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4 PROTECTING AMERICA'S SICK AND CHRONICALLY ILL

5 WEDNESDAY, APRIL 3, 2013

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The Subcommittee met, pursuant to call, at 1:00 p.m., in
11 Room 2322 of the Rayburn House Office Building, Hon. Joe
12 Pitts [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pitts and Burgess.

14 Staff present: Gary Andres, Staff Director; Sean
15 Bonyun, Communications Director; Paul Edattel, Professional
16 Staff Member, Health; Julie Goon, Health Policy Advisor;

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17 Sydne Harwick, Legislative Clerk; Katie Novaria, Professional
18 Staff Member, Health; John O'Shea, Professional Staff Member,
19 Health; Andrew Powaleny, Deputy Press Secretary; and Heidi
20 Stirrup, Health Policy Coordinator.

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|
21 Mr. {Pitts.} The subcommittee will come to order. The
22 Chair will recognize himself for an opening statement.

23 During the last several years, there have been few areas
24 of agreement between Republicans and Democrats on how our
25 health care system should be reformed to better serve
26 patients. From the beginning, however, one area that both
27 sides have designated as a top priority is coverage for those
28 with preexisting conditions.

29 In the Republican alternative to Obamacare, we proposed
30 \$25 billion over 10 years to aid Americans suffering from
31 preexisting conditions through new universal access programs
32 that reformed and expanded state based high-risk pools and
33 reinsurance programs.

34 Obamacare, unfortunately, provided only \$5 billion in
35 its Preexisting Condition Insurance Plan, PCIP, we will call
36 it, for this purpose until January 1, 2014. At the time of
37 the health care law's passage, Republicans argued that the
38 funding level was too low and would not cover all of those it
39 was meant to help.

40 The first real signs of trouble for the federally

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41 administered high-risk pools came in August 2012, when CMS
42 reduced payments to providers treating a high number of high-
43 risk pool enrollees, hitting hospitals especially hard.
44 Additionally, the agency cut the number of participating
45 pharmacies that provided certain types of drugs to program
46 enrollees. Next, on January 1, 2013, CMS increased the
47 maximum out-of-pocket costs for program enrollees by \$2,250
48 and mandated greater use of mail-order pharmacy. Finally, on
49 February 15, 2013, CMS announced that it was suspending
50 enrollment in PCIP altogether, due to financial constraints.

51 All of these actions were taken despite the fact that
52 enrollment in the high-risk plans was less than 30 percent of
53 what had been expected. Original estimates were that 375,000
54 people would sign up for the federal high-risk pools. In
55 fact, only approximately 110,000 individuals have joined.

56 CMS is now trying to stretch what is left of the initial
57 \$5 billion to cover those already enrolled in the program
58 until January 1 of next year. What will happen to those
59 people who had pending applications for PCIP when CMS cut off
60 new enrollment? What about those, by some estimates 40,000
61 people, who would have enrolled during the remainder of this

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62 year? They are left without options and without coverage.

63 On March 5, Speaker Boehner, Leader Cantor, Whip
64 McCarthy, Conference Chair McMorris-Rodgers, Chairman Upton,
65 Dr. Burgess and I sent a letter to the President asking that
66 he redirect funding from other Obamacare accounts to PCIP to
67 allow the program to continue accepting new enrollees.

68 Although we still hope for a full repeal of the health
69 care law and replace it with other reforms, we have reached
70 out to President Obama and asked him to work with us to help
71 those most in need get coverage and care. We are still
72 waiting for his response.

73 I want to thank all of our witnesses for being here
74 today. I look forward to your testimony. I would like to
75 conclude my statement at this time.

76 [The prepared statement of Mr. Pitts follows:]

77 ***** COMMITTEE INSERT *****

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|
78 Mr. {Pitts.} Since we do not have any of the minority
79 members here, I will recognize the vice chairman of the
80 committee, Dr. Burgess, for 5 minutes for his opening
81 statement.

82 Dr. {Burgess.} I thank the chairman for the
83 recognition. I also want to thank the witnesses for being
84 with us today. I appreciate you making the effort to be here
85 because this is an important issue. Some of you I have met
86 before. For others, this is the first time, but welcome all.

87 We hear a lot that Republicans don't have alternatives
88 or other ideas for the replacement of the President's health
89 care law. I know this is untrue. Many of you on the panel
90 know it is untrue. If anything, our party has a multitude of
91 ideas. But one overreaching aspect of policy that there
92 seems to be general consensus is, we do need to address the
93 needs of Americans with what are called preexisting
94 conditions. As the chairman said, the Affordable Care Act
95 created the new Preexisting Condition Insurance Plan,
96 affectionately known as PCIP. I think I will refer to that
97 as the federal plan so it won't be confused with State plans.

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98 But it was arguably duplicative of actions taken by 35 States
99 prior to 2010 that were operating high-risk pools, and they
100 served an estimated--well, over 200,000 Americans. It has
101 been shown that State-based programs do play an important
102 role in lowering the costs across markets and providing
103 coverage options for those who are faced with a preexisting
104 condition. In some States, the federal preexisting program
105 was merged with the State's existing high-risk pool, and in
106 others, like my home State of Texas, the PCIP plan operates
107 parallel to the State's pool. However, the federal
108 preexisting plan is providing coverage to 100,000
109 individuals, well short of the 375,000 that CMS estimated,
110 but still a significant and compelling group of people who
111 all have stories and deserve protection.

112 As a physician, insuring those with preexisting
113 conditions and assuring that they have access to affordable
114 health insurance is a top priority for me. As much as I
115 believed that the President's Affordable Care Act stretched
116 the bounds of constitutionality, and in fact, I still believe
117 that, I was concerned that if the Supreme Court felt as I did
118 that day and said look, this thing is outside the bounds that

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119 the Constitution places on the legislative branch, folks are
120 going to have the rug pulled out from under them who had been
121 in the federal preexisting program and then could be barred
122 from merging into a State's pool because the federal program
123 had previously provided them coverage. That is why to ensure
124 that that did not happen, I was prepared to answer that
125 challenge and introduce the Guaranteed Access to Health
126 Insurance Act of 2012 prior to the Court's decision to
127 provide States with the financial backing to decide how best
128 to provide coverage for their populations who would be in
129 this risk pool.

130 I will also note that unlike many of the complaints that
131 the federal preexisting program has faced, the bill did not
132 require those with preexisting conditions to jump through
133 hoops or to remain uninsured for some unreasonable period of
134 time before being eligible for coverage. There are always
135 stories of those who have done the right thing, insured
136 themselves and then for reasons kind of beyond their control
137 fall out of the system--they lose their job, they get a tough
138 medical diagnosis and then find themselves forever frozen out
139 of coverage. Those were the stories that people thought of,

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140 and people did come to us with that concern. In the summery
141 of 2009, many of you remember the rather tense town halls
142 that were held across the country, and what did people tell
143 us? Yes, they were worried about people with preexisting
144 conditions. They didn't want us to mess up what was already
145 working for arguably 65 or 68 percent of the country, and
146 they sure wanted some help with costs, and it turns out, we
147 failed on all three counts with the Affordable Care Act.

148 How many people have aged into the 6-month exclusion
149 since the Centers for Medicare and Medicaid Services made the
150 announcement that the federal program was now closed.
151 Someone who said well, I am going to start the clock in
152 October and I will be able to enroll in April now find
153 themselves frozen out of the system. Was it because that the
154 federal preexisting program was designed poorly, because its
155 costs were too high? Was it because maybe the problem of
156 serious preexisting conditions existing in a population that
157 wanted to purchase insurance was lower than estimated? We
158 will never know, but it would have been nice to think these
159 things through prior to adopting the Affordable Care Act.

160 I will admit that many of the current State-based

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161 programs are underfunded and lack the ability to meet their
162 needs. It is costly to deal with these issues. These people
163 are sick. They have multiple medical conditions.

164 I was prepared to authorize \$30 billion. Five billion
165 was what the federal program allowed. I was prepared to
166 authorize \$30 billion. I got people back in my district who
167 say, Dr. Burgess, \$30 billion, that is way too much money, we
168 don't have the money. Well, I will tell you what: it is a
169 lot cheaper than the \$2.6 trillion that this thing is going
170 to cost, and we wouldn't have had to blow up the whole system
171 in order to take care of those people that arguably are going
172 to need help. If we are serious about funding these programs
173 and dealing with these issues, these costs are but a drop in
174 the bucket as to what the Affordable Care Act will cost our
175 Nation.

176 Mr. Chairman, I see you have already been generous with
177 the gavel. I have consumed the time that you yielded back
178 and my time as well. I have considerably more, and I will
179 provide that for the record, and I am anxious to hear from
180 the witnesses, so I yield back.

181 [The prepared statement of Dr. Burgess follows:]

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182 ***** COMMITTEE INSERT *****

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|
183 Mr. {Pitts.} The Chair thanks the gentleman, and we do
184 have statements from the ranking members, Pallone and Waxman,
185 and I will ask unanimous consent to enter those into the
186 record. Without objection, so ordered.

187 [The information follows:]

188 ***** COMMITTEE INSERT *****

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|
189 Mr. {Pitts.} We have one panel today, and I will
190 introduce them at this time, and I would like to thank them
191 for taking time to come and share their expertise with us
192 today. First is Ms. Susan Zurface on behalf of the Leukemia
193 and Lymphoma Society. Secondly, the Hon. Mary Taylor,
194 Lieutenant Governor from the State of Ohio and Director of
195 the Ohio Department of Insurance. Thirdly, Dr. Sara Collins,
196 Vice President of the Commonwealth Fund. Fourthly, Mr. Ron
197 Pollack, Executive Director of Families USA. And finally,
198 Mr. Thomas Miller, Resident Fellow of the American Enterprise
199 Institute. Thank you all for coming.

