SMALL BUSINESS ACCESS TO HEALTH CARE

FIELD HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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FIELD HEARING ON SMALL BUSINESS ACCESS TO HEALTH CARE

THURSDAY, APRIL 4, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The committee met, pursuant to call, at 10:00 a.m., at Rock Valley College, Technology Center, Room 117, 3301 N. Mulford Road, Rockford, Illinois, Donald A. Manzullo, presiding.

Chairman MANZULLO. I am going to call this Small Business Committee to order.

As people find their way into the room here, let me just give the order of procedure on it. We do not have the lights here, but we would like you to limit your testimony to five minutes, and if you see me going like this, you have got about 30 seconds, and if you go over too much, then you will hear that. [Laughter.]

We are having two panels of witnesses. We have got four members of Congress here. I have got to be in Chicago later this afternoon. Everybody has to run, including the witnesses.

We will be joined shortly by Congressman Kirk, who is on his way from the Northfield area.

Exorbitant health care costs are one of the greatest expenses small businesses and the self-employed incur as they struggle to provide coverage for their employees. As Congress continues to examine our nation's health care problems, we need to remember that 60 percent of the estimated 43 million uninsured are small business owners, their employees and families.

Small business owners are unable to absorb the spiraling health care costs and find themselves priced out of the health insurance market. Many owners are faced with the choice of staying in business or providing their employees with insurance.

I personally know of a small business owner who pays over $700 a month for himself and his wife and has a $5,000 deductible to insure both of them. Both of them are seriously considering selling their business, going to work in another business just for the opportunity to receive health care benefits.

Our current health care system does not provide equal access to affordable, quality health insurance for small businesses. One of the reasons small businesses cannot afford health coverage for employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions.

Small businesses suffer from unequal treatment. What they want most is a level playing field when it comes to the delivery of health care.

Large corporations use their purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other hand, have to find their insurance on an individual basis. It makes it extremely difficult and expensive to find affordable health coverage.

I cannot help but wonder why insurance companies cannot offer affordable health care to small businesses. Why must insurance companies charge the most to those least able to pay these inflated prices?

I am heartened to see President Bush issue a plan for helping small businesses prosper in our country. The President is aware of the health care access and affordability problems facing small businesses, and his plan includes concrete steps to increase health security for employees of small businesses.

His agenda calls for an association of health plans to be available for associations that want to provide health coverage for their members, similar to what labor unions are doing. It calls for a permanent extension of medical savings accounts, including a significant reduction of the required deductible for these health accounts.

Congress needs to insure that there are many different health insurance options for small business owners to utilize. We need to help our businesses attract and keep employees, and nothing helps more than the ability to provide health insurance.

I look forward to the testimony of the witnesses here this morning, and I want to particularly thank those that have traveled long distances to be with us here today.

I will then yield to Congressman Jerry Weller, who came up last night to be with us this morning. Congressman Weller, do you have any opening remarks?

[Mr. Manzullo's statement may be found in appendix.]

Mr. WELLER. Well, thank you, Mr. Chairman. I have just brief remarks.

First, I want to commend you for conducting this hearing on an issue of great importance. You know, 99.7 percent of all employers are what we classify as small business, and small business provides over one half the jobs provided for in America.

So when you look at who has health insurance, who does not have health insurance, the vast majority of the 43 million Americans today who do not have health insurance are either the entrepreneurs themselves or the employees and their families of those who are involved or work for small business.

So clearly health care is a major concern for small business. That's why I believe your hearing by your committee today is so important. I commend you for your leadership.

But I also, Mr. Chairman, want to commend Chairman Manzullo for your leadership on efforts to expand medical savings accounts, efforts to give 100 percent deductibility for the self-employed for health insurance cost, to expand the opportunities for nursing home or long-term care insurance with full 100 percent deductibility for that, and also commend you for your leadership on establishing an association of health care plans, AHPs, as well as the refundable tax credit proposal we're currently debating in the Congress.

You have been a leader on this effort, and I welcome the opportunity to be part of your hearing today.

Chairman MANZULLO. Thank you, Congressman Weller.

Both Congressmen Weller and Ryan are members of the Ways and Means Committee, which is the committee that has jurisdiction over about 95 percent of health care issues. Members of the Commerce Committee might have said I misquoted on that, but the guys that write the checks are the ones that write the law. [Laughter.]

I would now yield to Congressman Ryan from the State of Wisconsin.

Mr. RYAN. Wisconsin.

Chairman MANZULLO. Did I say Mississippi?

Mr. RYAN. It is a little hilly up there.

First of all, Chairman Manzullo, I would like to thank you for inviting me to come down here. For those of you who do not know, my name is Paul Ryan. I represent the First Congressional District in Wisconsin, which is everything basically above here.

I have Green County, Rock County, Walworth County, Kenosha County and Racine County. That is the area that borders much of the Illinois state line, and so this is only about a half hour drive from my home town of Janesville. So I really appreciate the invitation.

Like most of us here, I believe that the current employer-based health care system has done a relatively good job of meeting the needs of workers and businesses alike. However, this system and workers' and businesses' budgets have experienced increasing strain due to the rising cost of health care coverage.

And I cannot tell you how many times I have traveled throughout the First Congressional District in Wisconsin where I hear comments from small business owners and local government entities who say, "We wish we could hire more people, but we cannot because the cost of health care is just too great."

So at a time when we are trying to get people back to work, now that we are presumably coming off of a recession, the cost of health insurance is becoming an even greater issue in terms of the issue of employment.

In Southeastern Wisconsin, like in Illinois, we have seen our manufacturing base erode, leaving behind many unemployed workers, and what has been the godsend have been small businesses. The engine of economic growth in Wisconsin and, I think, much of Illinois and throughout the country has been small businesses, and that's why I've watched your work at the Small Business Committee.

I simply want to add my comments to those of Congressman Weller in commending you, Chairman Manzullo, for really doing the yeoman's work in growing the advocacy of small businesses in Congress. You have really been very out front on small business issues, such as deductibility for health insurance, the 100 percent deductibility.

You have really done a lot of great work in that area, but one thing that I just wanted to bring to your attention is that the federal government from my perspective can play two crucial roles in encouraging the establishment and growth of small businesses and

ensuring that business owners are able to offer their new employees health care benefits.

First, the federal government can make it easier for entrepreneurs to start new businesses in the first place—and that is the work of the Small Business Committee that you have championed—by lowering taxes and reducing the cost of regulation on businesses so that entrepreneurs have the resources and the capital they need to sell their ideas and products and build productive businesses.

But the second way the federal government can actually help businesses is to lower the cost of health care so that employer-sponsored insurance is affordable and available.

In the Ways and Means Committee, where Congressman Weller and I work, we have heard a lot of testimony, and we have a lot of hearings on this issue. One of the recent testimonies we have received that I thought was fairly interesting was from Dr. Stuart Butler, a Ph.D. economist from the Heritage Foundation who recently made some interesting, eye-opening observations.

The first observation he made was about the high rate of uninsurance among employees of small businesses. The Kaiser Foundation estimates that only 55 percent of firms with ten or fewer employees offered health care insurance. This is compared to 99 percent of large businesses that offer insurance. He cited Congressional Budget Office data that found overhead costs of providing health insurance for businesses with fewer than ten employees can be over 30 percent of the premium cost, as opposed to just 12 percent for companies with more than 500 employees.

He also pointed out that while jobs these days seem to be transferable, health care is not transferable. This is because the tax code helps employers pay for insurance, but does little to help individuals who, for one reason or another, are forced to purchase their own insurance.

Basically if you lose your job, you lose your health insurance. And that is essentially how it works today. So we often hear this in Wisconsin, as I am sure you do here in Illinois, and it is no wonder that, according to the National Federation of Independent Business, 23 percent of small business owners in Wisconsin have experienced a 26 to 50 percent increase in their health care premiums in 2001 alone, 26 to 50 percent increase in their health care premiums for small businesses in Wisconsin last year alone.

So this is an issue that is in dire need of reform. I think you have identified some great productive ideas, like association health plans which help produce buying pools so small businesses can team together to get bulk purchasing rates through ERISA plans.

I think we have a range of witnesses who probably have different perspectives on this issue, but also the President has really taken a leadership role in this. He came to Congress and presented a budget with a health care refundable tax credit for individuals to buy health insurance, to expand the Association Health Plans.

And so now the time is right for action. Congress is engaged; your committee is engaged. And I think we have a President who is taking this issue very seriously. So I am very interested in hearing the witnesses today, and I appreciate you having us down here for this.

Thank you.

Chairman MANZULLO. I appreciate your opening statement.

The Small Business Committee is having a hearing in Washington next week that deals with the Health Care Finance Administration, HCFA. It is Chapter 4 of what we call HCFA horror days.

