exponentially. I think there is sometimes a disconnect that is not government costs, it is taxpayer costs, and there are tremendous implications and ramifications in moving more people into Medicaid welfare programs instead of encouraging them to get out of Medicaid. Instead of growing Medicaid, we should be reducing Medicaid, helping people. The best welfare reform is job creation and people becoming productive and having personal accountability and responsibility and providing for their families and obtaining the American dream.

So I just don't understand the concept out of Washington that we need to grow welfare and Medicaid. We need to reduce it. We need to shrink it. We need to have a full employment, equal opportunity

jobs bill rather than this kind of concept. We need to reduce health care. The minimal requirement under health care for insurance, I find it remarkable that, and the federal judge in Florida mentioned it in his court case, that a 20-year-old who wants to just have a high-deduction major medical or catastrophic health insurance plan is prohibited from doing that under the federal health care bill. The Federal Government mandates minimum health insurance requirements. And so that is a very costly requirement. And in fact, if they don't buy that insurance, they get fined or penalized by the Federal Government. My goodness, that is the heavy hand of the Federal Government and I agree with the federal judge. It is an unconstitutional reach by Congress to imply and implore the commerce clause for the first time in 200 years to both an economic activity and an economic inactivity.

Mr. PITTS. Thank you. Representative, you mentioned that Medicaid now consumes 31 percent of Pennsylvania's budget. You also mentioned that the Medicaid budget is growing at 12 percent a year. Do you think the Medicaid growth rate will increase as a result of this law, and if the State's revenue growth is 3 percent, I think you said, a year, and the Medicaid growth is 12 percent a year, or higher, what impact will that have on the ability of Pennsylvania government to provide other needed services?

Mr. BAKER. Thank you, Mr. Chairman. That was a great question. I think we are on a track of unsustainability and catastrophic budget crisis if we continue down this road of growing the welfare budgets, Medicaid budgets. I think it has been mentioned by previous speakers that vital, rare taxpayer funds are being crowded out by Medicaid costs that are better utilized for transportation, education or other health care needs, and this is definitely on a track of unsustainability if the federal court, Supreme Court decision doesn't strike this federal law down or if Congress does not repeal it.

Mr. PITTS. Thank you. The chair recognizes the gentleman, Congressman Thompson, for questioning.

Mr. THOMPSON. Thank you, Chairman.

Thank you, Senator, Representative. It is great to have you here. I appreciate your leadership specific to your areas of jurisdiction committee-wise.

Senator Vance, I just want to follow up the comments that Representative Baker made. The health care law contains a massive expansion of the Medicaid program in order to reduce the number of uninsured, which obviously we have heard this morning places heavy burdens on State budgets. Now, how will Pennsylvania respond to the expansion of the Medicaid program? Obviously it cannot raise taxes during this economic downturn so the tough question is, what is left?

Ms. VANCE. I don't think anyone will argue it is totally unsustainable. We cannot afford it. I know that the Federal Government takes the burden for a couple years but after that it comes back to Pennsylvania and to the taxpayers, and I cannot imagine our revenues increasing that dramatically that we would be able to cover that.

Mr. THOMPSON. You mentioned that employers have lost their flexibility in choosing benefits for their employees. The proponents

of the law said that they wanted to make sure that if you liked the insurance you had, you could keep it. However, the regulations coming from the Secretary of Health and Human Services would force as many as 87 million Americans with employer-based health care to change their plan. Do you think that we should pass legislation that would ensure that Americans can keep the plan they have now if they like it?

Ms. VANCE. Well, it appeared that the PR that came out about the federal health care bill that said if you like your insurance, you can keep it was speaking with a forked tongue because in essence that is not what happened. So yes, I believe that there should be able to have some determination for an employer to choose. And also, if it becomes such an important burden on the employer, that is why in Massachusetts, as you found out, they were willing to pay the penalty rather than because it was cheaper. We should have learned a lot of lessons from Massachusetts. Whether we did or not is questionable. People had an access card. They thought they had insurance but they had no access to real health care. They still have a huge increase in their emergency rooms. There are not enough basic health care practitioners and we have to put our arms around those who deliver basic health care, and just because you happen to have an insurance card does not mean you have access.

Mr. THOMPSON. Very good. I couldn't agree with you more. This should be about access and bringing down cost.

Representative Baker, always great to be with you. I appreciate the fact that we get a chance to work together quite a bit even outside of this area within the Pennsylvania 5th Congressional district. During the debate over the health care reform last Congress, there were a lot of promises made, primarily among them that the health insurance costs would decrease, and certainly as a part of my principles I led my professional life by and it certainly guided me in Congress as we refined and improved health care, whatever we did should decrease the cost of health care for every American. However, according to the nonpartisan Congressional Budget Office analysis, individual health insurance premiums were raised by an average of \$2,100 per family, and this increase comes despite President Obama's frequent promise that his health care plan would lower premiums by \$2,500 per year for an average family. What are some of the things that you would recommend to lower the cost of health care in Pennsylvania?

Mr. BAKER. It is a good question, and I often hear it, and thank you for your opening remarks. It is always good to see you and work with you on a number of issues in rural Pennsylvania. I am hearing from many constituents that they are not happy with this law for a number of reasons, this federal law, and one of them is that their health insurance premiums keep going up and so they don't believe the promise of those lowered premiums is really becoming a reality, and my good colleague, Senator Vance, just mentioned in her testimony that the price, the cost of health insurance keeps going up dramatically. But some of the ideas I think we ought to be pursuing and looking at at the State level, at least, is I think we ought to be considering applying for a medical loss ratio waiver. Some of the States have looked at those issues—Maine, Nevada, New Hampshire, Kentucky and 10 other States. We have al-

ready established a State-run high-risk pool. I think that is helpful in this regard. We may want to set up and consider a prescription drug donation program that provides for the poor and the uninsured with security of prescription drug coverage, complete a completely voluntary program for the reuse of expensive medications. I think to the degree that we can afford it, I think we need to look at paying medical school loans for some physicians and nurses as a recruitment and retention program here in Pennsylvania, especially encouraging providers to practice in rural and underserved areas. We need to look and perhaps allow for alternative health care arrangements, health care sharing ministries, for instance, in some areas that are providing good paradigms and models.

I have introduced a bill similar to the House of Representatives' to allow people to purchase health insurance across State lines, opening up competition, allowing for market-driven competition to lower down insurance premium rates. I think we need to consider equalizing the tax treatment of insurance for individuals, and I notice my time is up. I have many other suggestions that I could make but I just saw the button flashing here. Do you want me to continue?

Mr. THOMPSON. Go ahead.

Mr. BAKER. Some of the other concerns I think we need to consider, we need to review sunset costly insurance mandates before enactment. We really need to seriously look and have some conversations about these costly mandates and how they actually trigger and reflect a contraindication that we are heading in the wrong direction that, you know, mandates may sound good, feel good and may help some but it actually is a cost driver increasing health insurance. I think we need to provide perhaps tax breaks for people and businesses who buy and sell health savings accounts and we need to provide patients with a cost estimate of medical treatments. And lastly, allow the poor to use Medicaid dollars possibly to purchase private health insurance. We might want to take a look at providing a state income tax credit for purchase of long-term care insurance, perhaps offer again to the extent that we can afford it, offer premium insurance to Medicaid and SCHIP recipients who have access to employer-sponsored health coverage, maybe take a look at establishing a cash and counseling program for the disabled, and again, just generally stop costly Medicaid-mandated benefits before enactment.

Mr. THOMPSON. Great. Thank you. Thank you, Chairman.

Mr. PITTS. The chair thanks the gentleman. I have just a couple of more questions if you could take them.

Senator, Medicaid was initially created to provide care to low-income children. The reimbursement rates for Medicare are usually much lower than those of private insurance and even Medicare. Some doctors no longer take Medicaid patients because of the reimbursement rates. By expanding eligibility for the program, do you believe that we are potentially jeopardizing the quality of care for those that program was initially intended for?