200 Your written testimony will be made part of the record.
201 We ask that you summarize your testimony and opening
202 statement of 5 minutes each, and Ms. Zurface, we will start
203 with you. You are recognized for 5 minutes for your opening
204 statement.

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|
205 ^STATEMENTS OF SUSAN ZURFACE, ON BEHALF OF THE LEUKEMIA AND
206 LYMPHOMA SOCIETY; HON. MARY TAYLOR, LIEUTENANT GOVERNOR,
207 STATE OF OHIO; DR. SARA R. COLLINS, VICE PRESIDENT, THE
208 COMMONWEALTH FUND; RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES
209 USA; AND THOMAS P. MILLER, RESIDENT FELLOW, AMERICAN
210 ENTERPRISE INSTITUTE

|
211 ^STATEMENT OF SUSAN ZURFACE

212 } Ms. {Zurface.} Thank you. Mr. Chairman and members of
213 the Health Subcommittee, as a patient with blood cancer, it
214 is my honor to share my experience and those of other blood-
215 cancer patients as they have attempted to utilize the
216 Preexisting Condition Insurance Program.

217 I am a 42-year-old single mother with a full-time legal
218 career. I live in rural southern Ohio in an area that has
219 been clearly affected by the economic recession. I am a solo
220 practitioner with a modest law practice, a sizable portion of
221 which is dedicated to serving indigent clients.

222 I have two children, who thankfully have health coverage

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223 under their father's medical plan. I am active and I strive
224 to keep myself healthy. For the last 13 years, I have rarely
225 been ill and I have not needed health insurance coverage.

226 After my mother's death in September of 2012, I became
227 ill, and after nearly 8 weeks, I ultimately saw my family
228 physician and a series of tests were ordered. A week and a
229 half later, on January 9, I received the first test results
230 confirming a diagnosis of chronic lymphocytic leukemia, CLL,
231 one of the most common types of adulthood leukemias. The
232 bill for that analysis alone was \$7,600. After follow-up
233 tests and a three-day stay in the MICU at Wexner Ohio State
234 University Medical Center, I received over \$50,000 of medical
235 bills that I could not afford. Thankfully, the social
236 workers at the hospital immediately enrolled me in Ohio's
237 Hospital Care Assurance Program, HCAP. Because my income met
238 the threshold for eligibility, I currently have 100 percent
239 medical coverage. Eligibility for HCAP is reviewed
240 quarterly. I have been working full time since the beginning
241 of February, so I will likely lose eligibility for this
242 program.

243 In late February, I learned about the Ohio High Risk

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244 Pool program. Just before sending in my application, I
245 learned that the program was no longer accepting new patients
246 due to lack of funding. My options are limited. I cannot
247 qualify for Medicaid unless my income is low or I become
248 disabled by my CLL, and I cannot afford a high-premium or
249 high-deductible plan. If I am working at a normal capacity,
250 I will almost always exceed the level to maintain continuous
251 assistance through HCAP but not by enough that makes health
252 care affordable. Even without costly treatment, my CLL
253 requires regular medical care, blood screenings, and
254 screenings for secondary cancers. Without the benefit of
255 coverage, I have three options: do nothing at high financial
256 and health risk, declare medical bankruptcy or enroll in
257 clinical trials out of financial, not medical, necessity.

258 The Leukemia and Lymphoma Society has identified three
259 barriers that exist in this program. First, the 6-month wait
260 without health insurance that a patient must endure before
261 becoming eligible to enroll; second, premiums that are
262 prohibitively high; and third, the lack of portability across
263 networks.

264 I have submitted a representative sample of stories from

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265 patients who have been working with LLS as part of my written
266 testimony.

267 When seriously ill patients are forced to go uninsured
268 for 6 months, they risk deeper illness or death, bankruptcy,
269 and/or the potential loss of their homes. This barrier
270 cannot be changed through the regulatory process. We urge
271 Members of Congress to work together to remove this barrier
272 legislatively.

273 A second significant barrier is the relatively high cost
274 of coverage. Nearly 80 percent of the uninsured with high-
275 cost chronic conditions are individuals with incomes less
276 than 400 percent of the federal poverty level who will likely
277 find PCIP premiums unaffordable. Future enrollees in the
278 exchanges will be provided subsidized premiums and out-of-
279 pocket spending caps. However, that is not the case with
280 PCIP enrollees. Furthermore, a small subset of States
281 including Pennsylvania and several others have exacerbated
282 the problem by prohibiting third parties from assisting
283 patients by covering the cost of PCIP premiums. We urge
284 Members of Congress to enact commonsense reforms to the PCIP
285 program including providing premium support for those

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286 patients who may need assistance and by allowing patients to
287 receive third-party non-government assistance.

288 One final barrier that patients experience in PCIP is a
289 lack of portability across networks. For many patients, once
290 they have begun their care within a network, it is
291 emotionally difficult and cost-prohibitive to reestablish
292 relationships with new providers. The PCIP allows patients
293 to visit providers outside of a participating network.
294 However, the out-of-pocket deductibles are double those
295 within the network. There is no out-of-pocket cap, and a 50
296 percent coinsurance is added to any services obtained. We
297 urge Members of Congress to provide patients with the
298 flexibility needed to obtain the health care they require.

299 On behalf of the Leukemia and Lymphoma Society, myself
300 and the over 1 million patients living with or in remission
301 from blood cancer, thank you for the opportunity to speak
302 with you today. We urge Congress and the Administration to
303 work together to ensure continuity in the program as well as
304 policy fixes that could make it even more helpful for
305 patients who so desperately need it.

306 [The prepared statement of Ms. Zurface follows:]

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307 ***** INSERT 1 *****

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|
308 Mr. {Pitts.} The Chair thanks the gentlelady, and
309 especially thank you for sharing your personal experience and
310 for these recommendations.

311 The Chair recognizes Lieutenant Governor Taylor for 5
312 minutes for an opening statement.

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313 ^STATEMENT OF HON. MARY TAYLOR

314 } Ms. {Taylor.} Mr. Chairman and distinguished members of
315 the committee, thank you for the opportunity to testify this
316 afternoon regarding Ohio's experience with the High Risk Pool
317 program under the Affordable Care Act. My name is Mary
318 Taylor, and I am Ohio's Lieutenant Governor and also the
319 Director of the Department of Insurance.

320 States have regulated insurance for decades based on the
321 specific needs of their populations, economies and insurance
322 markets. Under the leadership of different Administrations,
323 Democrat and Republican, over the past 60 years, our
324 department has managed and regulated a competitive insurance
325 market for consumers and job creators. Because of our
326 regulatory environment, Ohio has a very competitive health
327 insurance market with 60 companies writing health insurance
328 business from which Ohio's consumers can choose.

329 In order to determine the impact of the ACA on Ohio's
330 vibrant market, my department commissioned a report conducted
331 by Milliman Inc. in 2011. This report projected premiums

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332 would increase in the individual market in Ohio between 55
333 and 85 percent. In addition, the report projected a
334 substantial shift in how people get their coverage, and as a
335 result, the size of the individual market in Ohio is
336 projected to more than double with the employer-sponsored
337 insurance market is decreasing.

338 In addition to these impacts, the ACA does little in the
339 way of reducing the underlying cost of care that has
340 historically driven the increasing cost of health insurance
341 coverage. This law is a one-size-fits-all national approach
342 to health care that removes the flexibility from States and
343 is laden with very narrow and rigid regulations.

344 More specifically to the High Risk Pool. The High Risk
345 Pool concept can be a useful tool to address access to health
346 insurance coverage if done well. However, implementing them
347 as mandated in the ACA is problematic. The federal
348 government's poor management and oversight of the program led
349 to its unsustainability and ultimately the untimely decision
350 to close enrollment in the program for new participants,
351 leaving a very vulnerable population without access to
352 insurance coverage.

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353 Ohio's High Risk Pool was organized in 2010 and is
354 administered by an Ohio-licensed private health insurer but
355 it is funded by HHS. Our department retained its general
356 regulatory authority over the High Risk Pool, including the
357 right to review premium rates and resolve consumer appeals.
358 Even though the program administered by Ohio was among the
359 most efficient and cost-effective in the country, the federal
360 management of the High Risk Pool program quickly caused
361 disagreements between the two agencies.

362 In 2011, the High Risk Pool submitted rates to both HHS
363 and the Ohio Department of Insurance for review and approval.
364 The Department of Insurance approved the rates that were
365 actuarially justified for the two High Risk Pool plans using
366 our normal processes. However, HHS refused to approve the
367 rates and directed the Ohio High Risk Pool Administrator to
368 artificially reduce rates for those in the lower-deductible
369 plan and artificially increase rates for those in the higher-
370 deductible plan. As regulators, we must ensure that each
371 block of business is solvent and that one pool of individuals
372 isn't subsidizing the cost of another pool of individuals.
373 As a CPA and insurance regulator where a primary concern

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374 relates to company solvency, forcing a company to
375 artificially set rates causes serious solvency concerns and
376 potentially puts the company at risk where it can't pay the
377 health claims incurred by those individuals and families who
378 have insurance coverage under the plan. Eventually HHS and
379 the Department were able to come to an agreement on rates,
380 but of course, this caused consumer confusion and pushed back
381 renewal dates.

382 Shortly after the problems with the rates were resolved,
383 we began having eligibility disputes with HHS. As the
384 primary regulator, the department reserved the right to make
385 final determinations on eligibility, but in these cases, HHS
386 demanded the Ohio High Risk Pool Administrator ignore the
387 department's determination and instead follow HHS's
388 directions. Ohioans who were clearly eligible for the High
389 Risk Pool according to our department's review were forced
390 out of the program by HHS, causing them to lose their only
391 available source of coverage.