HCFA is the organization that enters into agreements with over 50 medical providers and spends its time torturing medical providers, making absolutely incredible mistakes and actually driving up the cost of health care. We will be getting into that later on.

I get excited about these issues, especially when we can look at a government agency that can streamline and make things a lot cheaper.

Our first witness is Mike Holoka. Mike is an attorney in town, and we look forward to your testimony.

STATEMENT OF MIKE HOLOKA, ESQ., ROCKFORD, IL

Mr. HOLOKA. Thank you, Congressman Manzullo, Congressmen.

My name is Mike Holoka. I am an attorney in Rockford, as Congressman Manzullo has already stated. I am married to a physician. I have a 12 year old daughter.

We had a traditional medical plan for many, many years.

Chairman MANZULLO. Hang on just a second.

Congressman Kirk, why don't you come up here? Did you have an opening statement?

Mr. KIRK. I did not.

Chairman MANZULLO. Okay. Well, then why don't you have a seat, and, Mike, continue.

Mr. HOLOKA. Sure.

Chairman MANZULLO. We will start the clock all over again.

Why don't you just introduce yourself?

Mr. KIRK. It is Mark Kirk from the 10th Congressional District of Illinois, representing the suburbs along Lake Michigan.

Chairman MANZULLO. Okay. Can you tell us what are your committees?

Mr. KIRK. And we are on the Budget, Armed Services, and Transportation Committees.

Chairman MANZULLO. A busy guy. We just introduced our first witness, Mike Holoka.

Mike, start all over again.

Mr. HOLOKA. Okay.

Chairman MANZULLO. We know what your name is.

Mr. KIRK. And I am working on traffic tie-up problems on I–90. [Laughter.]

Chairman MANZULLO. He is on the right committee, a transportation issue.

Then what are you doing here, Congressman? [Laughter.]

Mr. HOLOKA. That is a problem that will never be solved maybe, but good luck.

I am Mike Holoka. I am an attorney here in Rockford. I am married to a physician. I have a 12 year old daughter.

We had a traditional medical plan for many, many years with Guardian Insurance, and we ran the plan through my practice because I am a sole practitioner. I have one employee. It was a lot more effective to run it through my practice instead of my wife's.

When we first started with the Guardian, we were probably at a premium of $4,000 to $5,000 a year. In about 1996, our premium had jumped up to somewhere near $8,200, and by the year 2000, our premium was $21,000 a year for Guardian traditional insurance.

Chairman MANZULLO. For how many?

Mr. HOLOKA. Just for the family, just for the family. No employees. Okay?

And we had no claims. So there was no reason to see this kind of rise.

Okay. Realizing that we could not afford to continue with this kind of a program, we started considering picking up a catastrophic insurance policy and self-insuring for like $25,000 or $50,000. The premium on that probably would have been somewhere in the area of $7,500 a year.

And we could not understand why the insurance companies were continuing to raise premiums at the rate they were because I knew physicians were being paid less. So I could not figure out what the problem was, why this cost was increasing.

But to solve our problem, one day my wife received a fax in her office, and it said something about an MSA. I had never heard of an MSA, medical savings account program. And I read over the plan, and I said this is impossible. This is too good to be true. They really cannot have this kind of program. It makes too much sense.

And some of the main features of the plan were we could pick up a deductible between $3,100 and $4,800 a year, which included all of us, not an individual deductible, with the opportunity to save up to about 75 percent of our deductible in something called the medical savings account. So we were able to put that money away which would grow or be invested in basically a favored tax status, you know, deferred taxation on that account.

So with the deductible we chose, $3,100, we could put about $2,300 a year into this account, and this, of course, could always be used for our deductible, pay our deductible or however we wanted to use it, or we did not have to use it at all. Okay?

The best part of the plan though was that you did not have this large premium, this $21,000 and going up into space. Who knows where it was going to end?

Our premium ended up being about $3,600 a year, and that was only because my wife was still on the maternity program. If we would not have had maternity, it probably would have gone down to almost half of that.

So it was amazing to me that we heard so little about an MSA insurance program like this, particularly in view of this insurance crisis and the way it was affecting small business, you know, on top of the way it was affecting the country.

So when I attended a small businessman's breakfast with Congressman Manzullo, I had the opportunity to explain how an MSA program worked to all of the people at that breakfast meeting, and to my amazement, it seemed that nobody had really heard about an MSA program, and going around the table, they were all like me and said, you know, "What is this? I don't believe this exists. You know, how do we do this? How do we get this thing put to-

gether?" And there were probably, I guess, 25 businesses represented at that breakfast meeting.

So it is my understanding there are any number of variables the way an MSA program works as far as the premium goes. You choose your deductible so that you can, in effect, choose how much of a premium you are going to pay.

One quote I received last year was for a $4,500 deductible. It was less than the $2,500 premium for my family, and that included dental if we wanted it for less than $1,000 a year.

It is not difficult to see how vital an MSA program is for small business when you consider the cost of what a traditional plan is.

Chairman MANZULLO. You are at five minutes, Mike.

Mr. HOLOKA. Okay. Let me just wrap up real quickly then.

So we are extremely pleased with this plan. We cannot believe all of the benefits we have. We are very happy with it. We think it should not only be extended to small business, but to everybody in the country.

And one of the features of an MSA is you can also continue it past 65, which means you do not impact Medicare, and if you started, say, at age 20 saving a couple thousand dollars a year in an MSA account, you could have a couple hundred thousand dollars or better by the time you reached age 65, all of which would also help the government in terms of managing health care as well.

Thank you.

[Mr. Holoka's statement may be found in appendix.]

Chairman MANZULLO. Thank you, Mike.

Mr. HOLOKA. You are welcome.

Chairman MANZULLO. Our next witness is Dr. Bill Kobler who is with the OSF Medical Group in Rockford.

We look forward to your testimony, Dr. Kobler.

STATEMENT OF BILL KOBLER, M.D., OSF MEDICAL GROUP, ROCKFORD, IL

Dr. KOBLER. Thank you, Chairman Manzullo and Congressmen.

I am pleased to be here to be able to present a little bit of the medical perspective on the rising cost of health care, which is obviously a logical contributor among many other factors to the rising cost of health care insurance. I can't really talk about what the cost of health care insurance is for me, although I do remember when I was last self-employed, and that is nine years ago now, I was spending $500 a month for family coverage at that time, and I cannot imagine what it would be now under different circumstances.

The problem is obviously very complex, multi-faceted, but I hope I can at least give some insight into the problems we face as health care providers and perhaps give you some of the reasons why I think that health care costs are going up with this insight maybe there are some ideas as to what we can do to help control those costs.

A recent article in the New York Times in January stated that the government reports that in 2000, national health spending shot up 6.9 percent to $1.3 trillion, the largest one year increase since 1993. And they said that hospital and drug costs were the main factors in the last increase.

Growth in health care spending has outpaced the 6.5 percent growth of the economy as a whole. Health care accounts now for 13.2 percent of the nation's total output, up from 13.1 percent in 1999 and 12 percent in 1990.

As a physician, I could argue that that is not a high enough percentage, but I think I will leave that alone for the time being.

What are some of the factors leading to these cost increases? An old problem that at least we as physicians, in deference to my associate sitting next to me, that is again rearing its ugly head in professional liability suites In the 1970s there was a crisis for physicians when all of the major professional liability insurers in Illinois pulled out of the market. We have now seen that again happen in this state, with St. Paul no longer writing coverage, and I am not sure that is not even nationally, and CNA has pulled out of that market as well.

Ken O'Bramowitz of the Carlysle Group states the rising cost of malpractice coverage is becoming the most important factors driving inflation for physician services. Many hospitals' insurers are not only increasing premiums, but are also reducing amounts of coverage and raising deductibles.

A Chicago Hospital in 2000 paid the St. Paul Companies $1 million for $40 million in coverage, with a deductible of $15 million. In 2001, for that same policy, the premium was raised to $1.8 million and cut the coverage to $10 million and doubled the deductible. So they are almost paying more than what they are getting back.

Insurers say that the increases are due to large awards by juries and large settlements. Some research suggests that the average jury award rose to almost $3.5 million in 1999, up from just under $2 million in 1993. And according to the Liability Monitor in Chicago, professional liability premiums are rising at an average annual rate of 30 percent.

The costs of this are obviously one factor, but there is another factor. Because of the increased risk of liability and the cost of insurance, physicians are practicing medicine more defensively. That means we are doing more tests. We are doing more procedures and things that we see would limit our risks.

Another item is the explosion in the availability of very good but very expensive prescription drugs. This is a serious problem for all recipients of health care.

