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THE RECENT HEALTH CARE LAW: CONSEQUENCES FOR INDIANA FAMILIES AND WORKERS

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION
AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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C O N T E N T S

THE RECENT HEALTH CARE LAW: CONSEQUENCES FOR INDIANA FAMILIES AND WORKERS

Tuesday, June 7, 2011
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and the Workforce
Washington, DC

The subcommittee met, pursuant to call, at 9:00 a.m., in room 301, Vanderburgh County Civic Center, 1 Martin Luther King, Jr. Boulevard, Evansville, Indiana, Hon. Phil Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe and Bucshon.

Staff Present: Casey Buboltz, Coalitions and Member Services Coordinator; Benjamin Hoog, Legislative Assistant; Brian Newell, Deputy Communications Director; Ken Serafin, Workforce Policy Counsel; and Megan O'Reilly, Minority General Counsel.

Chairman ROE [presiding]. The committee rule 7(c), all committee members will be permitted to submit written statements to be included in the permanent hearing record.

Without objection, the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material referenced during the hearing to be submitted in the official hearing record.

And good morning everyone and thank you all for being here. And I want to thank our witnesses for being with us today. We recognize that you all have busy schedules and we appreciate the opportunity to hear your thoughts and experiences on the very important issues of health care.

And second, I would like to thank all you all in the audience in Evansville for your hospitality, for hosting the first field hearing of the Subcommittee on Health, Employment, Labor, and Pensions.

And before we go on, I am just going to tell you a little bit about who I am. My name is Phil Roe. I am a physician. I practiced obgyn in Johnson City, Tennessee for 31 years and 2 years ago was elected to the Congress. And I found out that when you deliver your own voters, it worked out pretty well for me, having delivered almost 5,000 babies. [Laughter.]

So it worked out pretty well. And every time a junior high class—I am really nice to them because that is another voter that may be coming along.

But I wanted to tell you a little bit about myself. I grew up really not that far from here near Clarksville, Tennessee, about a 2-hour drive, and I am very familiar with your Evansville Purple Aces who routinely beat my Austin Peay Governors in basketball, so I am very familiar with this area.

When I looked and went to Washington, D.C., I went there. I am a veteran and I was mayor of our local community and still practiced medicine. And I saw in my patients that health care was getting more and more and more expensive. It was too expensive to come to the doctor, and it was too expensive to go to the hospital.

And secondly, we had a group of people in our community, at least where I live in rural east Tennessee in Appalachia where I live, that didn't have access to affordable health coverage. What I meant by that is let's say you were a carpenter and you didn't have full-time employment, but you worked and made $20,000, $25,000, $30,000 in a year, and maybe your wife worked at a local diner. And together, you got along okay, but you couldn't afford $1,000 a month for health insurance coverage. So we had that group of people who didn't have coverage.

And thirdly, we have a liability crisis in this country. When you have a liability crisis which is causing costs to go up with unnecessary testing and so on, that is an issue. The health care plan ahead of us today that we are going to talk about today I think did nothing to help control the costs, and it does nothing for liability. It does expand coverage through Medicaid and some other ways to do it which we will talk about, but it doesn't take care of the major problem which is it costs too much money.

As our first field hearing, there are few topics more relevant to our economy and challenges facing our families and small businesses than health care. Each year the cost of care goes up, placing even greater strains on budgets already stretched thin by a very difficult economy. Some patients refuse care simply because they can't afford it. Employers often choose between ending coverage or hiring new workers, and the burden imposed on taxpayers becomes even greater as Government programs expand and health care services grow more expensive and more unsustainable.

We know there are a number of factors forcing health care costs to rise such as an aging population, more advanced treatments, and greater use of health care services, coupled with fewer providers.

However, as is often the case, too much intervention by the Federal Government can make an already problematic situation worse. Instead of allowing choice and competition to encourage innovation and lower costs, a Washington knows best mentality can often discourage processes and lead to a one-size-fits-all approach that simply cannot work for a country as vast and diverse as ours.

That is why I, along with a strong majority of the American people, reject the Government takeover of health care that was imposed on the Nation last year. Any effort to reduce costs for America's workers and job creators was abandoned along the road of reform by Democratic leaders who favored a massive expansion of the Federal Government's role in health care.

For the first time in our Nation's history, private individuals will be required to buy health care or pay a penalty, the so-called man-

date. And the case will be heard tomorrow in the Court of Appeals in Atlanta, Georgia, the Eleventh Court of Appeals, on the individual mandate. It has been ruled on. And 26 States are enjoined in this lawsuit.

In a few short years, businesses with more than 50 employees will be mandated by law to provide Government-approved health care for workers or pay a fine, regardless of the difficulties these businesses may be facing just to keep their doors open. Proponents of the law say it includes relief for small businesses. Well, unfortunately, that relief is not only limited and temporary, but according to one analysis, it actually penalizes certain businesses for raising wages or hiring new workers. Can anyone seriously argue this is a good thing for an economy that has been plagued with high unemployment for nearly 3 years? Will this help the more than 13 million unemployed Americans who are searching for work?

A number of the law's provisions will not take effect until 2014, but already we are hearing from business leaders troubled by the uncertainty the law has created. This is unacceptable, especially at a time when certainty is needed to restore confidence and foster economic growth.

A 2,700-page health care law, which I have read in its entirety—and I can probably say not that many in Congress have. I don't know what it says about my intelligence, but I read the entire 2,700 pages. And it has led to more than 6,600 pages of new Federal rules and regulations, and that is just what the administration has accomplished in the first 14 months since the bill was signed into law. That is a difficult maze of bureaucratic red tape for businesses to navigate at a time when they should be focused on expanding their operations and creating new jobs.

As a doctor and a former mayor and a lawmaker, addressing these challenges remains at the forefront of my efforts serving the people of the 1st District of Tennessee, and as the chairman of the House Subcommittee on Health, Employment, Labor, and Pensions, it is clear the status quo is failing our families, workers, and job creators.

We appreciate the work of our witnesses who are helping us to chart a better course, one that will harness the creativity of the American people to lower the costs of health care for the Nation.

I want to note that another Indiana colleague of mine and subcommittee member, Todd Rokita, could not be here because of a previous commitment, but I know he too is committed to creating affordable health care for American businesses and repealing the onerous mandates created by the Affordable Care Act.

Three things I like about southern Indiana.

One is Central Standard Time. You guys got it here. I like that.

Number two, basketball. I love that.

And number three, I appreciate that you elected someone as competent as Dr. Larry Bucshon. He has really hit the ground running. There was essentially no learning curve for him. I know when I first got there, the first thing I was interested in was trying to find out where the bathrooms were. I mean, they don't tell you any of the important things when you get there. But Dr. Bucshon has gotten there, hit the ground running, and has been a tremendous

asset to our Committee on Education and the Workforce and on the subcommittee that I serve on.

So without objection, I now yield to my friend, Dr. Bucshon, a fellow physician, for any opening remarks he may wish to make.

[The statement of Chairman Roe follows:]

Prepared Statement of Hon. David P. Roe, Chairman, Subcommittee on Health, Employment, Labor and Pensions

Good morning everyone. First, allow me to take a moment to thank our witnesses for being with us today. We recognize you all have busy schedules, and we appreciate the opportunity to hear your thoughts and experiences on the very important issue of health care. Second, I would like to thank the people of Evansville, Indiana for their hospitality and for hosting the first field hearing of the Subcommittee on Health, Employment, Labor, and Pensions.

As our first field hearing, there are few topics more relevant to our economy and the challenges facings our families and small businesses than health care. Each year the cost of care goes up, placing even greater strain on budgets already stretched thin by a difficult economy. Some patients refuse care simply because they cannot afford it. Employers often choose between ending coverage and hiring new workers. And the burden imposed on taxpayers becomes even greater as government programs expand and health care services grow more expensive and more unsustainable.

We know there are a number of factors forcing health care costs to rise, such as an aging population, more advanced treatments, and greater use of health care services coupled with fewer providers. However, as is often the case, too much intervention by the federal government can make an already problematic situation worse. Instead of allowing choice and competition to encourage innovation and lower costs, a Washington-knows-best mentality can often discourage progress and lead to a one-size-fits-all approach that simply cannot work for a country as vast and diverse as ours.

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For the first time in our nation's history, private individuals will be required to buy health care or pay a penalty. In a few short years, businesses with more than 50 employees will be mandated by law to provide government-approved health care to workers or pay a fine, regardless of the difficulties these businesses may be facing just to keep their doors open. Proponents of the law say it includes relief for small businesses. Well, unfortunately, that relief is not only limited and temporary, but according to one analysis it actually penalizes certain businesses for raising wages or hiring new workers.

Can anyone seriously argue this is a good thing for an economy that has been plagued with high unemployment for nearly three years? Will this help the more than 13 million unemployed Americans who are searching for work?

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As a doctor and a lawmaker, addressing these challenges remains at the forefront of my efforts serving the people of the first district in Tennessee, and as chairman of the House Subcommittee of Health, Employment, Labor, and Pensions. It is clear the status quo is failing our families, workers, and job creators. We appreciate the work of our witnesses who are helping us to chart a better course, one that will harness the creativity of the American people to lower the cost of health care for the nation.

I want to note that another Indiana colleague and subcommittee member, Todd Rokita, could not be here today because of a previous commitment, but I know he too is committed to creating affordable health care for American businesses and repealing the onerous mandates created by the Affordable Care Act.

I will now recognize Dr. Larry Bucshon, a friend, colleague, and fellow physician for any remarks he wishes to make.

Mr. BUCSHON. Thank you, Chairman Roe, for that gracious introduction.

On behalf of the people of Evansville, please allow me to extend a warm welcome and offer our sincere appreciation for convening this hearing today. I think that, Chairman Roe, you will discover that people in Indiana have a profound love for their country and a lot of good ideas about how we can move this Nation forward. That is ultimately a goal we all share and one that we are really committed to.

These last few years have been a difficult time and promise for our great State because of what has happened in Washington, D.C. A tough economy has levied many hard choices on our families, workers, businesses, and State leaders. We have tried to meet these challenges head on through hard work and sacrifice. We have made progress but realize more work lies ahead. We must ensure the progress that has been made is not undone by bad policies out of Washington, D.C., which brings us to the reason for the hearing today.

At a time when businesses continue to struggle, millions of workers remain on the hunt for a job, and families are experiencing greater pain at the pump, our country now faces the consequences of the policies that are in place in Washington, D.C., including last year's Government takeover of our health care system with passage of the Affordable Care Act.

I was not in public office at the time when the health care legislation passed through the Congress. However, a strong majority of Americans joined the public debate in opposition to the Affordable Care Act, and in fact, the opposition to the Affordable Care Act has only increased since its passage. That is one of the few times that has ever happened with a policy that has been passed in Washington, D.C.

Last year, I had the great privilege of traveling around the district listening to local business owners, family farmers, and others expressing their concerns about the direction Washington, D.C. is taking our country. It is deeply unfortunate that the majority of people out there voices were being ignored at the time by the leaders in Washington in our Nation's capital.

This law includes thousands of pages of new mandates, some of which fall on job creators. It includes numerous tax increases, including a $20 billion tax on businesses that develop medical devices, and this is very important to Indiana since we have a very large medical device business in our State, as many as 20,000 employees. Those businesses employ, like I said, 20,000 or so Hoosiers, and they take a direct hit with a new tax based on the Affordable Care Act.

The administration has proposed more than 6,600 pages of regulations over the last year in an effort to implement and enforce the law. At a time when our economy and workforce needs certainty about the future, the regulatory environment simply creates confusion and anxiety and our workers and families are paying the price. Not only is the law piling additional burdens on job creators,

many of whom are struggling to meet their payroll, it is placing a greater strain on the taxpayers. Despite raising taxes by more than $500 billion and costing an estimated $1.4 trillion, the price tag for taxpayers continues to go up.

Here in Indiana, new insurance mandates will drive up health care costs for employers and workers. Also, our Governor estimates the expansion of the Medicaid program may cost the State upwards of $3 billion a year, a cost on the backs of Indiana taxpayers. Speaking as a fellow Hoosier, this is a Government takeover our State simply cannot afford.

It is clear we need a better approach to health care, one that reflects our national values of personal responsibility, a limited Government, an approach that encourages innovation and job creation. We cannot assume the best answers come from Washington, D.C. I am confident, with the help of our witnesses, we can identify real solutions that will lower the cost of health care and protect and create the jobs our Nation's workers desperately need.

Again, I would like to thank Chairman Phil Roe for coming to Evansville and for his leadership as the chairman of this subcommittee and for holding this important hearing today to hear what the people of Indiana have to say.

So with that, thank you, Chairman Roe.

Chairman ROE. I thank the gentleman.

And I would like to include in the record the senior Democratic leader on the Subcommittee on Health, Employment, Labor, and Pensions who could not be here, Rob Andrews. Without objection, I will include his statement for the record.

[The statement of Mr. Andrews follows:]

Prepared Statement of Hon. Robert E. Andrews, Ranking Minority Member, Subcommittee on Health, Employment, Labor and Pensions

Last week's unemployment report reinforces the urgent need for the Congress to have a laser-like focus on jobs. Unfortunately, the committee has not taken up a single piece oof jobs legislation this year. Instead, today's hearing continues fighting the battles of thee past, with the fourth hearing this year attacking the Affordable Care Act.

This health care reform law gives American families new protections against the worst abuses of the insurance industry. In the coming years, it will extend access to affordable, quality health care to those without it. And it contains critical measures to keep rising health care costs under control, without rationing care. Getting a handle on out-of-control health care costs is one of the keys to our long-term economic ggrowth.

The Affordable Care Act became law over a year ago. While it takes multiple years to implement, it has already begun to deliver positive results for Indiana families, children, and small and large employers.

Because of the Affordable Care Act, nearly 90,000 Hoosier seniors who hit the Medicare prescription drug donut hole paid less for their medications last year. Each received a $250 rebate check for a total savings of $22.4 million dollars. This year seniors who hit the donut hole are saving an average of $800.

One million seniors in Indiana may receive free preventive services and an annuaal wellness visit.

More than 80,000 small employers in Indiana may pay lower health care costs as a result of the law's small business tax credit.

Nearly four million Indiana residents are now protected against lifetime limit caps on their coverage and 3.5 million are protected against restrictive annual limit caps.

Nearly 300,000 Hoosiers are now protected against having their insurance company drop their health coverage when they need it the most.

More than 20,000 young adults in the state may now have coverage through their parent's health plan.

More than 200 employers and their employees are paying less for retiree health care by joining the Early Retiree Reinsurance Program.

The law has also been good for Indiana's economy by infusing millions of dollars in grant money to help the state strengthen its health care system. Indiana has received funding to develop a health insurance exchange, strengthen and potentially construct new community health centers, support prevention and health programs and invest in groundbreaking biomedical research.

Specifically, the state has received:

• More than $7 million toward the state's development of the health insurance exchange. The health insurance exchanges are a cornerstone of the Affordable Care Act that will allow consumers to shop for quality affordable health care of their choice.

• More than $550,000 for community and clinical prevention activities.

• Nearly $1 million for primary care training to expand the state's primary care workforce.

• More than $10 million to support 46 projects in the state that show potential in producing new and cost-saving therapies. These grants and tax credit also support good jobs and increase U.S. competitiveness.

Repeal of the Affordable Care Act would repeal all of these protections for individuals, families, and employers. It would repeal economic benefits for Indiana. And it would return inordinate power over our health care to the health insurance companies.

My Republican colleagues have not just proposed repeal of these benefits. They have an additional proposal these days: ending Medicare. The Republican plan will force seniors to pay more for health care coverage and prescription medications and jeopardize their right to long-term care benefits.

Under the Republican plan to end Medicare, an Indiana senior would be forced to pay more than $6,000 in higher annual health care costs in 2022 and $12,000 more by 2032, as well as an additional $9,800 in prescription drug costs over the next decade. For seniors and those with disabilities in Indiana's 8th congressional district, the Republican plan could increase preventive care costs by $293 million over the next decade. In addition, the more than 3,000 residents in nursing homes whose expenses are paid by Medicaid would be left without the care they need.

The Republican plan will have a devastating impact not only on seniors but also on young people right now who will no longer be able to depend on Medicare or a dignified retirement.

To cover the additional health care costs under the Republican plan, a 54-year-old today will need to save more than $180,000 by the time she retires. That is over and above what she should already be trying to save for a normal retirement.

And for those who are younger, the costs are even higher. A 25-year old will need more than half a million dollars in additional retirement savings to pay for their health care under the Republican plan.

The Affordable Care Act has now been debated for nearly three years. Re-litigating past fights will not move this country forward. The middle class has been under a decades-long squeeze. The last thing working families need right now is to have hard-won health care rights, like the guarantee of Medicare or the protections of the Affordable Care Act, taken from them.

There are better ways to spend our time in Congress, such as working together to grow and strengthen, rather than weaken, the middle class. Our focus should be on creating good jobs here in America.

Chairman ROE. Thank you.

And we have two distinguished panels today, and I would like to recognize Dr. Bucshon to introduce our first panel. I yield to Mr. Bucshon.

Mr. BUCSHON. Thank you, Mr. Chairman. It is a pleasure to introduce our first panel.

First of all, Robyn Crosson serves as Deputy Commissioner for Company Compliance Services with the Indiana Department of Insurance in Indianapolis. In that capacity, she reviews insurance policies and premiums to ensure compliance with Federal and State laws. She also serves on the Governor's Health Care Reform Team. Prior to her service in State government, she was an attorney in private practice.

Dr. David Carlson is a general surgeon with Evansville Surgical Associates which provides state-of-the-art general laparoscopic, thoracic, and peripheral vascular surgery services to patients in the tri-State area. Dr. Carlson joined the practice in 1997 and is certified by the American Board of Surgery and a fellow of the American College of Surgeons. He also serves on the active staff in the Department of Surgery at Deaconess Hospital and St. Mary's Medical Center both here in Evansville. Also, I would like to say Dr. Carlson has served his country in the Army Reserve Medical Corps and spent 3 months in Iraq serving his country in the recent conflict.

Elizabeth Wilson joins us today from Franklin, Indiana. She currently is employed at the retail store, Elder-Beerman, as she saves for graduate school, and also provides voice lessons and is a nursery attendant for the First Presbyterian Church in Franklin. Ms. Wilson graduated from Butler University in December 2010 with a bachelor of arts degree in applied music. She is with us today to share her personal story about the impact that the Affordable Care Act has had on her and her family.

Finally, Sherry Lang joins us today from Terre Haute, Indiana. Ms. Lang is a human resources director for Womack Restaurants, a member of the IHOP restaurant chain. Womack operates restaurants in Indiana and Ohio, employing nearly 1,000 full-time and part-time workers in 12 IHOP restaurants. Ms. Lang has a master's degree in human resource development and serves at the executive management level at Womack Restaurants. Since joining Womack in 2005, she has helped to grow the company from 3 to 12 restaurants.

So, welcome, panelists.

Chairman ROE. Thank you all.

Before we get started, I want to go over this lighting system that we have. It is there mainly to make sure that the Congressmen don't talk too long. But the way this works is you have 5 minutes to give your statements, and we will have 5 minutes to question. There may be a second round of questioning if we don't get through. The green light will come on. The amber light will mean you have a minute left, and the red light means that you need to start wrapping up your comments. We are not going to cut you off in mid-sentence. You can continue your thought, but just try to be cognizant of the lights.

So if you would, Ms. Crosson, you are first.

STATEMENT OF ROBYN CROSSON, CHIEF DEPUTY COMMISSIONER, COMPANY COMPLIANCE, INDIANA DEPARTMENT OF INSURANCE

Ms. CROSSON. Thank you, Mr. Chairman, and thank you, Representative Bucshon. It is a pleasure to be here, members of the committee.

My name is Robyn Crosson, and I am the Chief Deputy Commissioner at the Department of Insurance.

And before I go on, I just wanted to kind of explain a little bit of what the Department of Insurance does. A lot of people didn't even know Indiana had a Department of Insurance. Actually all

States and territories in the U.S. have departments of insurance or some sort of commission.

The primary thing we do is protect consumers. We have a consumer services division that answers all complaints brought by citizens and also by providers when they have issues. We regulate insurance companies. We don't regulate providers. And we also review all of the rates and contract language. That puts a heavy burden on us, particularly in company compliance for implementing the Affordable Care Act in addition to any State laws and regulations that we have.

By statutory authority, our legislature has deemed and ordered us to review all rates, premium costs before they are implemented and contracts before the State of Indiana or all health insurance, long-term care, Medicare, any sort of health pact policy. It also includes—all, in some way, shape, or form have been affected by the Affordable Care Act.

We are required to make sure that the premiums are reasonable in relation to the benefits that are provided and we do have actuarial reviews that perform those functions.

Currently in Indiana, we have approximately in each market—and when I say "market," I mean individual market where you can go out and buy a policy on your own—or a small group market, which is companies that have less than 50 employees, 2 to 50 in Indiana, and then the large group market is over 50, 51 and over. In three markets, we have approximately at any given time about 60 carriers that are actively marketing, although I will tell you that this number is dwindling. Currently we have experienced approximately 10 percent of the market has withdrawn, meaning either they have pulled out completely and will no longer do any business in Indiana or they will not do business with particular segments. Particularly the individual market and in some cases the small group market are being most severely affected, or they are just saying we are not going to currently going to actively market. We are going to see if we can stay alive until 2014, and then if we can, we will try to come back in on the exchanges if we can do that.

Particularly we are seeing this in smaller companies. The problem is these are smaller domestic Indiana companies. In a lot of cases, these are provider-owned in some cases insurance companies that serve niche markets within the State, have very good consumer services. We don't get a lot of complaints on them. They control their costs and they have good wellness programs. We have a lot of insurance companies throughout this State that operate that way, and really right now we are seeing them really rethink whether they can do business at all. So that is just kind of to give you a picture.

We have a healthy domestic insurance industry here in Indiana, and insurance employs a lot of Hoosiers. Just to give you an example, the top five insurance carriers—we just did a quick count—employ 5,600 people, just the carrier themselves. We have 44,944 resident agents licensed to sell accident and health. These are your neighbors. These are small business owners. We have 4,152 resident agencies that play a large role in the community, and we have grave concerns about what is going to happen to those people.

To give you an idea and a picture of who is impacted by this, the Affordable Care Act affects not only fully insured but also affects self-insure. You see self-insure in large corporations or large, usually over 100-150 people, where they bear all the costs and risk and just pay someone who administer their claims. But this affects both in most cases.