Ms. VANCE. Not only will it jeopardize the children but there are many physicians that no longer are willing to take Medicaid patients. I particularly notice this in my area with dental benefits, Medicaid dental benefits. It is almost impossible to find a dentist

who wants to treat Medicaid patients. It is a disaster for people to obtain care with these low rates, and let me stress, there is no easy answer to all this. What we need is flexibility. Pennsylvania is almost like five States wrapped into one. We need to have the flexibility to treat different areas and know what works. Rural areas are not the same as an inner city urban area, and we need to have flexibility. I think the best thing that could happen for all of us is to have some determination whether this law is in fact going to meet the appeals process, this uncertainty, because you are putting a lot of time and money into hypothetically thinking maybe you will have to do it, maybe you won't, and this uncertainty, it does nothing but drive up cost.

Mr. PITTS. Excellent point.

Representative Baker, Pennsylvania is home to a vibrant medical technology industry including medical devices and innovative new pharmaceuticals. The new health care law includes new taxes on these industries. The Chief Actuary of CMS has stated that these taxes would be passed on to patients. Others believe that these new taxes might lead to less innovation and further job loss. If either scenario is the outcome, do you believe this is good public policy?

Mr. BAKER. Absolutely not. I do not subscribe to the attitude that more taxes are better and that that empowers anyone. I think it is just the opposite, that it discourages innovation. It discourages entrepreneurship. It discourages people to be able to decide for themselves what to do with what little money they have left after taxes are taken out of their paychecks. And with the cost of everything going up every year, it just exacerbates an already difficult situation. We are still struggling to come out of the deepest recession that we have experienced and the longest recession that we have experienced since the Great Depression. It just seems to me that to impose a tax, one of them that you suggested on disabled people, for instance, a tax on prosthetic limbs and the like on certain medical devices, my goodness, how does that help anyone? I don't understand that. So no, I think less taxes are better.

Mr. PITTS. Thank you. Do you have any other questions?

Mr. THOMPSON. Sure.

Mr. PITTS. The chair yields to Congressman Thompson.

Mr. THOMPSON. Thank you, Chairman.

Representative Baker, thanks for your thoughts in that area. I mean, this is a country—in Pennsylvania, in particular, we have been a place of innovation when it comes to health care. We are blessed, when you look around the world in terms of quality and innovation in this country, and, you know, any time you tax something you repress it. Why would we want to end that legacy of being a place of innovation and quality?

A question for both of you. Roughly 21 percent of the total State spending, Medicare is already the single largest item in the State budget according to the National Association of State Budget Officers, and 31 percent based on your testimony here in the Keystone State. Realizing that Washington is in worst financial shape than most States, and we are working to make budget cuts of our own at the federal level, what can Congress do that would allow you to

reduce health care costs in Pennsylvania? Senator Vance will start and then we will check in with Representative Baker.

Ms. VANCE. I would repeat again, give us flexibility to make our own decisions. Hopefully those of us who work on the ground in Pennsylvania know what is needed in Pennsylvania. I don't have the vaguest idea what may work in another State. So if you want to help us, we need flexibility to be able to make informed decisions about the patients and the consumers that we hope to be able to help.

Mr. THOMPSON. Thank you.

Mr. BAKER. I agree entirely. We need more flexibility. We don't need more rigidity, more mandates. We need less mandates. We need to be able to use the power and the imagination and the freedom and the entrepreneurship of the States to be able to do more with less. That is what we are faced with, these deep deficits that all the States are experiencing, and it just seems to me that the more mandates that we get from Washington, the worse it becomes for us to try to make ends meet, and it crowds out other budget areas that are in desperate need of funding. So the cost implications of this federal health bill are just astronomical, and obviously the costs will grow exponentially unless we have waivers, unless we have mandate relief and unless we have additional flexibility.

Mr. THOMPSON. Thank you both for your leadership and testimony. Thank you, Chairman.

Mr. PITTS. The chair thanks the gentleman, and again, thanks to the panel for your excellent testimony, for taking time to testimony, for taking time to answer our questions. We look forward to working with you as we seek to modify, repeal or replace portions of this, parts of this new law, and I would like to thank you for the use of your facilities. This is beautiful.

So at this time the third panel will please come to the table. We will take a 5-minute recess before we continue.

[Recess]

Mr. PITTS. The subcommittee will reconvene for panel three. Our first witness of our third panel is Mr. Gene Barr. Mr. Barr is Vice President of Government and Public Affairs for the Pennsylvania Chamber. His responsibilities include directing all legislative and regulatory activity, marketing, membership and external communications. Our second witness, Kevin Shivers, has been the State Director of NFIB for the last 10 years. Mr. Shivers serves as NFIB's chief Pennsylvania lobbyist and leads the organization's grassroots and political activities. Our final witness is Ann Daane, is it? Ms. Daane joined Case New Holland in March 2008 as Vice President of Human Resources for North America. We look forward to hearing from each of you.

Mr. Barr, you have 5 minutes for your opening summary.

**STATEMENTS OF GENE BARR, VICE PRESIDENT, GOVERNMENT AND PUBLIC AFFAIRS, PENNSYLVANIA CHAMBER OF BUSINESS AND INDUSTRY; KEVIN SHIVERS, PENNSYLVANIA DIRECTOR, NATIONAL FEDERATION OF INDEPENDENT BUSINESS; AND ANN DAANE, VICE PRESIDENT, NORTH AMERICA HUMAN RESOURCES, CASE NEW HOLLAND**

**STATEMENT OF GENE BARR**

Mr. BARR. Mr. Chairman, thank you very much. Thanks to you and Congressman Thompson for the opportunity to be here. The chamber is the largest broad-based business advocacy group in Pennsylvania, and on behalf of our thousands of members across the Commonwealth, we thank you for this opportunity to discuss this law.

Interestingly, and you will hear it now, you will hear it outside, you will hear it wherever you go, there are others who talk about the benefits of the law. Yes, there are some benefits. Unfortunately, from the perspective of job creators in Pennsylvania and across the country, the huge negatives attached to this law greatly outweigh, in our view, the benefits attached to it. You heard much of that earlier. I am going to just briefly summarize the comments we have already submitted, and the reality is, what you heard from the governor, from the secretaries, from our elected officials today are exactly right. This is a major problem for Pennsylvania, for the Nation, for job creators.

From our perspective, what we need at this time, at this economic time here, is an increased focus on jobs. Obviously this is a balancing act between trying to take care of the most vulnerable in our society with trying to create those economic opportunities for everyone across the board. Unfortunately, this act works very deliberately and very strongly, in our view, against job creation.

For example, the application of the law applies when you have 50 or more employees. At this time when we are desperately seeking across this Nation to create jobs, and if you are an employer with 45, you are going to think twice before you add those five individuals as employees. We do not need to give employers at any time, particularly this time in this recession, reasons not to hire, and unfortunately, this law makes them think more than twice about that. We have had struggles with employers over the last year with a number of different issues coming out of Washington, health care being one, issues like card check being other things, which have actively sought to discourage our members from adding our citizens to the work rolls simply because it becomes too difficult and too expensive to make those kinds of hires.

The bill, the law, has, as you have heard, a number of tax increases relative to it. I am not going to get into all of those. You have heard them already and that is certainly true. The concern over debt is a real one. It is substantial, and this bill, despite what some of the proponents said, when you look at, for example, the remarks of the Chief Actuary, who is responsible for Medicare and Medicaid services, it is abundantly clear that the only way you can make this appear to positively address the deficit is through smoke and mirrors, double counting and so forth, and that has been done on a fairly large scale there. The other way, to be honest, the only

way you can make it happen is by the cuts in reimbursement they have proposed to doctors and hospitals that if they happen will severely impact the ability, as Senator Vance mentioned, for accessibility to health care, and if they don't happen, those cuts, then what we will have happen is obviously an increase in the debt.