The proposal to provide these drugs under the Medicare program is a wonderful concept, but frightening when one pauses to consider the source of the funds for this population who consume a very large percentage of pharmaceuticals.

Medicare, managed care and other private insurance plans have cut drug benefits in the last few years. They state that the average senior spends about $500 annually for medication, plus hundreds or even thousands more for private insurance policies to cover some of the cost of these prescriptions.

I saw a patient just the other day who in the year 2000 paid $7,000 for her medications.

There are a number of other factors I would like to briefly list which also I feel are driving up health care costs. The people of this country have an insatiable appetite for health care services. They

are bombarded with story after story of medical miracles, advertising of prescription pharmaceuticals, promises of unlimited access to health care made by the managed care companies. Yet there's very little incentive for them to utilize these services wisely.

There's an overwhelming burden of government regulation which is choking the medical profession in its attempts to provide care. Many of you know the alphabet soup as well as I, but the provisions of COBRA, CLIA, HEQIA, EMTALA, HCFA, now affectionately known as CMS, are burying us in needless paper work and documentation.

We attempt to follow the regulations at the risk of prosecution, fines, and imprisonment under a system so complex that it is impossible to meet all of its requirements. And now we will soon face the absolutely terror provoking HIPAA statutes within the next year.

We are facing a serious shortage of well trained nurses. Medical school costs are becoming so large as to discourage our best and brightest from applying to medical school, knowing that they will face declining incomes and loss of respect for the time they spend and dedication they demonstrate in their career choice as physicians.

As a doctor, my job is to investigate problems and try to solve them. It would be easy to become discouraged, but medicine is still the most rewarding of professions, one worthy of fighting for and defending. I am pleased to see this forum attempting to understand the problems of medicine and its availability to small businesses. After all, physician practices have traditionally been counted among the ranks of small business over the years.

If we can work together keeping the patient as the center of our focus, I am confident we will find a solution to our problems.

Thank you for listening to my testimony.

[Mr. Kobler's statement may be found in appendix.]

Chairman MANZULLO. Thank you for your testimony, Dr. Kobler.

Our next witness is Phil Bartmann. Phil is the owner and President of Radicom, Incorporated in McHenry, Illinois, coming over to see us this morning.

Mr. BARTMANN. Thank you for inviting me.

Chairman MANZULLO. We look forward to your testimony.

STATEMENT OF PHILLIP BARTMANN, PRESIDENT, RADICOM, INC., McHENRY, IL

Mr. BARTMANN. Thank you very much for inviting me.

As the Chairman said, I own Radicom, Incorporated in McHenry, Illinois, about 60 miles east of here. We have been in business since 1963.

We presently do employ 28 employees in three locations, two in the McHenry area and one in Appleton, Wisconsin. We are in the telecommunications business. Our employees range in age from 20 to their mid-60s and earn wages from 15,000 to $60,000 or more. Some of my employees have been with me for over 20 years.

We have always provided medical insurance for our employees, and the cost has always been covered by the company. We have a $250 deductible plan, and the company covers that deductible.

We recently—as a matter of fact, March 1st was the anniversary date of our health insurance. Our monthly cost for the same number of people went from $8,000 a month to $15,000 a month. Our health care for the coming 12 months will be $171,000. In 1997, we were paying $36,500.

The increase has been dramatic. Our per employee cost in 1997 for an individual was $2,433. This year it will be $6,128.

We are not contemplating asking our employees to help. Right now we charge them a token $10 a week so that those who may not need the insurance or are covered by their spouse will opt to not because you can see for a few dollars we can save a lot of dollars. And we have a few people, mostly spouses who do not take our insurance.

I am the chairman of the board of the McHenry County Economic Development Corporation, and we get to share horror stories. One that I heard just the other day, one of our very active members, she owns a custom woodworking company called Phoenix Woodworking, Woodstock. She had nine employees at the beginning of the week and now she has ten. She called me yesterday.

She has been getting six month increases. She just started providing insurance two years ago. She just received a 24 percent increase in health costs and six months ago she got a 19 percent increase.

It is totally out of control. We are fighting with this. This came as such a shock, this dramatic increase. We are fighting with ways to try and solve it. It goes right to the bottom line. We are a very competitive business. We cannot ask our customers to absorb it all, although they are the only ones to do it, them or the employees.

We are fighting very hard to see that we can protect both contingencies, that both will not suffer.

The proposal that Mr. Manzullo's committee has on the table to us, not being experts, but it seems like it would be a very viable option whereby a number of small businesses or any size business could join together and hopefully save money on health care costs.

That is what I have for my testimony. Thank you very much for listening.

[Mr. Bartmann's statement may be found in appendix.]

Chairman MANZULLO. Thank you, Phil. I appreciate it very much.

Our next witness is Ryan Brauns. Ryan is the Senior Vice President of Rockford Consulting and Brokerage.

Ryan, I look forward to your testimony.

STATEMENT OF RYAN BRAUNS, SENIOR VICE PRESIDENT OF CONSULTING, ROCKFORD CONSULTING AND BROKERAGE

Mr. BRAUNS. Thank you.

Good morning, Chairman Manzullo and Congressman Weller, Congressman Kirk, Congressman Ryan.

Rockford Consulting and Brokerage is a firm specializing in employee benefits.

Chairman MANZULLO. Ryan, would you keep your voice up? I do not think they are hearing all of it.

Mr. BRAUNS. Sure. The firm I represent specializes in employee benefits, specifically strategic plan design, fund analysis, employee

communications, and regulatory compliance. Members of the firm have collectively worked with hundreds of employer groups ranging in side from two wives to 60,000 employees, solving many complex cases, and we appreciate the opportunity to present our comments this morning regarding the health insurance industry, the vital role of the insurance broker, and the powerful engine of consumerism.

To begin, the words of Dickens actually came to mind when I was writing this testimony. "It was the best of times. It was the worst of times. It was the Age of Wisdom, and it was the Age of Foolishness."

Although no one is speaking French today, we are definitely fighting a battle. With the finest health care system man has yet devised, thousands of people from all over the world traveling to our system every year, other countries desperately trying to copy what we have, we threaten our own wondrous creation.

So where are we today? There are several possible points of insertion into a discussion about the status quo, the state of managed care, the outstanding quality of modern medicine, or the need for structural change that will yield behavioral change. I'd like to take a look today at, frankly, government regulation.

Business is the conduit to health insurance for Americans. Depending on whose study you see, the breakdown is usually something close to the table we have in the written testimony which shows about 64 percent, maybe 70 percent of Americans have health insurance through their employer. Yet business has been awash in a sea of government regulation.

One of the other witnesses enumerated a few: COBRA, OBRA, ADEA, ADA, ERISA, the Public Health Act, HEFRA, DEFRA, Tax Reform Act of 1984, not the least of which is the Internal Revenue Code, including Sections 162, 264, 79, 101, 61, 83. I could go on, just to identify a few.

I offer that not to be ridiculous, but to make the point that business is not just a wash. We are actually drowning in this regulation, and to be sure, much of these rules involve needed reforms and have done quite a bit of good. However, many have unintended consequences.

In fact, some foisted some severe unintended consequences on the system. One such law mentioned here a moment ago was HIPAA, formerly known as Kennedy-Kassebaum or the Health Insurance Portability and Accountability Act. It was created with the best of spirit in mind, to provide greater access to insurance. Yet it really had the opposite overall effect.

You see, it was not created in a vacuum. The law was applied to an already complex and difficult legal structure. There was little room for the private sector health care market to absorb this new burden. The market becomes more efficient, cannot clear, moves farther away from the equilibrium we want. In turn, costs are going up and social good is going down.

HIPAA passed in 1996. It really took effect the next year, beginning to propagate throughout the market. I don't think it's a coincidence that following the passage of HIPAA we had a concomitant rise in premiums, as well as a several million person increase into the ranks of the uninsured.

The guarantee issue portion of the law moves us closer to national health care and single payer model, and it actually created more uninsured persons. I give you the example of the State of Kentucky or Washington and New Jersey, where they actually put into effect guarantee issue.

Once that went into effect in Kentucky, many of the private health insurers who were writing individual health policies pulled out. Premiums went up by 60 percent, and we had more uninsured.

HIPAA stifles innovation and is foreclosing on solutions. Because the law makes bright line delineation between employee sponsored plans and individual plans, there is little chance to develop hybrid plans involving employer and employee contributions, particularly in the mode of defined contribution, which we heard so much about.

The greater the role of government in this market, the greater the chance for harmful rent seeking and sub optimal behavior as the players devote resources to look for loopholes. They stop profit seeking. The market becomes inefficient. It leads to more dissatisfaction.

What HIPAA has shown us, even though it had fine intentions, and some of the law is certainly very good, it did have unintended consequences, and it gives us a positive correlation between regulation and increases in uninsured.