And to give you a picture of who we are talking about, the full insured market—the estimate—comprises about 30 percent of the State. So in the individual market, that is 192,376 people. The small group market is 288,461 people, and the large group market, 456,867 individuals. And then for the self-funded, the other 70 percent that are affected by this—and I am not talking about Medicaid. I am not talking about Medicare—there are another 2.1 million Hoosiers approximately affected by this, not to mention employers and everything else in the State. These are just the people who are covered by this insurance.

I have two main themes and main side effects that we are seeing right now actively in trying to deal with and combat. The first one is that premiums are going up. The second one is the market is in chaos. Neither one benefits employers or consumers.

The first one—just what we are seeing in the department and as the Congressman indicated, $3.1 billion was the high estimate right now for what we are seeing. We are not done with the regulations that are coming out. There are always more that could be coming out, and those add oftentimes additional costs and burdens upon the State taxpayers, upon the companies, upon individuals, and upon employers. There are increased reporting responsibilities and we don't know what the exchanges are going to look like either. All these things are unknown. This is what we are estimating with now, $2.6 billion to $3.1 billion is what the Governor's current estimates are.

Effective on September 23rd of 2010, there were a series of market reforms, including expanding the dependent age to age 26, a prohibition on preexisting conditions for children under 19, among others, removing the lifetime limits on policies, and limiting the annual limit and phasing out annual limits completely over the next 3 years or 4 years, I guess, till 2014.

As a result, the early estimates we saw from carriers before these even took effect was that premiums were going to go up between 2 and 4 percent. But in some cases and in plans especially in the small employer arena and the individual market where people have limited drug benefits—maybe they were limited to $100,000 and $50,000 and $350,000—we saw increases as high as 35 percent where they were requesting these rates and getting all reviewed. I am not saying that they were definitely approved. But we are requesting these because of the removal of the limits in drug utilization, especially in the market. And so removing these limits has prohibited insurance companies and employers from capping costs.

There is discouragement on consumerism in the $2,000 deductible limit.

And then basically I just want to say the market is in total flux. There are so many things out there. The agents are not sure whether they are going to have jobs. Employers are cutting bene-

fits. In general, there is not a lot of incentive to—there is no incentive to control costs and there is no ability for employers to predict what their medical costs are going to be, especially with the removal of a lot of these limits in going forward. The medical loss ratio carriers are laying people off, cutting their costs, reducing compensation across the board to try, again, to survive until 2014, which is frankly unknown.

Thank you.

[The statement of Ms. Crosson follows:]

Prepared Statement of Robyn S. Crosson, Chief Deputy Commissioner, Company Compliance, Indiana Department of Insurance

Chairman Roe, Representative Bucshon, Members of the Committee, it is an honor to appear before you today to offer guidance on our nation's recent health care reforms.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). This legislation institutes numerous modifications to the regulation of private health insurance companies and the structure of health insurance policies.

The Indiana Department of Insurance (IDOI) supports Indiana Attorney General Zoeller's effort to overturn or repeal ACA on the grounds that it is unconstitutional to mandate citizens to purchase health insurance or pay a penalty. However, this litigation is presently pending, and will likely remain pending for quite some time. In the interim, IDOI diligently prepares for the onslaught of ACA's new requirements. First and foremost, IDOI continually examines the law in an effort to minimize adverse effects to the nearly 1 million Hoosiers with fully insured coverage.

As of July 1, 2010, Governor Daniels formed an interagency task force to analyze the various components of ACA. The task force includes representatives from the Governor's Office, the Indiana Family and Social Services Administration (FSSA),IDOI, and the Indiana State Department of Health and State Personnel. Indiana continually attends meetings with the U.S. Department of Health and Human Services (HHS), the National Association of Insurance Commissioners (NAIC), consumer representatives, industry representatives, other regulators and insurers. Indiana carefully reviews each newly promulgated regulation that implements ACA's provisions and provides policy feedback to the government and other interested parties regarding how the provisions should operate or to warn of the consequences. In addition, Indiana has been awarded federal grants to assist with the implementation of health care reform. The State has conducted a financial analysis of the ACA's impact to the State budget and estimates indicate Indiana will have to pay between $2.6 and $3.1 billion over the next ten years to support the ACA.

The following is a summarized timeline of some of the more significant changes with a focus on the effect on Indiana families and workers.

High Risk Pools

Within 90 days of ACA's March 2010 enactment, states were required to establish a high risk health insurance program, or instead defer to the federal government's Pre-existing Condition Insurance Plan (PCIP). On April 22, 2010, the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) reported that an estimated 375,000 individuals across the U.S. would enroll in the PCIP by the end of 2010.[1] So far that has not been the case. As of March 31, 2011, the number of Hoosiers enrolled in PCIP was 177, and the total across all states was 18,313.[2]

The strict eligibility requirements are one reason for the low enrollment. According to PCIP's own website, "You must have been without health coverage for at least the last 6 months. Please note that if you currently have insurance coverage that doesn't cover your medical condition or are enrolled in a state high risk pool, you are not eligible for the Pre-Existing Condition Insurance Plan."[3] Since Indiana's high risk pool, ICHIA, does not require a waiting period, most Hoosiers are forced to enroll in this program instead. Although a small portion of costs are funded through premiums, the bulk of the cost is covered through assessments and taxes. Insurers are assessed for 25% of the costs, while Hoosier tax payers fund the re-

[1] *http://republicans.energycommerce.house.gov/Media/file/Hearings/Oversight/040111/OImemo.pdf*

[2] *http://www.healthcare.gov/news/factsheets/pcip05062011a.html* (posted May 6, 2011).

[3] *https://www.pcip.gov/Eligibility.html*

maining 75%. Approximately 7,000 people are enrolled in this program that incurred approximately $110 million in claims during the 2009 calendar year. The establishment of PCIP may be intended to assist the uninsured and high risk, but the six month requirement stunts PCIP's potential to be of great assistance.

Changes to Annual and Lifetime Limits

Several of ACA's changes became effective September 23, 2010, including new rules controlling how health insurance companies can use annual and lifetime limits. ACA generally prohibits these limits, or in some cases restricts the amounts as part of a transitional period leading into 2014 when limits become fully prohibited. Limits enable insurers to properly estimate future costs, which facilitates appropriate pricing. Limits help ensure that companies remain solvent. Similarly, employers who are self-funded are less able to predict their annual medical costs because they are also subject to the annual and lifetime limits prohibition. Generally, health insurance costs are the second largest budget item for employers. Less certainty and fewer ways to control costs creates an incentive to discontinue offering health insurance. Insurance companies have reacted to this legislation by increasing premiums.

Mandatory Preventive Health Services Coverage and Essential Benefits

Effective September 23, 2010 under ACA, health insurance companies generally must cover preventive health services as defined by the federal government. The justification for this change in the law is that more Americans will visit providers earlier to use such services, decreasing the chance they will incur a costly illness later, thereby decreasing costs to insurers and therefore decreasing premium. However, the practical reality is different. Having additional preventive services paid for by insurance has generally not been enough to incentivize Americans to become healthier or get checked out for health problems more often. Instead, the legislation has merely caused insurance companies to change their accounting and increase premiums to cover the new costs of the mandated services. In addition, beginning January 1, 2014, plans offered by small group and individual insurers must include essential health benefits package characteristics, including cost sharing limitations as eligible. In cases where existing insurance plans do not cover an essential benefit, those plans must adjust by adding the benefit and likely will increase the premium to cover its costs. At this time we do not know what these benefits are. This adds additional uncertainty to the market and limits our ability to assess the impact of ACA.

Dependent Age Increased to 26

Effective September 23, 2010, insurers are generally required to continue coverage of a dependent up to the age of 26. This change was designed to reduce the number of younger dependents getting kicked off their parents' plan and foregoing coverage. While the intent was positive, it has led to a situation where certain employers, who budgeted for covering dependents for a lesser amount of time, now have to react to the change. Insurers and employers with self-funded insurance have generally reacted by increasing premiums to cover the extra years of cost.

Indiana previously required dependent coverage for children up to age 24. For policies effective after September 23, 2010 or at renewal subsequent to that date, coverage must be extended to children under age 26. Notice to parents of dependents who were previously removed must be provided and children must be added at the next open enrollment if they aged off. Although a child may be underwritten when he or she is reenrolled, the child cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Dependent coverage is extended to age 26 for individual and group products with an exception for grandfathered group products. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package when it falls outside a federally established threshold. Prior to January 1, 2014, if a young adult has the option of coverage through their employer, the parent's employer, if the plan is grandfathered, does not have to cover the young adult as a dependent on the parent's plan. Employers have suggested that extension of coverage will increase costs and have concerns about adverse selective tendencies since young adults can choose to stay on their parents' plans rather than take their employer plan, especially after January 1, 2014. This requirement imposes additional previously unanticipated risk upon employers who offer dependent coverage through their plans. Depending on the level of adverse selection, the result of this legislation may be that employers stop offering dependent coverage. Currently, there is a movement by employers to penalize employees whose spouses are covered as dependents on employer A's plan instead of receiving coverage through their own employer B. Usually, the penalty is an increased premium percentage or no employer contribution for the spouse's coverage.

Guaranteed Issue, Coverage, and Renewability

Effective September 23, 2010, insurers can no longer exclude benefits or limit coverage based on a preexisting condition for an individual under the age of 19. For plan years following January 1, 2014, this restriction applies to everyone. Also, beginning 2014 insurers selling new insurance can no longer discriminate on the basis of health status, medical history or claims experience. Moreover, beginning 2014, insurers must accept everyone that applies for coverage during open enrollment, the limited time period during each year determined by insurers when someone can sign up to an insurance plan. For plan years beginning January 1, 2014, all non-grandfathered, fully-insured plans must renew coverage or continue it in force at the option of the insured.

Currently, and within statutory limits, Indiana insurance carriers are permitted to exclude coverage temporarily for preexisting conditions. This enables carriers to insure for fortuitous rather than planned or known medical costs. ACA prohibits this practice for children under 19 currently and for all others in 2014. Indiana's small group market has had guaranteed issue for several years and will not be significantly affected by this, but the individual market will experience significant increases. Some carriers have suggested increases in the 50% range. We are currently evaluating the inclusion of the high risk pool members into the individual market and the increase associated with such inclusion. One of the consequences experienced in Indiana as a result of this legislation was that carriers stopped writing child-only policies. Carriers claimed that the law led to adverse selection, a fiscal situation that arises when a given pool of insured individuals is skewed, in that there is not an economically stable proportion of sick to healthy individuals in the pool, because healthy individuals leave, causing premiums to rapidly escalate for those remaining sick people. In an effort to curb this practice the government tried to limit plan-switching by restricting the time to switch, or the time in which to enroll, to only open enrollment periods, thereby preventing young individuals from waiting until they got sick to enroll. Indiana drafted Bulletin 181, requiring carriers wishing to sell child-only policies to do the following: 1. Hold an open enrollment period that must last at least 30 continuous days; 2. Designate that enrollment period; 3. Notify IDOI no later than December 1, 2010 of when the open enrollment period will occur so that IDOI may post on its website; 4. Post the open enrollment period on the insurer's website; and 5. Effect coverage within a reasonable period of time from enrollment. Despite IDOI's efforts, IDOI is aware of only one company offering child-only policies in Indiana. Generally, children under 19 are left with the option of CHIP, PCIP and ICHIA to the extent they qualify. IDOI is currently exploring options to continue to encourage carriers to re-enter the market. However, the consequence of the law thus far is that consumer choice has narrowed and premiums have increased.

Grandfathering

ACA allows for plans in effect on March 23, 2010 to be considered grandfathered. This affects the application of some of the September 23, 2010 market reforms. For example, the following do not apply to grandfathered health plans: mandated coverage for preventative services, mandated patient protections (i.e., OBGYN referral prohibition, in-network pediatrician considered child's primary care provider (PCP) and emergency services costs are the same for in-network vs. out-of-network), guaranteed availability and renewability of coverage, mandated cost-sharing limits, no discrimination based on health status and mandated coverage for clinical trials. Additionally, grandfathered plans will not be subject to the 2014 pricing restrictions. This means that the actuarial review process for insurance premiums at renewal will be split between grandfathered and non-grandfathered plans. In addition to increased and tiered actuarial duties, it has been suggested that IDOI will be the first arbiter of the grandfathering determination. This means increased reporting for carriers and additional rate and form review responsibilities for Compliance. Several insurers have reacted by requiring employers to provide coverage that is consistent with the new ACA reforms, rather than allowing employers to choose. Instead of increasing employer choices, which the law touted, employers' options are constrained.

International Statistical Classification of Diseases and Related Health Problems (ICD-10)

ICD-10 provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. Under ICD-10, every health condition can be assigned to a unique category and given a code. On August 21, 2008, HHS proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Under the proposal,

the ICD-9-CM code sets would be replaced with the ICD-10 code sets, effective October 1, 2013.

Although this may lead to improved health data tracking and positive healthcare outcomes, it carries a significant price tag for insurers. ICD-10 is sufficiently detailed to describe complex medical procedures, which becomes increasingly important when assessing and tracking the quality of medical processes and outcomes. The goal of such tracking is to improve patient outcome and quality of care. IDOI recognized this significant conversion cost in a letter submitted to the National Association of Insurance Commissioners (NAIC). This is the organization that was tasked by HHS with defining the medical loss ratio rebate calculation. In that letter, IDOI stated in pertinent part: "Such conversion costs, although significant, will be short-lived and therefore, affect the medical loss ratio calculation for a brief period, but leave lasting quality improvement potential. Given the benefits to patient care, ICD-10 conversion costs should be included as a health care improvement cost and included in the claims numerator." The final model adopted by the NAIC did not allow the inclusion of ICD-10 costs in the medical loss ratio (MLR) numerator as part of Quality Improvement Costs. Therefore, carriers must bear the cost of this conversion as part of their 15-20% administrative costs. Smaller carriers will likely be more significantly affected, since larger carriers can spread the cost over multiple companies.

Changes to the External Review Process

As of 2010, states must have internal and external review standards. The federal law requires strict compliance with certain provisions published in an HHS regulation, 42 USC § 300gg-19(b), that largely comported with the NAIC Model Act on External Review. Indiana's own external review statutes are highly analogous to the federal requirements, but it was determined through correspondence that Indiana was not in exact compliance. The State was able to get Senate Bill 461 passed and successfully amend Indiana's external review laws to be in compliance with the federal requirements. However, even with these changes, HHS has not yet confirmed that Indiana is in compliance. This is leading to uncertainty in the insurance market because insurers cannot determine their own compliance with Indiana Code. Sadly, this type of back and forth with HHS has been typical of the health care reform process thus far; chaotic, frenetic and rushed implementations. All of these issues combine together to create an uncertain insurance market, causing insurers to hesitate before participating or continuing to participate in Indiana's insurance market, reducing consumer choice of insurance.

Other Changes with Lesser or Unclear Impact

- September 23, 2010: plans that provide for emergency services cannot require prior authorization. Any cost-sharing requirement for emergency services provided out of network cannot exceed cost sharing requirements for in network emergency services.
- Beginning in 2014, insurers may not discriminate against providers operating within the scope of their practice.
- Annual HSA contributions are limited and there are deductible limits on small employer plans that may limit participation in popular high deductible health plans.
- States must track trends in increasing premiums and report this information to HHS. Such tracking and reporting may be funded initially in the form of grants, but long term the costs will be passed to the states.
- Waiting periods cannot be greater than 90 days.
- Carriers requesting a rate increase greater than 10% must file with both the state regulator as well as the federal government. Some insurers in certain states may be subject to a dual review process unless a state has an adequate review process. IDOI has requested that HHS recognize that it has an effective rate review process to avoid this dual review.

ACA provisions related to insurance increase the coverage requirements, mandate previously uncovered costs of individuals and dramatically increase reporting and administrative requirements. All result in increased costs that will likely be passed to consumers in the form of premium increases.

Exchanges

ACA mandates that over the course of the next few years, states must implement a health care exchange or the federal government will create one for each state. On January 14, 2011, Governor Daniels issued an Executive Order directing FSSA to work with IDOI and other applicable state agencies to conditionally establish and operate a health benefit Exchange, as a not-for-profit entity. The Order provides that a State-based exchange protects Hoosiers from undue federal regulation, maintains the existing free market and ensures that Hoosiers retain coverage choices.

The Executive Order stops short of committing to the Exchange, as there is little guidance at this point in time from the federal government regarding how the Exchange should operate. Nor do we have any information on how the federal Exchange will operate. The Order does allow the State to move forward in its planning and allows the State to prepare for the Exchange should we decide that it is in Hoosiers' best interests to commit. Indiana has received a federal exchange planning grant and a Level 1 establishment grant. We are using those funds to study the Exchange, which includes an information technology gap assessment, a study of the uninsured in Indiana and potential users of the Exchange, Exchange design options, and actuarial modeling. Our more recent funding will be used to identify the high and detailed level requirements, the information technology needs and design of an Exchange, and to identify the operating costs of an Exchange. In addition, on September 15, 2010, Indiana released The Affordable Care Act Stakeholder Questionnaire and collected responses through September 30. 478 responses were received and 409 responses were used in the analysis. All respondents indicated they were concerned about the cost of the legislation to their respective industries and businesses, and 80% indicated they were concerned about the health care system's ability to cope with the pent-up demand. Additionally, there was very little stakeholder support for a federally administered Exchange. Insurers preferred a State administered Exchange and businesses preferred a not-for-profit administered Exchange. The State released a questionnaire on Exchange design issues in March 2011where 2,600 responses were received. The survey mainly covered technical issues and market regulations, however, the write-in comments received from all respondents showed dissatisfaction with the Exchange. Respondents desired the guarantee of greater transparency and personal responsibility in the health care market place and they felt the ACA did not provide for these needs. In terms of design and Exchange goals, over half of the respondents supported making the Exchange a competitive environment for insurers—ensuring that the Exchange drives quality improvement and cost containment—and creating an Exchange that increases the portability and continuity of health care coverage. Finally, 95 employers responded to the question of whether they would continue to offer health insurance, of which 66% said they would maintain coverage, 3% would drop coverage, and 31% were undecided.

Medical Loss Ratio Limitations and Rebates

Under the law, no later than January 1, 2011, insurers of group health plans must report to the United States Department of Health and Human Services (HHS) regarding medical loss ratios (MLR) and must offer a premium rebate to participants if the loss ratio is below 85%. The federal government is redesigning MLR, a longstanding equation for determining whether an insurance company is properly paying out a sufficient amount in claims in relation to its revenue from premiums. Generally, a loss ratio is the amount of claims paid divided by premium collected, although the equation is significantly more complex under the law and considers several other criteria. What the law is saying here, essentially, is that certain insurers have to pay out 85% of their revenue from selling insurance. If the insurers do not end up paying out that much, then at the end of the year, they have to issue rebates, which are like refunds, to insured individuals. Furthermore, there are several situations where insurers operating in various states enjoy significantly different MLR thresholds, or use a different calculus in determining MLR. Indiana has historically followed the MLR model published by the National Association of Insurance Commissioners that established a baseline MLR of 55% with higher amounts for certain insurance. With this new law, insurers have to plan to pay more in claims either to initially meet the threshold or pay a rebate for not meeting it. Consequently, insurance companies are busy recalculating profit margins and using this new law to justify increasing premiums. ACA requires that individual and small group insurers have an annual medical loss ratio of 80% and 85% for large group insurers. The annual medical loss ratio involves a more complicated calculation than the traditional lifetime loss ratios utilized for the purposes of rate review. The simplest example of the annual medical loss ratio for the purposes of rebate calculation is the equation below:

Claims + Health Quality Expenses / Premium − Taxes (except for taxes on investment income/capital gains)

Although it has not been indicated through regulation, it appears that the intention is to place the burden for reviewing the rebate calculation on IDOI, similar to the rebate calculation for Medicare supplemental products that IDOI's actuary currently reviews. This new responsibility is in addition to the increased rate filing requirements for small and large group products. Currently, IDOI is reviewing whether applying the 80%/85% will disrupt the market if applied to all insurers in 2011.

In particular, smaller domestic insurance companies may be at an increased risk for insolvency and insurers that offer high deductible/HSA plans may have difficulty meeting this as well, which could affect the consumer-driven product market. Thus far, nearly 10% of the insurers operating in Indiana's individual market have withdrawn, and many others are threatening withdrawal in the near future. The private market's reaction to even these early requirements is ominous. 2014 is steadfastly approaching. Consumer choice is dwindling. Health insurance premiums are rising. In an effort to promote consumer choice and protect the insurance market, Indiana has applied for a waiver from the federal MLR requirements. This way Indiana can continue to apply its own criteria when reviewing rates for compliance, as IDOI and other regulators have the best knowledge of the market and will do what is best for Hoosiers. Obtaining the waiver will allow IDOI to have more autonomous control over its insurance market so that it can continue pursuing its top priority of protecting Hoosiers' interests and health care options in the face of ACA's churning sea of legislative amendments and its resulting economic fallout.

Chairman ROE. Thank you.
Dr. Carlson?

STATEMENT OF DAVID CARLSON, M.D., GENERAL SURGEON, EVANSVILLE SURGICAL ASSOCIATES

Dr. CARLSON. Mr. Chairman, Representative Bucshon, thank you very much for the opportunity to testify before the Subcommittee on Health, Employment, Labor, and Pensions.

I am President of Evansville Surgical Associates and have been practicing general surgery in Evansville for over 30 years.

I am not a health care policy expert, and I am definitely not an expert on this law. I am a health care provider. My limited time this morning permits me to comment on only a few aspects of this bill. My comments are derived from personal experience, from discussions with many of my colleagues over the last year since passage of the Affordable Care Act, from attempts at reading and trying to understand portions of this bill, and unlike Representative Roe, I have not read the entire bill. And I have also studied commentaries made by experts on all sides of the political spectrum.

I think very few of us would find fault with the intent of the new health care law, which is to provide health care coverage for those Americans presently uninsured and, among other things, to prohibit insurance companies from canceling policies without due cause, and to eliminate preexisting conditions as a basis for exclusion from insurance coverage, while at the same time reducing health care costs.

This bill is very complex and it is full of many new regulations, huge new bureaucratic entities, and what I think are many disincentives to small businesses to begin or continue providing health care for their employees. Despite the predictions by the administration that health care costs will be controlled and reduced, no one who has practiced medicine in the era of Medicare, which is heading toward insolvency, and Medicaid, which is straining the budgets of most States, should and can seriously believe that this massive new Government program can possibly control the cost of health care without rationing care or adding significant new taxes to the American public.