The other thing that you heard and certainly we are hearing it from our members is the pieces of the legislation that actively discourage, someone would maybe say cynically that was what the bill was intended to do, private employer-sponsored health care because as you run the numbers, as any employer must do, run the numbers in terms of profitability, expenses and so forth, when you come down to it, many times the penalty is going to be much easier to pay than continuing the cost of a mandated, standardized, top-down health care plan that many employers may not even quality for with what they offer out there now.

This individual mandate to buy, in addition, we believe Governor Corbett is exactly right in questioning along with others the constitutionality of this. You heard other comments about what has happened. We have already seen similar types of operations in place. We have seen Massachusetts take this, as was mentioned earlier. We have seen, sure, more people are insured but the problem is accessibility to health care. We have seen from everything we have seen higher ER visits for Massachusetts. Interestingly enough, I saw a study about a year or so ago in which the highest percent users disproportionate users of emergency room services are Medicare and Medicaid so current federal insurance is already not helping the ER side but is actually accelerating that.

You heard earlier as well the importance of flexibility for employers. The only way that employers can be successful is to be flexible and nimble and agile to deal with the day-to-day changes that occur in the marketplace and occur in their operations. This reduces significantly the flexibility that is available to employers in terms of health care, reduces their operations, and clearly will have an adverse impact on employers as we move forward.

There are a couple of things and again, you know, there was much made of the previous Speaker of the House comment about having to pass this bill so we could see what was in it. There was another comment that she made in speaking to a group of, I believe it was musicians and artists. She said well, we wanted to pass this bill so that you could all have health care coverage, and this is kind of a quote, go off and make music or create pictures or whatever you want to do. I do not believe the American people believe that that is the role of Federal Government, State government or any government to abdicate that kind of responsibility.

The other thing that we have heard quite a bit during this debate has been well, business hasn't come forward with any options. That is absolutely incorrect. A number of them were articulated today. I am not going to go through those. But the premise from the business perspective is, health care reform needs to be more than figuring out who gets stuck with an inflated bill. As was mentioned earlier, this bill does little to nothing to address the health care cost issue. That has to be addressed, and one of the ways, and particularly for us here in Pennsylvania that is a major problem as has been mentioned is legal reform. Former Vermont Governor

Howard Dean explicitly stated that they didn't touch that because they didn't want to offend the trial bar. Here in Pennsylvania, Philadelphia was recently named by a national group as the number one judicial hellhole in the United States. United States needs legal reform on a broad basis. Pennsylvania severely needs legal reform on a broad basis and it is something we are attempting to address here, and again, we are happy to hear Governor Corbett make that comment again.

There are a number of other things clearly that we would advance including allowing minors to be kept on the plan for some period of time beyond. All those things we are happy to talk about. Unfortunately, while there are a couple of good things, as I mentioned in the plan, the overwhelming majority of it is going to drive costs higher, reduce flexibility for employers, severely impact job creation in this country and in this Commonwealth, which is where we are here immediately concerned.

And finally, let me close with this. Chairman Pitts, I know that from our experience in the past you are a keen student of history, and a couple of months ago I ran across what I believe is a very interesting quote, and it came from Thomas Jefferson in 1802, and he said, "If we can but prevent the government from wasting the labors of the people under the pretense of taking care of them, they must become happy." That is a tremendous piece of foresight from over 200 years ago. Thank you.

[The prepared statement of Mr. Barr follows:]



## Testimony

Submitted on behalf of the  
Pennsylvania Chamber of Business and Industry

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**Public Hearing** entitled  
**PPACA and Pennsylvania: One Year of Broken Promises**

Before the:  
**Subcommittee on Health**

Presented by:

Gene Barr  
Vice President, Government and Public Affairs

Harrisburg, PA  
March 23, 2011

417 Walnut Street  
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Chairman Pitts and distinguished members of the Subcommittee, thank you for the opportunity to testify before you today on the pressures businesses are facing in the wake of the passage of federal health care reform legislation. I commend your efforts to further understand the impact the new health care law will have on the ability of businesses to compete, grow and create jobs as well as their capacity to offer their employees health care benefits.

I am Gene Barr, Vice President of Government and Public Affairs for the Pennsylvania Chamber of Business and Industry (Chamber). The Chamber is the largest, broad-based business advocacy association in the Commonwealth. We represent business of all sizes ranging from Fortune 100 companies to sole proprietors crossing all industry sectors. Our membership comprises nearly fifty percent of the private workforce.

The Chamber did not support the status quo before passage of the health care law. We opposed the misnamed Patient Protection and Affordable Care Act (PPACA) because it failed to rein in costs, and instead increased them, while loading job creators with mandates, regulations, new taxes and burdens. Rather than solve the problems in the health care system, PPACA largely ignores costs and instead redistributes money from producers in order to fund vast new entitlements and expand old ones – this was not an improvement over the status quo, it was a step backwards. Rather, the Chamber believes that we should replace PPACA and instead advance market based reforms, with a focus on lowering costs, increasing competition, and improving the health care delivery system.

Reforms made across the health system have interactive effects, and none will be felt more acutely than in the employer market. Small and large employers can expect systemic transformation over the next few years that will likely limit their options, increase benefit costs for many, reduce benefit costs for some, raise compliance costs, and change how health care is financed for all.

The basic premise of the law fundamentally shifts the foundation of employer-sponsored benefits in America. What has been a voluntary and flexible system will now be a one-size-fits-some landscape. Employers will be required to offer health benefits or face a penalty. Some small employers can also choose to offer coverage through an exchange rather than sponsor their own plan. Individuals must purchase coverage or pay a fine. Without adequate incentives to address steeply rising medical costs, insurance is likely to become more expensive. Because of the mandatory nature of the law, employers may find it more difficult to offer affordable coverage, may become competitively disadvantaged, and may drop coverage altogether in an effort to stay in business.

The legislation imposes a mandate that many employers provide health insurance and effectively forces some employers to change what the coverage must cover. This includes a minimum package of benefits determined by the law. Some employers may weigh the cost of providing coverage against these penalties and decide to drop coverage altogether. Under this scenario, workers will suffer as flexible employer coverage is replaced by public programs.

The Chamber does not believe that a mandate on employers to sponsor health insurance will make serious headway to cover the uninsured, but rather could lead to a loss of jobs.

Employers who can afford to sponsor health insurance typically provide generous benefits – and most large employers do. Employers who cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so – small employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits.

The Chamber strongly supports building more options and flexibility into the private insurance market, not expanding the public programs that are already bankrupting states and the federal government; that is why we so strongly support consumer-directed health care and programs that put employees and consumers in charge of their own health care dollars, programs like Health Savings Accounts and Flexible Spending Arrangements. Unfortunately, the Act does not make these programs more attractive; it places new mandates and limits on them, like prohibiting the use of HSA and FSA funds to purchase over-the-counter products without a prescription, and capping total FSA contributions. This does not lead to controlling costs or increasing efficiency.

It is true that there are parts of the legislation that will be beneficial to businesses and consumers. For instance, an increased flexibility in HIPAA requirements will allow employers to vary health insurance premiums, encouraging employees to participate in wellness programs. New initiatives like Accountable Care Organizations and the CMS Innovation Center will help public programs catch up to the value-driven practices that

private plans are developing. Grants to help small businesses create wellness programs could spur positive change, if Congress decides in a separate bill to fund them.

However, the benefits of these provisions are far outweighed by the problems created by the Act. After all, consumers will be the ones who pay the Act's hundreds of billions in new taxes. Taxes on insurance policies, on medical devices, on prescription drugs, all will trickle down to consumers. Taxes on employers who cannot afford to provide coverage will result in lower salaries and lost jobs. Lowered payments to doctors and hospitals by government programs will lead to higher premiums for those with private health insurance. And new taxes aimed at the wealthy will fall squarely on small business owners. Massive tax increases are not conducive to spurring economic growth and stemming our high unemployment.

