Hello, my name is Titus North, and I am a Certified Application Counselor (or CAC) with Citizen Power. I would like to thank the Committee for inviting me to this hearing.

I would like to start by giving you a brief background of myself and of Citizen Power and our reason for becoming a CAC .

As for myself, I am former Professor at the University of Pittsburgh where I taught political science and economics. I have 20 years of experience with the insurance industry as a researcher, a financial journalist, and even a translator for Japan's largest insurance company. At Citizen Power I was the lead researcher and author for our study, funded by The Pittsburgh Foundation, on the ACA entitled "Pennsylvania's New Insurance Landscape: PPACA and its Impact on Regulation." A copy of the book was mailed to each committee member's office last September, so you may have already seen it.

Citizen Power is a 501(c)3 non-profit organization that is engaged in public policy research, education, and advocacy in the fields of energy and health care. We were motivated to conduct our research project out of concerns regarding the spiraling health insurance premiums in the Commonwealth.

Before discussing our experience as a CAC, I would first like to point out that Citizen Power supports a public insurance system along the lines of the Single Payer model outlined in U.S. Congress bill HR676 or the Pennsylvania Health Care Plan outlined in Pennsylvania Senate Bill 400 introduced by Senator Ferlo. As such, we did *not* support the ACA, and continue to feel that the ACA is not a viable long-term solution to the health care crisis in this country.

The logic for public health insurance is based in three sound economic principles:
1. A public insurance system has the purchasing power that no private insurance company can match.
2. Large public insurance systems, like Medicare, have economies of scale that hold down administrative costs.
3. The core function of insurance is to pool funds in order to spread risk, and the larger the risk pool the more efficiently risk can be spread.

While many believe that marketplace competition in the insurance industry improves quality and reduces costs the way it often does with manufactured products, in fact it has the opposite effect. This is because the core insurance function of spreading risk is based on the laws of probability, which are well-known and cannot be improved on. Thus, in order to reduce premiums for certain customers, insurance companies are inclined to chop up the risk pool by health status, geography, age, and gender in order to secure the healthiest and cheapest to insure population for themselves. This leads to massive redundancies and inefficiencies.

I would like to point out that while proponents of public health insurance systems in the United States tend to be associated with the left, if you look around the world you find that many of the most effective public health insurance systems were put in place by conservative governments for conservative reasons. The first public health insurance system was devised by Otto von Bismark in the late 1800's in order to stem the outflow of German emigrants to the United States.

Bismark liked Germans and wanted them to stay in Germany. The highly rated systems in France, Italy, and Japan were the creation of conservative governments in those countries, and have resulted in much better health outcomes with far less expenditure. Conservatives and liberals in those countries still have arguments about how much the systems should be paid for by taxes and how much by users, but no one disagrees with the economic benefit to a public system.

Now, regarding Citizen Power's experience and how it relates to this legislation. In order to become a CAC, I had to pass an on-line training course drawn up by the U.S. Department of Health and Human Services. The training included a focus on ethics and on how to handle sensitive personal information. The fact is that anyone helping someone with the website, whether they are a CAC, a navigator, an agent, or just a friend, is going to be exposed to certain personally identifiable information, including dates of birth, and full social security numbers.

The process of setting up an account requires the applicant to input their name, email address, and then select a username and password. The website password does not have to be the same as their email account password, but it is not uncommon for an applicant to blurt out their email account password.

The identity verification process at the start of the application was contracted to Experion, a consumer credit rating agency. Experion sometimes verifies identity by asking multiple choice questions about which financial institutions the applicant has mortgages or auto loans with.

Anyone seeking federal tax credits must answer questions about their income and where that income comes from. They are asked questions about disabilities, their ethnicity, their history of incarceration or foster care, and even their pets names. Not all questions must be answered, but clearly an assister can be exposed to a great deal of sensitive personal information. And my experience is that applicants are so anxious to get health coverage that they will willingly give up these private details.

Clearly, there is the potential for abuse by an unscrupulous assister. That having been said, I believe our society has really gone off the deep end regarding was is required in background checks. Currently, agents licensed by the Insurance Department must submit a full set of fingerprints as part of their background check. This is a humiliation that once was reserved only for criminals. Nowadays, even teenagers working as camp counselors are being fingerprinted. If excessively intrusive requirements are made part of background checks, it could wind up greatly reducing the pool of much needed assisters.

Also, the application asks questions about what kind of health coverage applicants currently have, and it specifically asks whether they have applied for and been rejected by Medicaid or CHIP. A submitted application is used to determine eligibility for purchasing qualified health plans through the market place and help paying for it, but it is also used to pre-determine possible eligibility for Medicaid and CHIP. The website also specifically asks if the applicant wants their information forwarded to the authorities who determine Medicaid and CHIP eligibility. There is no way to avoid discussion of Medicaid and CHIP, so it would be a problem if any legislation seemed to prohibit discussion of these programs.

Finally, I appreciate that members of this committee have been engaged in trying to resolve the Highmark-UPMC dispute. I would like to bring to the committee's attention one aspect of the dispute that has wound up reducing the premium tax credits for southwest Pennsylvanians by probably many tens of millions of dollars and is adversely impacting the Obamacare exchange options for lower and middle income people. As the committee is aware, Highmark has introduced "Community Blue" insurance plans, which are low-priced but exclude most UPMC facilities from their network.

I certainly do not fault Highmark for offering low-priced plans, and the Community Blue plans are considerably cheaper than equivalent Highmark plans that offer full access to UPMC's excellent facilities. However, because of the way Highmark's decision to offer two similar Community Blue plans in the Silver category in southwestern PA interacts with the formula for determining premium tax credits, the Pittsburgh region has the second-lowest Obamacare subsidy levels in the United States.

Let me explain. The Obamacare system is designed to make a benchmark plan "affordable" to people within certain income ranges. If the benchmark plan is more than a certain percentage of family income, then tax credits will be available to reduce the taxpayer's share of the premium to the designated percentage of family income. If the taxpayer wants a more expensive plan than the benchmark plan, they must pay the difference. If they want a cheaper plan, they can pocket the difference.

The benchmark plan is defined as the second-lowest priced plan in the Silver Category. In the Pittsburgh area Highmark only offers one Community Blue plan in the bronze category and one in the gold category, *but two* very similar plans in the Silver category. Note that in other parts of the commonwealth they only offer one Community Blue plan in the Silver category. But in Pittsburgh it's two.

So what does this do? It guarantees that one of these low-priced, limited network plans will be the benchmark, upon which all subsidies are based. Only Tucson, Arizona has a lower benchmark. Highmark's plans that offer access to UPMC are priced 38% higher than Community Blue plans, and plans from other carriers are more expensive still. So lower income people in southwestern PA who depend on premium tax credits have no other affordable choice.

However, if Highmark stopped offering one of these Silver Community Blue plans, then the benchmark plan (the second cheapest plan) would be a different Highmark plan that includes UPMC in its network. Premium tax credits would be increased so that this new benchmark would become affordable. The plans from other companies would still be priced above the Highmark plans, but the difference would not be as large. More importantly, the Community Blue plan would wind up being free for many lower income people, and in some case there would be enough tax credits left over for a free dental policy to boot.

From my perspective as a CAC involved with low and middle income people, it would be preferable for Highmark to offer only one Community Blue plan in the silver category next year. This would result in many tens of millions of extra Federal dollars coming into the Pittsburgh region and would provide people with a much more meaningful choice. Thank you.