392 After protracted discussions between the department, the
393 Ohio Administrator and HHS, it became clear that HHS would
394 not recognize the department's authority. The Ohio

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395 Administrator was then forced to file a lawsuit against both
396 parties seeking clarification from the courts as to which
397 party they were bound to follow. An agreement was eventually
398 reached in which the department's regulatory authority was
399 upheld but this several-month-long ordeal demonstrated the
400 federal government's propensity to overreach and disregard
401 State regulation of insurance that resulted in harm to
402 consumers in the process.

403 While our pool has come with challenges, to say the
404 least, we feel this tool is not without merit. However, as
405 you seek additional funding to allow this program to continue
406 through 2013, we encourage you to ensure States are given
407 control and flexibility. Just as with the High Risk Pool in
408 Ohio, when a federal agency steps into a role in which they
409 do not have the experience or expertise to properly
410 understand the issue, it can have severe consequences for the
411 market and consumers. Knowing the challenges that lie ahead,
412 I encourage Members of Congress to continue working toward a
413 better solution. We will continue our work to improve
414 quality of care in Ohio, reduce costs, and truly inform Ohio
415 health care system.

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416 Thank you for allowing me the opportunity to testify
417 before you today, and I would be happy to answer questions
418 that you have at the chairman's request.

419 [The prepared statement of Ms. Taylor follows:]

420 ***** INSERT 2 *****

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|
421 Mr. {Pitts.} The Chair thanks the gentlelady for her
422 statement and recognizes Dr. Collins for 5 minutes for an
423 opening statement.

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|
424 ^STATEMENT OF SARA R. COLLINS

425 } Ms. {Collins.} Thank you, Mr. Chairman, for this
426 invitation to testify on the Affordable Care Act's
427 Preexisting Condition Insurance Program.

428 The major coverage provisions of the Affordable Care Act
429 go into effect in January 2014, providing new insurance
430 options for people without health insurance and sweeping new
431 insurance market reforms to protect people who must buy
432 health plans on their own. The Congressional Budget Office
433 projects the combination of new federal subsidies for
434 insurance and consumers protections will newly insure at
435 least 27 million people by 2021.

436 The PCIP program was one of several provisions of the
437 law that went into effect in 2010 aimed at providing a bridge
438 to 2014 for people have been particularly at risk of being
439 uninsured or poorly insured. About 135,000 previously
440 uninsured people with health problems who are not able to
441 gain coverage in the individual market because of their
442 health have enrolled in the PCIP program since 2010. The

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443 program has succeeded in providing transitional support for
444 thousands of people who were uninsurable in the individual
445 market. The 50-State program provided more affordable
446 coverage than people could gain in most existing State high-
447 risk pools which operated in only 35 States and, unlike most
448 State high-risk pools, the PCIP program offered immediate
449 coverage of preexisting conditions.

450 But the program's limitations were expected from the
451 outset and demonstrate why high-risk pools in general are an
452 inadequate substitute for the comprehensive insurance market
453 reforms and expanded health insurance options to go into
454 effect under the Affordable Care Act next January. The
455 PCIP's low enrollment relative to the millions of uninsured
456 Americans with serious chronic health problems reflects the
457 program's lack of premium subsidies. This means that its
458 potential benefits are out of reach for the vast majority of
459 the population. Seventy-nine percent of the estimated 7
460 million people who have a high-cost health problem who have
461 been uninsured for at least six months have annual incomes of
462 less than 400 percent of poverty. Half have incomes of less
463 than 200 percent of poverty. In the Texas PCIP program, the

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464 annual premium for a plan with a \$2,500 deductible is about
465 \$3,800. For a person with an income of about \$11,000, the
466 premium would comprise one-third of his income and the
467 deductible 22 percent of his income.

468 Like the existing State high-risk pools, premiums in the
469 PCIP have run well short of claims cost. Jean Hall and
470 Janice Moore found that medical claims relative to premiums
471 or the medical loss ratios in both State high-risk pools and
472 the PCIP program exceed 100 percent but that the PCIP medical
473 loss ratios are as much as seven times that of high-risk
474 pools in some states. This difference in medical spending
475 between the two risk pool programs is likely because the PCIP
476 program provides immediate coverage of people's health
477 problems. Combined with the fact that people must be
478 uninsured for 6 months, this has likely led to an
479 overrepresentation of people in the program with serious
480 health problems that have gone untreated for a long period of
481 time. The top four diagnoses or treatments in the federal
482 PCIP program are cancers, heart disease, degenerative bone
483 diseases, and follow-up care after major surgery or cancer
484 treatments. These conditions comprise more than a third of

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485 claims costs in the federal program.

486 The experiences of both the PCIP program and the State
487 high-risk pools demonstrate the profound inefficiency of
488 segmenting insurance risk pools. Without the benefit of a
489 broad and diverse group of insured people, both programs
490 operate at a considerable loss and depend on federal and
491 State financing to fund the enormous gap between premiums and
492 claims cost. Still, because of the high premium costs, both
493 programs suffer from low enrollment.

494 The Affordable Care Act's insurance market reforms take
495 effect next year, making it possible for people with health
496 problems or who are older to purchase a health plan with a
497 comprehensive benefit package. The expanded eligibility for
498 Medicaid and premium tax credits for private plans sold
499 through the new insurance marketplaces means that people with
500 low and moderate incomes with health problems will face far
501 lower premiums than they do now in the PCIP program. For
502 example, a 50-year-old man with an income of \$23,000 would
503 contribute about \$1,400 annually for a private plan offered
504 through the State insurance marketplaces next year. In
505 contrast, annual premiums for 50-year-olds at this income

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506 level in the PCIP proceed exceed this contribution by nearly
507 two times in Virginia, which has the lowest PCIP programs, to
508 more than 10 times in Alaska.

509 Starting in January, enrollees from both the PCIP
510 program and the State high-risk pool will join millions of
511 new enrollees in the new State insurance marketplaces with a
512 diverse age and health profile, which will help spread the
513 costs of care across a much broader risk pool.

514 One of the central goals of the Affordable Care Act is
515 to pool risk in insurance markets far more broadly than is
516 the case today. Extensive segmentation of risk in insurance
517 markets has fueled growth in the number of uninsured
518 Americans over the past several decades. The experience of
519 both the PCIP program and the State high-risk pools
520 underscores why a shared responsibility for health care costs
521 across the population and the lifecycle is essential for an
522 equitable and efficiently run health insurance system. Thank
523 you.

524 [The prepared statement of Ms. Collins follows:]

525 ***** INSERT 3 *****

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|
526 Mr. {Pitts.} The Chair thanks the gentlelady.
527 Mr. Pollack, you are recognized for 5 minutes for an
528 opening statement.

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|
529 ^STATEMENT OF RON POLLACK

530 } Mr. {Pollack.} Thank you, Chairman Pitts. Thanks for
531 your graciousness in hosting this hearing, and thank you, Mr.
532 Vice Chairman, Dr. Burgess, for this hearing.

533 Preexisting conditions obviously are a very important
534 matter with respect to what we should do for the large number
535 of people who are affected by it. I took a look at the
536 statistics for Texas and Pennsylvania to get a sense of how
537 many people have preexisting health conditions. I looked at
538 the totality of them. So in Pennsylvania, more than one out
539 of four people from birth through 64 have a preexisting
540 health condition. In Texas, it is 22.5 percent. Obviously,
541 the older you get, those between 45 and 64, in Pennsylvania,
542 it is 48 percent; in Texas, it is 46.4 percent.

543 Now, we are obviously not talking about all these people
544 in this hearing, and that is because most of them get
545 protection because they have employer-sponsored insurance,
546 and we think that is good. So what do we do with respect to
547 employer-sponsored insurance and what can we learn from that?

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548 Well, in employer-sponsored insurance, we do not deny
549 coverage to people because they have a preexisting condition,
550 and we think that is good. Employers don't typically ask new
551 employees, do you have diabetes, do you have a history of
552 cancer, do you have heart problems, and they don't charge
553 discriminatory premiums based on health status, and we think
554 that is good. We don't deny coverage for clinical care that
555 may relate to one's preexisting condition, and we think that
556 is good. We don't charge a prospective woman employee a
557 higher premium because she is more likely to be pregnant than
558 one of her male colleagues, and we think that is good. We
559 don't charge those of us who have a few gray hairs a whole
560 lot more in terms of premiums because of our age, and we
561 think that is good. And for workers who have difficulty
562 paying for premiums, say, a middle-class worker who might be
563 getting a salary of \$60,000 and yet family health coverage
564 now averages over \$15,000, one-fourth, we provide them with
565 help. Employers provide and pay for a substantial part of
566 the premiums, and we think that is good.

567 Well, as more and more people lose employer-sponsored
568 insurance, either because employers are finding it too

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569 expensive or more employees are going into part-time work or
570 functioning as contractors, I think there is a lot we can
571 learn from that, and the Affordable Care Act helps us do that
572 because in the individual marketplace, what the Affordable
573 Care Act will say just like we do with employer-sponsored
574 insurance, you are not to deny coverage due to a preexisting
575 conditions. You are not to charge a discriminatory premium
576 because of your health status. You are not supposed to deny
577 clinical care to somebody that fits with their health care
578 problems. We will not charge women a discriminatory premium.
579 We are going to limit the differential in what is paid and
580 what people who are older have to pay as premiums compared to
581 younger people. And we provide premium support for those
582 below 400 percent of poverty. And by the way, with respect
583 to premium support, in Pennsylvania there will be 896,000
584 people eligible for premium support come January 1. In
585 Texas, it will be 2.6 million people.