The insurance market is not easy to shop in for the small employer. The cost of information is high, and onerous regulations providing friction.

Chairman MANZULLO. Ryan, you are at your five minutes. Conclude shortly.

Mr. BRAUNS. Excellent. [Laughter.]

The last thing I would like to tell you about is consumerism. Consumerism is a very powerful engine, and I want to give you just a few statistics. In 1991, the drug industry spent $55 million on direct to consumer advertising. Now they are spending over $2 billion on direct to consumer advertising. It is a very powerful engine.

Lastly, I urge you to let Adam Smith's invisible hand guide this market. If we reduce the cost of information, eliminate the friction cost by onerous regulation, the markets will clear. We will have economies of scale. Equilibria will be achieved, and satisfaction will be high.

So when you go back to Washington, when you are in the well and you are addressing your fellow members on behalf of the nation, I hope your clarion call will be choice. It will be competition, and it will be consumerism.

Thank you very much for the opportunity, and I look forward to your questions.

[Mr. Brauns' statement may be found in appendix.]

Chairman MANZULLO. Thank you, Ryan, for your testimony.

Our next witness is Mick McCarty, and Mick is with Blue Cross/Blue Shield of Illinois.

I look forward to your testimony.

STATEMENT OF MICK McCARTY, BLUE CROSS/BLUE SHIELD OF ILLINOIS

Mr. MCCARTY. Good morning. Thank you, Chairman Manzullo and distinguished members of Congress.

Let me first of all start off by just explaining a little bit how Blue Cross/Blue Shield approaches the small group market. Today what we do is instead of having each small group stand alone, we pool all of these small groups into aggregates so that we have hundreds of thousands of employees in a pool, and that allows us to spread the risk out among these hundreds of thousands, spread the costs out among these hundreds of thousands.

We are able to provide the same level of discounts to a group of two that we are able to give to our largest customers.

We also offer benefit flexibility to the smallest of groups so that an employee could choose whether he wants to participate in a PPO, whether he wants to participate in an HMO, or whether he would like to participate in one of our MSA compatible type of programs.

So that is the approach we are taking now. Now, we have actually devised programs specifically for small businesses in rural areas. We recently lost another program to offer to groups in the 50 employee to 150 employee segments that is another small group type of product again.

So we are very focused on that small group segment, but there is only so much we can do in the face of rising costs and other factors, and I would like to spend a few minutes talking about those.

We all know that medical costs are going up. Some of it is inevitable. It is kind of a fact of life, but there are cost pressures that government can access. Congress and the general assembly must carefully examine any new mandated balancing the benefits of those mandates with the costs that are associated with them.

These costs fall hardest on the small employer groups. Back in 1965, there were eight health care mandates that we had to follow nationally. Today there's over 1,000, and they all did good things for many people, but they carried a cost. Small employers bear the burden of that cost significantly.

Another suggestion that should be considered is the use of subsidies to help small employers, whether they come from federal or local, statewide combination. These subsidies add dollars to the equation, and that is a good thing. But the subsidies need to be significant enough to encourage the employers to participate. Otherwise we have seen that the employers do not necessarily participate without significant subsidies.

I know that there is a lot of talk, and Congress is considering association health plans. These merit talk and discussion and perusal, but there are some issues that need to be discussed and understood about them.

First of all, the proposed legislation would actually undermine many of the state reforms that have already been put in place to protect small employer groups. A Congressional Budget Office analysis actually came out and said that with the implementation of association health plans, we could see prices rise, particularly for small employer groups, in four out of five cases.

The GAO also came out with a study that supported that.

There is a long history of concern about the associations that exist today similar to the association of health plans called MEWAs, and so there is a concern a little bit about making sure that if the association health plans are in the offing, that they are done right with the appropriate regulation.

Finally, the CBO would estimate that with the implementation of association health plans, you would only expect to see about a 1.3 percent increase in coverage. So while the thought is good and the appropriate structure might be good, we need to make sure that it is going to be successful and bring more people into the equation.

Another concern is the so-called patient rights legislation. Again, what that does is add costs, particularly the small employer groups. In Springfield, the Illinois State Medical Association is pushing legislation that would severely limit health plans by Blue Cross and Blue Shield's ability to catch and to fix abuse, particularly claims abuse.

At the same time, this legislation is going to add billions to the administrative cost, again, with no benefit to the patient. Again, this cost is passed on to employer groups, particularly small ones.

But enough of the negative approach or the things that I wanted to talk about there. There are some good things that can be done.

First of all, Governor Ryan and HHS and Secretary Thompson have worked together closely on several initiatives. One will allow the states to expand Kid Care to the families of eligible children. We heartily support this. We think this is extremely successful, and the results so far have been very favorable.

While I mentioned earlier the subsidies can be good, but the level of subsidy needs to be significant to really draw employers in, I do want to encourage tax credits for small employers for their low income workers. I also encourage you to press for acceleration of that full tax deductibility for the self-employed. I know that it is staggered out a number of years, and I know you worked hard and diligently to try to accelerate that. I continue to encourage that.

Expansion of medical savings account. I think it is a worthy experiment. Right now it is capped, and it is limited to a certain amount of people in the segment in the market, but I would certainly suggest expanding that.

A number of bills in the House, McCain-Schumer and its companion in the House, Brown-Emerson. That would have a favorable impact on the entry of generic drugs in the marketplace.

One thing that I found extremely interesting is that a focus group study found out that small employer groups do not understand insurance. They do not know all of the time that it is tax deductible and that there are implications to them by providing it to their employees.

I would encourage a broad based approach to informing and educating small employers about what their options are in a community and what type of tax implications they can enjoy by offering their employees employee benefits.

Chairman MANZULLO. Five minutes, Mick.

Mr. MCCARTY. I will wrap it up.

Defined contribution approaches, I think they also merit some review. We have not seen a lot of employers pushing towards that

right now. They still think it is something that could bring consumerism back into the equation, and at the federal level, Congress is struggling with several key issues affecting the small group market

And all I want to do is encourage whatever legislation and mandates are created, that they encourage people to get into the pool, encouraging high risk, low risk, everybody into the pool, and that will help us stabilize premiums going forward.

These are difficult times. I commend the committee for your effort to focus attention on the impact on health care costs to small businesses, and as we have for more than six decades in Illinois, Blue Cross and Blue Shield stand ready to help in any way.

Thank you.

[Mr. McCarty's statement may be found in appendix.]

Chairman MANZULLO. Thank you for your testimony.

Members of Congress will also be limited to five minutes. As the committee chairman, let me exercise my prerogative and go first.

I would ask you, Mr. McCarty, in your opening statement, you say essentially that Blue Cross/Blue Shield is already community writing for business pools?

Mr. MCCARTY. Yes. What we do is we have established these pools, and there are a number of factors that go into the rating on this particular group, but for the most part, what we are trying to do is take the lowest and the highest risks, squeeze them down into a narrow focus so that rates are somewhat stabilized.

The problem with doing that, Congressman, is that the better risks, as we try to squeeze everything in that community to a narrow focus, the better risks will look for rates elsewhere, where someone is not necessarily community or pool rating like we do.

Chairman MANZULLO. So does that mean that if you insure a corporation of 1,000 employees, that will be the same rate as insuring Mr. Bartmann's 23 employees?

Mr. MCCARTY. Actually, no. The pool is going to generate a rate based upon the experience of hundreds of thousands of people. And that will set a rate.

And some of this is already legislated in what we can do by the State of Illinois.

A group of 1,000, their rates are going to be determined strictly on their own experience. So it could be higher than this other pool with hundreds of thousands of people.

Chairman MANZULLO. Let's face it. Do you know of any large corporation that has higher rates than an employer with 23 employees with the same plan, the same coverage?

Mr. MCCARTY. I do not know of any. I am not saying that it does not exist. I would have to actually review that.

Chairman MANZULLO. Well, I would submit to you that the larger the pool, the bigger the corporation, the cheaper the rates are. As a member of Congress, I have Blue Cross/Blue Shield, and I think all of us here, you know, we have the same plan that Phil does with Blue Cross/Blue Shield.

But when you say that you are doing these business pools, is this lowering the rates of the people in those pools?

Mr. MCCARTY. It is keeping the rates lower than if we did not create the pools.

Chairman MANZULLO. But when you go to an individual employer or—I am sorry—when you go to a corporation, you insure that whole group, but you are not asking for any increased premiums based upon preexisting illnesses; is that correct?

Mr. MCCARTY. When we insure a large group.

Chairman MANZULLO. That is correct.

Mr. MCCARTY. The risks are evaluated, and preexisting conditions are considered in their experience, absolutely.