Making health insurance affordable for all begins with real reforms – reforms that protect doctors from frivolous lawsuits, change the way we pay providers to incentivize quality and not quantity, unleash small businesses to pool their purchasing power on their own and to look for more affordable policies in other states, and making serious efforts to crack down on fraud and abuse. These are the kind of reforms that were neglected in the Act. While the existing political reality makes a total repeal of the law impossible during this Congress, I am hopeful that Congress will make it a priority to repeal the most objectionable provisions like the employer mandate and as it did with the onerous 1099 reporting requirement, which impose burdens on businesses and hinder job creation and growth.

Thank you for this opportunity to testify, and I look forward to your questions.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman, Mr. Shivers, for 5 minutes for an opening statement.

#### STATEMENT OF KEVIN SHIVERS

Mr. SHIVERS. Thank you, Mr. Chairman and members of the committee. I am the State Director for the National Federation of Independent Business and I want to thank you for the opportunity to talk with you about the Patient Protection and Affordable Care Act and its impact on small business owners and workers. As I begin my statement today, I want to say for full disclosure reasons, NFIB is one of the groups I joined with the many States in filing a lawsuit against the Federal Government, and we are hopeful that this will reach an expedited conclusion. We hope it will, because this is such an impactful law and particularly on small business.

For small businesspeople, health care is a pocketbook issue. Nearly 81 percent of small business owners report that finding affordable health insurance for themselves and their employees is a challenge, and those small businesses that do have health insurance pay on average 18 percent more for the same health insurance benefits as large companies do. When the federal health law was signed, its proponents promised that the costs would decrease for small businesses. Not only have costs gone up the year after it has passed but the new law has added new compliance and paperwork burdens, making a flawed system even worse.

Across the Nation, it has been reported that insurance premiums in the small group market have risen 40 to 60 percent. We have heard the same here in Pennsylvania. Many small businesses fortunate enough to afford health insurance have had their plans canceled because the federal health law's new and restrictive rules have rendered them noncompliant. Others who are told that their health plans will be protected or grandfathered under the new law under the new law have learned their plans now are noncompliant. About 60 percent of businesses last year made small adjustments to their plans in order to manage rising costs. By making small changes or adjustments, these plans no longer comply with the grandfathering provisions under the Obama health care law, exposing businesses to more regulations and cost increases in the future.

It is estimated that as many as 80 percent of small businesses will be forced to give up their current coverage within the next 2 years. In an already uncompetitive market, more canceled plans and more regulations mean that small businesses have fewer choices than they had before the law was passed, making higher costs inevitable.

The new law also imposed myriad tax and paperwork headaches for small businesses. Compliance costs from the 1099 provisions alone will place an enormous burden on small businesses. The cost associated with tax preparation paperwork is the most expensive paperwork burden that the federal government imposes on small business owners. It costs as much as \$74 an hour. New taxes on various products, services and payroll are especially harmful to small business. And a new insurance company tax that will be paid almost exclusively by small businesses is expected to cost as much as \$5,000 per household.

The new federal law also has taken away one of the few consumer-directed pieces that currently exists in the health care marketplace today. The new law prohibits individuals from using pre-tax dollars, like those from a flexible spending account or a health savings account, to purchase over-the-counter items. Now individuals must make an appointment with their health care provider in order to obtain a prescription to purchase things like basic remedies to alleviate the discomfort of the common cold. This mandate further taxes an already over-utilized system and it forces doctors to take time away from patients who really need that medical care.

Another provision of the Obama health care law which has failed to live up to its promise to reduce health insurance costs is the small business tax credit we all have heard about. While proponents of the new federal law told us that tax credits would help small business to purchase health insurance, in reality, the tax credits are limited. The full value of the tax credit applies to only a small number of small businesses under very specific circumstances, and it is temporary, so the costs will rise again once the credits expire.

For more than two decades, small business owners have cited the rise in health care costs as their primary concern. Since 1999, premiums have increased nearly 100 percent in the small group market. Unfortunately, the new Obama federal health care law only perpetuates the problem. One year after its passage, small business owners are bracing for higher costs, more rules and regulations, fewer choices and less flexibility.

I want to thank you for considering the views small business and we stand ready to assist you in finding an alternative to this current federal problem. Thank you.

[The prepared statement of Mr. Shivers follows:]

**Testimony of  
Kevin Shivers  
Pennsylvania State Director  
National Federation of Independent Business**

**Before the  
House Energy and Commerce Health Subcommittee  
Harrisburg, PA**

**March 23, 2011**

Mr. Chairman and members of the committee, on behalf of the Pennsylvania small-business members of the National Federation of Independent Business, I want to thank you for inviting me to talk with you today about the Patient Protection and Affordable Care Act (PPACA) and its impact on small-business owners and workers.

For small business, healthcare is a pocketbook issue. Nearly 81-percent of small-business owners report that finding affordable health insurance for themselves and their employees is a challenge. Those small businesses that do have health insurance pay on average 18 percent more for the same health benefits as large companies.

When the new federal law was signed, its proponents promised that costs would decrease for small business. Not only have costs gone up one year after its passage, but the new law has added new compliance and paperwork burdens, making a flawed system even worse.

Across the nation, it has been reported that insurance premiums in the small group market have risen 40 percent to 60 percent. We have heard the same in Pennsylvania.

Many small businesses fortunate enough to afford health insurance have had their plans canceled because the federal health law's new and restrictive rules have rendered them non-compliant.

Others who were told that their health plans would be protected, or "grandfathered" under the new law have learned their plans now are non-compliant. About 60 percent of small businesses last year made small adjustments to their plans in order to manage rising costs. By making small changes or adjustments, these plans no longer comply with "grandfathering" provisions under the PPACA, exposing these businesses to more regulations and cost increases in the future.

It is estimated that as many as 80 percent of small businesses will be forced to give up their current coverage within the next two years. In an already uncompetitive market, more canceled plans and more regulations mean that small businesses have even fewer choices than they had before the law was passed, making higher costs inevitable.

The new law also imposed a myriad tax and paperwork headaches for small firms. Compliance costs from the 1099 provision alone will place an enormous burden on small business. The cost associated with tax paperwork is the most expensive paperwork burden that the federal government imposes on small-business owners -- as much as \$74 per hour. New taxes on various products, services and payroll are especially harmful to small business. And a new insurance company tax that will be paid almost exclusively by small business is expected to cost as much as \$5,000 per household.

The Patient Protection and Affordable Care Act also has taken away one of the few consumer-directed pieces that currently exists in the health care marketplace today. The new law prohibits

individuals from using pre-tax dollars, like those from a Flexible Spending Account or a Health Savings Account, to purchase over-the-counter items. Now individuals have to make an appointment with their healthcare provider in order to obtain a prescription to purchase basic remedies to alleviate the discomfort of the common cold. This mandate further taxes an already over-utilized system. It forces doctors to take time away from patients who really need medical care.

Another provision of the PPACA which has failed to live up to its promise to reduce health insurance costs is the small business tax credit. While proponents of the new federal law told us that tax credits would help small business to purchase health insurance, in reality, the tax credits are limited. The full value of the tax credit applies to only a small number of small businesses under very specific circumstances—and temporary, so costs will rise again once the credits expire.

For more than two decades, small-business owners have cited the rise in health care costs as their primary concern. Since 1999, premiums have increased nearly 100 percent in the small group market. Unfortunately, the PPACA only perpetuates the problem. One year after its passage, small-business owners are bracing for higher costs, more rules and regulations, fewer choices and less flexibility.

I thank you for your consideration of the views and concerns of small business. We stand ready to assist you on this and other issues affecting the men and women who work for or own a Pennsylvania small business.

Thank you.

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Mr. PITTS. The chair thanks the gentleman and recognizes Ms. Daane for 5 minutes for an opening statement.

**STATEMENT OF ANN DAANE**

Ms. DAANE. Thank you, Mr. Chairman and other members of the committee. Thank you for the introduction. I am Ann Daane, Vice President of Human Resources at Case New Holland, and I thank you again for the opportunity to testify today.