586 The point of all this is that the Affordable Care Act
587 creates systemic change starting January 1 that is truly
588 responsive to the needs of those people who have preexisting
589 conditions, and while we support changes that would enable

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590 those people who right now during this transition period
591 cannot get into the PCIP program, that should not be done by
592 undermining the more permanent changes that should be made
593 and will be made under the Affordable Care Act.

594 Ms. Zurface talked about two different changes in her
595 testimony, about there no longer being a 6-month wait and the
596 need for premium assistance. We agree with her. Of course,
597 those things would occur starting January 1. So our hope is
598 that there will be clear recognition that come January 1, we
599 have a much better way to deal with those folks who have got
600 preexisting conditions and it will work in a way that is
601 truly helpful to them.

602 [The prepared statement of Mr. Pollack follows:]

603 ***** INSERT 4 *****

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|
604 Mr. {Pitts.} All right. The Chair thanks the gentleman
605 for his opening statement and recognizes Mr. Miller for 5
606 minutes for your opening statement.

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|
607 ^STATEMENT OF THOMAS P. MILLER

608 } Mr. {Miller.} Thank you, Chairman Pitts, Vice Chairman
609 Burgess and members of the subcommittee for the opportunity
610 to speak today on protecting America's sick and chronically
611 ill.

612 Preexisting condition insurance plans, or PCIPs,
613 represented a poorly designed, halfhearted gesture within the
614 Affordable Care Act. It was aimed primarily at minimizing
615 political risks rather than addressing a serious problem more
616 immediately and comprehensively. PCIP coverage served more
617 as a cosmetic match to cover the consequences of slow
618 implementation of complex coverage provisions scheduled to
619 begin nearly 4 years after enactment of the ACA.

620 The program never received sufficient funding to do its
621 job seriously. The relatively small amount of funding and
622 limited attention to the program's structural details
623 appeared to conflict with the exaggerated rhetoric of the
624 Obama Administration in claiming that the extensive problems
625 of lack of coverage for tens of millions of Americans with

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626 preexisting health conditions were the primary political
627 rationale for enacting the ACA's regulatory coverage and
628 financing provisions.

629 The political ideology behind the core policies of the
630 ACA to install guaranteed issue, community rating, mandated
631 coverage, richer standard benefits and federal regulation of
632 health insurance trumped targeting the smaller but
633 significant problem of several million Americans with limited
634 or no insurance coverage due to serious preexisting health
635 conditions and addressing it more effectively.

636 The PCIP program managed to solve less of the problem,
637 enrolling fewer Americans than traditional State high-risk
638 pools had enrolled but at a higher per-person cost while
639 still running out of money. Pretty good for government work.
640 At the same time, it discouraged continuation beyond 2013 of
641 better tested State alternative mechanisms, the better-funded
642 high-risk pools. By setting its premiums for all at no more
643 than standard rates, contrary to the better practices of the
644 older State high-risk pools, or HRPs, and also imposing a 6-
645 month spell as uninsured to qualify for coverage, PCIP only
646 succeeded in mostly enrolling very desperate high-cost

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647 individuals who had no other alternatives for coverage.

648 Now, States administering pre-ACA HRPs did a better job
649 by charging enrollees somewhat higher premiums, offering less
650 comprehensive coverage and focusing on those individuals who
651 presented the most serious and costly medical conditions.

652 However, they too still need more robust sources of funding
653 to do their job more thoroughly and effectively. But
654 remember, simply trying to average or hide the same total
655 health care claims costs across a somewhat wider base--that
656 is the ACA approach--it may redistribute them but it doesn't
657 reduce those costs. If the forthcoming health exchanges are
658 plagued by premium spikes, implementation misfires, limited
659 enrollment and adverse selection, they may end up more
660 closely resembling somewhat larger versions of State-level
661 PCIPS than more competitive alternatives to the current
662 private insurance market.

663 Policymakers should consider the following ten points.
664 One, recognize that health care markets are local, not
665 national. So too are problems for persons with high-cost
666 conditions. Two, the rhetoric of delegating administration
667 of sensitive health policy provisions to State governments

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668 needs to be matched by the reality of federal officials
669 letting go of tight reins and trusting State officials with
670 more discretion over eligibility, benefits and appeals
671 issues, within much broader outcome-oriented federal
672 parameters. Three, be very cautious about imprecise
673 estimates, and they are often guesses, regarding the scale,
674 scope and costs of the medically uninsurable and others with
675 inadequate resources to handle very high-cost/high-risk
676 health conditions. Four, we should commit a generous amount
677 of a series of capped annual appropriations to support
678 continued operations of state HRPs and/or restructured PCIPs,
679 to be revisited upon subsequent evidence of larger enrollment
680 demand or higher but medically necessary costs. Five,
681 publicly subsidizing the high-cost tail of health risks can
682 strengthen the rest of the private health insurance market.
683 Six, raise unsubsidized premiums charged for most enrollees
684 in high-risk pool plans to at least 150 percent of standard
685 rates, but then provide income-based subsidies for lower-
686 income people. Separate the issue of income support from that
687 of protection against losing or lacking coverage solely due
688 to elevated personal health risk. Seven, complementary

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689 policy reforms can help such as better portability from group
690 to individual market provisions with creditable coverage, no
691 requiring exhaustion of COBRA benefits, retargeting premium
692 subsidies, and building information transparency mechanisms
693 that reward better patient choices and provider practices.
694 Eight, keep as many older state HRPs as possible in business
695 after 2013, as an insurance policy against major problems in
696 exchange implementation and individual mandate enforcement or
697 compliance. Allowing such coverage to be considered qualified
698 insurance under ACA would minimize post-2013 disruptions in
699 the continuity of coverage and care. Nine, if the overall
700 costs of health care don't rise more slowly, and individual
701 incomes don't rise more rapidly in the near future, no amount
702 of subsidized insurance tinkering can keep up with the larger
703 problem. Finally, the preexisting condition issue is still a
704 largely limited, modest problem. Solve it instead of using
705 it as a political excuse to politically hijack the rest of
706 the private insurance market. Thank you.

707 [The prepared statement of Mr. Miller follows:]

708 ***** INSERT 5 *****

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|
709 Mr. {Pitts.} The Chair thanks the gentleman and thanks
710 all the witnesses for their opening statements, and I will
711 now begin questioning and recognize myself 5 minutes for that
712 purpose.

713 Mr. Miller, let us just continue with you. You have
714 given us a great list. When Obamacare was enacted into law,
715 you wrote that the program was designed in a way that would
716 lead to inevitable problems. What are the principle
717 features, if you could name a couple, of PCIP that led you to
718 believe that the program would run out of funding?

719 Mr. {Miller.} The program was weighed down by the
720 larger overall program, but within the provisions of PCIP,
721 the two core provisions, of course, are designing it with the
722 6-month requirement for uninsured coverage, which created a
723 flaw in it from the start, and secondly, the massive
724 underfunding relative to what the potential range of the
725 problem was. The only reason why some budget estimates said
726 well, we might get under the wire on this, CBO simply said,
727 well, they will close down the program when they run out of
728 money, and the actuary who readjusted a little bit of the

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729 original program from HHS basically said the same thing.
730 They have provisions written into the law for the PCIP
731 administrators or HHS to carry out the worst practices of the
732 private insurers they blame, which is as soon as we run out
733 of money, we hollow out the benefits, we close the doors, and
734 therefore we have met our budget, and it is not surprising
735 that we got there. Maybe we got there a little later because
736 it was a slow take-up but in essence it was a program
737 designed to have an early expiration date on the coverage.

738 Mr. {Pitts.} Thank you.

739 Governor, you mentioned a number of administrative
740 problems and litigation. Are you still having administrative
741 problems with the feds or with HHS regarding the
742 administration of your pool? Is all the litigation solved?

743 Ms. {Taylor.} The most recent lawsuit has. We have
744 come to an agreement on the resolution of that. As I did say
745 in my testimony, we are pleased that the Department of
746 Insurance continues to be seen as the regulatory arm of
747 health insurance in Ohio, at least as it relates to the High
748 Risk Pool, so at this point the two major issues that we
749 face, both the rate issue in 2011 and protecting consumers

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750 and protecting consumers' coverage in Ohio have both been
751 resolved.

752 Mr. {Pitts.} Thank you.

753 Ms. Zurface, can you describe your thoughts at the time
754 when you found out that PCIP was not an option due to HHS
755 closing the program to new applicants?

756 Ms. {Zurface.} I can try. It was sort of an
757 interesting experience for me. I had, as I indicated in both
758 my written and my oral testimony, started in February trying
759 to figure out how I would now begin to finance this very
760 expensive health venture, and one of the things that I came
761 across was the Ohio High Risk Pool insurance. I saw my
762 specialist at the end of February, and at that time my
763 specialist indicated to me that he would like for me to enter
764 into a clinical trial that is having very good results for
765 lenalidomide in the treatment in my specific chronic
766 lymphocytic leukemia, which is chemotherapy resistant and a
767 bit more aggressive due to chromosomal mutations. So he had
768 suggested that I go ahead and enter into that clinical trial
769 at this time. I actually took some time to step back from
770 that, being basically healthy at this point, and said I think

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771 I want to take a little bit of time and watch my numbers and
772 see exactly what this cancer is doing inside my body and what
773 I need to do to manage it at this time. It was within about
774 a week and a half, 2 weeks from that point in time that I
775 found out that maybe I don't have the time to step back and
776 do that because if I don't enter into that clinical trial
777 sooner rather than later, then it is likely that that trial
778 will fill up and there won't be any type of reasonable,
779 affordable treatment option available for me. So I really
780 had to step back and assess what I am going to do with regard
781 to my health care condition at this time.