The point has already been made that the expansion of Medicaid is estimated to cost $3 billion to $4 billion over the next decade for the State of Indiana. Indiana is one of the few States in relatively stable financial condition, but it simply cannot afford this price tag

without a significant increase in taxes or reduction in services, which will obviously affect every Hoosier worker and employer in a negative way.

Indiana has been a leader in medical tort reform, and malpractice rates for physicians in this State are considered reasonable by most. The health care law is completely silent on medical liability tort reform. Logical and reasonable nationwide tort reform is certain to help lower medical costs. Unless protected by real tort reform, Indiana physicians and physicians throughout the country will have no choice but to continue protecting themselves from medical liability by ordering unnecessary tests, thereby fueling skyrocketing health care costs.

The employer mandate requires most small businesses to provide insurance to their employees or pay penalties or both. My surgical practice, which is a small business, has about 70 full-time employees and we provide them with excellent comprehensive health care insurance. Under the law, most of our employees would be eligible for Government subsidies for the purchase of health insurance because their household income is less than $88,000 for a family of four, which is 400 percent of the Federal poverty line. My company, therefore, faces a penalty equal to the lesser of $3,000 per subsidized employee, those eligible for the subsidy, which would total about $200,000 or $2,000 per employee if we don't offer health care insurance. So basically whichever we choose, this law is going to cost my company an additional $120,000 a year if we continue to provide our current health care insurance to our employees. Many small businesses, when faced with this type situation, are simply going to drop employee coverage, absorb the penalty, and let the Government provide Medicaid-style health care for their employees.

Finally, let me say a few words about access to health care. I cannot speak for all physicians. Evansville Surgical Associates accepts all patients regardless of insurance or lack thereof because of the nature of the services we provide, which is often acute care and emergency surgery. I know from discussions with my primary care colleagues that a sudden increase in the number of Medicaid patients seeking medical attention simply would overwhelm them and the system. There are not enough physicians to see these patients and most practices cannot survive on Medicaid reimbursement. As presently designed, this new law, while providing health coverage, does not offer a tenable solution to the problem of access to the health care system.

This concludes my remarks. Again, let me express my appreciation for the privilege of testifying before the committee.

[The statement of Dr. Carlson follows:]

Prepared Statement of David Carlson, M.D., Evansville Surgical Associates

Thank you for the opportunity to testify before the Sub Committee on Health, Employment, Labor, and Pensions.

I am President of Evansville Surgical Associates and have been practicing general surgery in Evansville for over 30 years. My group includes 17 surgeons and we employ over 70 individuals. We are by definition a small business.

I am not a healthcare policy expert and I definitely am not an expert on this law. I am a healthcare provider. My limited time this morning permits me to comment on only a few aspects of this bill. My comments are derived from personal experience, from discussions with many of my colleagues over the last year since passage of the Patient Protection and Affordable Care Act, from attempts at reading and try-

ing to understand portions of this bill, and from commentaries made by experts on all sides of the political spectrum.

Very few of us would find fault with the intent of the new healthcare law, which is to provide health care coverage for those Americans presently uninsured and, among other things, to prohibit insurance companies from canceling policies without due cause, and to eliminate pre-existing conditions as a basis for exclusion from insurance coverage, while at the same time reducing healthcare costs.

This bill is very complex and full of new regulations, huge new bureaucratic entities, and many disincentives to small businesses to begin or continue providing health care for their employees. Despite the predictions by the administration that healthcare costs will be controlled and reduced, no one who has practiced medicine in the era of Medicare, which is heading toward insolvency in the future, and Medicaid, which is straining the budgets of most states, can seriously believe that this massive new government program can possibly control the cost of healthcare without rationing care or adding significant new taxes to the American public.

The expansion of Medicaid will cover one in four Hoosiers, and is estimated to cost the state between $3.1 billion to $3.9 billion over the next decade, according to an actuarial analysis by Milliman, Inc. of Indianapolis. Indiana is one of the few states in stable financial condition, but it simply can't afford this price tag without a significant increase in state taxes or a reduction in state provided services, which will affect every Hoosier worker and employer in a negative way.

Indiana has been a leader in medical tort reform and malpractice rates for physicians are considered reasonable by most. The new healthcare law is completely silent on medical liability tort reform. Logical and reasonable nationwide tort reform is certain to help lower medical costs. Unless protected by real tort reform, Indiana physicians will have no choice but to continue protecting themselves from medical liability by ordering unnecessary tests, thereby fueling skyrocketing healthcare costs.

The Employer Mandate requires most small businesses to provide insurance to their employees, or pay penalties, or both. My surgical practice, which in essence is a small business, has about 70 full-time employees and we provide them with excellent comprehensive healthcare insurance. Under the new law, most of our employees would be eligible for government subsidies for the purchase of health insurance because their household income is less than $88,000 for a family of four, which is 400% of the federal poverty line. My company therefore faces a penalty equal to the lesser of $3000 per subsidized employee, which totals $210,000, or $2000 per employee, which totals $120,000. So this law would cost Evansville Surgical Associates an additional $120,000 per year to continue providing our current health coverage to our employees. Many small businesses, when faced with this situation, will simply drop employee coverage, absorb the financial penalty, and let the government provide Medicaid style health care for their employees.

Finally, let me say a few words about access to health care. I cannot speak for all physicians. Evansville Surgical Associates accepts all patients regardless of insurance or lack thereof because of the nature of the services we provide, which is often acute care and emergency surgery. I know from discussions with my primary care colleagues that a sudden increase in the number of Medicaid patients seeking medical attention simply would overwhelm them and the system. There are not enough physicians to see these patients and most practices could not survive on Medicaid reimbursement. As presently designed, this new law, while providing health coverage, does not offer a tenable solution to the problem of access to the health care system.

This concludes my remarks. Again let me express my appreciation for the privilege of testifying before this Committee.

Chairman ROE. Thank you, Dr. Carlson.

Ms. Wilson?

STATEMENT OF ELIZABETH WILSON, FRANKLIN, IN

Ms. WILSON. Chairman Roe, Representative Bucshon, and members of the subcommittee, thank you so much for the opportunity to testify today on this important topic. I am honored to appear before you.

I would also like to thank Ranking Member Andrews and Young Invincibles for helping to give me the opportunity to share my story.

My name is Elizabeth Wilson and I live in Franklin, Indiana, just south of Indianapolis. I am a prime example of how the Affordable Care Act has benefitted young people and their families in Indiana. Starting the year I turned 21, my health deteriorated for reasons that are still not completely clear. Coping with this sickness forced me to leave school for what should have been my senior year of college at Butler University. In the past 3 years, I have had four surgeries, a lot of tests and procedures, and I have had two hospitalizations for complications from chronic pancreatitis.

On my 23rd birthday, while I was in the hospital for acute pancreatitis, I aged out of my mother's insurance. Luckily, my family had access to COBRA and my mother was allowed to maintain coverage for me for a brief period at my family's expense. As you might expect, the high premium put a heavy financial burden on my family and me. Without the Federal dependent coverage extension and considering the long string of health challenges I faced over the past few years, I could have seen dire financial and health outcomes.

I could not have continued to pay the mounting health care bills to the hospital, my primary care physician, or the various specialists that I had seen for the past few years if I were not able to reenroll on my mother's health plan in January of 2011 because of the Affordable Care Act. Now that young adults can stay on their parents' insurance until the age of 26, I have good coverage to help pay for ongoing doctors' visits and medical issues that I face. I can't tell you how good it feels to be insured when, for a while, I thought that I wouldn't be at this point, saving for grad school while working, and trying to put my best foot forward and deal with my ongoing condition.

I wish I could tell you that my health problems were resolved, but unfortunately they are not. I finally did get a diagnosis of sorts this past year. It is a condition called undifferentiated connective tissue disease. It is an autoimmune disorder and that means I will probably be dependent on drugs, doctors' visits, testing, and therapies for the rest of my life to manage my symptoms and obtain a quality of life that all young Americans hope for. Well, a diagnosis of undifferentiated connective tissue disease doesn't necessarily give a patient a lot of guidelines to expect from what will happen. My doctors in my case are concerned that my symptoms signal the start of a more serious disease like Lupus, and so I do have to have ongoing testing to confirm that I do not have Lupus or that I do, which is difficult to do with that disease.

Luckily, I do know that any insurance that I have can't put a lifetime cap on what they will cover for my condition and can't kick me off just for being sick, even if my condition worsens. So this knowledge brings me some peace of mind.

My litany of health problems also means that I will have the dreaded preexisting condition, but just after I age off my mom's plan, discrimination based on preexisting conditions will be prohibited and insurance companies won't be able to discriminate against me anymore for something beyond my control. It is difficult enough

to start out as a recent graduate and try to make it these days. To do that with the extra burden of severe health problems, plus the full financial burden of treating them, is just too much.

I am certainly not alone in my struggles with health care or coverage. In fact, both my younger brother and my best friend went without coverage for more than a year. My best friend had some routine health screens that came back abnormal during that time and was unable to seek out specialist care to deal with them. And my family friend is now in a nursing home because she could not afford the newer drugs for multiple sclerosis which potentially could have slowed the progress of her condition. She is less than 45. She had to leave her two young children in the care of an 18-year-old relative.

Over the next few years, reform will help to address much of the circumstances for these problems, along with expanded affordable insurance options and access to preventive care. Those are the consequences of the recent health care law for Indiana workers and families.

I am now 24 years old, and I have finally graduated from college. After spending another year out of school to deal with my medical problems, I will be starting at grad school within the next academic year. Fingers crossed. I have to get accepted first. My health care problems have caused me to start 2 years later than I had originally planned, but thanks to the health care I have received and will continue to receive because of the Affordable Care Act, I will at least have the opportunity to start at all.

I have learned that we are all vulnerable to unexpected illness and injury regardless of our age. And my story could have ended more tragically for both me and for my family. That more tragic tale was prevented by the recent health care law.

[The statement of Ms. Wilson follows:]

Prepared Statement of Elizabeth Wilson, Franklin, IN

Chairman Roe, Ranking Member Andrews, and members of the subcommittee. Thank you for the opportunity to testify today on this important topic. I am honored to appear before you today. I would also like to thank Young Invincibles for helping to give me the opportunity to share my story.

My name is Elizabeth Wilson, and I live in Franklin, Indiana. I am a prime example of how the Affordable Care Act has benefited young people and their families in Indiana. Since the year I turned 21, my health deteriorated for no known reason. Coping with this sickness forced me to leave school for what should have been my senior year of college at Butler University.

On my 23rd birthday, while I was in the hospital for acute pancreatitis, I aged out of my mother's insurance. Luckily, my family had access to COBRA, and my mother was allowed to maintain coverage for me for a brief period, at my family's expense. As you might expect, the high premium put a heavy financial burden on my family and me. Without the federal dependent coverage extension, and considering the long string of health challenges that I've faced over the past few years, I could have seen dire financial and health outcomes.

I could not have continued to pay the mounting healthcare bills to the hospital, my primary care physician, or the various specialists that I had been seeing for the past few years if I were not able to reenroll in my mother's health plan in January 2011 because of the Affordable Care Act. Now that young adults can stay on their parent's insurance until the age of 26, I have good coverage to help pay for the ongoing doctors' visits and medical issues that I face. I can't tell you how good it feels to be insured, saving for grad school, and trying to put my best foot forward and deal with my condition.

I wish that I could tell you that my health problems were solved, but unfortunately, they're not. I finally got a diagnosis this past year, with a condition called

Undifferentiated Connective Tissue Disease. It is an autoimmune disorder, and that means I will be dependent upon on drugs, doctors' visits, testing, and therapies for the rest of my life to manage my symptoms and obtain a quality of life that all young Americans hope for. What is more worrisome is my doctors' concern that my condition is caused by the early stages of a more serious disease like Lupus or rheumatoid arthritis. Luckily, I know that any insurance that I have can't put a lifetime cap on what they will cover for my condition. They also can't kick me off just for being sick, even if my condition worsens. This knowledge brings me some peace of mind.

My litany of health problems also means that I'll have the dreaded "pre-existing condition." But just after I age off my mom's plan, discrimination based on pre-existing conditions will be prohibited, and insurance companies won't be able to discriminate against me anymore for something that I can't control. It's difficult enough to start out as a recent graduate and try to make it these days. To do that with the extra burden of severe health problems, plus the full financial burden of treating them, is just too much.

I'm certainly not alone in my struggles with health care or coverage. In fact, both my younger brother and my best friend went without coverage for more than a year, and a family friend is now in a nursing home because she had no access drugs that could have slowed the progress of her multiple sclerosis, forcing her leaving her two children with an 18-year old relative. Over the next few years, reform will help address all of that, with expanded affordable insurance options, and access to preventive care: those are the consequences of the recent health care law for Indiana workers and families.

I am now 24 years old. I have finally graduated from college. After spending another year out of school to deal with my medical problems, I will be starting at graduate school within the next academic year. Because of my health problems, I will be starting two years later than I'd originally planned. But thanks to the health care I have received and will continue to receive because of the Affordable Care Act, I will at least have the opportunity to start at all.

We are all vulnerable to unexpected illness or injury, regardless of our age. My story is far too common a reality that could have ended in a more tragic tale. That tale was prevented by the recent health care law.

Chairman ROE. Thank you, Ms. Wilson.

Ms. Lang?

STATEMENT OF SHERRY LANG, H.R. DIRECTOR, WOMACK RESTAURANTS

Ms. LANG. My name is Sherry Lang, and I am the Director of Human Resources for Womack Restaurants. We are a 12-unit IHOP franchisee based in Indiana with restaurants in Ohio. I am here today to represent my company and the restaurant industry and small business.

I have a master's degree in human resource development and over 17 years' experience in corporate HR. I spent the last 12 years at the executive level, and so I have been involved in all areas of business management.

I started with Womack Restaurants in 2005 and helped grow this company from 3 IHOP restaurants to the current 12. We currently have an expansion plan in place to build an additional 13 IHOP's.

I guess I am here today to share my experience and my understanding of how this health care law will affect our company and similar companies in Indiana.

The restaurant business is unique. It is really built on a small business model and profit margins are commonly only 5 to 7 percent. We are the most labor-intensive of any industry. We rank dead last in revenue per employee at $58,000. If you compare this to the next closest industries, hotels are about $107,000 in revenue per employee, retail at $170,000, banks at $443,000, and oil refin-

eries whose revenue is about $4 million per employee. Again, restaurants are $58,000.

The cost to employers of this health care law is completely, 100 percent dependent on how many employees you have, regardless of your revenue and regardless of your ability to pay. We conservatively estimate with our company the cost of buying health care insurance will be over 50 percent more than our company's earnings. And our company is very profitable.

It is a one-size-fits-all law for employers and this industry doesn't fit. Though some restaurant companies currently offer coverage now, most of those are mini-med plans. They are very limited coverage plans and they are designed specifically for employers like retail and restaurants. Even those plans will not qualify to meet the definitions of mandates in 2014.

The only viable alternative for our industry is to pay the $2,000 per employee penalty, and that is not tax deductible. That means, first, we have to earn that $2,000, and then we have to pay taxes on it. And so the true cost of that is about $2,800 per employee.

A quick study of public restaurant companies shows that many didn't earn enough in 2010 to pay the penalties, and they simply will not survive. These penalties equal 60 percent of our earnings, and gain, by restaurant industry standards, we are a very profitable company.

Restaurants are also facing many, many challenges. We have rising commodity prices, State and local taxes, unemployment taxes, energy prices, and so on. And yet, restaurants—we cannot raise prices in this economy. Our only alternative is to cut costs. Cutting costs means cutting staff, reducing hours, making a lot more people part-time. It is going to be trimming services that are provided by other small business that are directly supported by the restaurant industry such as food suppliers and equipment suppliers.

In addition, we have considered stopping our new restaurant development and may even forfeit the agreement we are already invested in. And that agreement was about $360,000. This future development would equal about $22 million in construction and development spending, and at least 260 full-time jobs. I would also like to point out that the restaurant equipment industry is one of the uniquely American manufacturing industries, and it has already been devastated in this economy.

The restaurant industry has such an important role in this economy. We employ 12.7 million people. Restaurants are often a first opportunity for young or unskilled workers and a place where they can actually turn that part-time job into a career. 50 percent of the managers in our company were promoted from within and started out with us as hourly staff. My first job was in a restaurant. The owner of my company started in a restaurant. It is also a unique industry in that it offers a lot of second chances for people starting over. It is an opportunity for those reentering society after incarceration. It is a second job for those digging out of a financial hole. We need this industry, but it cannot support this health care mandate and continue to thrive.

Furthermore, our lenders, as required by regulators, require us to maintain certain levels of profitability via our loan covenants. Our mortgages, our leases, our franchise agreements—these things

are often 15 to 20 years long. We have major obligations that we cannot walk away from in 2014. Profit equals development. If there is little or no profit, there will be no development.

On a related note, I am really seriously concerned that we are not going to be able to continue offering the health care plan that we offer now to our management and our office staff, based on the changes in who we must provide coverage for, as well as the compensation rules.

In summary, the goal of providing health insurance to everyone is noble and good. In theory, we support it, but this industry cannot afford to pay this bill. It comes down to basic math. At $58,000 in revenue per employee, $3,000 of that is profit. The cost of health care per employee is about $10,000. That leaves a $7,000 debt. Our only option is to pay the penalties. But even that, simply paying the penalties is going to be devastating for most of us in this industry.

Thank you.

[The statement of Ms. Lang follows:]

Prepared Statement of Sherry Lang, Womack Restaurants

My name is Sherry Lang. I am the Director of Human Resources for Womack Restaurants, a 12 unit IHOP Franchisee in Indiana and Ohio. I am here today to represent my company, the restaurant industry and small businesses. I have a Master's degree in Human Resource Development and over 17 years' experience. I have spent the last the last 12 years at the executive management level where I have been involved in all areas of business and business decisions. I started with Womack Restaurants in 2005 and have helped grow this company from 3 restaurants to the current 12 restaurants. We have an expansion plan to build 13 more IHOPS. I am here to share my experience and understanding of how the new healthcare law will affect our company and impact our future expansion.

The restaurant business is built on a small business model, with profit margins commonly of only 5 to 7%. We are the most labor intensive of any industry, ranking dead last in revenue per employee at $58,000 per employee.[1] Compare this to the next closest industries, Hotels, at $107,000 per employee, Retail at $170,000, Banks at $443,000, and Oil Refineries at over $4 million per employee. The cost to employers of new healthcare law is completely dependent on the number of employees, regardless of ability to pay. We conservatively estimate the cost of purchasing health insurance to be over 50% greater than our company's earnings. And our company is very profitable by industry standards.

The law is one-size-fits-all for employers, and our industry doesn't fit. Though some restaurant companies offer coverage now, many are "mini-med" plans which are limited coverage plans for employers like retail and restaurants. Many will not meet the mandates by 2014. The only viable alternative for our industry is to pay the $2000 per employee penalty, which is not tax deductible. We have to earn that $2000 dollars first and then pay taxes on it, bringing the actual cost of the penalty to about $2800 for each employee. A quick study of public restaurant companies shows that many did not earn enough in 2010 to pay the penalties and will not survive. For my company, these penalties amount to 60% of our earnings, and again, our company is very profitable by industry standards.

Restaurants are already facing many challenges, rising commodity prices, rising state and local taxes and unemployment taxes, rising energy prices and so on. Restaurants are unable to raise prices in this economy. Our only alternative is to cut costs. Cutting costs means cutting staff and reducing hours worked, putting more employees into part time status, and trimming services provided by other small businesses that are supported directly by this industry such as food suppliers and equipment suppliers.

Additionally, we will be forced to cease new restaurant development and may forfeit the development agreement we invested in. That agreement cost $360,000. This future development would amount to $22,000,000 in construction and development spending, and at least 260 full time restaurant jobs. I would like to also point out

[1] CNN/Money's Fortune 500 Report, 2009

that the restaurant equipment industry is a uniquely American manufacturing industry. That industry has already been devastated by the economy.

The restaurant industry serves an important role in our economy, employing 12.7 million people.[2] It is a source of 1st opportunities for young or unskilled workers who can turn a part-time job into a career. 50% of our Managers were promoted from hourly staff. My first job was in a restaurant. The owner of my Company started in restaurants as well. It's an industry of 2nd chances for people starting over: re-entering society after incarceration, or a 2nd job for those digging out of a financial hole. We need this industry but it cannot support this healthcare mandate and continue to thrive.

Furthermore, our lenders, as required by regulators, require us to maintain certainly levels of profitability via loan covenants. Our mortgages, leases, and franchise agreements are commonly 15 to 20 years long. We have major obligations that we cannot walk away from in 2014. Profits equal development and if there is little to no profit, there will be no development and growth.

On a related note, I have serious concerns that we will not be able to continue to offer the coverage we currently offer to my management and office staff, based on changes in who we must provide coverage for as well as the compensation rules.

In summary, the goal of providing health insurance to everyone is noble and good, in theory we support it, but the restaurant industry can't afford to pay the bill. In comes down to basic mathematics. At 58k in revenue per employee, we average $3000 in profit. The estimated cost of healthcare will be $10,000 leaving a $7000 per employee gap. Our only option is to pay the penalties. Simply paying the penalties will be devastating for most of us in this industry.

Chairman ROE. I thank all of the panelists.

I am going to start with making a statement, and then I will ask some questions.

First, Ms. Wilson to you, you cannot write a 2,700-page bill and not have some good things in there. I personally liked the 26-year-old—it is going to cost money and you understand that all the testing you have required costs a lot of money and somebody has to pay for that. So that is going to run the costs up. But that part of the bill I actually like. I like it.

I had three kids. When they got out of college, none of them had health insurance coverage. I had to buy them an individual policy on the individual market, which is not tax deductible.

And one of the things we could do very simply—the year I ran for Congress to make my health insurance cheaper was to treat me like a large corporation. I got no tax break. I had to go out on the individual market and buy that insurance which made it much more. If I had worked for a big company, it would have been tax deductible and made it much cheaper for me. So that part I like.

A couple or three things that were mentioned by the panel that we need to discuss work on—there was no question about preexisting conditions. I dealt with it in my patients who had breast cancer, which I saw most frequently, and other problems. Rescission by the insurance companies. That is a situation that needs to be dealt with. So there is no question there are some good things in here.

The problem with this is is anytime you have a massive, almost incomprehensible bill—and I have this. If any of you all would like to have it—I have a four-page summary—we will be glad to email it to any of you. It is a little simpler language. You can see when these things come into play. And I will be glad to make those available. We get your email. We will make sure the staff emails this to you.