Chairman MANZULLO. They are considered, but the potential insureds are not asked for any previous medical conditions; isn't that correct?

Mr. MCCARTY. That is correct.

Chairman MANZULLO. But if you went to Phil Bartmann, you would have to ask those questions of those 23.

Mr. MCCARTY. That is correct.

Chairman MANZULLO. So then it is really not a pool.

Mr. MCCARTY. It is a pool in the sense that we are trying to drive everybody into a narrower focus. Not everybody is going to have the same rate, exactly correct, Congressman.

Chairman MANZULLO. Perhaps I do not understand the narrow focus on it, but to me a small business pool would be to take every small business person and say we are going to take all of their rates and treat you the same as ABC Corporation. We are not going to look at any preexisting maladies. We are not going to increase your rates based upon the fact that somebody, that one employee out of 23 had a heart attack this past year or a bout with cancer.

That would be a true pool.

Mr. MCCARTY. That is where our origins actually started, Congressman. That is where we began as Blue Cross and Blue Shield. As other insurance companies got into the marketplace, particularly the for-profits, they began trying to sap out the better risks.

So today where we are at is we are trying to maintain a community rating as closely as we can, but what happens is the better risks are lured away by other entities, other health plans that have a different approach to this marketplace.

Chairman MANZULLO. Such as?

Mr. MCCARTY. Other types of insurance companies?

Chairman MANZULLO. Yes.

Mr. MCCARTY. I do not want to be indicting here, but any type of for-profit company is going to be looking to maximize profits as opposed to something else.

Chairman MANZULLO. I understand.

Phil, did you look at Blue Cross/Blue Shield?

Mr. BARTMANN. They are one of them we looked at last year.

Chairman MANZULLO. What type of rates were you quoted for 23 employees? Do you remember?

Mr. BARTMANN. I do not remember, but they were not in the final three, two or three.

Chairman MANZULLO. Okay.

Mr. BARTMANN. We had United Health Care and Nipon were the two finalists, I know, last year, and we ended up with Nipon.

Chairman MANZULLO. Okay. Mike, on the medical savings accounts, you went ahead and developed your own form. Is that what you did because nobody offered that product?

Mr. HOLOKA. Well, the product was actually offered by a couple of insurance companies. Fortis is one. Unicare is another one, and I cannot tell you all of the carriers who would provide it.

And there is a company that essentially gives us the information and the quote rates and everything, and then we go through them. They are like a brokerage firm.

Chairman MANZULLO. Okay.

Mr. HOLOKA. And that is how we discovered this and were quite pleased with it and quite surprised.

Chairman MANZULLO. So a person could just call up one of those insurance companies, and they would have a package to set up the MSA.

Mr. HOLOKA. That should, but you might have to go through a broker to get that. You may have to go through an insurance broker, you know, who writes the insurance and charges, you know, a small premium for that as well.

Chairman MANZULLO. Okay.

Mr. HOLOKA. I do not know whether you could write directly to the company or not and get that information.

Chairman MANZULLO. But you had to draw up your own plan because you were the first, one of the first?

Mr. HOLOKA. No, the plan, as I understand it, by statute is limited to 750,000 businesses.

Chairman MANZULLO. Right.

Mr. HOLOKA. Okay, and I do not know how many had already taken advantage of it. Maybe 25,000 or so. There were not a great number of companies that had taken advantage of it. And, in fact, I had to go through, I think, four or five brokerage houses to figure out who actually would set up these MSA accounts, and Merrill Lynch in this area turned out to be the brokerage firm that was——

Chairman MANZULLO. Financial house.

Mr. HOLOKA. Yes, financial house where you could actually set up an MSA account. Some of the other brokerage firms like A.G. Edwards, for example, they did not have the ability to even set up an MSA account. So there was no way you could deposit money.

Chairman MANZULLO. Ryan, does your company offer access to an MSA account?

Mr. BRAUNS. We do. And I would like to echo something Mick said, which is that many small employers do not understand the options that are available to them. There are things like MSA accounts that are out there, either qualified MSAs or even nonqualified MSAs, which gets into the consumerism idea.

What we like to see is people who are very interested in accruing personal health accounts, like the President spoke about, on a use it or keep it model so that they are financially engaged and they take more responsibility when it comes to the decision making process.

But if I could answer a question you asked of Mick, we have many clients, all ranges of employee size, numbers of employees. We have routinely had 25 and 30 life employer groups that have

had much lower premiums per single, per family than a 100 or 200 or 300 life case. Now, by and large you would think the larger case is going to be a little bit less expensive, and oftentimes it is, but that does not mean that there is not a 25 life group that may have a $150 single rate and only a $310 family rate, and you might have a four or 500 life group that could be double that.

So that 25 life group with the good rate is not going to be interested in joining a pool. They want to keep their good rate.

That is our concern about pools as I represent clients. They are afraid that they are going to get pushed into a pool with a lot of risk that is worse than theirs.

Chairman MANZULLO. But you would agree that the larger pool, the larger numbers of potentially insured, the lower the premiums are going to be.

Mr. BRAUNS. Possibly and usually. The question I have though is how do you keep the groups, and this is what we are waiting to see in the industry; how do you keep those employer groups in the plan? What happens when you get the pool going and one of these employer groups says, "You know, we are all very healthy. We can get a cheaper rate outside. We want to exit"?

So what is left is by and large a sicker group, and over time it could start to spiral. We have had several association plans here in Illinois collapse in the last few years. A large school association just collapsed this last year, 250 school districts, for that very reason. The good risk exits, and the bad risk stays.

Chairman MANZULLO. Congressman Weller.

Mr. WELLER. Well, thank you, Mr. Chairman.

And let me first commend your panel. This has been a very informative presentation. I know we have a second panel. So I look forward to hearing that as well.

But let me, since we are limited on time, direct my questions. First I want to direct my questions to the two business owners on the panel, and the experiment with the medical savings accounts, Mr. Holoka, one of the arguments for medical savings accounts, and Dr. Kobler brought up this issue, is they help control over utilization. People, you know, take advantage of health care benefits maybe more than they really need to, and of course, that drives up cost.

And I was wondering from your experiment with medical savings accounts how medical savings accounts, the incentives involved in medical savings accounts will affect over utilization.

Mr. HOLOKA. Well, I agree that there is utilization when you are not having to pay anything for medical care. When you have a deductible, of course, you are paying the first dollars out of that deductible. So, for example, we had a $3,100 deductible for the first year we were in the MSA program. We probably spent about $2,800 of that.

Now, I did not sit there though and calculate whether or not we should go to the doctor, you know, or whether or not we should have a physical or something of that nature based on how much of that deductible was left, nor did I say, "Let's go ahead and spend some more money so we pass the deductible and then the insurance company can pick up the rest."

So I really think that is more of an individual situation. Obviously, I guess you could plan it in such a way that if you needed surgery, you could use up the deductible and then go and have your surgery that year and make sure the surgery was picked up. I guess we can all be calculating or even very good stewards of our money in that way.

But I do not think that is much of a risk. You see, the thing about small business people is that they are survivors. And really, you know, with all respect to Congress and everyone else, if we approach these problems like a business where it was actually our money on the line, and I think Congressman Manzullo does that very well; if the entire Congress would do that, then I think we would solve these problems, but we do not tend to do that.

We tend to see this unlimited amount of money, this unlimited amount of corporations out here that just can afford to spend money willy-nilly, and that is why we are driving up health care costs.

I am sure the doctors here would testify that the paper work that they have to go through is just unduly burdensome. At this point it is almost impossible to keep up with. And on top of that, the paper work actually can cause you to become a criminal in this country.

Why if you make a mistake on a HCFA form, why is a doctor going to jail and losing his business? Because that has happened to a number of doctors in this country.

Mr. WELLER. And I would like to direct a follow-up question to Dr. Kobler.

I would note, based on Mr. Holoka's comments, that the Ways and Means Committee, after we return after this break that we are currently on, we plan to take up Medicare modernization, legislation that Nancy Johns, the Chairman of the Health Care Subcommittee of Ways and Means is moving and which she has taken the lead on, which is designed hopefully to provide for some real regulatory relief, address the reimbursement issues, as well as provide prescription drug coverage as a component of Medicare.

That is her goal, and of course, she will be leading that charge when we resume later this month.

Sticking with the subject of MSAs, Doctor, what has been your experience with patients who participate who have MSA coverage?

Dr. KOBLER. Well, I am not sure that I have had enough patients in town that actually are insured by MSA, at least not that I am aware of when I look at the route slip as they come in. Most of them have the traditional managed care companies that we have here locally, as well as the national firms.

State medical society, the AMA are all on record as saying that MSAs are probably a very good thing and probably should be expanded.