Chairman Pitts, we are proud that New Holland began here in Pennsylvania and that New Holland remains the North American brand headquarters. We have large facilities, and we are very proud of our many employees who build, develop and design equipment. We have more than 1,600 employees here in Pennsylvania.

Today I am going to speak about the health benefits that we as employees receive from Case New Holland. For all of us, our health care benefits are important, and for our company, we want to make certain that we receive the highest quality health care at an affordable price. We believe that Congress has not done enough to reduce the cost of health care.

In the United States, all full-time and part-time Case New Holland employees are eligible for coverage. Almost 90 percent of our active workers elect coverage for themselves and for their families. We cover 17,200 active employees and their families at a cost of \$76 million annually. We also provide coverage to 11,800 retirees and their families at an additional cost of \$72 million. We offer a choice of consumer-driven health care plan options and these plans have account-based incentives that let enrollees make their own decisions about their health care needs. We also have wellness and chronic care management programs, and almost nine out of ten of our employees participate in at least one wellness activity every year. That has resulted in a significant decrease in the health risk factors for those who participate.

We believe that the health reform law needs to be changed. The rising cost of health care is affecting job growth, and is hurting all American companies who must compete in the global market. Rising costs are also affecting every American worker. The new law does not control health care spending. We believe it adds additional costs for our employees, and for Case New Holland, we expect to spend \$126 million over the next 10 years just to comply with the new provisions.

We are most concerned about the following three items in the health reform law. Number one, the new taxes that are imposed on prescription drug manufacturers, medical device manufacturers and insurance products. These new taxes will be passed on to us as purchasers in the form of higher costs. Secondly, the new law makes reductions to Medicare payments. Providers will shift costs to private purchasers, which will increase our costs. And thirdly, the new law requires employers to make plan and benefit changes—adult child coverage to age 26, new prevention and wellness coverage, new appeals and grievance processes.

There are more than 130 million Americans who receive health care coverage through their work. At a time when many employers are struggling merely to offer coverage, these new plan and benefit requirements will add more cost. We do want to see changes in the

health care system to reduce overall costs. We have five suggestions on what should be changed.

Number one, support consumer-directed health care plans. These innovative options empower our workers to make decisions about their own health care needs. Employers should have flexibility in their plan design so they can be innovative for their employees. Secondly, medical liability reform must be enacted. The Congressional Budget Office estimates that medical liability reforms would save \$52 billion over 10 years just in public programs alone. It would save even more systemwide. Number three, adoption of health information technology. We need adoption of health information technology to create a more efficient health care marketplace. Number four, change Medicare payments to reward value, not the volume of service. And lastly, repeal those provisions of the new health care reform law that increase costs on employer-sponsored coverage.

We must work together to find solutions to our health care cost crisis. For Case New Holland, we will continue to offer our employees coverage. It is important that they are healthy and productive. But we need greater competition and consumer engagement in a more efficient health care system. Our country needs this because Americans are paying more and more for health care and getting less and less value. Americans are fearful of losing their jobs and their health insurance coverage at the same time, and America is in an economic situation where we cannot afford the rising costs of health care.

In conclusion, Case New Holland believes Congress must fix what isn't working, then move forward to create solutions that address the underlying health care crisis: the costs.

Thank you again, Chairman and the committee, for allowing me the opportunity to speak to you today.

[The prepared statement of Ms. Daane follows:]

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Statement of

Ann Daane

Vice President of Human Resources for the North American Region

Case New Holland

on

“PPACA and Pennsylvania: One Year of Broken Promises”

Before the

United States House of Representatives Committee on Energy and Commerce

Subcommittee on Health

March 23, 2011



Ann Daane  
Vice President, Human Resources

**U.S. House of Representatives Committee on Energy and Commerce,  
Subcommittee on Health  
Hearing on "PPACA and Pennsylvania: One Year of Broken Promises"  
March 23, 2011**

Mr. Chairman and members of the Subcommittee, I am pleased to present testimony on the impact of the Patient Protection and Affordable Care Act on our nation's large employers. I am Ann Daane, Vice President of Human Resources for the North American Region, and am here on behalf of Case New Holland (CNH), a world leader in the agricultural and construction equipment businesses. Case New Holland is supported by 11,600 dealers in approximately 170 countries. CNH has over 8,500 employees in the United States, alone, and over 30,000 employees worldwide. In the Commonwealth, New Holland, Pennsylvania is the birthplace of one of CNH's predecessor companies, New Holland, and remains the North American brand headquarters for New Holland agricultural equipment. Since its humble beginning in 1895, the company's presence in New Holland has grown to a campus that totals over 340 acres, including a 150-acre engineering test farm. In addition to a major manufacturing plant, the campus includes a 130,000 square foot Administrative Center, an 85,000 square foot Technical Center, an 88,000 square foot Crop Harvesting Test Center, a 21,000 square foot Conference and Learning Center, and over 150,000 square feet of engineering facilities. In addition, CNH Capital

occupies a separate 25,000 square foot facility and CNH has a parts depot in Mountville, PA. The Technical Center and engineering facilities serve as the design headquarters for rotary combines and headers, hay and forage equipment, crop production equipment and cotton harvesters.

The plant in New Holland manufactures both New Holland and Case IH brand hay, forage equipment, mowers, rakes and spreaders, and occupies over 700,000 square feet. The plant employs over 500 people and sources inputs from 400 suppliers. It is the world's largest single-plant producer of small square balers, pull-type forage harvesters, disc mower conditioners, disc mowers and round balers. The New Holland plant exports 22% of its production to 41 countries. Since 1999, CNH has invested over \$61 million in its New Holland operations.

CNH employs over 1,600 people in the Commonwealth of Pennsylvania. **In the United States, all full-time and part-time CNH employees are eligible for health coverage with almost 90% percentage of our active employees and their families - a total of 17,200 individuals - electing health insurance coverage, at an estimated cost of \$76 million.** We also cover 11,800 of our retirees and their families, at an additional cost of \$72 million. In Pennsylvania alone, we cover more than 5,000 individuals, at a total cost of over \$21 million. Our employees are our most important asset and making certain that they receive the highest quality health care at an affordable price is critically important.

That is why we are innovative in our health care benefit plans. We offer our employees a choice of consumer driven health plan options with account based incentives that empower our workers to make choices about their families' health care needs. We offer a wellness program, which raises employees' health awareness, assists with lifestyle changes and maintenance, and has decreased participating employees' health risk factors over three years by up to 18%. Sixty-two percent of our employees participated in a health assessment, biometric health screening and review with a health advisor. Eighty-eight percent of employees participated in at least one wellness activity in the last 12 months. All of our health care options include a chronic care program, called Condition Care, which offers personal assistance to employees to improve their adherence to clinical guidelines and improve their health.

Today, we encourage you to evaluate the impact of the law on employer-sponsored health insurance coverage and to repeal those provisions that only add more costs to our system without creating greater value. Rising health care costs are inhibiting job growth and damaging the ability of U.S. companies to compete in global markets. Rising health care costs are also imposing a major strain on the household incomes of many Americans and burdening State and Federal budgets. In these times of financial insecurity, maintaining jobs and retaining affordable health care benefits is a high priority for both employees and employers. That is why

we support changes in the law which strip away additional costs that do not add greater value to our already too expensive system.

Even before the enactment of the new law, employers made difficult economic decisions about whether to offer health insurance and face enormous increases year after year. Over 150 million Americans get health insurance coverage from their employer. As a country, we are spending more than \$2.7 trillion on health care in 2011, or more than \$8,600 per person, and the numbers are rising. It's critical that we focus on ways to improve efficiencies to reduce costs. Employers, employees, governments and other purchasers of health care coverage cannot afford a health care system that is growing at two to three times the rate of inflation. We need an affordable, sustainable health care system - and the stakes could not be higher.