782 Mr. {Pitts.} Now, because you are self-employed and not
783 able to work at this time, as I understand it, your
784 treatments are covered by Ohio's Hospital Care Assurance
785 Program. Is that correct?

786 Ms. {Zurface.} At this time, as long as I take my care
787 through Ohio State Medical Center, I do qualify under their
788 regulations for the HCAP program, and in fact, there is a
789 separate program administered for OSU physicians. So as long
790 as the part of my care that is managed at OSU Medical Center
791 is actually covered on a quarterly review basis, so each

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792 quarter they will flag my status and I will have to resubmit
793 income, profit and loss information for that.

794 Mr. {Pitts.} So long as your income remains below a
795 certain level, this program will cover you?

796 Ms. {Zurface.} Yes, sir.

797 Mr. {Pitts.} And are you saying that it would be more
798 beneficial for your health to not work and be covered by HCAP
799 than to work full time and surpass the income minimum and
800 have no coverage at all?

801 Ms. {Zurface.} I would argue that it is never more
802 beneficial for my health for me to not be working. Both
803 mentally and physically, it is better for me to be as active
804 as I possibly can be. From a financial standpoint, it may
805 look like at least on paper that it would be more beneficial
806 for me to choose not to work or at least not to work at a
807 full capacity in order to maintain health care.

808 Mr. {Pitts.} My time is expired. I have a lot more
809 questions for you but let us go to the vice chairman, Dr.
810 Burgess, for 5 minutes for questions.

811 Dr. {Burgess.} Thank you, Mr. Chairman.

812 Ms. Zurface, let me just ask you, you are an attorney.

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813 I actually am a physician in my previous life. So we both
814 are in professions that are--we went into them to help
815 people, and if I understand your testimony correctly, you in
816 fact function as a public defender at some point. Is that
817 correct?

818 Ms. {Zurface.} Somewhat. The program that we have in
819 my county is called court-appointed counsel. All of the
820 attorneys in our area that practice criminal law actually
821 serve as court-appointed counsel, but it is very similar to
822 the public defender program.

823 Dr. {Burgess.} And you of course are paid for that
824 work, are you not?

825 Ms. {Zurface.} I am.

826 Dr. {Burgess.} And where does that payment come from?

827 Ms. {Zurface.} That money comes out of the county fund.
828 Our county commissioners establish an hourly rate for our
829 court-appointed counsel.

830 Dr. {Burgess.} Well, wouldn't it be better if the
831 federal government just took that over and we paid you for
832 that?

833 Ms. {Zurface.} Oh--

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834 Dr. {Burgess.} You don't have to answer.

835 Ms. {Zurface.} I was just going to say--

836 Dr. {Burgess.} It is rhetorical.

837 Ms. {Zurface.} --it is a rhetorical question. I wonder
838 how the federal--where that money would come from with regard
839 to the federal government and why would it be better if the
840 federal government--

841 Dr. {Burgess.} The same place all of the money comes
842 from. Take it from someone else at the point of a spear and
843 they give it to us willingly after we threaten them with
844 lifetime incarceration and the impounding of all their
845 personal property.

846 But Lieutenant Governor, your discussion of how
847 difficult it is to work with Health and Human Services and
848 the Centers for Medicare and Medicaid Services, to me, that
849 would be an argument against the federal government taking
850 over that program that the county is so ably administering
851 and taking care of those people who get into trouble with the
852 law but are too indigent to afford their own lawyer. Would
853 that be a correct assumption?

854 Ms. {Taylor.} Mr. Chairman, Dr. Burgess, yes. Our

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855 experience specifically with the High Risk Pool working with
856 HHS, working with the federal government, has proven to be
857 less than rewarding. I think States are well prepared to
858 regulate insurance as we have done for, you know, decades,
859 and I think that these types of issues are best addressed
860 closer to home where you can react quicker and in a more
861 thoughtful way with regard to market changes, economic
862 conditions, the needs of your citizens. It is a long way of
863 saying yes.

864 Dr. {Burgess.} Yes, you can react quicker, and that is
865 important, and you know the people with whom you are dealing.
866 I mean, your State is arguably a little different from my
867 States, and the needs and the things that would need to be
868 met for the constituents might be different in the two
869 States, and you are in a position and your counterpart in my
870 State would be in a position to have the facility to be able
871 to make those decisions on a much more real-time basis.

872 I just have to tell you, I sat down with your
873 counterpart in my State on Monday, and of course, this is a
874 little far afield from what we are talking about today but
875 the Medicaid expansion, which is being much discussed, and

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876 the litany of complaints that come forward from the State
877 folks about trying to deal with the Centers for Medicare and
878 Medicaid Services. They have created a regime over there
879 which is almost impenetrable. So it is any wonder that no
880 one at the State level wants to buy--they don't want to buy
881 any more of that. They have had enough of it, and I
882 certainly understand that.

883 Mr. Miller, I remember back to 2008, and we actually
884 talked about this issue of the State risk pools a lot back in
885 that year, as I recall. I don't remember why we discussed it
886 but we did, and I got to tell you, I was a little bit
887 encouraged after the summer town halls of 2009 that I alluded
888 to, and those were somewhat rough events, but we came back to
889 Washington in September and the President was going to
890 address a joint session of the House and Senate, and I
891 thought, oh, good, they have realized the error of their ways
892 and they are going to put the pause button on here and we are
893 going to hit the reset button, but alas, I was mistaken. It
894 was fast forward, if anything.

895 But one of the things the President said that day that
896 really got my attention or that night and it really got my

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897 attention was that Senator McCain was right with his approach
898 to helping people with preexisting conditions and this
899 expansion of the State pools and reinsurance, that might be
900 the way to go, and I thought for a brief moment there was a
901 glimmer of understanding but what do you think happened?

902 Mr. {Miller.} Well, they had some of the music but not
903 all the lyrics. Consensus is often a mile wide and an inch
904 deep in those type of things, and that was in a compromise
905 moment to try to get some type of legislation through while
906 bowing in the direction of temporary bipartisanship. There
907 are always seeds of agreement between the two sides and then
908 we kind of get overpowered by broader imperatives to get it
909 all and to implement your program and get it, you know,
910 comprehensive. You can find Republicans and Democrats
911 agreeing we need to help people who are in desperate straits,
912 who can't help themselves. We need to be generous and kind
913 and compassion as a good society. But there is a difference
914 between doing that and running everybody else's life in micro
915 detail, and that is what we got as kind of--you know, the
916 loss leader was, well, we will do some things for some people
917 we can give you an anecdote about, but meanwhile, look at the

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918 rest of what the law is going to do. It is turning upside
919 down what are the arrangements that people are quite happy
920 with and would like to continue and you are going to be in a
921 different world within a year. All these ideas that somehow
922 waves of happy, young and healthy people will be ready to pay
923 twice as much in their insurance premiums and everyone will
924 come out ahead and everybody will be subsidized, it is not
925 going to work that way, and that is the problem in trying to
926 shoehorn people into theoretical arrangements that don't
927 match their preferences and practices.

928 Dr. {Burgess.} Thank you, Mr. Chairman.

929 Mr. {Pitts.} The Chair thanks the gentleman. We are
930 going to continue with another round. We have got lots of
931 questions here.

932 Let me continue with you, Ms. Zurface. What do you plan
933 to do now that funding for the new enrollees in the PCIP
934 program has been pulled by HHS?

935 Ms. {Zurface.} I am going to take it one day at a time.
936 I have no choice but to continue with my medical care, so I
937 am going to continue making my appointments and managing my
938 care as best I can, do my very best to not incur great

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939 expense to myself and see what is available for me, and I
940 will take advantage of the HCAP program and any similar
941 program that is available. I will take advantage of whatever
942 the Leukemia and Lymphoma Society is able to offer. I will
943 just take it one step at a time.

944 Mr. {Pitts.} The added burden of not knowing if your
945 CLL treatments will be covered must add unneeded stress to
946 your life as a single mother, does it not?

947 Ms. {Zurface.} It sure does.

948 Mr. {Pitts.} Mr. Miller, after HHS's announcement that
949 new applicants would be shut out of the preexisting condition
950 program, we sent a letter to the President asking to work
951 together to redirect funding in the President's health care
952 law to ensure that no sick American is turned away, and as I
953 mentioned, 1 month year we have yet to hear from the
954 President. My understanding is at the time of enactment,
955 roughly 18 programs in PPACA received greater or comparable
956 funding than the preexisting condition program. Couldn't
957 this funding such as the mandatory appropriations in the
958 Prevention and Public Health Fund provide the resources to
959 help enroll new individuals in a high-risk pool program?

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960 Mr. {Miller.} It could certainly help contribute to it.
961 The Administration apparently has broader priorities which
962 look more at 2014 than what people are going through in 2013.
963 I know some of the money has been taken out of the Prevention
964 and Public Health Fund for the doctor fix, so it is a bit of
965 a basket that gets raised several times. There might be, I
966 think, \$8 billion or \$9 billion, depending on how you want to
967 count it, for the remaining authorization. That could
968 certainly make a contribution to provide real relief of a
969 tangible nature. A lot of the stuff in the Prevention and
970 Public Health Fund is a little bit more on the exotic side.
971 It could be done in the right way but we don't have much
972 evidence that is actually working in that manner. It is a
973 little bit more of a political slush fund. So that would
974 provide some means of a contribution.

975 We will need more money than that if you wanted to do
976 this on a longer-term basis, and I think there have been
977 previous proposals for more enhanced funding in a different
978 environment, and I am not sure if the votes are there to get
979 that right now. But when you are looking at people who have
980 a very identifiable condition--you know, these are the folks

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981 who you would want to put into a special-needs plan. We know
982 they have got a serious condition. They need actually more
983 intensive medical management. You would like to coordinate.
984 You have already identified the population. It is going to
985 cost money to subsidize them. That is something we should do
986 and that should be a higher priority perhaps than subsidizing
987 everyone's insurance all the way up to 400 percent of the
988 federal poverty level. But that is a different political
989 agenda than helping the most unfortunate people right now in
990 ways that can help.