We have a physician in Illinois down south who eats, drinks, and sleeps MSAs. I get E-mails from him all the time about it, and I really think that, you know, the points that Mr. Holoka made as well. I think it does make you look a little bit more at how you are spending your health care dollars.

I guess the potential concern that I have as a physician, especially in primary care where we practice a lot of prevention is to

be sure that people are not going to try to save that money and not do some of the things that they should do preventatively, and we would hope that they would be good stewards of those dollars that way as well.

I think that is one of the potential weaknesses of that, but I am not sure. I have not seen the statistics to suggest that that is a problem at this point in time.

Mr. WELLER. Okay. I assume I have a little bit of time left, Mr. Chairman. Am I about out of time.

Chairman MANZULLO. You are about out of time. Two more minutes.

Mr. WELLER. Two more minutes. Okay.

Let me direct my last question to Mr. Brauns. You are an advocate of choice and opportunity and consumerism, I believe, from the comments that you made, and you are an advocate of the refundable tax credit proposal, which Chairman Bill Thomas has been an advocate of in the Ways and Means Committee and others.

Included in the earlier versions of the Economic Security and Stimulus Package that we passed out at the House of Representatives, the refundable tax credit that helped laid off workers covering up to 60 percent of their premiums as a way to help insure they had continued health care coverage while they were unemployed until they went back to the work place where they had health coverage.

From your perspective in marketing insurance coverage, health care products to your customers, how would your business market to this refundable tax credit approach? If I am a worker and I have this refundable tax credit, it is a new thing for me. I do not really know what to do with it. How would you market it and explain it to them and show them how it would work?

Mr. BRAUNS. I think, number one, it would be very well received. I know there is tremendous pressure that is building up in this system, and we all know that. A lot of it would depend, I think, on what the actual structure of that is.

Would it be a voucher that they could take? It is going to come every month or is it going to be handled through the payroll deduction system that goes against their FICA and whatnot? Are the employers taking care of that? Are they going to get this voucher and then be able to go out to the individual health insurance market and then go to that insurance company and say, "I have got this voucher now and I can afford to pay these premiums"?

Some of it depends upon how that is actually going to be structured, but we would be very excited to be able to market a product like that, and I think it would be very well received.

You know, by and large, most employers are very paternalistic. Most employers want to take care of their people, and they are looking for any way they can to increase benefit and find ways that they could give more money to employees to help them buy more insurance.

Employers, I do have to tell you though, there is so much pressure in the system. They would like to get out of being an insurance company. If there was some way that they could do that paternalistically, if they knew this product is a defined contribution, and it has not taken off yet because defined contribution has

created this huge individual health insurance market, and particularly in the State of Illinois, you cannot go to, say, Blue Cross and get a guarantee issue health insurance policy for one person.

If you could, the rates would obviously be expensive, but you may have a lot of employers saying, "Take your voucher and go do that."

And then the employer would be able to provide 401(k) matches, more life insurance, more disability, more vacation days, other things that the employer would like to do for the employee.

Chairman MANZULLO. Congressman Ryan.

Mr. RYAN. Thank you, Chairman Manzullo.

I would like to talk to Mr. McCarty and Mr. Brauns about the AHPs and about pooling, and I would like to nail down a definition of pools.

I understand that it is in the best interest or in the self-interest of a state Blue Cross/Blue Shield to oppose association health plans because those are ERISA plans that move beyond state borders. But I'd like to nail down this definition of a pool because we are throwing this word around so much.

When you say you are pooling your small business individual rates in the State of Illinois in Blue Cross/Blue Shield, you are pooling that after you saw the coverage within your own insurance structure; is that correct?

Mr. MCCARTY. Yes.

Mr. RYAN. So it is not a pool you are going out into the marketplace saying, "Here, Mr. Bartmann. We have a pool for you." You are just marketing it as a Blue Cross plan for his business, correct?

Mr. MCCARTY. When we market to a small group, we are marketing individually to him. The rates are set up on his demographics. Some risk factors do go into that.

Mr. RYAN. And you see if there is a heart attack in his business or if there are preexisting conditions in his firm, something like that, correct?

Mr. MCCARTY. Yes.

Mr. RYAN. Okay. So the pool of the association health plan that we are talking about is a little bit different than that kind of pool concept. So I just want to make sure that we are not saying that these are the same things.

The association health plan pool is a national pool, an ERISA plan which goes through state borders much like any Fortune 500 company will have for their employees.

You know, General Motors, which has a plant up in Janesville, has a huge ERISA plan for all of their hundreds of thousands of employees, and that crosses state borders. They do not have preexisting conditions. They do not have demographic questionnaire studies, and they benefit from very good insurance packages, very low rates, and rates much, much lower than rates for a small business.

So the goal of pools, as echoed by the President in Wisconsin in February and which we talked about in the Ways and Means Committee, is to give small businesses access to those same kinds of economies of scale, for those same kinds of benefits that an ERISA pool provides, just like the Fortune 500 company gets.

Would you like to comment on that?

Mr. MCCARTY. Just to clarify our position is not to oppose association health plans. Our position is that they need to be structured appropriately so that, number one, they do not undermine existing legislation to existing states. That is number one.

And number two, that they are regulated appropriately enough so that the mistakes that have happened with prior association type plans do not happen again.

And, number three, that as we venture into this, it is also structured correctly to bring more people into the pool, into——

Mr. RYAN. Adverse selection.

Mr. MCCARTY. Yes, because otherwise you get a modest enrollment, it does not catch on, and it winds up having selection issues which causes, again, a burden for particularly small employers.

Mr. RYAN. That is a compelling point. I think the adverse selection point that, Ryan, you mentioned is a very compelling point, but if you compare that to the status quo, we have a 60 percent uninsured rate for small businesses right now. That is not acceptable, and that is under a state-by-state regulated environment.

So the status quo obviously is why we are having this hearing, because that is unacceptable.

Mr. MCCARTY. Sure.

Mr. RYAN. But I think if you look at the adverse selection studies that when you apply adverse selection studies to ERISA pools, you do not have adverse selection nearly to the extent that has been suggested with state insurance pools because adverse selection goes away with association health plans because they are able to evolve with the marketplace. They are able to change.

And so if a businessman like Mr. Bartmann is looking to join an AHP or stick with what he has, he will make that decision in the beginning. He will make that decision. He will adverse select, as you put it, right away.

If he joins the AHP, he can always get out, but the idea that the sick will only be left in the AHPs is an idea that has been pretty well defeated intellectually and through many studies, including the CBO and CMS that show you risk will be well spread. Adverse selection on the national level does not really occur because if it would, it would occur with other ERISA plans, and that is just simply not the case these days.

So there is a great story to be told on pooling with ERISA plans across the state boundary lines. That shakes up the system. That abandons in many cases a state-regulated system, but the state regulated system we have today under which Blue Cross operates is giving us this huge rate of uninsured and these unacceptable rates of increase of health insurance premiums for small businesses.

So I think there is a broader story to be told with respect to pooling. I hate to give more of a speech, but——

Chairman MANZULLO. Your five minutes is up. So——

[Laughter.]

Mr. RYAN. We deal with this a lot in our committee.

Chairman MANZULLO. Congressman Kirk.

Mr. KIRK. Thank you, Mr. Chairman.

We met when you held a hearing on a similar topic in my congressional district. We met with Sammy Davis, Jr., the real Sammy

Davis, Jr., who operates Handyman, Incorporated in Mundelein, and Handyman has gone the way that, Phil, you might be looking at. Handyman employees are now completely uncovered because of the rates and the increases.

Chairman MANZULLO. You said that was going to happen.

Mr. KIRK. And it has happened, yes. So Handyman, with 13 employees; is on their own.

Now, Sammy belongs to a number of associations, and I wanted to just ask you. Are you a member of the McHenry Chamber of Commerce?

Mr. BARTMANN. I am the Chairman of the McHenry County Economic Development Corporation.

Mr. KIRK. Are there any other associations that you are already a member of?

Mr. BARTMANN. NFIB.

Mr. KIRK. At the NFIB?

Mr. BARTMANN. Almost from the beginning, yes.

Mr. KIRK. Right. And it would seem to me that NFIB would be an ideal place for a national association health plan.

Mr. BARTMANN. That is right.

Mr. KIRK. Very broad membership, and you do not have that option right now?

Mr. BARTMANN. No.

Mr. KIRK. That is, I think, something that is very important for us to have a Medical Savings Accounts for the truly small entrepreneur, but to allow you to join through NFIB or, I think, ideally the county Chamber of Commerce or even the town Chamber of Commerce in the case of my people.

One of the reasons why costs are going up so much is because of enormous jury awards against doctors and hospitals, where you get into the unlimited amounts of money that could be awarded through "pain and suffering" awards.