The new law does not control health care spending. The new law increases costs for employers who choose to offer health insurance coverage — especially in the near term — leaving employers with a difficult decision about whether to offer health insurance coverage at all. For CNH, we expect to spend \$126 million over the next ten years just to comply with the new provisions in the law. Let me discuss some specifics:

1. The health care reform law requires new taxes to be imposed on prescription drug manufacturers, medical device manufacturers, and insurance products. These new taxes will be passed on to employers, employees, and other purchasers of health care services.

2. The health care reform law makes significant reductions to Medicare payments. As a result of reduced payments, providers of services will shift costs to private payers.

3. Employer sponsored health insurance plans are required to make plan design and benefit changes starting as early as 2011. These requirements are adding additional costs as we work to comply with many new benefit and processing requirements. These requirements include expanding dependent coverage up to age 26; new prevention and wellness benefit coverage; new appeals and grievance processes; and limitations on lifetime and annual limits. Over the next few years, more requirements will be imposed on our plans – including the potential that an excise tax may be imposed if plan costs exceed a specified amount. All of these requirements cost employers and employees money – at a time when many employers are struggling merely to offer and find health insurance benefits for their workers at all.

At CNH, we want to see changes in the health care system that reduce overall costs and reward value. When it comes to scientific advances, medical technology and the quality of our doctors and hospitals, the American system is the “gold standard,” but our system is burdened because consumers have no understanding of real costs and we are reimbursing providers for the volume, not the value of services. We want our employees to get services in the private marketplace that place more emphasis on an efficient health care system. Here are some of our suggestions on how to improve the costs of health care in America today:

1. We must preserve consumer directed health care plans (CDHP). We currently provide our employees with these types of account based plans, using HRAs and HSAs. They are valuable benefit plans that empower consumers to make decisions about their own health care needs. Currently, 67% of all CNH employees have elected a CDHP option. Behavior change and active employee participation as consumers has produced annual savings of \$7.3 million. These savings have been achieved without cost-shifting to our employees. The law needs to ensure that these innovative options are available.

2. Medical liability reform must be enacted so that we can reduce the costs associated with defensive medicine. The CBO, in its recent report "Reducing the Deficit: Spending and Revenue Options," estimates that enacting a number of targeted reforms could increase tax revenues by nearly \$13 billion and decrease health care spending by roughly \$52 billion over the next ten years. These reforms include:

- A \$250,000 cap on awards for noneconomic damages,
- A cap on punitive damages of \$500,000 or two times the value of awards for economic damages,
- A statute of limitations of one year for adults and three years for children,
- A fair share rule that replaces the rule of joint and several liability, and

- Permission to introduce evidence of income from collateral sources at trial.

3. Creating greater consumer value and efficiency through health information technology. All providers, plans, employers, and employees should use health information technology—which we have — so that we can reduce the costs of a “paper-held” health care system and reduce duplication in services.

4. Reward providers that offer quality care and value in the health care system. Medicare and Medicaid payments must be changed — these systems currently pay for the *volume* of care. This payment system is outdated and shifts costs to the private marketplace. Combining the impact of value based purchasing and rewards for quality with the use of health information technology is key.

5. Permit innovation in employer-sponsored plan design that empowers consumers to become more active in their own health care decision-making. We need greater transparency in cost and quality information so that our employees can make informed decisions about their own health care needs. Locking in benefit designs or restricting access to information will only increase costs.

6. Repeal those provisions of the new health care reform law that “increase” costs on employer-sponsored coverage.

At CNH, we believe that any real solution to health care reform must come from greater competition, innovation, choice and a marketplace that serves every consumer who has the tools to make the right decision. It is important for us and for the U.S. economy that we control the intensifying health care spending.

We need to work together to find solutions to our health care crisis — it is one of costs increasing faster than we can afford and one of health coverage that has become unaffordable for many Americans. The challenge we face is to find unique American solutions that can instill greater competition and consumer engagement in our health care system so that we do not have:

- Americans paying more and more money for health care services and getting less value;
- Americans fearful of losing their job and their health insurance coverage at the same time; and
- America in an economic situation where we can not afford the rising increase in health care spending for public and private programs.

We believe Congress must fix what isn't working and move forward to create solutions that address the underlying health care crisis —the costs.

Mr. PITTS. The chair thanks the panel for their opening statements, and I will begin with questioning. I recognize myself for 5 minutes.

Mr. Barr, in your testimony, you state that PPACA limits the flexibility of consumer-driven plans like health savings accounts, flexible savings accounts. Shouldn't Congress promote rather than restrict consumer involvement in health care decisions? Would you elaborate?

Mr. BARR. Mr. Chairman, I could not agree more. Over the years, many of our employers here in Pennsylvania and across the country have moved more and more to these health savings accounts. Oftentimes it works well with many other benefits or options, which is why we talked about the flexibility. Sometimes employees would rather have these HSA versus another plan, have more on another piece of the benefits side. This virtually eliminates that by making a standardized top-down this is what you are going to have to cover. HSAs also have a very positive benefit in that they have retirement options as well. There are retirement benefits, and we constantly hear that Americans don't save enough for retirement. This is a vehicle that allowed them to do that while also making participation, making them cognizant about what their health care costs are. Here in Pennsylvania, you heard Governor Corbett mention about the Health Care Cost Containment Council. The chamber is a member of that. We believe that by driving out more information to employees they are going to be able to make these kinds of informed decisions.

And finally, someone passed on to me a little while ago a very interesting piece of information, and that is, out of all the medical procedures, there are only two that have gone down in cost in recent years. Those two are plastic surgery and Lasik surgery, which interestingly enough are typically ones that aren't covered by insurance and ones that people go out and shop for. I think it shows the market works. We have to continue to drive people into the market, have consumers make informed decisions, not create a plan that must be applied to everybody to the detriment of individuals, to the detriment of employers. Thank you.

Mr. PITTS. Thank you. Again, Mr. Barr, this is a simple question. Will the new health care law cost our economy jobs, in your opinion?

Mr. BARR. Mr. Chairman, absolutely we believe it will. First off, as I mentioned, there are detriments to jobs creation here that cause employers to think twice about whether or not they want to add those jobs. There are enough issues out there on other public policy sides that clearly make it more difficult for employers to add jobs already, and I mentioned some of the things that we have seen that have been discussed in Washington and we have been fortunate they have been held off, things like card check. The other problem becomes the debt side, and one of the things that Kevin had mentioned was the 1099, which fortunately Congress has passed and I guess is sitting awaiting the President's signature. What it demonstrates, yes, this 1099 provision which required employers to report everything about \$600 needed to be done away with. The problem is from a financial and a debt perspective, what was built into the law was well, great, everyone is not going to be

able to comply with this, it is going to make us \$17 billion, therefore this works again on that house of cards upon which, in my view, this entire law is built, this financial house of cards, once you start pulling pieces out of it, none of it holds together. From the individual mandate to the other financial pieces, once you begin picking at the real problems in this, it falls apart.

Mr. PITTS. Thank you.

Mr. Shivers, the Obama Administration has touted the availability of a small business tax credit created by PPACA. However, I see the credit as creating an incentive to depress wage increases and too limited to help many small businesses. Do your members generally believe this credit will significantly help small businesses provide coverage to their employees?

Mr. SHIVERS. No, we don't. I mean, we have encouraged our members, you know, if—we actually have a tax calculator and there are links to the Internal Revenue Service site where you can actually as a business owner, you know, plug in your information and learn if you are eligible for that credit. We advise our members if you are eligible for the credit, take advantage of it. The problem that we are finding, I think it was the Congressional Budget Office reported recently that the average credit that a small business receives is only going to cover about half of the cost increase in premiums. So if premiums have gone up 40 percent and, you know, the credit is only going to cover 20 percent of an increase, I am still left with a 20 percent increase in my health care costs.

Mr. PITTS. If Congress, Mr. Shivers, would have passed legislation allowing for small business health plans, I think we used to call them association health plans, rather than PPACA, would that have done more to help job creators provide health insurance? Would you expound on that?