991 Mr. {Pitts.} Dr. Collins, in your opening statement you
992 said that PCIP provided immediate coverage for preexisting
993 conditions. However, this leaves out an important context.
994 Didn't the ACA require patients to be uninsured for 6 months
995 before they became eligible for PCIP?

996 Ms. {Collins.} Right, so the intent of the PCIP program
997 was to provide immediate coverage for people who had been
998 uninsured for a long period of time, or at least 6 months,
999 and to immediately cover their preexisting conditions. As
1000 Mr. Miller pointed out, most State high-risk pools do not
1001 cover your preexisting condition right away, so the intent of

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1002 the law was to cover people's conditions immediately. The
1003 intent was also to provide insurance coverage to people who
1004 didn't have health insurance coverage, so that was very clear
1005 in the law. It was designed as a transitional provision so
1006 that people who are uninsured who had immediate health care
1007 needs could get coverage over this 3-year period.

1008 Mr. {Pitts.} Well, Ms. Zurface's testimony indicates
1009 that this requirement had real effects on patients
1010 desperately seeking coverage for a preexisting condition.
1011 Didn't this requirement essentially force patients to let
1012 their conditions deteriorate while they waited for the ACA's
1013 arbitrary 6-month waiting period to run out?

1014 Ms. {Collins.} It was certainly difficult for people
1015 who had to wait to get coverage. It is one of the
1016 characteristics of our current insurance system that will go
1017 away next year where people are prevented from pursuing
1018 careers like Ms. Zurface is right now in terms of having more
1019 flexibility in their jobs, their educational pursuits because
1020 they have to not make above a certain amount of money to
1021 maintain their health insurance coverage. All that goes away
1022 in January so that people don't have restrictions on what

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1023 they can do anymore in their careers just to maintain their
1024 health insurance coverage. So this was again a transitional
1025 provision. There were several transitional provisions in the
1026 law. This wasn't the only one--the ban on lifetime benefit
1027 limits, the phase-out of annual limits on what health
1028 insurers can place on your benefits, so this was part of a
1029 large number of provisions that went in right away that did
1030 provide coverage to a lot of people who really needed them--
1031 young adults. About 6 million young adults came on to their
1032 parents' policy over the last year. So they were in no way
1033 designed as the endpoint in the provisions but as really a
1034 beginning point.

1035 Mr. {Pitts.} I wanted to get one more question in. Mr.
1036 Pollack, does it concern you that the Administration has cut
1037 off funding for this program?

1038 Mr. {Pollack.} Obviously I would like to make sure that
1039 everybody who has a preexisting health condition can get
1040 coverage, and it is very concerning that people who have a
1041 preexisting condition like Ms. Zurface are right now without
1042 the opportunity to get the coverage they need. But what is
1043 very important in terms of the compassion that we have all

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1044 talked about with respect to people with preexisting
1045 conditions is that come January 1, all these problems are a
1046 thing of the past. People are not going to have to wait 6
1047 months in order to get coverage. People are no longer going
1048 to be put in a totally different people just because they
1049 have got a health problem. People are no longer going to be
1050 charged a discriminatory premium because they have got a
1051 health problem. So to the extent that you, Mr. Chairman and
1052 Mr. Vice Chairman, are interested in fixing this temporary
1053 problem with additional funds, we support that, but not by
1054 undermining the long-term architecture of the legislation
1055 which is going to be far more effective than this temporary
1056 measure.

1057 Mr. {Pitts.} Thank you. My time is expired. Dr.
1058 Burgess, you are recognized for another 5 minutes, second
1059 round.

1060 Dr. {Burgess.} Undermining the long-term architecture.
1061 Well, that is an elegant of talking about something when in
1062 reality what we should have been told 3 years ago before this
1063 thing was signed was the dog ate my homework so I am going to
1064 turn in the rough draft, and Ms. Zurface in her testimony

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1065 talks about how this particular provision was not in the bill
1066 that passed this very committee on the House side in July of
1067 2009 but it was added. The Senate Finance Committee staff
1068 added it. In fact, most of this was written by the Senate
1069 Finance Committee staff. It wasn't even written by
1070 legislators. And the thing was rushed through on Christmas
1071 Eve. There was a big snowstorm coming to town and the
1072 Senators wanted to get home for Christmas so they had to vote
1073 on it. And they voted, and they got 60 votes for the
1074 Affordable Care Act.

1075 Now, everybody felt--I am sure Chairman Waxman if he
1076 were here would tell us that he was working on the conference
1077 committee even before Christmas and New Year's that year, and
1078 he was preparing himself for the conference committee. The
1079 President came to the Democratic retreat that year and all
1080 the discussion was how we are going to get this ironed out
1081 even before the conference and we will get a bill that both
1082 the House and the Senate can support. But it didn't happen,
1083 did it? Because there was a special election in
1084 Massachusetts. Scott Brown was elected, the first time a
1085 Republican was elected from Massachusetts since the Earth

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1086 cooled the first time, and there were no longer 60 votes in
1087 the Senate. So Harry Reid told Nancy Pelosi this is it, this
1088 is what you get, I can't change it. So most people don't
1089 realize this. H.R. 3590 was the bill that was voted on on
1090 Christmas Eve. Thirty-five ninety was passed by the House of
1091 Representatives in July of 2009 but it wasn't a health care
1092 bill then, was it? It was a veterans' housing bill. A
1093 veterans' housing bill passed the House. I don't think many
1094 people voted against it. It went over to the Senate, sat in
1095 the hopper, and then it was amended, and the amendment read
1096 ``Strike all after the enacting clause and insert'' and this
1097 was what inserted.

1098 So here you had a bill that had passed the House in a
1099 different form, passed the Senate, came back over to the
1100 House, and if you don't change anything, you can sign it into
1101 law, and that is what the next 3 months was all about: how
1102 to convince enough Democrats to vote for really what was a
1103 rough draft. It would never have done what this thing has
1104 done to Ms. Zurface if it had been fixed but there was not
1105 the ability to fix it because there weren't 60 votes for any
1106 type of fix in the Senate. It was the very worst type of

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1107 process that gave rise to the very worst type of policy and
1108 then for reasons that I will never understand got signed into
1109 law, and we are having to deal with it, and we can see it
1110 affects real people in very profound ways.

1111 Now, I would submit that the letter that the chairman
1112 referenced to the President, and I realize it is just a band-
1113 aid on a problem, Mr. Miller, but the Prevention and Public
1114 Health Fund, yeah, we have raided it for a lot of things--
1115 trade promotion authority, doc fix--so let us raid it for
1116 this as well. I mean, goodness knows, it is a political
1117 slush fund. It was added, again, by Senate Finance staff for
1118 reasons that I certainly am not privy to. I think, Mr.
1119 Chairman, perhaps we can submit again to the President that
1120 he reconsider his inaction on this because we have heard
1121 testimony from compelling witnesses today that something
1122 needs to be done before we can all lay down in the Elysian
1123 Fields of the Affordable Care Act on January 1, 2014, we are
1124 going to have to deal with this, and the Prevention and
1125 Public Health Fund I think is the logical place to go. If
1126 there is not quite enough money there, then certainly let us
1127 go to the Patient Center for Outcomes and Research

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1128 Initiative. There is another place where a lot of dollars
1129 are just sitting. The Center for Medicare and Medicaid
1130 Innovation, a lot of dollars are just sitting. There is no
1131 reason to have them just sit there. Let us them let them
1132 help real people and help real people today.

1133 Now, Mr. Pollack, in your testimony you said in your
1134 calculation 68 million people have preexisting conditions,
1135 and 100,000 are now covered under the federal PCIP program.
1136 There is a bit of a discrepancy between those two numbers,
1137 isn't there?

1138 Mr. {Pollack.} Of course there is, and I explained
1139 that. The reason that--

1140 Dr. {Burgess.} And I accept your explanation.

1141 Mr. {Pollack.} --there is a discrepancy with respect to
1142 that--

1143 Dr. {Burgess.} Let me ask you the question, sir--

1144 Mr. {Pollack.} --explained right at the beginning--

1145 Dr. {Burgess.} --before my time runs out--

1146 Mr. {Pollack.} --is that most of those folks are in
1147 employer-sponsored insurance, and it has the same attributes
1148 and protections--

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1149 Dr. {Burgess.} And those very folks begged us--

1150 Mr. {Pollack.} --that will not be provided in the
1151 individual market.

1152 Dr. {Burgess.} --begged us not to disrupt what they
1153 were receiving, and it looks like we have. But let me ask
1154 you a question. If you thought that this was a serious
1155 problem that it was, was the Administration wrong in only
1156 putting \$5 billion toward this problem?

1157 Mr. {Pollack.} Would I favor more money put into this
1158 as the temporary measure? Of course I would. And I
1159 certainly would like to see the temporary problems that are
1160 significant problems that they be fixed but not by
1161 undermining, as I said before, the key architecture of the
1162 Affordable Care Act, whether it is a prevention care fund,
1163 which is very important to promote good health care. It
1164 shouldn't be sickness care; it should be health care.

1165 Dr. {Burgess.} Sir--

1166 Mr. {Pollack.} And I don't think that we should be
1167 undermining--

1168 Dr. {Burgess.} Reclaiming my time.

1169 Mr. {Pollack.} --with respect to clinical guidelines.

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1170 Dr. {Burgess.} The architecture underlying the
1171 Affordable Care Act is anything but elegant; it is bizarre.
1172 It would be the nicest way to describe it. It is macabre.