I just throw it out to the panel here. What would be the impact, in general, of medical malpractice reform?

Specifically, the House included this as part of the Patients' Bill of Rights. It gives us the ability to expand health care coverage and lower cost.

Mr. MCCARTY. I do not have any specific information on the impact.

Mr. KIRK. Well, let me just throw out one number. I just talked to some OB–GYNs in my district. The up front cost, the first thing they have to pay before they see Patient One was $90,000 for medical malpractice coverage, and so that is built into their fee schedule right away.

Mr. MCCARTY. Right. So, yes, there would be a favorable impact on premiums for small employer groups, for large employer groups, for everybody, for individuals, if education were enacted to protect providers from unusually large or outrageously large settlements.

Mr. KIRK. And it is important that we are not talking about limiting someone's economic damage. It is the treble, quadruple damages when a jury in a rural county in Illinois says, "Let's give them a $2 billion award." That has a ripple effect throughout the system.

Go ahead.

Mr. HOLOKA. Yes, in answer to your question, how it impacts on a particular doctor's practice and their premium, of course, it puts a lot of pressure on the doctor to see enough patients to come up with, you know, the premium. But, of course, there are a couple of reasons for that.

One is when you have PPOs, HMOs, and you have the government through Medicare and other legislation limiting the amount a doctor actually receives, you're really slashing the doctor's wrist at the point.

The second thing is as far as impacting the general cost of medical care, health care throughout an entire state, for example, we can go back to Indiana in 1980. In 1980, Indiana enacted caps on the amount of recovery you could make in a medical malpractice, economic or otherwise. So it was enacted, and that cap was $100,000 at one level and then $500,000 at the next level. Okay? And that was only for catastrophic that you could go between the $100,000 and $500,000 recovery.

Okay. When Indiana first started this, they were 28 in the country in health care costs. Okay? In 1990, ten years of experience, Indiana was still 28th in the country in health care costs. So I really think that medical malpractice per se has really no effect or just so small as to be negligible on the actual cost of health care.

Now, how it impacts doctors' offices, I mean, that is another thing. If a doctor cannot generate enough income, then, of course, they are going to have to close their office, but to the malpractice carriers, they have to base this on what their experience is.

The second thing is that there is no such thing as treble damages and all of these other things in medical malpractice. We have done away with punitive damages in Illinois. We have had reform to that degree.

We have cut attorney's fees in medical malpractice cases. There is no other area in Illinois that we have cut attorney's fees in, other than through the work comp. statute to attorneys that are handling cases on behalf of the injured people.

Mr. KIRK. And yet in the Congress we hear, especially from places that include rural areas like this one, that there are whole regions where you cannot get obstetric care.

Mr. HOLOKA. Well, I will tell you what. I know of no place in this area where you cannot get obstetric care.

Chairman MANZULLO. I mean, you have to understand, too, that a lot of things are rural because they saw some cows. [Laughter.]

We are at five minutes.

Mr. KIRK. Okay. Mr. Chairman, I would just point out that our colleagues from other states, Iowa, et cetera, will give you a long list of driving distances that you will have to get to to find obstetric care, and that is due to the enormous malpractice costs that only a suburban/urban area could handle the cost structure of that.

And so we have got real access to care issues erupting in the country now because of the enormous liability cost of being in this field.

Mr. HOLOKA. Can I just make one comment to that? I know a general surgeon in town who went out of business, and it was not because of her health care premium. I am sorry. It was not because of her medical malpractice premium. It was because of the way her

fees continued to get chopped down to the point that she could not stay in business.

And when you are charging $80 for an office visit, and you are getting $8 and $10 and $12, you cannot even cover the cost of a nurse, let alone make any kind of profit. You are killing yourself in overhead.

So I think the problem is multi-faceted, and it cannot just be directed to medical negligence cases. And again, I would say the proof is in the pudding. Medical negligence cases are such a small amount of the actual cost of health care as to be negligible.

Chairman MANZULLO. Okay. We want to thank the panel for coming and testifying. You are welcome to sit through the rest of the testimony this afternoon.

And we are going to take about a ten minute break. During that period the second panel can go up there.

All of the complete written statements will be made a part of the record.

[Recess.]

Chairman MANZULLO. The Committee will come to order.

Our first witness on the second panel is Ryan Levin. He is V.P. of Product Development and Risk Management at the Destiny Health Insurance.

I look forward to your testimony.

STATEMENT OF RYAN LEVIN, VICE PRESIDENT OF PRODUCT DEVELOPMENT AND RISK MANAGEMENT, DESTINY HEALTH CARE

Mr. LEVIN. Thank you.

Good morning, Mr. Chairman, Congressman Kirk and Ryan. Thank you for the opportunity to speak before you this morning.

I think from our perspective we have a very similar perspective to yours: trying to understand the——

Chairman MANZULLO. Ryan, would you keep your voice up? You have got a very soft voice.

Mr. LEVIN. Our perspective is very similar to that of your committee: trying to understand the reasons for high health care costs and more specifically, the uninsured and the increasing number of uninsured.

We believe that there are two interrelated reasons for the number of employed uninsured. The first is cost, and that is one that has been discussed in quite some depth this morning. The higher the cost of health insurance, the greater the likelihood that someone is going to opt out, some people because they cannot afford it, and I think that is plain for everyone to see.

The second reason for employed uninsured, I think, is a little less apparent, but interrelated with the first, and that is that there are a number of employed uninsured who actually can afford health insurance, but choose not to. The reason for that is that health insurance provides them with no value because they are healthy, or at least no perceived value.

Now, the problem with that is that if healthy people choose to opt out, the risk pool on average gets sicker and costs continue to increase. So in many respects, you get into a vicious circle where

the higher the health care costs go, the fewer people participate and the higher the health care costs go.

So we looked at the situation and said, well, we need to understand the underlying reasons for these high health care costs, and there have been a lot of reasons spoken about this morning. There is one that has not been thought about much and has not been discussed much, and that is the role of the consumer in health care costs.

We believe this is actually a very key component to rising health care costs, consumer demand, because consumers really are driving health care costs in many respects. I will give you a couple of examples.

First, drug costs. We all know that drug costs are a big driver of health care costs overall. One of the reasons for that is technology. Technological advances have increased drug costs and increased the number of prescriptions and probably saved other health care costs.

But there is one more reason, and that is consumer demand for drugs. We all watch TV and read magazines, newspapers, see the increasing number of direct to consumer drug advertisements. Because the drug companies understand that advertising directly to the consumer will drive demand for their products.

One study performed by Prevention Magazine found that 87 percent of people who asked their physician for a particular drug are prescribed that drug. Now, the problem is that while the providers of these health services understand that consumers are driving demand and driving utilization of these services, health insurance does not understand that because health insurance plans typically dissociate the member or the consumer from the cost of the health care that they are consuming. They are essentially spending someone else's money because all they are paying is a very small portion of the total cost of health care.

Another area where consumers are driving health care costs is in their response to managed care. Managed care is a tool, a mechanism that has been used by many health insurance carriers and specifically HMOs to reduce health care costs. They have used things like networks, gatekeeper models where you cannot get care other than through a gatekeeper to control health care costs.

Consumers understandably are rebelling against these controls because it restricts their freedom of choice. By doing that and because the insurers and HMOs have been forced to react to that, there has been less ability for them to control health care costs, and that, too, is one of the reasons that health care costs have been increasing.

So we believe that health care costs are a big driver of the uninsured, and the fact that there is little value for the healthy is another big driver of the uninsured. These two are interrelated.

So the solution we feel has two components. First is to control the costs of health care by creating the right incentives within the health insurance infrastructure, and the second is to introduce value for the healthy, to encourage them to participate and thus reduce the average cost per participant in the health insurance system.

There are many consumer driven solutions that are being touted today, and this is a relatively new movement. The model I am going to describe is based on one that is currently being successfully used by our sister company, a company called Discovery Health. They have over 1.2 million members using this model and have demonstrated substantial success in controlling health care costs.

In fact, this model was based on the medical savings account concept that we spoke about earlier but is in a substantially higher evolved state. The model relies on one fundamental principle, and that is that different types of health care costs need to be dealt with differently.

There are those types of health care costs that are substantially within the member's control or discretion and others that are less within their control. Those within the member's control include things like the more routine, day-to-day health care costs, doctor office visits, acute prescription drugs.

Those less within the patient's control are hospitalization and surgery, those high cost, high severity things that happen less frequently.

Chairman MANZULLO. How are you doing on time, Ryan?

Mr. LEVIN. I think I have another minute or two. [Laughter.]

Chairman MANZULLO. I will give you another minute. Go ahead.