Mr. SHIVERS. Absolutely. Small business health plans, the idea that a flower shop could partner with a tool-and-dye maker that could partner with a barbershop and be able to get that economies of scale and be able to purchase their health insurance at a substantially lower cost and also have enough people within their pool to manage that risk, it provides a couple of things. Again, it lowers costs but it also gives employers greater flexibility. We had heard that there were some, you know, businesses and insurance companies that were even debating the idea of providing a consumer-directed health care option, a health savings account as part of this small business health plan to even drive savings even further. Unfortunately, it was one of those plans that never even made it into the drafting room, I guess.

Mr. PITTS. Thank you.

Ms. Daane, what plans are you putting in place to prepare for the requirement that you provide health insurance to your employees or face a penalty? Would you ever consider dropping coverage or paying the penalty if it would be less costly?

Ms. DAANE. Our employees are our most important asset, and right now we have not even considered dropping coverage for our employees. Certainly the plans that we put in place are an important way for us to control spending. Our wellness plan is an important way for us to control spending. But should the costs continue to increase, we will need to make difficult decisions about how

what we are going to do. That could impact the number of jobs that we have. We may need to move labor to lower-cost regions.

Mr. PITTS. What has been your experience with your wellness program? How has it been structured and what kind of success have you seen? Has it resulted in lower costs?

Ms. DAANE. It has. Our wellness program has been very successful, and the employees who participate have seen their health care risk factors drop by as much as 18 percent. We have 88 percent of our employees participate in at least one of our wellness activities over the last year. We include things like annual health assessment, biometric screenings, lifestyle improvement programs like smoking cessation, walking programs. We give them access to personal coaches to develop individual plans for health goals. We make a 24/7 nurse line available to them. A conservative estimate for the amount of savings that we have seen from these plans is about \$1.6 million net return annually.

Mr. PITTS. Thank you. The chair recognizes the gentleman, Mr. Thompson, for questioning.

Mr. THOMPSON. Thank you, Chairman. Thanks to the panel for being here and being part of this important issue we are talking about.

Mr. Barr, I want to follow up, I thought you did a great job of describing in terms of the 1099 reporting mandate, how that really is a taxing scheme in terms of dipping into the pockets of small businesses more than anyone else and going after revenue. I wanted to look at that from the standpoint, you know, we have worked hard to try to repeal that section. I know we voted on it, I think a number of times, and we are waiting for the Senate to do the right thing and the President also to do the right thing, but if that is unsuccessful and that reporting mandate is allowed to go forward, what would that mean for your member companies?

Mr. BARR. Well, obviously it creates a whole new paperwork burden for everyone across the board and obviously smaller businesses would be much more at risk for that than others. However, there is one positive from the 1099 requirement in terms of job creation. My understanding is the IRS is standing ready to hire many hundreds of people in order to take care of 1099 requirements. I guess that is the only caveat to the lack of job creation.

Mr. THOMPSON. I think they have to get funding through the House first, and I don't think that is going to happen.

Mr. BARR. Congressman, it is a great question. It is a severe problem, and again, you point out, you are exactly right. It is a tax. The IRS knows it. Not every business, particularly small to medium size, will have the wherewithal to fully comply, and we all know, compliance with federal tax regulations is burdensome, cumbersome and very difficult, and they know that, and again, they built the \$17 billion into their finance calculations.

Mr. THOMPSON. Have any, not just that mandate but any of the new mandates within the health care bill impacted the cost of coverage for your member companies at this point?

Mr. BARR. Clear, when you look at mandates, here in Pennsylvania we dealt with mandates over the years. We have one of the highest number of mandates that is required coverage for insurance here in Pennsylvania. We know that that drives up the cost

as we look at more mandates coming down. Obviously those that we have not done here in Pennsylvania will lead to that as well, and clearly, when you have a prescribed, standardized, minimal, our employers are going to have to look at it. Employers who believe they have a good plan now may not have a plan that meets the guidelines when that comes down and will have to make those modifications quite obviously at a higher cost.

Mr. THOMPSON. Thank you.

Ms. Daane, one promise we continually heard during the health care debate was that if you like your health care plan, you could keep your health care plan. Do you foresee your employees being able to keep their current plans?

Ms. DAANE. I think we will work very, very hard to be able to let them keep their current plan. Part of the issue for us is that right now the law is so unknown and so nebulous that it is hard for us to know whether our current plans will be in compliance with the legislation. So it is very hard for us to be able to say whether or not they will be able to keep their plan. I think as challenging for us is that unknown, that uncertainty costs us money as we work with consultants, as we work to try to understand whether or not our plans are compliant. We need some clarity on the bill.

Mr. THOMPSON. In terms of the plans, do you have a cost estimate for an increase in 2011 to comply with several new provisions of the law, specifically the adult child coverage and expanded benefits and administrative requirements?

Ms. DAANE. We think for 2011, just for the small amount of compliance that we are going to need to do with this bill, it is going to cost us \$1.2 million. Even with all the unknowns in the bill, we do know that the costs kick in more aggressively in 2013 and 2014. So it is \$1.2 million for 2011. It is about \$126 million over the next 10 years. Those are frightening numbers.

Mr. THOMPSON. They are. And how many employees—because you talked about you do full time and part time so that \$1.2 million is spread over how many employees?

Ms. DAANE. Ten thousand, approximately.

Mr. THOMPSON. Mr. Shivers, good to see you. Thanks for being part of the panel. My question for you is, even with the exemption for companies with 50 or fewer employees, do you see the employer mandate harming the growth potential of smaller or mid-sized firms, especially those with low margins? In other words, the employer mandate is simply a tax on jobs.

Mr. SHIVERS. Yes, I do see it as a problem. President Obama when he was lobbying for the law visited Pennsylvania, actually visited one of our members who told him that this was going to be a burden on her business. She ran a bakery up in Allentown. And the President said but you have fewer than 50 employees, and she said but I won't grow. You know, where is the incentive for me to expand my business because I am always going to worry about what are the mandates and provisions under that law.

The other issue is, even though those small businesses may be exempted, they are still responsible for following many of the reporting requirements and other provisions under the law. You know, that 1099 provision is going to be extraordinarily high threshold for a small business to meet. Of course, it varies from in-

dustry to industry but, I mean, we have heard of one small company who may have filed, like, 25 forms last year, under the new rules would be required to file as many as 300. There was a small business in Lancaster that reported to the newspaper that this would require them now to file as many as 3,000 forms. So you can imagine just the cost of paperwork. And all of it is intended to trip a business up because if I don't file a form, I file that form incorrectly, now I am subject to audits and, you know, now I am going to be, you know, dealing with all kinds of other costs and other issues that are associated with just trying to protect my business.

Mr. THOMPSON. Thank you.

You know, we have heard the Democrats speak a lot about the incentives in the new law for small businesses to continue to provide coverage, and they often refer to the small business health care tax credit. Is this tax credit of any value to your member companies?

Mr. SHIVERS. Again, what we are finding is that, you know, the credits that are offered are very small, very modest. You know, if you are looking at a business of 25 employees at an average wage of \$50,000, they might qualify for a partial credit. But, you know, that partial credit is going to be tricky. You know, a business with 19 employees at an average wage of \$35,000 would receive no credit because of the way, the formula that is used to calculate that credit. So, you know, businesses that are eligible for it, we tell them take advantage of it but at the end of the day it is not going to mitigate the cost increases that they are seeing in their premiums right now.

Mr. THOMPSON. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and we will start a second round.

Ms. Daane, you said that your compliance costs are \$126 million to comply with the new law over the next 10 years. How does this affect your ability to hire new employees, new workers when so many Pennsylvanians are desperately seeking a paycheck today?