1173 And honestly, I cannot--if the money is there in other
1174 programs, Mr. Chairman, I cannot see why the President and
1175 the Secretary have not responded to what is a very reasonable
1176 request that this committee has submitted in written form,
1177 and I will just reiterate that I think they should respond,
1178 and if they don't, I believe we should ask the question again
1179 as nicely as we possibly can. I will yield back, Mr.
1180 Chairman.

1181 Mr. {Pitts.} The Chair thanks the gentleman. We are
1182 going to go to another round, if that is okay. I still have
1183 some questions. I think you do.

1184 Governor Taylor, in your testimony you state that Ohio
1185 commissioned a study to estimate the effects of PPACA on
1186 premiums when the law is fully implemented. It found that
1187 premiums will increase by as much as 85 percent. Recently,
1188 the Society of Actuaries issued a report with a similar
1189 finding, estimating that Ohio's individual market could see
1190 premium increases as high as 80 percent. Do these estimates

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1191 lead you to believe that many will forego coverage because of
1192 the ACA's costly requirements?

1193 Ms. {Taylor.} Mr. Chairman, we are clearly concerned by
1194 the changes that will be implemented starting in 2014 that
1195 are going to very severely negatively impact the cost of
1196 premiums in Ohio. Both studies are somewhat consistent in
1197 that premiums in our individual market will rise by as much
1198 as 85 percent. Of course, from a State perspective, yes, I
1199 am concerned. I would prefer to have more flexibility to
1200 come up with individual State solutions that solve Ohio's
1201 problem and Texas, solve your problem the way it best suits
1202 Texas, and I think given some flexibility, our goal would be
1203 to use a more market-based approach and help make the cost of
1204 insurance more affordable and more accessible using free-
1205 market approaches rather than providing federal subsidies
1206 that I think the High Risk Pool must somewhat look at what we
1207 might expect in the future where you have premiums being
1208 artificially held down by companies who are pressured by HHS
1209 and then ultimately premiums aren't covering the cost of the
1210 type of care that is being provided, and as a regulator, one
1211 of our primary concerns is, of course, solvency of the

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1212 companies. Consumers are severely harmed if companies don't
1213 have enough capital or reserves to stay in business to pay
1214 those claims and ultimately it is the consumer who will
1215 suffer. So my preference would be back to a market-based
1216 approach that reduces the cost of premiums for everyone and
1217 makes it more affordable and more accessible that way.

1218 Mr. {Pitts.} Would you continue to elaborate on what
1219 efforts Ohio is undertaking to reform health care in Ohio?

1220 Ms. {Taylor.} Yes, Mr. Chairman. Well, as I stated in
1221 my testimony, unfortunately, a lot of what we see in the ACA
1222 is not dealing with the root of the problem which is how you
1223 actually drive down the costs of health care. Really, it is
1224 more just insurance regulation or changes in insurance
1225 regulation. In Ohio, we have our Medicare and Medicaid
1226 groups working together so that they are coordinating the
1227 coverage of individuals that are eligible under both plans in
1228 order to save money. We have an office of health
1229 transformation that is working with individual providers,
1230 hospital providers across the country to help better
1231 coordinate care between those that receive services for
1232 mental health, for example, and then also how they receive

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1233 services for physical health, doing a better job of
1234 coordinating those services to help drive down costs using
1235 technology to look at how we provide better care for
1236 patients, higher quality at lower cost. So working both on
1237 the Medicaid side but also then working on the private-sector
1238 side by partnering with providers across the State. And
1239 ultimately it has allowed us to hold down the increases that
1240 we would have otherwise seen in Medicaid so that we can have
1241 more flexibility with how we manage the Medicaid program and
1242 also the Governor has broken out in this most recent budget
1243 separately identified our Medicare director as a cabinet-
1244 level director versus working for a different agency.

1245 Mr. {Pitts.} Now, based on the problems you have dealt
1246 with already, could similar regulatory problems occur? Do
1247 you foresee your State having additional problems with the
1248 implementation of the Affordable Care Act once the law is
1249 fully implemented?

1250 Ms. {Taylor.} Mr. Chairman, I guess if we look back at
1251 our experience with the High Risk Pool, and I guess the
1252 statement is pretty much true that if you want an indication
1253 of the future, look at the past. Of course, we are concerned

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1254 about disagreements with federal regulators both as a State
1255 regulator but then how does that impact consumers?
1256 Ultimately it impacts consumers, impacts companies, creates
1257 uncertainty in the market, which makes it much more difficult
1258 from an administrative perspective for all of us to deal with
1259 the difficult issues.

1260 Of course, we are concerned about the premium increases
1261 and the costs that that will bring. If you look at Ohio's
1262 High Risk Pool just as an example, we have about 3,500 people
1263 covered in our High Risk Pool and the costs ultimately we are
1264 projecting, costs being paid for by the federal government,
1265 somewhere between \$135 million and \$140 million to provide
1266 subsidies for that care. So of course, we have a cost issue.
1267 And then of course, I have already stated the concern we have
1268 with artificially holding down premiums that ultimately puts
1269 at risk the companies that are there to pay the provider
1270 claims and pay the claims for consumers.

1271 Mr. {Pitts.} Thank you. I want to sneak one more
1272 question in here.

1273 Ms. Zurface, your situation is not a special case. Can
1274 you talk a little bit about the number of patients who you

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1275 reference in your written testimony who are facing the same
1276 government barriers as you do?

1277 Ms. {Zurface.} My situation is not a special case, and
1278 I think that is why I am is because it is becoming almost the
1279 rule as opposed to the exception, especially now that there
1280 is not the funding available for this preexisting condition
1281 insurance program available right now. I believe that we
1282 submitted about eight different testimonies in the written
1283 transcript that was provided to you. Each one of people is
1284 obviously too sick to be before you today, which is why I am
1285 representing those people as well. The problem that we have
1286 in trying to identify how many people are being affected is,
1287 we are only aware of the people who are being affected when
1288 they contact us directly, so we don't know who is having
1289 trouble, who got kicked out of the program, who applied too
1290 late to be permitted into the program. We don't know those
1291 numbers right now. I do know that the Leukemia and Lymphoma
1292 Society is working on making sure that we can have additional
1293 data to submit to the committee and we would be happy to
1294 provide more written information to you, but at this time the
1295 only people that we have direct information on are the ones

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1296 whose stories are already in the record.

1297 Mr. {Pitts.} Now, how did you hear about the Leukemia
1298 and Lymphoma Society and how have they helped you through
1299 this trying time?

1300 Ms. {Zurface.} I had a magnificent experience with the
1301 Leukemia and Lymphoma Society. In 2005, shortly after my
1302 grandmother had been diagnosed with non-Hodgkin's lymphoma, I
1303 joined the Leukemia and Lymphoma Society's Team in Training
1304 and became an advocate and a fundraiser for them through
1305 cycling, so I did that for a season and then many of my
1306 friends that I met through that excursion remained advocates
1307 for Team in Training. So I was already familiar with the
1308 Leukemia and Lymphoma Society when I received my diagnosis in
1309 January, and they were one of the first resources that I
1310 looked up to determine whether there would be any type of
1311 premium assistance available in the event--as I am self-
1312 employed, one of the things that does happen is, I can't say
1313 I have X amount of dollars available for monthly income, so
1314 on a month-to-month basis my income may change and fluctuate
1315 so I may have a good month followed by a bad month, and I am
1316 sure that a lot of people who are self-employed understand

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1317 exactly what I mean by that. So what I would need is
1318 something to fall back on, a fallback position, to even be
1319 able to make those premiums on a regular basis to make sure
1320 that I don't have a lapse in care once I am able to become
1321 insured, so I was researching that issue and came back in
1322 contact with the Leukemia and Lymphoma Society, who actually
1323 provided a symposium in March in Cincinnati, and I attended
1324 that symposium and reconnected with the agency. So they do
1325 have a lot of resources available for people in my situation.

1326 Mr. {Pitts.} Thank you, and again, thank you for
1327 sharing your personal experience and representing the other
1328 patients that you have referenced.

1329 Dr. Burgess, you are recognized for another 5-minute
1330 round.

1331 Dr. {Burgess.} Thank you, Mr. Chairman. Are you sure
1332 you want to do this?

1333 Let me just ask Ms. Zurface, you are a lawyer. I mean,
1334 you followed what happened in the Supreme Court last year,
1335 and a lot of the argument that was brought against the
1336 Affordable Care Act was based upon the constitutionality of
1337 using the Commerce Clause to compel the purchase of health

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1338 insurance. Now, had the individual mandate existed for years
1339 ago, would you have had health insurance?

1340 Ms. {Zurface.} If the individual mandate had existed 3
1341 years ago, it would appear that I would have been mandated to
1342 have insurance, so by nature, yes, I would have to say I
1343 would have had insurance 3 years ago prior to the time that I
1344 would have been diagnosed with this.

1345 Dr. {Burgess.} Except that those things that were a
1346 barrier for you to purchase insurance 3 years ago would still
1347 have been a barrier. I mean, the cost. You yourself point
1348 out how your income can fluctuate quite a bit during the
1349 year. One could even visualize a scenario where at one point
1350 you might be eligible for the Ohio Medicaid expansion, under
1351 138 percent of the federal poverty level. At another point
1352 when you get a lot of work, you might be making too much
1353 money to qualify even for the subsidies in the exchange. And
1354 of course, as you know, people who then earn more income than
1355 would have allowed them to receive a subsidy. You don't know
1356 going into a year what kind of year you don't know going into
1357 a year what kind of year you are going to have, do you?