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[2] National Restaurant Association

When we start looking at costs, let me give you a little history lesson. We will start with Medicare. The Congressional Budget Office first said this bill was budget neutral. Well, how they got to budget neutrality was taking $500 billion out of an underfunded Medicare program. Right now it is underfunded, and right now under current estimates in 11 years, it is broke. I mean, in 13 years it is broke, 2024. So we took $500 billion out of that. We took money out of a class act. We use student loans to pay for this. We use taxes on business to pay for this bill.

If you go back and look at Medicare when it came into play in 1965 and started in 1966, it was a $3 billion program. The Government estimators—there was no Congressional Budget Office—estimated this would be a $15 billion program in 25 years. The actual number was over $100 billion. They missed it by seven times.

Our experience in the State of Tennessee. We started with a program called TennCare to help control health care costs, exactly the things we were talking about in 1993: access and affordability. That is what we are talking about. That is what you were talking about, Ms. Wilson, is access you would lose if you didn't have your health insurance coverage. We reformed Medicaid in our State. It was a $2.6 billion program. In 2004, 10 budget years later, it was an $8.5 billion program. It took up every new dollar that the State of Tennessee took in.

And what we were finding was less and less and less physicians were accepting it. And why is that? Dr. Carlson mentioned this.

In our State—I don't know about Indiana, but in our State TennCare or Medicaid there pays about 60 percent of the cost of actually providing the care. Medicare pays about 90 percent of the costs. So how are those costs made up? Well, they are shifted to the private insurers. I mean, the hospitals have to pay their personnel and buy the new equipment that we use. So that cost-shifting also forced the costs up, not only this bill did with its requirements.

And also remember that you as a person no longer get to pick which insurance. The Government will decide what an essential benefits package is, not you as an individual. And when that happens, then the costs will go up when someone else other than you decides.

Health care decisions in my opinion should be made between physicians and their patients, not insurance companies and certainly not the Federal Government.

And there are a lot of onerous things we may not have time to go into about the current bill.

I want to know from the standpoint—and something that you all ought to read is some testimony we had in front of the Lockton Group about a month or so ago. I mean, we are business, and the restaurant/entertainment business—this particular bill is devastating for your business. Could you go into that, Ms. Lang, in a little more detail?

Ms. LANG. Well, you know, one of the common things in the restaurant industry—and this plays into a little bit—is that turnover averages about 125 percent in casual dining. We are very good. We are about 84 percent. But if you think about that, 84 out of every 100 employees turns over within a 1-year time. That is just one

other piece beside the fact that at a very profitable level a company in this industry averages about $3,000 in profit. So we either have a $7,000 gap if we are going to provide coverage. Well, that is impossible. Now we are out of business. Or we give up two-thirds of our profit. The penalty is $2,000. We are averaging $3,000 in profit. Nobody is going to stay in this industry and continue to develop restaurants. Why would you? They are literally going to take two-thirds of our profit.

The administrative burden of the constant turnover and how would we do that. I mean, it would simply be impossible. We would not offer coverage. It is not an option.

And many restaurants, especially large restaurant groups that have numerous restaurants, have separate groups of employees. And so for our professional staff, our managers and our administrative staff, we offer coverage, full-blown health package, 401(k), you know, the whole deal. We will probably have to eliminate that coverage. So I think the default, the accidental impact of this is that they are going to take away coverage for people that already have it.

Chairman ROE. Let me just finish and I will yield to Mr. Bucshon.

In this HR report, one of the things that also is brought out is that in the exchange, this Federal exchange that is yet to be determined—by the way, we are spending $14 billion—that is with a B—to set up these exchanges around the country, not to provide care for patients or if I write a prescription to care for that patient to get a prescription, but set up some more bureaucracy. Let's say you drop your coverage. And we provided health insurance coverage for our employees since 1968 in our practice. If they go into the exchange, the subsidy the Government gives them won't be as much as the subsidy I am paying right now for them.

And secondly, that subsidy—what they have to pay extra is not tax deductible to them. So their coverage is actually going to go up if they are forced into the exchange, and you are going to be forced to drop coverage because you can't afford it. And therefore, it forces the cost even higher. I think that is the unintended consequences that nobody figured out before they passed this bill.

Ms. LANG. Absolutely. I think the unintended consequences is that and that you are going to have all these people in the exchange. They will probably have lesser coverage. A lot of it is going to be politically defined rather than defined by people who know and understand health care.

Chairman ROE. Dr. Bucshon?

Mr. BUCSHON. Ms. Crosson, I want to ask you the first question. In regards to the exchanges, what are some of the issues and concerns about establishing the exchanges and how the State of Indiana is going to be able to manage the exchange? And do you have any idea from what you are seeing now how many more people may be on the exchanges higher than the estimate that the Federal Government has said will go onto the exchange? In my view, that is going to be a serious problem for the State.

Ms. CROSSON. Thank you. That is a very good question.

The first answer—I end up saying this a lot whenever I talk about health care reform—is I don't know, which is very frus-

trating. The biggest concern I have is you don't know. We don't know essential benefits. We don't know what it is going to look like, and when we ask, when we are trying to compare whether and decide whether to run a State exchange or whether the Federal Government would, one thing you would want to know is what I am comparing. What is the Federal Government version going to look like versus the State? The Federal Government tells us we don't know. We will be flexible. Then I get a phone call and they said—it is going to be unique to each State is what you need. And then I get a phone call from someone in the Budget Office for HHS referring to the Federal exchange meaning across multi-State, meaning one-size-fits-all. So I don't know the answer.

I do know that they are estimating about 500,000 new Medicaid participants. The challenges and concerns are why as a small business would you go to into and offer insurance at all, especially if you have a narrow profit margin. Who is going to pay for it? How is it going to be sustainable? We are spending billions of dollars to set these up, but they have to be sustainable if you set it up on the State being at least a year of setting up. So somebody will have to pay for the administration, the reviews, the reporting requirements, the technology, and we don't know what any of that is going to look like.

And finally, we don't know who is going to be around to participate on what insurance carriers. What about our small dental carriers? That is going to be—we heard for the essential benefits. So are vision carriers going to be able to participate on the exchange? Are they just going to go out of business because of major health insurance is going to take over that as part of their coverage? Are they going to partner up?

Those are just a few. The big one is we just don't know. We don't have the regs. We don't have the information.

Mr. BUCSHON. So overall, with all the new mandates on the insurance industry, in aggregate do you think these mandates are going to raise the cost of insurance in the State of Indiana?

Ms. CROSSON. Absolutely. Our insurers have been telling us in the individual market a minimum of 50 percent by 2014. We are hearing estimates ranging from 50 to 90 percent, and that is in the individual market. This is where your family or you—you purchase for your child. And then in the small group, at least 10 to 30. And again, we still don't have all the regs out. We have only got 6,600 pages.

Mr. BUCSHON. Chairman Roe?

Chairman ROE. One of the things—we are going to have a second round if it is okay—of questions and just briefly. And let talk a little bit or ask again a little, Ms. Crosson, about the individual mandate, how you see that affecting costs in the State. Then I will give you a personal example of how I think it would affect me.

Ms. CROSSON. The individual mandate—I had the privilege to speak with the Governor about it and talk with his task force about it and really the average citizen. And the best way I can explain it is this. Even if it is upheld, which Indiana is part of the 26-State litigation and the Governor's office in the State of Indiana and the Department of Insurance is—but even if it is upheld, it is ineffec-

tive. It is a great thing to get more people into the pool. It spreads the risk and that is a fundamental, basic concept of insurance.

But here is the problem. It is fear money. You have a choice between paying—especially for 19- to 25-year-olds, their premiums are going to go for maybe $100-$120 a month to probably $400 to $500 because they had only paid a third of the price of the highest charge. So now you are faced with $400-something a month when you were paying $128, or you wait until you get sick, you purchase coverage when you need it, and then you pay a $95 penalty that is prorated by the number of months you are covered. You are 19 to 25. What are your priorities and you are healthy? It is nothing. And you have a choice. $400-something is rent or a tuition payment or, or. And that is what you are looking at.

And even though the costs go up year after year, and when you are prorating and you just go in when you need it, as far as premium costs, what is going to happen is you don't have those young folks you want in to spread the risk who are healthy and don't need to utilize the services as often. If you are healthy, people are going to choose to stay out anyway until they really need it, and that is going to drive costs to skyrocket.

Chairman ROE. Here is another issue that many people are not aware of is that since 1986, there is a law that is called MTALA. For instance, if I am on call at the emergency room, it is illegal for me not to see someone regardless of whether they are legally in this country or whether they can pay or not. If I am a doctor in the emergency room and somebody needs care, I am going to see you. So that is the law of the land now.

And what has happened in Massachusetts where they have an individual mandate and where they have no preexisting conditions and no deniability—and you are exactly right. What has happened there is—we thought that the emergency room visits would go down because everybody had a primary care doctor. That is not what happened. What happened was the Massachusetts care actually pays about what Medicaid or less does, so less doctors are seen. The emergency room visits have not gone down. I just read an article in either JAMA or the New England Journal of Medicine the other day about that.

And secondly, people wait until they get sick, and then they can't be denied. So they buy the insurance coverage. Harvard Pilgrim Health Care Plan had that experience, and their experience was about six times per month cost for those people because they waited until they got sick, couldn't be denied, bought the insurance, when they got well, dropped it and paid the penalty because it is a lot less.

Now, I mean, I wouldn't do that. I would go ahead and buy the insurance because I think you ought to be covered. But that is happening right now in Massachusetts. Indeed, they hold costs down.

But again, back to the first premise that we have had. Have costs been held down? And the answer is no. They have the highest insurance costs in America.

Dr. Carlson, one of the things that I am concerned about—and I wanted to hear your take on it—is the biggest concern I have when I would have a Medicare patient or a TennCare patient, was finding a primary care doctor for them. And I would operate on

them, and then I would go try to find someone. I am extremely worried about this in access because if you can't get access to the physicians, the quality of your care goes down.

Have you noticed that here where Medicare patients are having a harder time finding a primary care doctor?

Dr. CARLSON. We have noticed that. A number of primary care physicians are not accepting any new patients and some who are accepting patients will definitely limit the number of Medicare patients they see. So our office is tasked many times with trying to assist the patient in finding a primary care physician, and it is tough. We have a list of physicians, and there are not many that we rely on to take these patients.

So access is a problem, and the reason is—several reasons. One is just the number of patients the individual doctor can see, and number two is the rate of reimbursement. You have to run your practice. You have to make a profit to pay your employees, and you can't do that if you see a great deal of Medicare or Medicaid patients. It is very difficult to do that.

Chairman ROE. Dr. Bucshon?

Mr. BUCSHON. Yes. Dr. Carlson, I also wanted to comment on how defensive medicine—how you see it affecting the overall cost of the health care system. There is some debate on that in Washington, D.C., and some say that that is not actually a significant percentage of the health care cost. But can you comment on your experience?

Dr. CARLSON. I don't know exactly what the figures are, but it definitely contributes to health care costs. I will just give you an example. We cover the trauma programs in Evansville. We see lots of patients come to the emergency room with trauma, some major trauma, some minor trauma, but once a patient is designated a trauma patient, regardless of how minor the injury seems to be on a quick examination, virtually all those patients get CT scans of the head, the neck, the chest, the abdomen, and the pelvis, thousands of dollars worth of tests. They are not medically necessary many times, but you certainly don't want to be caught missing something. And so everybody gets this. That is just one example of the cost that is unnecessary but physicians order it. They don't want to get trapped.

Chairman ROE. Will the gentleman yield?

Mr. BUCSHON. I will yield.

Chairman ROE. I use the example of when I was in residency, we didn't make much money. I mean, I made $280 a month, probably about what you made. Both of us may have been overpaid, but anyway that is about how much money I made. And I remember I moonlighted in some of the emergency rooms. If you would go to the emergency room and a patient would come in and they had some right lower quadrant pain, you would press—press on them, you would get a blood count, which is $15-$20, whatever it was then. And you would say I don't think have—your temperature is 99, white count is 10,000, probably not anything. You are probably okay. Once you go home, if it gets worse, why don't you come back and we will take a peak at you. And if you vomit, you know, just come on back if the symptoms get worse. That is how we did it 30 years ago.

Today—you are absolutely right—you are going to glow in the dark when you leave the emergency room. [Laughter.]

And the reason you are is because that has now become the standard of care, unfortunately. It is not the standard of care.

And so those are the kinds of things I think that suddenly add to the cost that is out there that you can't calculate what it is, but I know it and you know it. You can examine a patient's abdomen. I can guarantee you a skilled surgeon as you are and not needing a lot of the testing that is done, but you may get that test to protect yourself in case the 1 in 1,000, 1 in 100, whatever it may be, because if you do, you just get your pen out and start writing zeroes and commas and the check.

So it does add to the cost and doesn't add to the quality. And I think that is one of the things we have to address and we are not addressing it Washington. And quite frankly, I don't know what we wouldn't mess it up in Washington. It may best be left to the State level where you can do that.

I think I finished my questioning of this panel. I really appreciate your being here and taking your time to come and prepare your testimony. It has been very helpful, and I think we need to do more of this around the country and less of it in Washington. Thanks very much for being here.

We now would like to have our second panel come in.

Thank you all. [Applause.]

Thank you all for your attention, and I would like to take this opportunity to welcome our second panel. Dr. Bucshon, I will now yield to you for introduction of our second distinguished panel.

Mr. BUCSHON. Thank you, Chairman Roe.

Again, it is a pleasure to introduce this panel, and thank you all for coming and being willing to testify.

First is Representative Mark Messmer who serves the people of the 63rd district in the Indiana House of Representatives. Mr. Messmer is also a mechanical engineer and co-owns Messmer Mechanical, a plumbing and heating contracting business founded by his mother and father. Messmer Mechanical is based in Jasper, Indiana, and has 47 employees.

The Reverend George Philip Hoy formerly represented the 77th district in the Indiana House of Representatives. He is a resident of Evansville and a retired ordained minister of the United Church of Christ. He is now serving as the interim pastor of Zion United Church of Christ in Henderson, Kentucky. He serves as the religious co-chair of Tri-State Jobs with Justice and chaplain of the Central Labor Council and is testifying today on their behalf.

Denis Johnson serves as the Vice President of Operations for Boston Scientific's Spencer, Indiana plant. Boston Scientific has about 15,000 employees in the United States and about 1,000 of those employees are located in Spencer, Indiana, which is in the 8th congressional district, where they produce 2.2 million less invasive medical devices every year.

Mr. Glen Graber is the President of Graber Post Buildings in Odon, Indiana which manufactures and distributes materials for post frame structure and metal roofing projects. Graber Post employs approximately 210 workers.

Thank you all for being here.

Chairman ROE. Thank you all, and let me explain the lights again for you all that weren't here. It is 5 minutes per testimony, and the red light will go on at the end of the 5 minutes. The amber light in the middle means you have 1 more minute to complete your testimony. If you are in the middle of a thought, please go ahead and finish it. We are not going to cut the sound off.

So with that, Mr. Messmer, you may begin.

STATEMENT OF HON. MARK MESSMER, INDIANA HOUSE OF REPRESENTATIVES; MESSMER MECHANICAL

Mr. MESSMER. Hello, my name is Mark Messmer, and I am the Vice President and co-owner of Messmer Mechanical. We are a family-owned contracting business with 47 employees. There are 32 of those that are members of the Local 136 plumbers and pipefitters. 12 are full-time non-union employees, and 3 part-time employees.

We pay 100 percent of the health insurance costs for our employees. The union members' insurance costs our company $5.95 per hour. If the nonunion employees need family coverage, they pay the difference between the cost of the employee coverage and the family plan.

Our health insurance premiums have paced well beyond the rate of inflation for a long time. In 2009, our rates went up 28 percent; in 2010, another 26 percent; and in 2011, after implementation of the Patient Protection and Affordable Care Act, otherwise known as Obamacare, they went up a whopping 44 percent. So much for affordable.

Rising medical insurance costs have made it impossible for us to provide any raises during the 2009-2010 recession, and it made it extremely difficult to reinvest in our business.

We have exhausted all the easy fixes to our rising medical insurance costs. We raised the deductible in 2009 from $500 to $1,000 per person, and in 2011, we had to raise the maximum out of pocket from $3,000 to $4,000 per individual and $8,000 per family. The employees that are buying family plans in 2011 were allowed to raise their deductible to $3,500 per person or $10,500 per family just to hold their costs to the 14 percent increase. These changes are only shifting the cost of medical procedures to the patient, not cost containment.

We bid out our insurance every year to various insurance carriers around the area, and a 44 percent rate increase was the lowest we could get. Our rate increases are not due to history of our group. I confirmed from our agent that the major factor driving our rates through the roof is the impact of Obamacare on the medical insurance industry, and our small group pool—he said about half of the underwriters have dropped out of providing coverage in Indiana. Less competition means higher rates.

The temporary small business tax credit is very counterproductive to the very idea of growing your business. Businesses that grow will be penalized for that success. How stupid is that? When the institutional attitude of Congress is one that looks to punish businesses for being successful, our American economy and our individual liberty are in great danger.

I see nothing in Obamacare that will help in lowering the cost of providing insurance for my employees. We were told that cost containment was the goal of the new law. The problem with our current system is I pay in premiums to an insurance carrier who pays for procedures to doctors and hospitals to services provided to a third party person. It is a vicious cycle with the end consumer of the service having no connection to the cost. They have no skin in the game. The system is forcing me to the point of dumping my coverage and just saying the heck with it. Let the Government take it over, but we are all in trouble when that happens.

Looking ahead, I see nothing but more trouble ahead for businesses of all sizes. The taxing on private insurers, which is going to happen in 2014, will only be passed on through to the small businesses who purchase those plans like myself. The $100 billion they are projected to generate will punish the small businesses that Congress was supposedly protecting with the small business tax credit. What a joke. Congress tells you they are going to help you with one hand and nail you with the other.

Plus, the requirement for those over 50 employees to insure part-time workers, jobs creation is going to be almost impossible. We are at 47 employees now. Do you think we are going to let our company grow to 50 without repercussions? When insurance is required for part-time employees, I will have to fire my part-time workers. I cannot afford to keep them. It will be almost impossible for an entrepreneur to get a new business started.

The individual and company penalties for not providing or buying insurance are obviously set artificially low now to encourage me as a business owner to drop my coverage. When I compare a $2,000 fine versus the $10,000 to $15,000 that these plans are headed toward, it will be much easier just to pay the fine. It is blatantly obvious to me that as soon as the Government sees the millions of new uninsured people that these low fines are encouraging, those fines will escalate dramatically. They will come down like a hammer on small and large employers alike and be another crushing blow to jobs creation in this country.

Where in any of this debate has there been an attempt to promote programs like HSA's that put the consumer directly into the decision-making process of their health care dollars? Why was there no attempt to implement malpractice reform like the State of Indiana has adopted? Why not change the rules that would allow me to buy insurance across State lines to bring more competition and more carriers into our markets?

If cost containment was the goal, then why was everything that has been implemented under Obamacare destined to raise the overall health care cost and, in turn, my insurance costs?

If Obamacare is so great, why has the Health and Human Services Secretary written 1,372 waivers so far? Putting it bluntly, that is a bunch of crap. If it is good enough for me and my business, it is good enough for you and it is good enough for every other employer in this country.

Thank you.

[The statement of Mr. Messmer follows:]

Prepared Statement of Hon. Mark Messmer, Member, Indiana House of Representatives; Vice President, Messmer Mechanical, Inc.

Hello, my name is Mark Messmer. I would like to thank Congressman Bucshon for inviting me to be here today. I am Vice President and co-owner of Messmer Mechanical, Inc in Jasper, IN. We are a family owned plumbing and heating contracting business that was founded by my father and mother, Gerald and Linda Messmer, in 1970. We are long time members of the National Federation of Independent Businesses. We have 47 employees. There are 32 that are union members of Local 136 plumbers and pipefitters, 12 full time nonunion and 3 part time employees. Of our union employees 9 are building trade journeyman, 18 are residential journeyman and 5 are apprentices.

We pay 100% of the health insurance costs for our employees. The union members' insurance costs our company $5.95 per hour. The building trade members have that insurance fee paid to the local 136 medical insurance fund. The residential journeyman and apprentices receive that amount in cash, which they can use to go out and buy a private insurance plan on their own, or buy the same insurance that we provide to the nonunion employees. If our nonunion employees need family coverage, they pay the difference between the cost of the employee coverage and the cost of the family plan.

Our health insurance premiums have historically increased well beyond the rate of inflation, which is typical for most small employers trying to provide insurance for their employees. In 2009 alone our rates went up 28%, in 2010 another 26%, and in 2011, after the implementation of the Patient Protection and Affordable Care Act, they went up a whopping 44%. The new law ignores the rising cost of health insurance. In fact, the mandates, coverage requirements and taxes exacerbate the affordability problem. The out of control cost of our employee medical insurance is quickly becoming a prohibitive expense for our small business and other small businesses throughout the country.

The recession we are still dealing with has compounded the problem. During 2009 and 2010 when our company struggled to break even due to the recession's impact on the construction industry, it became very difficult to justify continuing to cover medical insurance benefits for our employees. Rising medical insurance costs made it impossible to provide any raises during that time frame, and made it extremely difficult to reinvest in our business.

We have exhausted all the "easy" fixes to our rising medical insurance. We raised the deductible from $500 to $1,000 in 2009 to hold the increase at 28%. In 2011 we had to raise the maximum out of pocket from $3,000 to $4,000 per individual and $8,000 per family to hold the increase to 44%. The employees that were buying family plans were allowed to raise their deductible to $3,500 per person and $10,500 per family to limit the increase in those plans to 14%. These changes are only shifting the cost of the medical procedures to our employees, not cost containment. Further cost shifting is inevitable if the law is enacted as written, increasing costs for individuals, employers and the federal government.

We bid out our insurance every year and did again this year and the 44% increase was the lowest rate we could get. We have been with SIHO for 4 years and were with Anthem for 3-4 years before that. I confirmed with our insurance agent that our rate increases were not due to the medical history of our group. We have a relatively young pool and have had almost no change in the amount of claims in our group for several years and have no high risk cases in our group. I also confirmed from our agent that the one major factor driving our rates through the roof is the impact of the new law on the medical insurance industry. He confirmed over the last year that the rate increase is largely due to raising the dependant coverage age to 26, no pre-existing condition exclusions for children, no lifetime benefit limits, no rescissions, and no cost sharing for preventative services have all impacted our rates. He also said one of the biggest causes for the increased costs is the fact that about half of the underwriters have dropped out of providing medical insurance in Indiana, and with less competition means higher prices. While these early provisions are popular, they all have only one impact on costs and that is to drive them higher.