Ms. DAANE. We cannot sustain any kind of a system where health care costs grow faster than the rest of the economy. The costs take us in the wrong direction, and it is going to have a significant impact on our labor cost. We compete in a global economy, and as labor costs increase, it has a devastating impact on our ability to be able to maintain employees in the United States. To adapt to the cost pressures, we are going to make some difficult decisions. We are going to be forced to move jobs to other regions where labor costs are lower. We are going to have to eliminate some jobs altogether or certainly we are going to have to think about how much expansion we can tolerate. We may have to reduce benefit levels, and that could include both medical benefits, retiree contributions, those kinds of coverages. We would have to make some very, very difficult decisions.

Mr. PITTS. Thank you.

Mr. Barr, much of the focus regarding the impact of this new health care law on employers centered on the employer mandate. However, I believe an overlooked factor has been the compliance costs associated with the new law. Forms will be required for employers from numerous federal departments and agencies, be it De-

partment of Labor or HHS or the IRS, in order to enforce new federal mandates. You briefly mentioned in your statement compliance costs. Can you expand further on the onerous compliance costs that will burden businesses with reams of paperwork, audits, whatever?

Mr. BARR. Certainly, Mr. Chairman. Part of it we talked about a little bit already, which has been this 1099 requirement. In addition, given that there is going to be a standardized—some of this is still evolving quite certainly but given that we have a standardized plan with the minimums you are going to have to meet, you are going to have to document to the Federal Government that your plan meets those. You are going to have to continue to make all of the requirements and all of the reporting this is calling for so that the Federal Government can ensure that you as an employer are, one, sending in your 1099. My understanding is this was done so as not to deliberately undercount employees. You are going to have to continue to maintain that your coverages meet minimum standards for the Federal Government and all of those other things that surround that. We all know the paperwork continues to burden businesses, small, medium and large. This simply adds to that burden in many ways. And again, we really do hope the 1099 requirement goes away. It is probably the most burdensome piece of this.

Mr. PITTS. And Mr. Shivers, on the grandfather provision, do you think it is fair that if a small business could find an insurance company that would provide a less-expensive policy than their current plan that they would lose their grandfathered status?

Mr. SHIVERS. That is very unfair, sir. You know, the President promised that, you know, if you like your health plan you will be able to keep it under my law, and what we are finding is that is not the case. In fact, 80 percent of businesses are expected to drop their coverage within the next 2 years and, you know, many small employers are doing their level best to keep the coverage that they have, you know, to use it to attract good, quality workers, and, you know, with the cost drivers when you are facing a 40 to 60 percent premium, you have got to make some tough choices in terms of how you pay for that coverage. And just making a slight change in that plan to address the proliferation in cost, you are ineligible. That just simply isn't fair.

Mr. PITTS. Thank you. The chair recognizes the gentleman, Mr. Thompson, for additional questions.

Mr. THOMPSON. Thank you, Chairman.

Mr. Shivers, can you explain how impending regulations authorized by Obamacare such as the essential benefits package jeopardize the availability of coverage options already offered by small businesses?

Mr. SHIVERS. Not specifically understand that particular regulation, Congressman. I can tell you one of the challenges that our member are concerned about is, you know, my plan that exists today may not quality once the regulations are, you know, actually published and, you know, that creates the predictability and instability in a system that makes it really hard for a small businessperson or any businessperson to be able to plan and run their company.

Mr. THOMPSON. Is it fair to say that obviously individual businesses are all unique in terms of their characteristics, the average age of their workforce, you know, when businesses get to know their employees and the demographics, characteristics, and the fact is that they might wind up having to pay for some type of mandated coverage which may not even apply. There may no need for that health care service among the characteristics and the demographics of their workforce.

Mr. SHIVERS. That is correct, sir. You know, for many—you know, there is a competition issue, and, you know, for small businesses, you know, it is not just a competition for consumers, it is a competition for good workers, and, you know, for years, small businesses have been frustrated because they haven't been able to offer to good prospective workers the same kind of benefit packages that larger companies could do at a lower cost, and, you know, this system does nothing to, you know, raise the bar for that business to give them additional tools with which they can go out and attract good, quality people to their workforce. You know, we have come up with a one-size-fits-all cookie-cutter approach and you are absolutely right. You know, my workforce and the people that I am attracted to work in my company may be very different and then another company and that lack of flexibility is a very big problem under this law.

Mr. THOMPSON. Well, Washington has been famous for one-size-fits-all cookie-cutter approaches, whether it is health care or energy policy or education, and it always fails. Always fails the individual citizens in the end.

Ms. Daane, you mentioned that the Medicare and Medicaid reimbursement system shifts more costs onto private insurance. That is certainly something I saw in my responsibilities as a manager within a rural hospital. Medicare and Medicaid never paid more, they always paid less. And so when you determine your rates and you determine your rates based on the cost of the service to provide, you really have to take into account what we call payer mix, and as government paid less, in my professional opinion, let alone my life experiences, that is why commercial insurance gets more expensive, which was absolutely ignored within this process of looking at the health care bill.

In your view, will that problem be exacerbated if 20 million more people are enrolled in the Medicare programs, some of whom used to have private insurance?

Ms. DAANE. Without a doubt. You know, cost shifting is something that we already see as a certain percent of the cost of coverage for our employees. You add their people to the Medicare, to the Medicaid system, there is going to be more cost shifting. Our cost as a private employer is going to go up without a doubt. I think then you marry that to the method of reimbursement, which is you are reimbursed on volume, not on value, that then, you know, kind of exponentially increases the damage that that does. We are a company that makes products that are used by rural consumers, and we have employees in rural areas. Chairman Pitts has been to our plant. Mr. Thompson, I would invite you to come. We make the best round bailer in the world and we are very proud of that. Our customer, our employees in the rural part of many of the

States where we do business, we need to have a system that ensures that those rural providers continue to exist, that there is, you know, kind of the continued vitality of rural providers, both hospitals and service providers. The bill as it stands does not do that. In fact, it is very detrimental to that.

Mr. THOMPSON. And my final question to Mr. Barr, what are your thoughts as to whether employers in general will drop health insurance coverage and pay a \$2,000-per-employee penalty?

Mr. BARR. Well, Congressman, that is going to come down to an individual decision. Ann mentioned the fact that they are probably not going to do it. They have to attract a certain kind of individual. Certain large companies may be better situated. The reality is, someone is going to sit down and look at what the cost of family coverage and single coverage is going to be for them to provide as a mandate, particularly now that it becomes standardized to all their employees if they have a 7,500-person operation, and they are going to have to weigh those. They are going to have to look at the cost of providing health care versus \$2,000 a person, as I mentioned. A cynical person might say for those who really wanted a government-run plan, this is certainly one way this is going to accelerate that, and clearly, individual companies, individual employers are going to be making those decisions, sometimes purely for survival. In order to keep going, they are going to have to do that.

The other thing that I will just say in summary, and I guess one of the things that we have seen from the employer base is that we have got to learn to trust the free market and entrepreneurs more. We continue to get this, well, we are going to prescribe, you are going to give this set of benefits and this set of benefits, and you have heard, you know that doesn't work. You know from your experience that doesn't work. Every situation is different. Geographic areas are different. And what works in a given area doesn't work in another. Certain employees value certain benefits more than others. And to the extent that we take that flexibility—you have heard that word a lot—to the extent that we put those mandates on, we make it so much more difficult to have a competitive jobs environment here.

Mr. THOMPSON. Thank you. Thank you to each one of you.

Mr. PITTS. And again, thank you for taking time to present testimony and answer questions. This has been a tremendous panel as you share your expertise.

One of the jobs we have is to educate the public as to the requirements and the costs of PPACA, and there is no one better than the employer community to do that, and as we do that and as we look to modify, repeal and replace PPACA with real reform, we look forward to working with you in that regard and we hope that we will have much better news for you on the second anniversary of Obamacare before it is fully implemented as we meet again. Again, thank you very much.

In conclusion, I would like to thank Governor Corbett, all of the witnesses, the members that participated in today's hearing. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to please respond promptly to these questions.

The subcommittee is now adjourned.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