1358 Ms. {Zurface.} Not, not at all.

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1359 Dr. {Burgess.} As far as your billings and collections.
1360 So you may be eligible for a subsidy and receive the subsidy
1361 but, you know what, at the end of the year, we may ask for
1362 that subsidy back because you have had a good year. So it is
1363 not quite as straightforward as just yes, if the mandate had
1364 been there, I probably would have had insurance. The
1365 barriers would have still existed, I submit, that the very
1366 things that prevented you from purchasing that insurance 3
1367 years ago will in fact still be there for people who are now
1368 simply required to buy insurance, and some will because,
1369 well, it is the law, I got to do it, and others will no, it
1370 is still too expensive, it is still too much of a barrier,
1371 the fine is relatively modest, at least for several years for
1372 a single individual earning under a certain level, it is \$600
1373 or \$700, and yeah, if they catch me, then fine, I will pay
1374 the fine, but otherwise, I can make a payment on a bass boat
1375 for what I can buy insurance, and a lot of people are just
1376 simply going to elect not to do that. So I don't know if we
1377 changed, and Mr. Miller, you are bound to have some thoughts
1378 on the concept of whether the individual mandate will change
1379 the behavior of people who are looking at the insurance

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1380 market and are kept out of it because of some of the barriers
1381 that have been discussed today.

1382 Mr. {Miller.} Well, CBO relied upon a small sample size
1383 of Massachusetts to basically make its projections on
1384 coverage take-up, and although they have their covered their
1385 tracks a little bit since then, they were assuming that
1386 people would just be good Americans obeying the law, and the
1387 mandate as a command was a big factor in its projections of
1388 the take-up, not just the subsidies alone. They haven't
1389 really dialed back on what those assumptions are in terms of
1390 what would be the coverage from the mandate, which is now
1391 just seen as a tax, and when you see things as a tax, other
1392 people have looked at this and said well, you are going to
1393 make a financial calculation: do I pay a small tax or do I
1394 pay a much higher premium, particularly with those premiums
1395 for some individuals are going much higher than what it
1396 actually cost them in insurance. So there is a lot of
1397 skepticism as to how effective the weak mandate as it
1398 currently exists both before and after the Supreme Court,
1399 what it will really mean in terms of pushing people into
1400 coverage to pay much more than they ordinarily would pay.

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1401 Dr. {Burgess.} And there is still the safety net of
1402 community rating and guaranteed issue. You can buy the
1403 insurance in the emergency room or perhaps even in the
1404 ambulance on your smartphone on the way to the hospital after
1405 the accident.

1406 Mr. {Miller.} Correct. I mean, we have Medicaid
1407 coverage, which is actually provided after the fact, and it
1408 has been going on for some time. We have signed them in
1409 surgery actually. And certainly it depends upon--all the
1410 regs aren't there as to how they will handle the guaranteed
1411 issue under the Affordable Care Act, whether they will have a
1412 waiting period or only an enrollment period for a couple of
1413 months.

1414 Let me just take a moment, because I know we are about
1415 to finish. I sit here. I would like to stand in
1416 astonishment. Ron means well and said a lot of nice things
1417 at the hearing. I read his report last summer for Families
1418 USA in July of 2012. There was no nuance in that. It was a
1419 screaming headline: nearly 65 million Americans, you know,
1420 at risk of losing their coverage but for the Affordable Care
1421 Act. Not one word or sentence in there about all the

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1422 protections for people with employer-sponsored coverage.
1423 This problem of overshooting the mark and saying run for your
1424 lives, you are about to lose everything. HHS had a report in
1425 2009, had over 125 million people at risk. It is marked down
1426 to 65 million in Ron's report. And another by Commonwealth,
1427 12.5. When the serious people look at this and say where is
1428 the problem, you can get to about 4 or 5 million where it
1429 actually--that is where people are not getting coverage.
1430 Now, in some cases they may get a little bit of a rate-up in
1431 their premiums, but we ought to talk about where the problem
1432 is and what the dimensions are. It is a serious enough
1433 problem without exaggerating it, and then we can deal with it
1434 in a forceful, effective way. But it is used to leverage a
1435 larger agenda, which is to rope everybody into something else
1436 which we wouldn't support because you want to scare people
1437 that you are about to be at immediate risk, when that is
1438 overstated.

1439 Mr. {Pollack.} Well, it is not people--

1440 Dr. {Burgess.} I am about to run out of time. In fact,
1441 I am out of time. But Mr. Chairman, if I could, I would just
1442 like to ask a question of Dr. Collins because the issue of

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1443 cost has come up, and of course, we were tasked to fix were
1444 preexisting conditions, not messing up the system as it
1445 currently exists, and then to help people with cost. It
1446 looks like we failed on all three points, but on the aspect
1447 of cost, the Commonwealth Fund put out a paper a few months
1448 ago from Minnesota that talked about--I think you called it
1449 the activated patient where the costs were lower for someone
1450 who actually was an active participant in their care, and we
1451 had all the hearings leading up to the Affordable Care Act
1452 and we heard from experts on Medicaid and we heard from
1453 experts on this, experts on that, but we never brought on,
1454 say, Governor Mitch Daniels from Indiana, who with his
1455 Healthy Indiana plan and creating that activated patient
1456 population found that he brought his costs down significantly
1457 over a 2-year span.

1458 It seems like that would be a logical way to approach
1459 things. We are talking about States expanding Medicaid. We
1460 are not talking about people who are already mandatory
1461 populations, that is, people in nursing homes, people who are
1462 blind and disabled, children. We are talking about new
1463 coverage for basically young adults who are healthy. Why

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1464 wouldn't we use this activated patient model that the
1465 Commonwealth Fund wrote about in incorporating that
1466 expansion?

1467 Ms. {Collins.} You know, I think you raised a very good
1468 point, and I think the discussion of costs earlier is really
1469 important. I think the viability of the Affordable Care Act
1470 and the coverage expansions over time will depend on the
1471 affordability of the premiums, but half the law does address
1472 the underlying cost drivers in the system through a
1473 significant set of delivery system reforms, a lot of which
1474 have already gone into place. I think the law also
1475 encourages, unlike some of the comments that have been made
1476 here, huge innovations at the State level, so States have
1477 enormous flexibility in designing their insurance exchanges
1478 if they want to do so. They also have primary responsibility
1479 for regulating their insurance markets, and the delivery
1480 system reforms, we are seeing a slowdown in health care costs
1481 over the last couple years. Part of that is recession
1482 related but part of that is probably structural, so we are
1483 seeing changes in the system that are both being driven by
1484 innovations like going on in Ohio, Indiana, but also some

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1485 that are being driven by incentives and new grant funding
1486 provided under the Affordable Care Act.

1487 This is a hugely important problem for the United
1488 States. It will determine the viability of the coverage
1489 provisions over time. There are insurance market regulations
1490 that do address premium growth. We have already seen a huge
1491 decline in the number of premium rate increase requests from
1492 insurance companies because of the rate review program that
1493 has been in effect for the last year. The medical loss ratio
1494 requirement is also having a huge impact, 1.5 million in
1495 rebates and administrative cost savings last year just as a
1496 result of that provision alone. So the Affordable Care Act
1497 is not just about coverage. In fact, over its 10-year budget
1498 projection, it actually reduces the overall deficit because
1499 of these additional delivery system reforms in addition to
1500 the coverage requirements.

1501 Dr. {Burgess.} Well, you know, Governor Daniels said in
1502 a piece in the Wall Street Journal several years ago now,
1503 even before while we were still debating the Affordable Care
1504 Act, that by providing his State employees with a high-
1505 deductible policy for catastrophic coverage and then

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1506 providing them the funds to pay that high deductible should
1507 they be required to do so, allowing them to keep the money in
1508 those health savings account if they didn't spend it, he came
1509 to the conclusion that something magic happens when people
1510 spend their own money for health care, even if it wasn't
1511 their own money in the first place, and I don't know why
1512 there has been such a resistance to accepting that lesson
1513 that he has shown so elegantly in Indiana and why we won't
1514 allow it to occur in more places.

1515 Lieutenant Governor, I will give you the last word. I
1516 rather suspect that the flexibility that Dr. Collins spoke
1517 about is something that you would welcome. Is that not
1518 correct?

1519 Ms. {Taylor.} Mr. Chairman, Dr. Burgess, yes. I guess
1520 my comment with regard to all of the flexibility that has
1521 portended to be given to the States both in how exchanges are
1522 organized, if you read the rules and regulations, if you look
1523 at at least Ohio's history with dealing the High Risk Pool,
1524 my definition of flexibility as it relates to dealing with
1525 HHS and CMS is, you can have as much flexibility as you want
1526 as long as you do it my way, and unfortunately for Ohio, we

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1527 have the experience that we have had little flexibility, and
1528 if there was as much flexibility as is being suggested, I
1529 think you would have less concerns or issues coming from
1530 individual State regulators who say you tell us we can
1531 regulate our market, but when you disagree with what we have
1532 concluded as with the High Risk Pool and whether or not
1533 individual consumers were eligible for coverage, it was up to
1534 us until you decided no, and that is unfortunately the
1535 experience that we have had.

1536 Dr. {Burgess.} Thank you, Mr. Chairman. My time is
1537 expired. I will yield back.

1538 Mr. {Pitts.} The Chair thanks the gentleman.

1539 We have other questions, but we will ask the members to
1540 submit their questions for the record and ask the witnesses
1541 to respond promptly when you receive those questions. This
1542 has been an excellent hearing, very, very important issue,
1543 and I want to thank the witnesses for taking time to come
1544 present their testimony.

1545 I remind the members they should submit their questions
1546 by the close of business on Wednesday, April 17. So without
1547 objection, with thanks to the witnesses, this subcommittee is

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1548 adjourned.

1549 [Whereupon, at 2:26 p.m., the subcommittee was

1550 adjourned.]