The supposed small business tax credit is very counterproductive to the very idea of growing your business. The tax credit is temporary and so targeted that very few small businesses will be able to take advantage of it. Businesses that are successful and should be encouraged to continue to provide coverage are penalized for that success because they are ineligible for the credit. The same can be said of the insurance companies that are successful. Instead of being looked at as good businesses that provided great customer satisfaction, they have been demonized and targeted.

I see nothing in the new law that will help in lowering my cost of providing or health insurance to my employees, only policy that will move the costs upward in the wrong direction. We were told that cost containment was the goal of the new law. The whole idea of public buy-in on $10 prescription co-pays and $25 office co-pays have no connection with what those things actually cost. The problem with our current system is that I pay a premium to an insurance carrier, who pays hospitals and doctors for services used by a third person. It is a vicious cycle with the end consumer of the service having NO connection to the cost. The consumer of the service has no skin in the game. As the consumer is further removed from the interaction, as mandated by the new law, they are encouraged to utilize more medical services. The cost pressures in the current system will force me to the point of dumping my coverage instead of promoting flexibility and encouraging me to keep coverage. I fear that day for all of us.

Looking ahead I see nothing but more trouble for businesses of all size. The taxing on private insurers in 2014 will only be passed through to all purchasers of insurance. Those purchasers are me, the small business owner. This is an $8 billion tax in 2014, growing to over $14 billion in 2018. The $100 billion it is proposed to "generate" over the next ten years will be born on the backs of the small business owner and vastly outweigh any savings from the small business tax credit. Advocates for the law tell you they are helping you in one hand but this tax will nail you with the other. This small business health insurance tax, or HIT, will once again punish the 2 million small business owners and their employees, effecting 26 million people covered under these plans. Additional coverage mandates, removal of all annual and lifetime limits, guaranteed issue and renewal, and restrictions in underwriting factors will continue to drive up my costs. The requirement for employers with over 50 employees to insure part time and seasonal workers provides strong disincentives toward job creation. When insurance is required for part time employees, I will be unable hire another part time worker. It will be almost impossible for an entrepreneur to start a new business and hire.

The fines and penalties on individuals and companies for not buying or providing government-approved insurance are set so artificially low that the incentives encourage me as a business owner to drop coverage. When I compare a $2,000 fine verse the $10,000-$15,000 that these policies are headed toward, it won't take much longer for me to be forced to pay the fine. The low individual penalty along with the elimination of pre-existing condition exclusions encourages individuals to wait until they get sick to buy a policy. It is blatantly obvious to me that as soon as the government sees millions of new uninsured people in this country that the low penalties are encouraging, those penalties will escalate dramatically, by five or ten fold. The new law cannot be paid for as shown by the current projections. The inevitable increase in the penalty and fine costs will come down like a hammer on small and large employers alike, kill job creation, and be another crushing blow to our individual freedom and liberty.

Where in any of this debate has there been any attempt to promote affordable options like HSA's that put the consumer directly into the decision making mode of how their health care dollars get spent? Why was there no attempt to implement malpractice reform like the State of Indiana has adopted? Why not change rules that would allow me to buy health insurance across state lines to bring more competition and more carriers into our markets? By removing lifetime limits from insurance policies, do you not think that hospitals will be encouraged to charge more for services they provide and raise overall costs? I think that seems obvious. If cost containment is the goal, then why was everything that was implemented in the law destined to raise overall costs, and thereby, my insurance costs?

I would like to thank you once again for the invitation to be here today and would be happy to answer any of your questions.

Chairman ROE. Thank you, Mr. Messmer.
Rev. Hoy?

STATEMENT OF REV. GEORGE PHILIP HOY, RET., UNITED CHURCH OF CHRIST

Rev. Hoy. My name is George Philip Hoy. I have been an ordained minister in the United Church of Christ for more than 50 years. I am now retired and serving as interim pastor of Zion United Church of Christ in Henderson, Kentucky. However, I am

a lifelong Indiana resident and have lived in my current home in downtown Evansville for 29 years.

I am also Religion Co-Chair of Tri-State Jobs with Justice and Chaplain of the Central Labor Council. I have also been an elected official. I served on the Vanderburgh County Council for 12 years and in the Indiana House of Representatives for 4 years.

I speak in support of the Affordable Health Care Act. Why? I am a firm believer in a single payer health care system. The legislation that is now law offers numerous benefits to the State of Indiana and its citizens.

There are 28 definable benefits achieved in 2010, 19 definable benefits in 2011. From personal and professional experience, I wish to address a few of those benefits.

During the past few years, I have had open heart surgery and my wife has been treated for breast cancer. Yet, we count ourselves among the more fortunate citizens of the United States. If not for Medicare and the insurance we have through my denomination's pension board, we would be facing bankruptcy.

Last Sunday, Paul, a member of our church who is now undergoing chemotherapy, said he couldn't wait until his last chemotherapy session in December. After his final treatment, he will have to file for bankruptcy. His medical debt, as of Sunday, was $300,000. He has a job but no health insurance. When he asked the hospital for help, he was offered a 10 percent discount.

The Affordable Health Care Act has a number of provisions for the less fortunate. It gives immediate access to affordable health care for uninsured individuals with preexisting conditions. We have 17, soon to be 19 grandchildren. Four of our grandchildren have preexisting health conditions. I am grateful that our grandchildren will be assured of coverage because of the Health Care Act.

Extending dependent coverage is also important to our family. One of our grandsons, an honors college graduate, is still awaiting an opening as a school teacher. He is single, living at home, and working as a substitute teacher. Thank God, he is covered by his parents' insurance due to the provisions of the Health Care Act.

Closing the so-called "donut hole" for those on Medicare is another important provision of this act. Fortunately, my denomination offers my wife and me the excellent prescription coverage. However, I have watched less fortunate retirees forced to visit food pantries because they could not afford both groceries and medicine. Or worse, I have seen cases of people cutting back on needed medicines without consulting their physicians because they couldn't pay their bills.

Mandating the coverage of preventive screenings and immunizations is, in popular parlance, a "no-brainer." Just think about the cost and, more importantly, the prevention of suffering that flu shots alone ensure.

In Indiana, the increased funding for community health centers will nearly double the number of patients seen over the next 5 years. For those whose main interest is in dollars and cents, these increased health services can only contribute to a stronger economy in the form of a healthier workforce.

The act provides for more doctors where people need them, especially in low population rural areas. It provides funding for the Na-

tional Health Service Corps for scholarships and loan repayments for doctors, nurses, and other health care providers. In Indiana, this will help the 8 percent of our population who live in an underserved area of our State.

Some 84,400 small businesses can be helped by the new small business tax credit that will make it easier to provide coverage to their workers.

The act will give consumers some protections from negative policies of the insurance industry. Lifetime limits will not be placed on the coverage individuals receive. Insurance companies will no longer be able to drop people from coverage when they get sick. An appeals process will be required. Patient's choice of physicians will be protected.

In my opinion as a Christian pastor, adequate health care in the richest country in the world is a human right and a moral necessity. The Affordable Health Care Act moves us closer to achieving something very important as it relates to a term not used often enough in our political discussions. That term is "the common good."

The nations of what is called the developed world have all embraced national health care plans. The time is way past for us to catch up with them. The Affordable Health Care Act is not perfect, but it is a good giant step forward.

Tweaking the Affordable Health Care Act to make it better is one thing. Repealing it would be an unconscionable act by an unfeeling legislature. Repealing it in my estimation would be immoral.

Thank you for holding this hearing and thank you for allowing me this opportunity to testify.

[The statement of Rev. Hoy follows:]

Prepared Statement of Rev. George Philip Hoy, Ordained Minister, United Church of Christ

My name is George Philip Hoy. I have been an ordained minister in the United Church of Christ for more than 50 years. I am now retired and serving as Interim Pastor of Zion United Church of Christ in Henderson, KY. However, I am a lifelong Indiana resident and have lived at my current home in downtown Evansville for 29 years.

I am Religion Co-Chair of Tri-State Jobs With Justice and Chaplain of the Central Labor Council. I also have been an elected official. I served on the Vanderburgh County Council for 12 years and in the Indiana House of Representatives for four years.

I speak in support of the Affordable Health Care Act. While I am a firm believer in a single payer health care system, the legislation that is now law offers numerous benefits to the State of Indiana and its citizens.

There are 28 definable benefits achieved in 2010 and 19 definable benefits in 2011. From personal and professional experience I wish to address a few of those benefits.

During the past few years, I have had open heart surgery, and my wife has been treated for breast cancer. Yet we count ourselves among the more fortunate citizens of the United States. If not for Medicare and the insurance we have through my denomination's pension board, we would be facing bankruptcy.

On Sunday, Paul, a member of our church who is now undergoing chemotherapy, said he couldn't wait until his last chemotherapy session in December. He added that immediately after his final treatment he will file for bankruptcy. He has a job but no health insurance. His medical debt, as of Sunday, was $300,000. When he asked the hospital for help, he was offered a 10 percent discount.

The Affordable Health Care Act has a number of provisions for the less fortunate. It gives immediate access to affordable health care for uninsured individuals with pre-existing conditions. It also eliminates pre-existing conditions that exclude covering children. We have 17, soon to be 19 grandchildren. Four of our grandchildren

have pre-existing health conditions. I am grateful that our grandchildren will be assured of coverage because of the Affordable Health Care Act.

Extending Dependent Coverage is also important to our family. One of our grandsons, an honors college graduate and one of the four grandchildren with a pre-existing health condition, is still awaiting an opening as a school teacher. He is single, living at home, and working as a substitute teacher. Thank God he is covered by his parents' insurance due to the provisions of the Affordable Health Care Act. We also have several nieces and nephews who benefit from the extended coverage for young adults.

Closing the so-called "donut hole" for those on Medicare is another important provision of the Affordable Health Care Act. Fortunately, my denomination offers my wife and me excellent prescription coverage. However, I have watched less fortunate retirees forced to visit food pantries because they could not afford both groceries and medicine. Or worse, I have seen cases of people cutting back on needed medicines without consulting their physicians because they couldn't pay their bills. Now, in addition to the $250 payment they received and the new provisions of the law, they will not have to choose between buying groceries, paying utility bills, and paying for the medicines that they need.

Mandating the coverage of preventive screenings and immunizations is, in popular parlance, a "no-brainer." Just think about the cost and, more importantly, the prevention of suffering that flu shots alone ensure.

In Indiana, the increased funding for Community Health Centers will nearly double the number of patients seen over the next five years. For those whose main interest is in dollars and cents, these increased health services can only contribute to a stronger economy in the form of a healthier workforce.

The Act provides for more doctors where people need them, especially in low population rural areas. It provides funding for the National Health Service Corps for scholarships and loan repayments for doctors, nurses, and other health care providers. In Indiana this will help the eight percent of our population who live in an underserved area of our state.

Some 84,400 small businesses can be helped by the new small business tax credit that will make it easier to provide coverage to their workers.

The Act will give consumers some protections from negative policies of the insurance industry. Lifetime limits will not be placed on the coverage individuals receive. Insurance companies will no longer be able to drop people from coverage when they get sick. As mentioned before, children with pre-existing conditions cannot be excluded. An appeals process will be required. Patient's choice of physicians will be protected.

Some 28 reforms took place in 2010 and another 19 reforms are taking place this year. In subsequent years other reforms and benefits will accrue. It will take some time to live into all of the benefits.

In my opinion as a Christian pastor, adequate health care in the richest country in the world is a human right and a moral necessity. The Affordable Health Care Act moves us closer to achieving something very important as it relates to a term not used often enough in our political discussions. That term is "the common good."

The nations of what is called the developed world have all embraced national health plans. The time is way past for us to catch up with them. The Affordable Health Care Act is not perfect, but it is a good giant step forward.

Tweaking the Affordable Health Care Act to make it better is one thing. Repealing it would be an unconscionable act by an unfeeling legislature. Repealing it would be immoral.

Thank you for holding this hearing and thank you for allowing me this opportunity to testify.

Chairman ROE. Thank you, Rev. Hoy.

Mr. Johnson?

STATEMENT OF DENIS JOHNSON, VICE PRESIDENT OF OPERATIONS, BOSTON SCIENTIFIC

Mr. JOHNSON. Chairman Roe, Dr. Bucshon, thank you very much for inviting me today to testify on the impact of the Patient Protection and Affordable Care Act on Indiana's medical device industry.

My name is Denis Johnson and I am the Vice President of Operations at Boston Scientific manufacturing facility in Spencer, Indiana.

Boston Scientific is one of the world's largest medical device companies dedicated to less-invasive medicine. Our company's mission is to improve the quality of patient care and the productivity of health care delivery through the development and advocacy of less-invasive medical devices and procedures. We accomplish this by continually refining our existing products and developing new technologies that are designed to reduce risk, trauma, cost, and procedure time.

Boston Scientific has 15,000 employees in the U.S. and invests $1 billion each year in research and development to develop new products.

In Spencer, we have over 1,000 employees who produce 2.2 million less-invasive medical devices every year. Their average salary and benefits package is significantly higher than the State average. Nearly half of our employees live right in Owen County, so our impact on this rural part of the State is significant and growing. We are good community partners as well. Boston Scientific contributes nearly $150,000 a year to local charities and hundreds of volunteer hours for worthy causes such as Christmas for Kids, Hoosiers Outrun Cancer, local schools, and various other health-related events. Because of our significant impact in America's heartland, Spencer was highlighted in a recent ad campaign that showed the impact and opportunity companies like ours have for our workers, their families, and the community.

The medical device industry is a uniquely American success story, both for patients and for our economy. The United States is the world leader in manufacturing lifesaving and life-enhancing treatments for patients. At the same time, the medical technology industry has become an important engine for economic growth, especially in Indiana.

Our industry employs more than 400,000 workers nationwide. In Indiana alone, there are nearly 20,000 Hoosiers working at more than 300 FDA-registered medical device manufacturers, with an annual payroll of $1.1 billion. The industry has grown by nearly 30 percent in recent years and provides high-quality jobs that pay 40 percent more than the average wage in Indiana.

Nationwide, the industry is fueled by small businesses and entrepreneurs providing high-quality jobs: 62 percent of the firms have less than 20 employees and only 2 percent more than 500. Additionally, the medical device industry is a net exporter, totaling more than $33 billion annually and has consistently enjoyed a favorable balance of trade. With the aging of U.S. and foreign populations and the accelerating pace of biomedical discovery, the growth potential for this industry is strong.

Boston Scientific strongly supported health care reforms that improve quality by advancing the cause of the evidence-based medicine as part of the debate on the Affordable Care Act. We strongly advocated for the creation of a comparative effectiveness research institute to help clinicians and patients better understand the benefits of alternative treatments. This research could pave the way

for more personalized medicine and better care by learning what works best for different populations.

We advocated for the reforms to encourage greater coordination among health providers and called for greater emphasis on individual patient responsibility, prevention and wellness. We also highlighted the potential of remote monitoring technologies to improve care by better tracking and managing patients with costly chronic diseases.

While we are very proud of the progress we have made in improving patient care and see immense future opportunities to provide jobs and contribute to long-term economic growth in the United States, we are very concerned about the burden of the medical device tax on the industry. The new health law imposes a 2.3 percent excise tax on most types of medical devices. The excise tax is based on revenue, not profit, and begins in 2013. This harmful new tax is expected to collectively increase Federal taxes on medical device companies by $20 billion through 2019 and will cost Boston Scientific alone more than $100 million a year in additional taxes. Such a severe increase in tax liability will undoubtedly force us to cut critical R&D funding and inhibit job creation and retention.

Contrary to the stated goals of the President's reform efforts, the medical device tax will actually increase health care costs and undermine another of the White House's important objectives: promoting innovation. The U.S. Congress should embrace the value of the medical technology industry to our economy and our health care system by repealing this onerous tax. It will stifle innovation, destroy jobs, and thwart patient access to breakthrough technologies that have saved and enhanced millions of lives.

The medical device tax should be repealed for three important reasons.

First, this tax will stifle innovation and cost thousands of high-paying jobs. It will dramatically increase the effective tax rate for medical technology companies, severely reducing financial resources that should be used for R&D, clinical trials, and investments in manufacturing. This impact will be especially hard on smaller companies.

Second, this new tax will increase health care costs, not contain them, as much of the 2.3 percent increase will be passed on to consumers either directly or indirectly.

Third, there is no device industry windfall for the health care reform. Unlike other industries that may benefit from expanded coverage, that has not been seen in Massachusetts where health care reform law became law and the basis for the new Federal law. There was no device windfall.

Conclusion. The bottom line is the regressive tax would undermine America's and Indiana's global leadership position in product innovation, clinical research, and patient care. In this challenging economic environment, this tax will most assuredly hinder the development of the next generation of breakthrough treatments.

Again, thank you for inviting me to testify on the Affordable Care Act impact on the medical device industry. I look forward to answering your questions.

[The statement of Mr. Johnson follows:]

Prepared Statement of Denis Johnson, Vice President, Operations, Boston Scientific

Thank you for inviting me to testify today on the impact of the Patient Protection and Affordable Care Act (PPACA) on Indiana's medical device industry.

Boston Scientific is one of the world's largest medical device companies dedicated to less-invasive medicine. The company's mission is to improve the quality of patient care and the productivity of health care delivery through the development and advocacy of less-invasive medical devices and procedures. We accomplish this by continually refining our existing products and developing new technologies that are designed to reduce risk, trauma, cost, and procedure time. Boston Scientific has 15,000 employees in the U.S. and invests $1 billion each year in research and development.

In Spencer we have nearly 1,000 employees who produce 2.2 million less-invasive medical devices every year. Their average salary and benefits package is significantly higher than the state average. Nearly half of our employees live right in Owen County, so our impact on this rural part of the state is significant, and growing. We are good community partners as well. Boston Scientific contributes nearly $150,000 a year to local charities and hundreds of volunteer hours for worthy causes such as Christmas for Kids, Hoosiers Outrun Cancer, local schools and various other health related events. Because of our significant impact in America's heartland, Spencer was highlighted in a recent ad campaign that showed the impact and opportunity companies like ours have for our workers, their families and our community.

The US and Indiana Medical Technology Industry

The medical device industry is a uniquely American success story—both for patients and for our economy. The United States is the world leader in manufacturing life-saving and life-enhancing treatments for patients. At the same time, the medical technology industry has become an important engine for economic growth, especially in Indiana.

Our industry employs more than 400,000 workers nationwide. In Indiana alone, there are nearly 20,000 Hoosiers working at more than 300 FDA registered medical device manufacturers, with an annual payroll of $1.1 billion. The industry has grown by nearly 30% in recent years and provides high-quality jobs that pay 40 percent more than the average wage in Indiana.

Nationwide, the industry is fueled by small businesses and entrepreneurs providing high-quality jobs: 62% of firms have less than 20 employees and only 2% have more than 500. Additionally, the medical device industry is a net exporter, totaling more than $33B annually, and has consistently enjoyed a favorable balance of trade. With the aging of US and foreign populations and the accelerating pace of biomedical discovery, the growth potential for this industry strong.

Impact of the Patient Protection and Affordable Care Act (PPACA) on Indiana's Medical Device Industry

Boston Scientific strongly supported health care reforms that improve quality by advancing the cause of evidence-based medicine. As part of the debate on PPACA, we help clinicians and patients better understand the benefits of alternative treatments. This research can pave for the way for more personalized medicine and better care by learning what works best for different populations.

We advocated for reforms to encourage greater coordination among health providers and called for greater emphasis on individual patient responsibility, prevention and wellness. We also highlighted the potential of remote monitoring technologies to improve care by better tracking and managing patients with costly chronic diseases.

Medical Device Tax Will Impede Innovation and Patient Access to Medical Technology

While we are very proud of the progress we have made in improving patient care and see immense future opportunities to provide jobs and contribute to long-term economic growth in the United States, we are very concerned about the burden of the medical device tax on the industry. The new health law imposed a 2.3% excise tax on most types of medical devices. The excise tax is based on revenue, not profit, and begins in 2013. This harmful new tax is expected to collectively increase federal taxes on medical device companies by $20 billion through 2019, and will cost Boston Scientific alone more than $100M a year in additional taxes. Such a severe increase in tax liability will undoubtedly force us to cut critical R&D funding and inhibit job creation and retention.

Contrary to the stated goals of the president's reform efforts, the medical device tax will actually increase health care costs and undermine another of the White

House's important objectives—promoting innovation. The US Congress should embrace the value of the medical technology industry to our economy and to our health care system by repealing this onerous tax. It will inevitably stifle innovation, destroy jobs, and thwart patient access to breakthrough technologies that have saved and enhanced millions of lives.

The Medical Device Tax Should be Repealed for Three Important Reasons:

First, this tax will stifle innovation and cost thousands of high-paying jobs. It will dramatically increase the effective tax rate for medical technology companies—severely reducing financial resources that should be used for R&D, clinical trials and investments in manufacturing. The impact will be especially hard on smaller companies whose innovations are not immediately profitable.

Second, this new tax will increase health care costs, not contain them, as much of the 2.3% increase will be passed on to consumers either directly or indirectly.

Third, there is no device industry "windfall" from healthcare reform. Unlike other industries that may benefit from expanded coverage, a majority of device-intensive medical procedures are performed on patients that are older and already have private insurance or Medicare coverage. In Massachusetts, which passed a healthcare reform law which became the basis for the new federal law, there has been no device "windfall" despite the addition of 400,000 covered lives. The lack of a windfall is Conclusion The bottom line is this regressive tax would undermine America's, and Indiana's global leadership position in product innovation, clinical research and patient care. In this challenging economic environment, this tax will most assuredly hinder the development of the next generation of breakthrough treatments. Again, thank you for inviting me to testify on the impact of PPACA on the medical device industry. I look forward to answering your questions.

Chairman ROE. Thank you, Mr. Johnson.

Mr. Graber?

STATEMENT OF GLEN GRABER, PRESIDENT, GRABER POST BUILDINGS

Mr. GRABER. Hi. My name is Glen Graber and thanks for inviting us to come up.

I started the company in 1973 with three men in the Odon, Indiana area. We build post frame buildings which you used to call them pole barns because they use round posts for them. But anyway, we manufacture wood roof trusses up to a 100-foot clear span and roll form our own metal and build buildings all over four or five States and have wholesale customers in provinces in Canada and probably about 25 States in the U.S.

But our company has 210 employees. We have 180 employees in Odon, Indiana, and then the other 30 are over in Versailles, Missouri at a sister company.

But we started doing health care, I think, in '01, somewhere thereabouts, and it cost about 50 cents an hour back then. Now I think we're up to about $2.25 an hour thereabouts, just under $1 million for a year's worth of health care for everybody. And it just keeps increasing.

I didn't tell you about my education. I went to school 8 years in grade school, and my dad taught me most of what I know. He taught me to work. He made me work and he almost made me like it. [Laughter.]

Anyway, this health care thing. It's just going to keep going up and keep getting more expensive. I think our health care went up about 30 percent last year or I guess you would say this year. I think they quoted a year ahead. But I can't see it doing anything but just keep going up.

And most of the technical things that they all talked about, there is really no reason for me to reiterate on that. But we just can't afford it. There is just no way. I can see it doubling in the next 2 or 3 years for Graber Post. Right now, it is about 1 percent of our total gross sales is what it is costing us. But profit margins just keep getting smaller and smaller also in the industry.

We just got to get more business people in Washington, D.C. and let a few of the lawyers go home. [Applause.]

This country is worth saving and we got to work on it.

Thank you for having me.

[The statement of Mr. Graber follows:]

Prepared Statement of Glen S. Graber, Graber Post Buildings

My name is Glen Graber and I am the President of Graber Post Building and Martin Metals. I started Graber Post in 1973 as a 3-man Amish building crew that built post frame buildings. In 1987, I invested in a computerized roll former, which allowed Graber Post to purchase truckloads of steel coils and then roll our own steel siding panels according to its customers' specification. Over the past few years, our company has grown and we've added a new $1 million state of the art facility in 2007 to house the company's office, showroom and Hardware store.

We employ a total of 210 employees and currently offer a group health insurance plan to every employee. When we began offering health care to our employees in 2001, our total cost was $.50 per hour per employee, based on 2000 hours of work. Currently, our cost per hour per employee is $2.25; a $1.75 per hour per employee increase over a ten year period including a 30% increase from 2010 to 2011. Our current total cost is $945,000, and if the increase from this last year is any indication, I believe it will only continue to rise.

The rising cost of medical care and health insurance is impacting the livelihood of many Americans. The inability to pay for necessary medical care not longer affects only the uninsured, but is increasingly becoming a problem for those with health insurance. Over the past several years, the premiums that we have paid have more than doubled, as I previously indicated. As an employer, the more my costs for insurance goes up, the less money is available to invest in the company—expanding a customer base, upgrading technology or even increasing wages. The recent healthcare law has forced us to re-evaluate our plan benefits and shift some of the healthcare costs to the employees by raising deductibles and co-pays in order to sustain our healthcare plan.

The new mandated changes to health insurance—no lifetime benefit limits and restricted annual limits, no cost sharing for specific preventive services, no pre-existing condition exclusions for children, dependents covered through age 26—are good for employees. As an employer, I have to wonder how much premiums will be affected by the mandated increase of plan benefits. The average annual premium increase is currently about 10% to 12%. However, our company is experiencing increases well above that average. Our company is working with our insurance agent to come up with creative ideas that allow us to keep our current plan design and to control the costs passed onto the employees. We want to be engaged in promoting the health of our employees and their dependents while at the same time protecting our bottom line.

Chairman ROE. Mr. Graber, a couple of comments. One, it was the burley tobacco patch that convinced me chemistry wasn't that hard. That is where I grew up. It was in a tobacco patch in Tennessee. It convinced me if I studied chemistry, I wouldn't have to raise tobacco.

And secondly, we have 15 doctors in the Congress and about 240 lawyers, and we finally have them outnumbered. [Laughter.]

You all have opened a tremendous number of questions and issues with your testimony. Let me go back. It is an extremely complicated—the American health care system started out as a mom and pop business for one doctor, and it expanded. I can think back to my medical career. In 1970, when I graduated from the Univer-

sity of Tennessee College of Medicine, we had five antihypertensives, five high blood pressure medicines. There probably are 50 or 100 now.

Mr. Johnson, I have used much of the Boston Scientific new technology to help make things better for my patients. I don't want to see that stop. Our cancer survival rates are going up and up and up.

And I remember at St. Jude's Children's Hospital, when I was medical student there, 80 percent of the children died. Today 80 percent of the children live. We have seen incredible advances. We do not want to see that stop.

The challenge how do we make this more affordable. That is what I think I heard this panel talking about was how do we expand access.

I am going to tell you a story of a person that Dr. Bucshon and I had a conversation with a week ago tomorrow. And this particular person said that he sort of understood consumer-driven health care where the consumers were responsible for the first dollar of coverage. He sort of got that. He said he had a rash on his back and he went to his dermatologist and they gave him some medicine. His co-pay was $10. And he was out on the campaign trail and he forgot his medicine and his prescription card. So he had to go buy it and it was $400. And he said, well, you know, I am not itching that bad. [Laughter.]

So he made a consumer decision based on that. But he said, you know, you can't make consumer-driven choices in health care because my daughter was 3 months old and she got meningitis and had to go into the hospital. And he was absolutely right. You can't make a consumer-driven choice when your family has that kind of issue.

That person was the President of the United States. That is who we had the conversation with last Wednesday morning, and that is exactly what he said.

And to hold the cost down—after this is over, I want to meet with some of you all because I have some ideas. Let me give you an example of how some companies—a health savings account. I have one. This is a debit card right here. I had to go to the hospital and get some biopsies myself. And one of my friends I went to medical school was doing the surgery. I didn't call the insurance company. My doctor said I needed to have it done. That was a doctor-patient decision. He said, Phil, you need to have this done.

I went down to the outpatient clinic and I said, look, I don't want your most expensive thing. You are going to get your money in a millisecond. So they gave me a 35 percent discount. Rev. Hoy, if we can't get a 50 percent discount for that person, I will be shocked. They gave me a 35 percent discount. They then said now 45 percent is what they will give you for a cash customer. I go in. I get my biopsy. I go home. I have had it done.

John Deere corporation uses a health savings account, consumer-driven health care. They have had no or minimal health care premium increase in 5 years.

We also have to do disease management. 75 percent of all the money we spend on health care today is chronic disease management. It is high blood pressure, diabetes, smoking cessation. In this

country, unfortunately, obesity has become a real problem and type 2 diabetes.

One company, AFG, which is a company at home—Holston Munitions—everything that boils up, just about, in a war we make it in east Tennessee. And they have a program there of wellness. For instance, if you come in and you have high blood pressure, diabetes, hypertension, smoking, you are a train wreck waiting to happen. They pay you to correct those things. They pay for good incentives, not bad ones, not pay you to be sick, pay you to be well. And they have had a minimum health increase in 5 years. We could do that for the country without this incredibly complicated system that we have devised.

And, Rev. Hoy, you bring up some good issues. There are people out there who are uninsured. Those folks are tough. And what I would recommend we do for someone like him is a high risk pool that the taxpayers subsidize in the State. So he could have insurance affordable like anyone else. I think that is a group that have these preexisting conditions that maybe are uninsurable. You absolutely can do that.

So I want to hear Mr. Messmer again. I think you made some great points in your business of 47 people about why you are not going to go to 50. Why would that be?

Mr. MESSMER. Well, the price of mandated part-time coverage—in the summer, we like to employ a lot of the college kids or people who are retired who want part-time work. And at 50, the mandated provisions that are going to kick in—to me that is going to be an impediment to growing my business past 50. At that point, we are going to mandate additional coverages and mandate more provisions on those companies. And so anybody who is at that growth point in their business, we are going to say at 49 you are a good company and we are going to give you some breaks on the 50 or 51. And all of a sudden, you are just going to expose your company millions of dollars more cost. So it is going to be prohibitive for any company to want to make that growth step.

Chairman ROE. Dr. Bucshon?

Mr. BUCSHON. Thank you, Chairman Roe.

Mr. Johnson, a lot of attention has been focused on this medical device tax and it is onerous for Indiana's, like you said, 20,000 employees. How is your company going to handle that tax? What do you think that is going to mean for the consumers of health care?

Mr. JOHNSON. It is causing consternation within the company and it is under consideration currently. Having recently walked into Indiana University Hospital up in Indianapolis and seen an improved device kit used, my theory is that it will stifle innovation because some of that money will have to come from R&D.

When we talk about preexisting conditions, we talk about the standard of care and we talk about procedures that everybody wants access to, many of which weren't available 5, 10, 20 years ago. And I think it is real important for our kids and for our families that we continue to develop those technologies so there will be better treatment for them in the future.

Mr. BUCSHON. The other question is in regards to regulation in our country. I mean, the FDA is, obviously, important to you.

Where does Boston Scientific stand on FDA reform and streamlining the approval process?

Mr. JOHNSON. Well, innovation is critical and we see many companies starting to focus their development and launching new products 2, 3, or more years ahead of U.S. in Europe and other countries. And so procedures and treatments are available overseas that are not available right now because of the timeline it takes to get a product approved.

Mr. BUCSHON. And I want to comment on that as far as regulation goes. The FDA is one of the organizations right now that is in my view stifling innovation, and it is true that around the world, based on what the European Union and others are doing, people are getting ahead of us here in the United States because of what the Federal Government is doing to businesses like yours and small businesses around this country. So we are taking a serious look at reform in Washington, D.C. as it regards regulation, and that is not only through the FDA, but that is through all the other regulatory agencies which we really haven't touched on too much today about what is happening right now with job creation in our country.

But I do have serious concerns going forward. Since I was a heart surgeon and being in medicine, I understand that if we want to stay at least equal with or ahead of other countries, as far as research and development goes and innovation, this type of taxing on American employers and American businesses has to stop because other countries are getting ahead of us.

So thank you for your testimony. I yield back.

Chairman ROE. Just to tag team right quickly, a friend of mine is a hospital administrator on regulations. OSHA came in to examine where a handicap rail was in the handicap bathroom. So they said, no, it is in the wrong place. It needs to be up here. So he moves it and puts up there. The TOSHA, the Tennessee State Occupational Safety Administration, came in and said that rail is in the wrong place. It needs to be down here. I told him there is a simple solution. Just put bracket and when TOSHA comes, put it one place, when OSHA comes, put it in another. [Laughter.]

The problem with that is it is expensive. It costs. It is funny. Who pays for that? We do when we go to the hospital. It is very frustrating to see these kinds of regulations that one agency does just the opposite of another, and they both think they are following the rules.

We had Secretary Sebelius, as you all are, in front of our committee the other day. She is the Secretary of Health and Human Services which oversees Medicare and Medicaid. And I asked Secretary Sebelius, how many people do you think the Affordable Care Act is going to increase coverage to? And she around 30 million people.

I said, well, we have 2,700 pages. You have read it and I have read it. Let me explain how I can do almost all of that in two paragraphs. And she said, how is that? And I said, well, your own actuary at the Centers for Medicaid and Medicare Services said we are going to expand Medicaid by 24.7 million people. If you do that, that is almost 25 million of them. About 6 million, as you heard me say a minute ago—I like the 26 and under provision of the

plan. Those two things cover almost 30 million people. 10 million people that are uninsured in this country are illegally in the country. We have 15 million people who are eligible who haven't signed up currently for Medicaid. So you have programs available already.

And, Mr. Messmer, in your comment, one of the things that disturbed me—for a low-income worker, the most important thing is to make more money, to have a higher income. If you are required, when that requirement comes to buy insurance, as their salary goes up, their subsidy goes down. It is exactly the opposite of what you should be doing because they can't afford it now.

So I think we got to step back and take a look at the single biggest issue in America today is to get our people back to work. If you have a job, a lot of these problems go away. My father worked in a factory making shoe heels. He was a union member and worked in a factory and lost his job to Mexico when I was in the Army in Korea near the DMZ in 1973 and 1974. I know something about that. And that is by far and away the most important thing because if you have got money and a job, you can afford to buy some things.

So I mention that simply out of frustration because they have made this bill—well-intended. I don't mean that the intention is bad—incredibly expensive and complex.

And we have invited the President to meet with the physicians, the Doctors Caucus.

And another frustration I have, there were nine of us M.D.s just practicing doctors out there with decades of experience. Not one of us was asked a thing about this Affordable Care Act. Not one about this. Now, why would you have that expertise available to you and never ask a question to them? Dr. Roe, what do you think about this? And I would have had some suggestions through the 20 years' experience almost I have had with TennCare and certainly with taking care of patients and so forth, just as you have, Mr. Messmer, and you, Mr. Graber, in your business that you have.

So if I sound frustrated, I am. And it is something I hope that works, but I hope that we can overturn it and start over. And how do you make it more affordable? How do you do that? Well, you allow your business to get in business with him and share those costs. You put thousands of small businesses together. You go and partner up with some folks in Tennessee and maybe instead of 47 people you are insuring, you got 47,000 you are insuring. Why we don't do that is beyond me. Why we don't go across State lines and allow your businesses to get together.

We have two hospital systems in my district. Mountain States Health Alliance with all their hospitals have 9,000 employees. Welmont has 6,000. They can't get together and have 15,000 people as one group. They are not allowed to by law now. And so unless we start doing some smart business things, as you point out, Mr. Graber, get some people up there like myself that have run a small business for 30 years or helped run one for 30 years, we can help lower these costs.

Before we have our final closing comments, I want to yield to Dr. Bucshon for any further questions.

Mr. BUCSHON. Thank you, Chairman Roe.

Mr. Graber, first of all, you are the American dream. That is why this country is the greatest country on earth. And it is commendable what you have done with your business. I hope that we don't get in your way in Washington, D.C. That is as a first comment.

What actions do you think you are going to have to take in your business as far as your employees go as it relates to the Affordable Care Act? What are you talking about with your board and with the other members that run your company?

Mr. GRABER. Well, the big thing is I am the same as everybody else here. We have no clue what the real total bottom line rules are going to be. It is just a big confusion mess. We don't know if it is going to double in the next 2 years—the cost. At some point, it is not going to be affordable, but I don't know what the penalties are. I heard different penalty figures here if you don't comply. But we have never laid anybody off at our company. We work full-time even if it is in the wintertime. We cut back hours, but we work a lot of overtime in the summer. And we have been able to provide this health care and take care of our employees. They are the best asset we have.

Mr. BUCSHON. Thank you, Chairman Roe. I don't have any further comments as far as questions go.

Chairman ROE. Let me finish up and just give you a couple of examples, Mr. Graber. We started our practice with four doctors and 12 employees. We have been very blessed and we were able to grow that. I think we have 84 doctors now and 350 employees. And we have provided health insurance since 1968, retirement benefits, and we want to continue to do that.

We have about 300 people who get insurance through our practice right now. And it is about $6,000 per insured person. If one person goes to the exchange, we can drop all of our employees into the exchange and pay a $2,000 fine. And you multiply $2,000, or even with the taxes $2,800, times 300, you get a number. It is $600,000-$700,000. if you take the $4,000 we save and multiply it times 300, you get $1.2 million we could put to our bottom line. I have talked to a business in west Tennessee that said we are happy with our insurance as it is. We like the way our insurance is. If we have this essential benefits package, it will cost our business $40 million. If they drop them to the exchange, it will save that business $40 million. And as the testimony we had the other day from Lockton Group, is that we are not going to be the first to drop our health insurance in the exchange. We are not going to be third either because it is going to put you at a disadvantage as a company. So that is why people are looking at this because they can see—and especially the restaurant industry and the entertainment industry. They have such thin margins that they have to.

I want to say one other thing about Medicare. You have heard a lot about it in the last couple weeks. If you haven't been on Twitter—that is a joke. [Laughter.]

I am old enough not to know how to Twitter, so I keep out of trouble. [Laughter.]

If you look at Medicare, Rev. Hoy, right now my mother is 88 years old and lives on a Social Security check. We live in the same house we lived in for 50 years and a small pension and what I help

her with. She pays the same essentially that Warren Buffet does who is a billionaire. So I think there is a little imbalance there.

If you look at what has been recommended, one of the things that has been recommended in Congress is if you are 55 years and older, nothing changes in your health care. If you are 54 and younger, you will be offered exactly the same health insurance plan that a Congressman has, exactly what I would have until last year when I turned 65. I have Medicare Part A now myself. I would have rather stayed on what I had, but I can't. I am on Medicare. So at 54, you have that.

You are offered premium support, and what does that mean? That means when you turn 65, that your premium will be negotiated by the Federal Government just like they do now for the 12 or so plans that I have an option to pick from, that Dr. Bucshon has an option to pick from. They negotiate with the insurance companies the best price, spreading this risk over lots of people. The voucher is where we send you a piece of paper and you go have to do that. This is not a voucher system.

Also, a higher income senior like myself will have to pay more for their insurance when they are 65 because they will be indexed because of your amount of money that you make. If you are a lower-income senior or like your friend who has a preexisting condition, they will pay less. And I think this is a way that you can balance it as opposed to the way Medicare is today, which my mother, who has a $1,100 Social Security check per month, plus a small pension, plus what I give her, pays the same as Warren Buffet. We can fix that.

And the reason we are even talking about it is because, as every business person has said here, the current system is unsustainable as it is. Not making a decision is not a choice. We have to do that. We have to do that to save these programs for future generations.

The Hoy family is much more prolific than the Roe family. I only have two grandchildren, but I want to make sure that my grandchildren have the opportunity to have the same kind of life that I had.

The witnesses have been terrific. You all are amazing to sit out there for 2 hours and listen to politicians talk. I thank you for that, and we will be around afterwards if you would like to talk. I will make sure that any of this information that I have—you are certainly welcome to it.

This has been very helpful to me and I want to continue to go. I live in northeast Tennessee in Johnson City, which is up in the mountains of east Tennessee. Maybe many of you know where the Bristol Motor Speedway is. That is where my home is. A very similar area, agricultural area, rural area, biggest town in my district, 60,000 people. So we are not in a big urban area in other words. But we rely on small businesses like Mr. Graber's and like Mr. Messmer's, and we rely on big companies like Mr. Johnson's to provide the technology I used in the operating room. I think we can do better.

The other thing that I want to bring up before we leave, which is very disturbing to me—and actually this is an article in the New England Journal of Medicine. I know probably most of you all don't go to sleep reading that. I still do. But it is an article about a plan

that is current law right now I want explain to you all before we leave here. It is very important because I will be testifying next Tuesday in front of the Energy and Commerce Committee about this. We have 125 cosponsors, including Democrats right now.

The Independent Payment Advisory Board is a bureaucratically appointed board by the administration. And I don't care if it is a Republican or a Democrat. I don't want either one of them doing it. And I've never understood for the life of me why health care is a Republican or a Democratic issue. I have never seen a Republican or Democrat heart attack in my life, and I have never operated on a Republican or a Democrat cancer. They are just cancers and just heart attacks. I guarantee you Dr. Bucshon has never done a bypass operation on a Republican or a Democrat. We may have delivered a few Republican babies in my area. I will say that. [Laughter.]

Where I am going with this is IPAB is a 15-person board that will make decisions for Medicare based on strictly costs. We are spending $550 billion this year on Medicare. If we spent $600 billion—the Congress has given up its, I think, constitutional authority to decide how those dollars are spent. That bill says you have to cut that spending. The CMS, the Centers for Medicaid and Medicare Services, says you have to cut that spending.

Well, here is the news flash. $500 billion less in Medicare and we are adding, me being one of them, 3 million new seniors per year when the boomers hit. So we are going to have in the next 10 years 35 million more people seeking care. And that is one of the ways the President wants to hold it down. And what you will have is if you have more services chasing fewer dollars, you are going to create weights. And if you do that, you create quality issues and you create cost issues. And this is on the back of our senior citizens.

I am going to do the best I can. I know some of you all out there are on Medicare. I am going to go down swinging for you to get rid of this. And this is Republicans and Democrats.

And to let you know that this was not in the House version of the bill. When it didn't pass, it got stuck in the Senate version of the bill. And I have a letter right here in my package signed by some really conservative people, Barney Frank, Henry Waxman, and others who oppose this also. [Laughter.]

And Congressman Neal actually penned this back last year.

So this is going to come up. And if you would do me a favor, if you don't want your care rationed—and I am not going to use the term "death panels" and all that. It is just going to be rationing of care. You are going to have more services chasing fewer dollars. And I believe that Congress—that is me that is beholding to you who elect me—ought to be the one to make those decisions, not a bunch of bureaucrats, half of whom can't be health care people that are going to be making those decisions.

So I am very passionate about that because I can see that as a way to ration care for our senior citizens. And that is on the books now. Follow the bill that I have out there, and I am going to try to remove that if I possibly can.

So these two panels have been absolutely fantastic. I have had a wonderful time here in Indianapolis, and I want to do this more and get among you all.

Mr. BUCSHON. Evansville.

Chairman ROE. Evansville. Sorry. [Laughter.]

I was thinking about Butler in the final four. I got to see them play. I watched them play in Indianapolis. I was there.

But thank you all, the panel. You were terrific. Thank you for the audience. You all have been terrific. And we will hang around. Dr. Bucshon and I will hang around if you have got questions.

Do you have any closing comments?

Mr. BUCSHON. I am just going to make a few comments and say thank you, Mr. Chairman, for coming to Evansville because Phil Roe, when it comes to health care issues is a really hard act to follow. He understands the issues very in-depth. He practiced himself for over 30 years. He embodies the same thing that I think all of us try to do in health care, that the bottom line is it is about the patient. And everything that we do and try to do in Congress is about taking care of people, making sure that American citizens have access to quality medical care for all Americans at a cost that we can all afford going forward.

In my view, the Affordable Care Act doesn't make that happen. It is big Government really I think at its worst. It places mandates on individuals to buy health insurance which I think is unconstitutional. It expands the Medicaid program in the States which is an unfunded mandate which will cause all of Hoosiers' taxes to go up. It creates a subsidized exchange which no one knows how to set up, and ultimately the default is that the Department of Health and Human Services in Washington, D.C. will tell us in Indiana how to establish our exchanges. We don't want that. We want to maintain our individuality here as a State and not have a one-size-fits-all exchange program.

The other thing is I think from what you have heard today from small business and large business owners is that ultimately in my view most people are eventually going to be forced onto a Government health care program in the future based on the Affordable Care Act.

Businesses, large and small, as you heard today, have a very difficult time complying with the law because, first of all, the law is very complicated, and you don't necessarily know what you have to do.

Secondly, it is just onerous on employers, and it is much cheaper in the long run for people just to jettison their private health insurance for their employees, and that will force people onto exchanges or Medicaid.

In my estimation, the Affordable Care Act underestimates the number of people that that will happen to. And I think when we see the bottom line results, we are going to see that the Federal Government's budget as it relates to subsidizing health exchanges and Medicaid is going to go through the roof in a time right now when we are already in a critical budgetary crisis in Washington, D.C. because of what Washington, D.C. has been doing with our money really for decades.

And Chairman Roe and myself are there right now also trying to deal with the larger issue of what do we do——

[Audio Disruption.]

Mr. BUCSHON [continuing]. Price that all of us can afford.

So, again, Chairman Roe, thank you for coming to Evansville. You have become a great friend. I know you know this inside and out and are a wealth of information.

I look forward to meeting with the President, with you, and the Doctors Caucus. We have extended that invitation and President Obama told Chairman Roe and myself directly last Wednesday face to face that he would do that and talk about these issues and I take him at his word. So I look forward to that, and I look forward to moving forward again with a goal of providing quality health care at a reasonable cost for all Americans and that is what my concern is.

Thank you.

Chairman ROE. Thank you.

Before we close the hearing out, I serve on the Veterans Affairs Committee, and being a veteran, if you are a veteran out there, I want you to just hold your hand up so I can thank you personally for your service to our Nation. [Applause.]

If I can ever be of any service to you. I know Dr. Bucshon feels the same way. We would not be a free Nation without these veterans sitting in this room. We have got a lot of young people. I have been to Afghanistan. I am going back in the near future and hopefully Dr. Bucshon will be going with us to visit and put boots on the ground. These are brave young men and women. They make me proud.

And I had one of the greatest compliments I have ever had in my life, and it probably won't be what you think it is, but it was a young man that I met the other day that I delivered and then got to nominate him to the Naval Academy. That was a true honor to do that. He served his first year there, and I look at these great young men and women that are serving our Nation now. I just thank you so much for the service to our country.

We will keep this record open for 14 days for comments.

[An additional submission of Mr. Andrews follows:]

Prepared Statement of Elmer Blankenship, President, Indiana Alliance for Retired Americans

My name is Elmer Blankenship, President of the Indiana Alliance for Retired Americans. Our members wish to thank Chairman Phil Roe and Ranking Member Robert Andrews for the opportunity to send a statement on this important concern for Hoosiers. Thanks also to Indiana's 8th District Congressman Larry Bucshon for securing space for the hearing.

The Affordable Care Act became law last year and already millions of Americans are benefitting from its provisions. Seniors are saving money on prescription drugs and receiving free preventive care through Medicare. Insurance companies are no longer allowed to discriminate against children and others who are sick. Small businesses are receiving billions of dollars in tax credits to provide health care for their employees.

The Affordable Care Law reduces our nation's debt by eliminating waste, fraud and abuse in the health care system, reducing the growth of health care costs, and preventing excessive profit-taking by private insurers. According to the Congressional Budget Office, this will reduce the deficit by over $200 billion over the next ten years and by more than a trillion dollars in the decade after that.

There are important consequences for Indiana families and workers. The Affordable Care Law affects families, workers and seniors in the 8th District of Indiana

which includes Evansville. This year the Affordable Care Law provides a 50% discount for prescription drugs for Medicare beneficiaries who enter the Medicare Part D "donut hole" and lose coverage for their drug expenses. The discount increases each year until 2020, when the donut hole is eliminated. There are 10,000 Medicare beneficiaries in the 8th District who are expected to save money and be better able to afford needed prescriptions with the elimination of the donut hole. Medicare is also improved for the 117,000 beneficiaries in the 8th District by providing free preventive and wellness care, improving primary and coordinated care, and enhancing nursing home care. The new law strengthens the Medicare trust fund, extending its solvency from 2017 to 2029.

Insurance companies' can no longer deny coverage to children with pre-existing conditions and will be banned from discriminating against adults with pre-existing conditions in 2014 under the Affordable Care Law. There are 117,000 to 297,000 residents in the 8th district with pre-existing conditions like diabetes, heart disease, or cancer, including 8,000 to 36,000 children. The 19,000 to 48,000 individuals in the district who currently lack insurance coverage will be able to purchase individual policies under the new law.

Affordable Care Law allows young adults to remain on their parents' insurance policies up to age 26. In Rep. Bucshon's district, 2,300 young adults have or are expected to take advantage of this benefit.

The ban on annual and lifetime limits. The health reform law prohibits insurance companies from imposing annual and lifetime limits on health insurance coverage. This provision protects the rights of 416,000 individuals in the district who receive coverage from their employer or through the market for private insurance.

More Americans will be covered. When fully implemented; the health reform laws will extend coverage to 94% of all Americans. If this level of coverage is reached in the district, 46,000 residents who currently do not have health insurance will receive coverage.

The Affordable Care Law protects individuals from soaring insurance costs by requiring reviews of proposed rate increases and limiting the amount insurance companies can spend on administrative expenses, profits, and other overhead.

Hoosiers living in Indiana's 8th District and millions of other Americans are benefitting from the Affordable Care Law. It needs to be protected, supported and expanded.

Respectively submitted,

ELMER BLANKENSHIP.

This information is based upon the following sources: the U.S. Census (data on insurance coverage rates and types of coverage, small businesses, early retirees, income, and district populations); the Centers for Medicare and Medicaid Services (data on Medicare enrollment and the Part D donut hole); the Department of Health and Human Services (data on uncompensated care, Early Retiree Reinsurance Program participation, and preexisting conditions); and the Congressional Budget Office (data on health insurance coverage and deficit reduction under the Affordable Care Act).

[Additional submissions of Ms. Crosson follow:]

STATE OF INDIANA
MITCHELL E. DANIELS, JR., Governor

IDOI
INDIANA DEPARTMENT OF INSURANCE
311 W. WASHINGTON STREET, SUITE 300
INDIANAPOLIS, INDIANA 46204-2787
TELEPHONE: (317) 232-2385
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Stephen W. Robertson, Commissioner

May 13, 2011

Via Email and FedEx Overnight
United States Department of Health and Human Services
Attn: The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary,

On behalf of the Indiana Department of Insurance (IDOI) and the State of Indiana, I write to request relief from the Patient Protection and Affordable Care Act's (ACA) medical loss ratio (MLR) requirement as provided in 42 USC § 300gg-18(b)(1)(A)(ii) in order to avoid destabilization of the Indiana insurance market. Below you will find information demonstrating the need for a phased-in implementation beginning in 2011 continuing through 2014. This letter addresses the specifics of IDOI's request as related to consumer driven health plans (CDHPs) and these plans' corresponding health savings accounts (HSAs) and individual major medical health insurance policies.

I. Background.

Indiana has a robust individual health insurance market with more than 60 carriers actively marketing and writing business. All but five are smaller carriers, many of which are domestic to Indiana or have a physical presence within Indiana. Indiana's robust market provides consumers with choices and competitive premiums. They also serve to prevent market domination by a single player. Because of the large number of carriers, IDOI provides a comprehensive response based upon information obtained from both the Supplemental Exhibits filed with carriers' annual filings to IDOI as well as information provided by a sampling of 13 carriers offering coverage in Indiana. This represents about 147,357 total covered lives for individual products. Segregating individual responses and attempting to gather information from all carriers selling products in Indiana is unduly burdensome.[1] IDOI respectfully requests that the Secretary move forward with her determination based on the information provided herein.

[1] 45 C.F.R § 158.320 (2010).

42 USC § 300gg-18(b) provides the Secretary with the authority to adjust the percentage within a State:

> (1) Requirement to provide value for premium payments.
>
> (A) [B]eginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis. . . .
>
> (ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that *the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.*

The information required to be submitted in support of these requests in sections II and III is provided herein.

II. The State of Indiana respectfully requests a waiver for Consumer Driven Health Plans (CDHPs) sold in both the small group and individual major medical health markets.

In an effort to avoid market destabilization and continue to find innovative ways to bring down the actual cost of health care coverage, IDOI requests on behalf of the State of Indiana that CDHPs sold in both the individual and small group markets be exempt from the 80% minimum medical loss ratio as provided in 42 USC § 300gg-18(b)(1)(A)(ii).

According to America's Health Insurance Plans' (AHIP) 2010 report, enrollments for CDHPs, which are generally coupled with HSAs, have increased nearly 25% from 2009.[2] Currently, Indiana has the fifth highest percentage; 8.1% of the state's population, or approximately 360,000 people under the age of 65 with private health insurance, utilize CDHPs/HSAs. In particular, 73% of Indiana's nearly 29,000 state employees (excluding public university employees) participate in a CDHP/HSA.

Because of the success Indiana has witnessed just through our State personnel's utilization of CDHPs, Indiana strongly supports these plans for cost, affordability and quality purposes. The State of Indiana, as the plan sponsor for its state government employees, contributes about 55% of an employee's deductible into an account for CDHP participants, and the participants may contribute additionally to cover a portion of the out-of-pocket costs. The employee's contribution and control of the HSA continues to encourage individuals to make value-based decisions regarding their health care. Participants are empowered to take control of their health and the services they choose to access. Such empowerment results in patients asking

[2] *"January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans."* America's Health Insurance Plans Center for Policy and Research. May 2010. www.ahipresearch.org.

questions about treatment options, comparing cost and quality among providers and engaging in healthier behaviors to minimize health costs in general.

According to an independent study by Marsh & McLennan Companies (Mercer) commissioned by the State of Indiana in May 2010, there is no evidence that CDHP participants defer important health care services in any material way during the four-year study period.[3] Mercer's conclusion was based on the lack of reporting over the study period of any issues of adverse results from deferred care (e.g., union grievance, press reports), and the migration patterns were a one-way flow from the traditional preferred provider organization (PPO) plans to Indiana's two CDHPs.

Indiana's commitment to CDHPs is further evident in its Medicaid expansion to its citizens through the Healthy Indiana Plan (HIP) which operates similar to a CDHP. HIP provides a CMS approved benchmark equivalent benefits plan to adults under 200% of the federal poverty level (FPL). Consumer choice drives participants to take into consideration quality and cost when making their health care choices. Based on their ability to pay, participants are required to make monthly contributions into their Personal Wellness and Responsibility Account (the POWER account) that funds the plan's deductible. Members have the opportunity to lower their contributions if there is a balance in their account, and they complete their requisite preventative health care services.

There is evidence that the POWER account and the foundation of consumer driven tenets are driving personal responsibility. Emergency room usage is lower in HIP than in Indiana's other Medicaid programs and is lower than other comparable state Medicaid programs. Over 76% of HIP participants received their required preventative services and over 94% of HIP members report satisfaction with the program. HIP provides an alternative to traditional Medicaid programs and shows strong potential for consumer driven plans to impact patient behavior and encourage personal responsibility.

Although deductible factors are included in the proposed MLR regulation, which recognizes that the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles, the factors are not sufficient to stabilize the CDHPs' small group and individual markets. HSAs help to offset and reduce the monthly premiums for participants. In turn, the carrier receives less premium, and paid claims by the plan are reduced because consumers are covering some of their medical costs through their HSA. This encourages the consumer to be an active participant in making health care decisions based on costs, quality, benefits and outcomes. However, because of the necessity of tracking deductible and out-of-pocket costs, administrative costs for the plan remain the same.

Because plans with a large number of policyholder cost-sharing elements (deductibles, co-insurance and co-pays) will have a lower actuarial value (AV) than plans with smaller policyholders cost-sharing elements, loss ratios for CDHPs will naturally be much lower than loss ratios for more expensive policies having more generous benefits. Because of premiums,

[3] Gusland, Cory, Harshey, Tyler, Schram, Nick, and Swim, Todd. *Consumer-Driven Health Plan Effectiveness Case Study: State of Indiana*, Marsh Mercer Kroll Guy Carpenter Oliver Wyman, Chicago, IL: Mercer Health and Benefits, LLC, May 20, 2010.

individual consumers and small employers tend to trend towards CDHPs. Demographically, younger people tend to trend towards these plans because of affordability. Early entrance into an HSA and CDHP allows for a build-up of an HSA during times of health and availability of increased funds in years of sickness. This combined with the portability of HSAs allows individuals to financially prepare for costs of care later in life. The long-term benefit of these plans is to encourage individuals to consider the costs of health care when they are younger so that they can be engaged with their decisions as they access health care during their more mature years. Ultimately, the education and financial protection aspects of CDHP/HSA plans provide Indiana residents with the tools to manage health care costs over the long-run.

Those carriers with a large number of CDHPs on their books will be at a competitive disadvantage compared with those carriers that do not. Carriers with a large number of CDHPs cannot increase the AV without consumer objection potentially being manifested through consumers dropping their coverage. As a result, carriers are either faced with withdrawing from the CDHP market or paying rebates that could pose solvency issues. None of these unintended consequences should limit the choice for consumers for these plans, nor should they thwart a shared state and federal goal of actually lowering medical costs.

For the reasons mentioned above, Indiana requests a permanent waiver for individual and small group individual CDHPs plans from having to comply with the 80% MLR.

III. IDOI respectfully requests that individual major medical health carriers receive a waiver from the 80% MLR requirement through 2014. In the alternative, IDOI requests that carriers be required initially to meet a 65% MLR, and have it implemented incrementally over a four-year period.[4] IDOI further requests that new market entrants and products be exempt from MLR until 2014.[5]

IDOI has requested relief through 2014 to avoid destabilization of the individual market during this time of significant changes. Current market practice is to maintain the same premium for an individual consumer for the duration of their contract period (e.g. 1 year). Then at renewal, any pricing adjustments requested and approved by IDOI are applied to the renewal term of the policy. Again, the rate provided at renewal is maintained for the next contract term, et cetera. Employers and individuals appreciate the consistent pricing throughout the term of the policy because they are able to budget for insurance expenses. Fluctuations throughout the year would cause significant uncertainty and may increase those unable to maintain insurance.

Today in the group and individual markets any employer or individual may apply and become insured at any time. Therefore, a carrier may have one approved rate on January 1 and

[4] 2011 –65.00%
2012 –68.75%
2013 –72.50%
2014 –76.25%
2015 –80.00%

[5] A new market entrant would be defined as one that has not previously sold individual major medical health insurance products in Indiana for the previous ten year period.

another on July 1 due to pricing adjustments requested and approved by IDOI. Individuals who purchased insurance prior to the July 1 implementation receive one premium through the duration of their contract period and those at July 1 receive the revised premium. Upon renewal the following year, those who purchased prior to July 1 of the previous year will receive any premium adjustments approved subsequent to their purchase. From 2011 through 2013, carriers are able to adjust the rate because new policies are entering the pool all the time. Adjustments may be made and applied to the new and renewing entrants throughout the year in order for the carrier to manage their medical loss ratio.

Effective January 1, 2014, significant market changes will affect the market, among them: guaranteed issue; mandated coverage; the merging of high-risk pools with the standard market; implementation of essential benefits; and the integration of the previously uninsurable population that will initially have high health care costs because of pent-up demand. IDOI believes because of information reviewed thus far that is supported by its actuarial consultants that these dramatic market changes will result in significant premium increases. Unfortunately, accurate pricing without previous experiences may prove to be extremely challenging to the carriers who remain in the market. Allowing the MLR phase-in period to extend through 2014 provides some mechanism to stabilize the rates, maintain current consumer friendly pricing consistency market practices and maintain a robust insurance market.

Unlike today where individuals purchase and renew throughout the year, in 2014 ACA will essentially integrate the whole market into one effective date for policies on January 1, 2014. This includes those previously uninsured and those insured. There will no longer be a dynamic effective date throughout the year, aside from potential open enrollment periods which will be fixed. However, because everyone is mandated to have the defined minimum coverage effective January 1, 2014, there should not be significant renewals throughout the year. The exception will be those who lose coverage from their employers or other qualifying circumstances, and at this time, IDOI is unable to predict whether this will be a significant number of lives. If the carriers continue current market practice of maintaining the same premium throughout the contract period and only adjusting price on renewal, the carriers will be unable to make adjustments throughout the year if they see their experience is better or worse than expected in order to meet MLR. If the carrier under prices the product, it runs the risk of insolvency.

By contrast, if a carrier over prices the product due to fear and market uncertainty, consumers will pay more for the contract period and then may receive a refund approximately six months after the policy term. Therefore, consumers lose the ability to utilize their financial resources in a timely and efficient manner. Additionally, the carrier will have an MLR rebate issue and be subject to significant administrative costs over and above those anticipated which could lead to a solvency issue in the long-run. Thus, giving carriers some relief through 2014 will: 1) encourage carriers to maintain the current market practice of pricing stability throughout the period of the contract that allows consumers to budget for premium; 2) encourage

conservative pricing behavior; and 3) protect solvency participating carriers which ensures that claims will be paid as appropriate.

A. Indiana's Current Individual Health Major Medical Policy Standards.

Indiana law does not identify a specific MLR for major medical insurance policies. However, in reviewing premiums, IDOI relies upon the National Association of Insurance Commissioner's (NAIC) model act, which provides for a 55% lifetime loss ratio per product, as a guide. Indiana has never required a minimum annual MLR by market. ACA's annual minimum loss ratio for rebate purposes differs from the lifetime minimum loss ratio reviewed as part of the rate review process in Indiana. ACA's MLR combines the experience of all individual plans, which adds health quality expenses to the numerator for claims and subtracts taxes from the denominator for premiums. The MLR reviewed by IDOI as part of the rate review process is simply claims divided by premium. IDOI considers both lifetime MLR, which considers the entire lifespan of the insurance product from initial sale to closing of the product, and annual MLR which is the experience from the previous annual cycles, during the rate review process.

Because IDOI has not previously instituted MLR requirements similar to those required by ACA, carriers, particularly smaller local and in many cases provider owned carriers, need time to adjust their pricing accordingly. Information IDOI has received from carriers indicates that many will discontinue sales activities in hopes of minimizing the risk of not meeting MLR requirements, which destabilizes the market by providing fewer choices. Additionally, uncertainty as to benefits, implementation of market reforms throughout most of 2011 and continuous release of new information (*e.g.* Student Health Insurance Regulation released on February 11, 2011) place the market in continuous flux which makes pricing extraordinarily difficult under the best circumstances. Proper pricing is essential for market participation and solvency. Therefore, IDOI believes that without the phased-in implementation of MLR, the health insurance market in Indiana will be destabilized.

B. Operational and Financial Information.

An 80% MLR is much more difficult to meet in the individual market because of higher administrative expenses such as marketing and servicing of the policies on a one-on-one level with consumers. This is the nature of individual products in the market as it is structured currently. In addition, there are lower average premiums coupled with higher average deductibles in this market than in the group market. It is also common for individual plan consumers to submit their payment via credit card, which adds an additional 2-3% in costs depending on the creditor.

For plans underwritten as individual major medical policies, MLRs are much lower in earlier years but increase over time as more health complications develop, resulting in more claims incurred. Because of Indiana's robust market, a portion of the insurance market in Indiana is heavily weighted with newer business because healthy Indiana consumers have the ability to shop the market for the best value. In effect, this limits the ability for the individual

market to meet ACA MLR requirements as compared to other health insurance markets that have a larger, mature mix of old and new policies with correspondingly higher MLRs.

Selling new products that are underwritten during 2011 through 2013 will be disadvantageous to companies that lack large blocks of older business. Thus, new nonprofit carriers, newer companies and new products will face significant if not impossible obstacles to enter the market. These disincentives destabilize Indiana's previously robust and dynamic markets. Only larger and older carriers will have incentive to maintain or increase marketing efforts, thus giving companies with significant market share an even greater advantage and share of the market.[6] Even though the larger carriers would likely be better positioned to immediately implement an 80% MLR, these rebates will not likely be able to be offset by slim business margins. IDOI has attached Exhibit A that shows estimated rebates, individual earned premiums, adjusted earned premium, preliminary MLR, covered lives and net income loss for 2011. As a result, more individual carriers would exit the market. According to www.healthcare.gov, a single 35 year-old female wishing to purchase insurance has more than 240 plan options from among eight of the carriers doing business in Indiana that reported information to HHS. Many others do business in the state currently making even more options available. Exit from the market further reduces choice and destabilizes the Indiana market.

C. Premiums in Indiana.

The average annual new business premium is about $4,800.00 per policy, but there is considerable variation based on age, gender, tobacco use and plan design, among other things. The plan variety and benefit options have a wide range of price points that enable consumers to select affordable coverage that meet their specific needs.

Although there is no statutory limit in Indiana on how much a rate can be increased or decreased based on an individual's health status for individual plans, Indiana Code Title 27 grants the commissioner of IDOI authority to review all rate and form (policy/contract language) filings. Premiums must be reasonable in relation to the benefits provided by the policy.[7] All carriers operating within Indiana must file rates and forms and have them approved by IDOI *before* insurance products are marketed or sold to the public.[8] For the rate review process to begin, the carrier must complete a filing and provide the required data as outlined on the individual checklist at http://www.in.gov/idoi/2592.htm. For example, if a carrier requests a premium increase, it must file the request electronically and provide an actuarial memorandum that includes the following illustrative list that is based on an NAIC model requirement:

[6] For example, according to information provided in the Medical Supplement to the Annual Financial Filings, Anthem Insurance Inc. has approximately 65% of the market in Indiana in the individual market with the closest competitor Golden Rule Insurance possessing approximately 10% of the market.
[7] Ind. Code § 27-8-5-1.5(l)(1).
[8] Ind. Code § 27-8-5-1.5(g).

- the products affected;
- when the increase would take effect;
- percent of increase requested;
- loss ratio for each product;
- the number of covered lives;
- claims paid;
- medical trends;
- premium collected; and
- a summary report.

Carriers must certify that the information provided to IDOI is accurate. IDOI has the right to request additional information as needed to evaluate the request. Currently, Indiana considers a loss ratio to be the amount of premium spent for claim payments divided by the premium collected.

IDOI has an actuary on staff who reviews all documentation to determine if the insurance company submitted reasonable actuarial assumptions and trends. Additionally, pursuant to the Rate Review Grant I, IDOI contracts with an outside actuarial firm to perform review as well. This part of the review process can involve many conversations between IDOI's actuary and the insurance company. Following the actuarial review, IDOI's compliance review team meets weekly for discussions regarding the carrier's rate request. During this review, it may be determined that additional information is needed to clarify any concerns the team may have.

In addition to the actuarial recommendation, the compliance team considers the history of premium increases, the number of affected insureds and the impact distribution of the increase. The team also considers whether the product is open or closed and the annual Indiana and national medical loss ratios for the product. Once this review process is complete, IDOI approves, disapproves or recommends approval of an increase other than what was originally requested based on its actuarial review. If the carrier accepts the recommended increase, the negotiated rate is approved. If not, the filing is disapproved and the carrier may seek an administrative hearing before the Commissioner.

Because Indiana has sufficient rate review authority, its individual market has remained diverse with numerous carriers offering coverage to thousands of residents. For example, its prospective rate review authority[9] prevents small carriers from under-pricing, which protects the companies' solvency. Similarly, it prevents larger carriers from anti-competitive practices. Most importantly, rates must be actuarially justified in order to be approved. Although most of these carriers are in good financial health, an 80% MLR could force carriers to reevaluate their reserves and risk assessment, resulting in an increased risk based capital (RBC), which, in turn, could increase premiums.

[9] Ind. Code § 27-8-5-1.5(g).

D. Benefits.

Currently, Indiana consumers have a wide variety of benefit options to choose from to meet their financial and health needs. Indiana Code § 27-8-5-3, et seq., provides the minimum individual accident and sickness policy provisions that must be in all individual policies sold in the State of Indiana. In addition to specific contract language, Indiana law also provides for specific mandated benefits. The following are benefits that either must be provided by statute or, if a policy offers them, they must be provided according to particular criteria:

- **Mental retardation.**[10] If an individual accident policy provides that medical expense coverage of a dependent child ended due to the reach of the limiting age for dependent children, the policy must state that the reach of such limiting age does not refer to the termination of medical coverage of dependent child if the child is: (A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and (B) chiefly dependent upon the policyholder for support and maintenance.[11]

- **Mental Illness and Substance Abuse.** An individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions. Treatment limitations or financial requirements on the coverage of services for a mental illness are prohibited unless similar limitations or requirements are imposed on the coverage of services for other medical or surgical conditions.[12]

- **Pervasive Developmental Disorder (PDD).** The carrier must provide coverage for the treatment of a pervasive developmental disorder of an insured (autism or Asperger's Syndrome).[13] A written treatment plan for each individual with PDD must be developed and signed by the treating physician or a psychologist or physicians specializing in the treatment of PDD and treating the individual with PDD.[14]

- **Newborns.** An individual insurance policy must cover newborns. Benefits applicable for the individual or family member shall be payable with respect to a newly born child of the insured, certificate holder or subscriber from the moment of birth.[15]

- **Dependent Age 24.** Before September 23, 2010, an individual policy must have provided for coverage of a child of the policyholder to children under the age of 24 years, *if the policyholder requests such coverage.*[16] House Bill 1486 of the 2011 legislative session expanded the age to 26 to be consistent with ACA.

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[10] Ind. Code § 27-8-5-2(a).
[11] Ind. Code § 27-8-5-2(a)(8).
[12] Ind. Code § 27-8-5-15.6(d)-(e).
[13] Ind. Code § 27-8-14.2-4.
[14] IDOI Bulletin 179.
[15] Ind. Code § 27-8-5.6-2.
[16] Ind. Code § 27-8-5-28.

- **Orthotic and Prosthetic Devices.** An individual policy must provide coverage for orthotic and prosthetic devices.[17]

- **Mastectomy and Reconstructive Surgery.** An individual policy providing coverage for a mastectomy may not be issued unless it includes coverage for prosthetic devices or reconstructive surgery.[18]

- **Adopted Children.** Any individual policy or plan must cover newly adopted children of the insured or enrollee.[19]

- **Breast Cancer Screening Mammography.** An individual policy must provide coverage for breast cancer screening mammography.[20]

- **Diabetes.** An individual health insurance policy must provide coverage to the insured for the medically necessary treatment for diabetes.[21]

- **Diabetes Self-Management Training.** An individual health insurance policy must provide coverage for medically necessary diabetes self-management training.[22]

- **Coverage for Medical Food.** An individual insurance policy must provide coverage for medically necessary food.[23]

- **Colorectal Cancer Testing Coverage.** An individual insurance policy must provide coverage for colorectal examinations and laboratory tests for cancer in accordance with the American Cancer Society guidelines for an insured who is at least fifty years of age or less than fifty but at a high risk for colorectal cancer according to the American Cancer Society.[24]

- **Reimbursement for Off-Label Drug Treatment.** An individual insurance policy may not exclude coverage of a covered drug for a particular condition on the grounds that the drug has not been approved by the federal Food and Drug Administration (FDA) if the drug is recognized in at least one standard reference compendium, and it is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies.[25]

- **Postpartum Hospital Stay; HIV Testing; Payment.** An individual insurance policy that provides maternity benefits must provide minimum benefits to a mother and her newborn child that cover a minimum length of postpartum stay at a hospital, exam of

[17] Ind. Code § 27-8-24.2-5.
[18] Ind. Code §27-8-5-26(1)-(2).
[19] Ind. Code § 27-8-5-21(a).
[20] Ind. Code § 27-8-14-6(a).
[21] Ind. Code 27-8-14.5-4.
[22] Ind. Code 27-8-14.5-6(a).
[23] Ind. Code § 27-8-24.1-5.
[24] Ind. Code § 27-8-14.8-3.
[25] Ind. Code § 27-8-20-7.

newborns for disorders listed in Indiana Code § 16-41-17-2[26] and HIV testing of newborns.[27]

- **Inherited Metabolic Disease.** The coverage that must be provided cannot be subject to dollar limits, coinsurance or deductibles that are less favorable to a covered individual than the dollar limits, coinsurance or deductibles that apply to other coverage for prescription drugs or physical illness under the insurance policy.[28]

- **Coverage for Care Related to Clinical Trials.** An individual insurance policy must provide coverage for routine care costs that are incurred in the course of a clinical trial if the policy would provide coverage for the same routine care costs not incurred in a clinical trial.[29]

- **Chemotherapy.** For an individual insurance policy, orally administered chemotherapy must not be subject to dollar limits, copayments, deductibles or coinsurance provisions that are less favorable to an insured than dollar limits, copayments, deductibles or coinsurance for intravenously injected chemotherapy.[30]

- **Morbid Obesity Surgical Treatment.** An individual insurance policy shall offer coverage for non-experimental, surgical treatment by a health care provider of morbid obesity that has persisted for at least five years if nonsurgical treatment supervised by a physician has been unsuccessful for at least six consecutive months.[31]

All policy requirements including mandatory benefits are explained in greater detail on IDOI's filing company individual accident and health policy review standards checklists located at http://www.in.gov/idoi/files/Individual_Checklist_4-10(1).pdf (nonHMO individual policies) and http://www.in.gov/idoi/files/Individual_HMO_Checklist_4-10.pdf (HMO individual policies).

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[26] (1) Phenylketonuria; (2) Hypothyroidism; (3) Hemoglobinopathies, including sickle cell anemia; (4) Galactosemia; (5) Maple Syrup urine disease; (6) Homocystinuria; (7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department; (8) Congenital adrenal hyperplasia; (9) Biotinidase deficiency; (10) Disorders detected by tandem mass spectrometry; and every infant shall be given a physiologic hearing screening examination at the earliest feasible time.
[27] Ind. Code § 27-8-24-4.
[28] Ind. Code § 27-8-24.1-6.
[29] Ind. Code § 27-8-25-8.
[30] Ind. Code § 27-8-32-5.
[31] Ind. Code § 27-8-14.1-4.

E. Amount Paid to Agents/Brokers.

1. Impact on Agents/Brokers.

Indiana has approximately 25,814 licensed resident health agents and 2,682 resident agencies. Absent relief from a waiver, *existing* individual business that was priced according to existing MLR expectations will now be subject to losses for the companies operating in those lines of business. Because carriers negotiated vendor contracts related to administration and claims management as well as agent compensation contracts related to marketing, distribution and servicing of policies, these contracts cannot generally be retroactively changed for policies issued prior to the federal MLR requirements. As a result, this puts significant pressure on companies' operating expenses and exposes them to significant financial losses.

After these agent/broker contracts expire, carriers will likely be forced to reduce agent/broker compensation in order to meet MLR requirements. The per-enrollee costs of claims administration and policy administration are higher for individual policies relative to group prices (expressed as a percentage of premiums). In Indiana, the individual market has traditionally relied heavily on agents and brokers, which generate high distribution expenses, especially in the policy's first year.[32] By contrast, in the group market these same services may be undertaken by a human resources consultant whose compensation is paid by the employer and not incorporated into the premium, which spreads this expense over a large pool of policies.[33]

2. Impact on Consumer Access to Agents/Brokers.

Although the presence of the exchange in 2014 will likely reduce the role of agents and brokers in the long-run, a mass reduction of companies utilizing agents and brokers has a long-term effect because it will disrupt the distribution channel on which many of these smaller carriers rely to bring their products to market. Because smaller carriers cannot rely solely on name brand recognition, agents and brokers are vital until they can modify their marketing strategy to target sales for product placement on the exchange. Between now and 2014, the inability to use agents as a distribution channel could prevent many companies from surviving long enough to market their products on the exchange. In the end, limiting distribution channels via reduction in agents and brokers coupled with an inability to write new business would leave consumers with less choice in both the short-run and long-run. Mitigating the unintended consequences of the MLR requirement, by providing the requested waiver, would enable companies to extend utilization of agents and brokers between now and 2014.

3. Impact on Benefits and Cost-Sharing of Existing Products.

As a result of a carrier minimizing its marketing activity prior to 2014 because of the 80% MLR requirement, carriers may choose to terminate their existing blocks of business and

[32] http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf., April 28, 2010.
[33] http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf., May 14, 2010.

leave the individual market to avoid inescapable losses and avoid solvency concerns, five have done so already. In fact, Indiana has received letters from carriers warning that a withdrawal from the individual health insurance market could be imminent because of this MLR regulation. Additionally, it has received notices that some carriers may withdraw from the health insurance market altogether. Because of more federal mandates, increased utilization and the likelihood that providers will shift costs of uninsured and underinsured patients to insured patients, the culmination of these trends will likely increase premiums at least in the short-run. As a result, Indiana consumers may be forced to purchase coverage that has fewer benefits and higher cost-sharing components.

Although individual carriers are not statutorily required to notify IDOI that they are withdrawing from the individual market, most carriers do notify this agency out of courtesy. In addition to federal regulations mandating renewal found at 45 C.F.R. 148.22, Indiana law also mandates that existing individual policies be renewed for its policyholders.[34] However, if a carrier has ceased offering new products and, thus, new insureds have ceased entering the pool, premiums skyrocket because it forces those that are healthier to exit from the product prematurely because of spiraling costs, and it leaves only those in the pool that are sick, which is known as a product's death spiral. Because more carriers are likely to pull out and many of the insureds will not be able to obtain more affordable coverage until 2014, it will leave these individuals with no other options but to go without or purchase a plan through the Indiana Comprehensive Health Insurance Association (ICHIA), which is Indiana's high risk pool, or the federal Preexisting Condition Insurance Plan (PCIP). The PCIP is often not a practical solution for the very sick because one has to go without coverage for six months. Although ICHIA works for the traditionally "uninsurable" who have serious, chronic health problems, it was not meant for people who could traditionally obtain health insurance and pay their premiums. Such individuals would not be eligible for PCIP because they were previously insured, but lost coverage because their carrier withdrew from the market. Certainly ACA did not intend such a consequence.

IV. Conclusion.

Indiana's individual major medical insurance market currently enjoys the presence of numerous carriers that offer a vast array of choices for consumers. IDOI believes this is the best way to make prices competitive, by forcing larger carriers to remain consumer focused so that they do not rely solely on leveraging their market share to meet only their needs. On balance, Indiana contends, and has supported its contention with data, that consumer driven plans are cost effective, quality focused and are a tool to help stabilize costs by forcing consumers to contemplate health care consumption.

Indiana remains strongly committed to ensuring CDHP plans continue to be available to its residents. Individual carriers likely can meet a 65% MLR in 2011 and phased-in gradually to 80% in 2014 after accounting for permitted adjustments for qualified expenses, taxes and credibility. Without an adjustment to 65% initial MLR that is phased-in over a four-year period of time, carriers will pay out at least the amounts as demonstrated in Exhibit A. This estimate will likely be significantly more because it does not take into account the significant

[34] Ind. Code § 27-8-5-3(a)(13).

administrative expenses associated with the rebates. To date, at least five carriers have withdrawn from the Indiana individual major medical health insurance market since ACA was enacted, totaling just fewer than 3,500 policies or more than 20,000 total covered lives (small group and individual). Currently, another carrier with approximately 1,165 total lives covered is closely contemplating a withdrawal from Indiana's market. At a minimum without the MLR waivers requested herein, choices will be severely limited and IDOI anticipates many more of its carriers will reduce their market presence due to the unintended consequences of 42 USC § 300gg-18(b)(1)(A)(ii). Such withdrawal will destabilize the Indiana insurance market.

For these reasons, IDOI respectfully submits this waiver request and calls for relief from the MLR regulation for both consumer driven health plans (individual and small group) and individual health plans. Please contact Robyn S. Crosson at 317.234.6293 or rcrosson@idoi.in.gov for further questions. Thank you for your time and consideration to these matters.

Sincerely,

Stephen W. Robertson

Stephen W. Robertson
Indiana Commissioner of Insurance

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

April 15, 2011

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health
CMS Region V
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Ms. Johnson:

This State Plan Amendment (SPA) submission contains the required documents to request that the Healthy Indiana Plan (HIP), currently operated under an 1115 waiver, be the coverage vehicle for the newly eligible in 2014.

Despite our repeated attempts to get direction from CMS on how to proceed in order to continue HIP, we have not received any formal guidance. Former FSSA Secretary Anne Murphy sent letters to CMS on May 17, 2010 and August 30, 2010. Governor Mitch Daniels also sent a letter to HHS Secretary Sebelius on January 14th, 2011 asking for a response by February 28th. To date, we have not received a response to these requests.

We submit this SPA and hope it will provide us a vehicle to discuss the future of HIP and our current 1115 waiver. Thank you for your consideration of this SPA submission.

Regards,

Michael A. Gargano
Secretary

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Mitchell E. Daniels, Jr.
Governor

January 14, 2011

The Honorable Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Sebelius:

I wanted to make one last attempt to persuade you not to force the termination of the Healthy Indiana Plan (HIP), Indiana's program for low-income uninsured citizens. While there are many other aspects of the Patient Protection and Affordable Care Act (ACA) with which I disagree, I am especially disappointed that the bill may succeed in thwarting State-led innovation and consumer-directed healthcare programs that show strong promise to engage consumers in making cost and quality conscious decisions.

HIP, a home grown Indiana program, covers our uninsured population under a Center for Medicare and Medicaid Services (CMS) 1115 waiver. HIP is the nation's first consumer-driven alternative to traditional Medicaid. It features an HSA-like account, the Personal Wellness and Responsibility or POWER account, to which participants are required to make monthly contributions on a sliding scale basis. The program structure is designed to promote prevention, personal responsibility and cost-conscious consumption of healthcare services.

Attached are letters we have sent CMS with data demonstrating the program's significant accomplishments and popularity among its participants. After several phone calls with CMS staff, I am troubled by the feedback we have received regarding the future of the HIP program.

Your staff has advised us that our State Plan Amendment (SPA) to extend HIP into the future will be rejected, in part because of HIP's required participant contributions. The required contribution is central to the HIP structure, and eliminating the program's POWER account would effectively be the demise of this program. The over 98% of participants making contributions on time have proven that the Medicaid population is capable of making this very modest payment, which is critical to appropriate utilization and cost-containment. CMS's position favors dependency over personal responsibility, and disregards the ability of low income people to make choices for themselves.

HIP was implemented with bi-partisan support in the Indiana General Assembly and reflects the values of our state. Indiana prefers to promote this program that contains consumer-focused incentives for personal responsibility instead of a traditional Medicaid entitlement program. This month our legislature will consider a bill that calls for the

HIP plan to be the coverage vehicle for the newly-expanded population under ACA, and in 2011 we plan to submit the aforementioned SPA to accomplish this.

The HIP 1115 demonstration waiver is set to expire on December 31, 2012. Our goal is to extend HIP not only for 2013, but through 2014 and beyond. Please review HIP's advantages carefully and allow this program not only to survive, but also to serve all of Indiana's newly-eligible Medicaid population.

Under the new proposed rules, an application for a waiver extension is a significant effort. With the implementation of ACA looming over us, we have neither the money nor time to expend if a one year extension of our current waiver is the most you will permit. If HIP is not going to be the coverage vehicle in 2014, we have no choice but to dismantle the program for the current 45,000 current beneficiaries, and devote our finite resources to transitioning these individuals to the traditional Medicaid program. I ask that you give HIP careful review and give us official guidance no later than February 28th, 2011.

Ninety-four percent of HIP enrollees surveyed indicated they were satisfied with their coverage and 99% indicated that they would re-enroll in the program. In the passing of the ACA legislation, it was often promised that if people liked the insurance they had, they would be able to keep it; for HIP enrollees, this promise is now in question.

I hope that your forthcoming guidance will provide Indiana with the flexibility needed to continue flourishing and creative programs like HIP. Now more than ever, States need the tools to be able to improve a struggling Medicaid program, and Indiana is ready to try. Thank you for your consideration.

Sincerely,

Mitch Daniels

Attachments

STATE OF INDIANA

EXECUTIVE DEPARTMENT
INDIANAPOLIS

EXECUTIVE ORDER 11-01

FOR: ESTABLISHING THE INDIANA HEALTH BENEFIT EXCHANGE

TO ALL TO WHOM THESE PRESENTS MAY COME, GREETINGS:

WHEREAS, the Congress of the United States enacted and the President of the United States signed into law the Patient Protection and Affordable Care Act (on March 23, 2010) and the Health Care and Education Reconciliation Act (on March 30, 2010) (collectively referred to as "PPACA"); and

WHEREAS, there are numerous serious operational and constitutional challenges to the PPACA; and

WHEREAS, it is unclear how these challenges will impact whether Congress repeals, modifies, or does nothing to change existing PPACA language; and

WHEREAS, PPACA Section 1311(d)(1) requires the health benefit exchange to be "a governmental agency or a nonprofit entity that is established by the State"; and

WHEREAS, PPACA Section 1321(c) provides that if a State fails to establish an exchange, or is determined by the federal government not to have made sufficient progress toward establishing an exchange by January 1, 2013, the health benefit exchange for that State shall be established by the federal government; and

WHEREAS, there is limited federal guidance on health benefit exchanges, and no information at this time on how a federally-based exchange would be formed or how it would operate; and

WHEREAS, Indiana currently believes a State-created exchange protects Hoosiers from undue federal regulation; and

WHEREAS, the stringent timelines make it prudent for any State to conditionally analyze, plan, and prepare for a state-based exchange; and

WHEREAS, it is crucial that the health benefit exchange maintain the existing free market and assure coverage choices to Indiana citizens, coordinate with all appropriate stakeholders and utilize State resources efficiently and effectively; and

WHEREAS, a health benefit exchange structured as a new State agency or placed within an existing State agency would be an unnecessary, costly and burdensome expansion of State government; and

WHEREAS, a health benefit exchange structured as a nonprofit corporation will be best able to coordinate and leverage resources of existing State agencies and respond to, work with and protect the interests of the wide range of stakeholders involved, including Indiana citizens, State agencies, Indiana businesses, qualified health plans and the federal government.

NOW, THEREFORE, I, Mitchell E. Daniels, Jr., by virtue of the authority vested in me as Governor of the State of Indiana, do hereby order that:

1. The Indiana Family and Social Services Administration will work with other applicable State agencies, including the Indiana Department of Insurance, to cooperate in conditionally establishing and operating an exchange.

2. Assuming there is no forthcoming federal guidance that changes Indiana's decision, Indiana Insurance Market, Inc. (the "Exchange") shall be formed as an Indiana nonprofit corporation to serve as the Indiana health benefit exchange pursuant to PPACA.

3. The Secretary of the Indiana Family and Social Services Administration or the secretary's designee shall serve as the incorporator of the Exchange.

4. If after due analysis the State deems it appropriate to proceed with a State-created exchange, and after it has been determined by the federal government that the State of Indiana has made sufficient progress toward establishing an exchange, a Board of Directors will be selected to manage operations of the Exchange.

5. The Board of the Directors of the Exchange shall include representatives of appropriate State agencies and the Indiana General Assembly. Standing committees will be appointed that represent appropriate stakeholder representation, including, but not limited to, consumers, providers, and actuaries.

IN TESTIMONY WHEREOF, I, Mitchell E. Daniels, Jr., have hereunto set my hand and cause to be affixed the Great Seal of the State of Indiana on this 3rd day of January, 2011.

M E Daniels, Jr.

Mitchell E. Daniels, Jr.
Governor of Indiana

Charles P. White

ATTEST: Charlie White
Secretary of State

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Mitchell E. Daniels, Jr.
Governor

April 30, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

Thank you for your recent letter presenting Indiana's options for the new temporary high risk pool program being developed in connection with the Patient Protection and Affordable Care Act.

Years before the passage of national health care legislation, Indiana committed itself to increasing the availability of affordable healthcare and promoting wellness through our Healthy Indiana Plan for low-income uninsured citizens and the INShape Indiana fitness program. In addition, our state currently operates its own high risk pool, the Indiana Comprehensive Health Insurance Association, which provides coverage to approximately 7,000 individuals who would otherwise be uninsured.

However, the implementation of the new federal risk pools presents us with insuperable concerns. First and foremost, it is impossible to assess either the total cost of the program or what Indiana's total share of that cost would be. Our uncertainty was confirmed by your recent testimony before Congress, when you were unable to provide any estimate for the cost of the risk pools. What does seem certain, according to both our actuary and yours, is that the allocated federal funding for this project will be exhausted well before 2014, apparently leaving states responsible for the excess costs.

Second, you have not provided us with the extent of the mandates or requirements for a state choosing to run the new program. The Department says that participating states are required to submit a plan and enter into a contract with the Department in May, but there will be no regulations prescribing mandated benefits or eligibility requirements until June at the earliest. And, as this is a contract rather than a grant program, we have every reason to anticipate that if states such as ours do not run the high risk program commensurate with yet-to-be-determined federal standards, we will be subject to lawsuits or other penalties. No responsible state, nor any public or private entity for that matter, would make such an agreement without knowing the terms, costs or other exposures its taxpayers were taking on.

The Honorable Kathleen Sebelius
Page Two
April 30, 2010

We carefully analyzed the options presented to us, but in the end this was not a close call for Indiana: the risks Indiana is being asked to take are well beyond any range of acceptability. Given the options the federal government has presented, we have elected to allow the U.S. Department of Health and Human Services to establish a coverage program for Indiana instead of expanding our existing high risk program and exposing Indiana taxpayers to an open-ended and potentially enormous new burden.

Please let us know how best to communicate to Hoosiers the procedure to enroll in the federal high risk pool that you say will be accepting enrollees in July. We will want to make sure interested high-risk citizens have a chance to obtain whatever coverage you decide to make available across the country.

Sincerely,

M E Daniels, Jr.

Chairman ROE. Being no further business, the committee stands adjourned.

[Whereupon, at 10:53 a.m., the subcommittee was adjourned.]

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