Mr. LEVIN. What our model does is it uses a personal fund that belongs to the member to pay for those more routine costs. The key is whatever they do not use they keep, and that fundamentally changes the way they behave about health care specifically in those areas where they have discretion and control.

And the results of studies performed by our sister company show dramatic reductions in spending on those discretionary health care costs.

On the other side, we use insurance, risk pooling, to protect people against the high severity and high cost events like hospitalization and surgery, where they have very little control.

Wrapped around this are incentives for people to take the preventive measures they should be taking, keep healthy, keep fit, wellness incentives, and very healthy rewards for using those incentives.

The results of this structure are lower costs because the incentives are structured correctly, and very importantly, value for the healthy because suddenly and for the first time healthy people get value out of their health plan designed in this way.

Chairman MANZULLO. Okay. Thank you very much.

Mr. LEVIN. And thank you for your time.

[Mr. Levin's statement may be found in appendix.]

Chairman MANZULLO. The next witness is Amy Jensen. Amy is the Director of Federal Public Policy at the National Federation of Independent Businesses.

Amy, we are looking forward to your testimony.

I am going to excuse myself about two minutes. Mark, would you take over as Chairman. I will be right back.

Mr. KIRK [presiding]. Yes, Mr. Chairman.

STATEMENT OF AMY JENSEN, DIRECTOR, FEDERAL PUBLIC POLICY, NATIONAL FEDERATION OF INDEPENDENT BUSINESSES

Ms. JENSEN. Thank you, Mr. Chairman and members of the committee.

I specifically want to thank Chairman Manzullo for all of your hard work to help solve this very important problem for small business and also to these strong members who have done tremendous things to help small business better afford health insurance.

I am also glad to have this hearing in Rockford since my family lives in Wheaton. So I could take the opportunity to be back home.

My name is Amy Jensen, and I am Director of Federal Public Policy for the National Federation of Independent Business. NFIB is the nation's largest small business advocacy organization representing more than 600,000 small business owners in all 50 states and also in the District of Columbia.

Nothing is more important to NFIB than solving the health care problems of small business. We firmly believe that association health plans in removing the restrictions of medical savings accounts are necessary steps to create more affordable health care options for small businesses across the nation.

According to the most recent information from the Census Bureau, nearly 39 million Americans did not have health care coverage in 2000. That is nearly one out of every seven Americans.

Since that time a slow economy, higher unemployment, and rising health care costs likely mean that more Americans became uninsured, and two million Americans became uninsured due to job loss in 2001.

Over 60 percent of our uninsured population consists of small business owners, workers, and their family members. The high rate of uninsured in the small business community is largely due to the lack of available options for small business and also an increasingly shrinking small group insurance market.

We know that the smaller the business, the less likely it is to provide health insurance. Sixty percent of businesses that have three to nine employees offer health care benefits, while most large firms are able to offer coverage.

Even in the best of times, the small business health care plan only covers about 57 percent of the employees, many choosing to go without coverage due to the high costs. For the smallest of the small offering health coverage is a constant battle.

At NFIB can substantiate that the high cost of health care is the number one problem of small business owners today. NFIB surveys show that for the past decade small business owners have ranked the cost of health insurance as their number one problem, higher than taxes, regulations, and every other problem.

Our members also have told us that they believe providing health insurance is the right thing to do, right for their employees and right for their business. However, the high cost of health insurance often prevents them from doing this.

As you know, Mr. Chairman, NFIB has provided several witnesses who testified before your committee, as well as Representative Thune's subcommittee, and all of them have experienced double digit health care premium increases. Elaine Smith from Gran-

ite City, Illinois experienced a 26 percent increase this year. Ron Hatch of Yankton, South Dakota experienced a 50 percent increase. And Phil Bartmann, who testified previously and one of the Chairman's constituents, experienced nearly a 100 percent increase.

On average, a worker in a firm with less than ten employees pays 17 percent more for health insurance than a worker in a firm with 200 or more employees.

Small businesses need more bargaining power so that they can have access to affordable coverage for their employees. In today's society when it comes to purchasing health care, the rules of the game are stacked against small business. The small business with the least income actually pays the most, while Fortune 500 companies are able to offer exceptional benefits, have more modest annual cost increases, and have more choices for their employees.

These companies have benefited from the economies of scale that come from being able to purchase health care in a large group across state lines. Unfortunately under today's law, it is impossible for small business to purchase health care in the same manner as their big business counterparts.

Association health plan legislation like H.R. 1774, the Small Business Health Fairness Act, introduced by Fletcher and Dooley, levels the playing field by enabling small businesses to purchase their health care like big businesses and union plans, through AHPs under what's called ERISA.

HPs are a private market solution. It builds upon what has been proven to work, and if small business could purchase health care in the same manner and under the same rules as big business, premiums would go down and coverage would increase.

Allowing small businesses to purchase health care through association health plans will allow them to save on administrative costs and bring to the market the amount of bargaining power in sufficient numbers to absorb risk without substantially increasing premiums.

As you have heard, insurance companies are not fond of AHPs. AHPs, it is true, would compete with current insurance options, but NFIB believes that that competition is long overdue.

MSAs also offer an alternative solution. Eliminating the regulatory burden on MSAs would benefit small business. MSAs without the current restrictions would provide positive benefits to employees by giving them control over their own health care dollars.

And making MSAs more workable by easing the regulatory burden on them would provide yet another affordable health care option to small business.

Tax credits for individuals would also be anther welcome option.

One of the most frequent complaints of small business purchasing health insurance today are drastic high rates that force them to drop or completely restructure their employer sponsored health care coverage. Allowing small business to purchase health insurance through AHPs will minimize this problem.

Chairman MANZULLO. How are you doing on time, Amy?

Ms. JENSEN. Just wrapping up——

Chairman MANZULLO. All right.

Ms. JENSEN [continuing]. To say we thank you for your strong work on AHPs and MSAs, and I look forward to your questions.

[Ms. Jensen's statement may be found in appendix.]

Chairman MANZULLO. Thank you very much.

I am sorry I had to leave. We have got several members of our staff up from Washington taking four different cars in as many different directions and trying to coordinate that out there.

Our next witness comes from the Illinois Manufacturers' Association. He is Vice President of Government Affairs, Boro Reljic.

Mr. RELJIC. Reljic, yes.

Chairman MANZULLO. Boro Reljic, and the reason I asked Boro to come here is that there has been a bill that had been passed out of the Health Committee of the State House of Representatives here in Illinois that would allow employees of employers with less than 25 employees to join the State of Illinois employees' health risk pool, which I guess would be the ultimate associated health plans.

We found out about it, and Amy has a copy of all of the work that has been done on it, and you have come here to testify in behalf of that.

STATEMENT OF BORO RELJIC, VICE PRESIDENT OF GOVERNMENT AFFAIRS, ILLINOIS MANUFACTURERS' ASSOCIATION

Mr. RELJIC. Well, I was trying to figure out. I know that that is the scope of what you wanted to talk about, and I could just go right through my testimony, but there will be some mention of that.

Chairman MANZULLO. That will be fine.

Mr. RELJIC. Thank you.

Again, my name is Boro Reljic. I am Vice President of Government Affairs for the Illinois Manufacturers Association. The IMA is the oldest and largest state industrial association of its kind in the United States. We formed in 1893 to collectively address the problem from the railroads that they presented to us. So we have been around a while.

And health care is really one of the most significant problems that are facing our members now. You have heard the stores of the significant increases that our companies have seen.

The association itself is not just small employers, but large employers as well. We represent companies like Caterpillar Tractor and John Deere, as well as companies like Zenith Cotter and Rockford Spring Company here in this area. So we are a mix of both large and small employers or members of the Illinois Manufacturers Association.

Some of the numbers that have been tossed out particularly about health care costs are significant. According to the National Association of Manufacturers, health care costs have increased by more than 300 percent between 1980 and 1990, or $73 billion to $223.6 billion.

Health care costs in 1999 were 470 percent more expensive than 1980, again, $73 billion to $343 billion. And as long as we continue to see the cost of health insurance premiums increasing in the double digit manner in which it is, we are going to continue to find a vicious cycle of more uninsured.

And we were concerned about that, and so the Illinois Manufacturers Association has a couple of viewpoints at least on the state

level where we work most often to try and address some of those problems as we see them.

One, which was mentioned by the representative from Blue Cross and Blue Shield is Illinois' insurance code mandates. Collectively the various insurance code mandates account for 20 percent of premiums right now in Illinois. So you need to keep in mind that the various insurance code mandates that are placed on group health, which only impacts the small employers because larger employers that have the ability to self-insure, these mandates do not cover.

Another reason that we see in the recent increase in health care costs is the erosion of managed care. Providers are not happy with some of the things that are happening in the marketplace, and we need to make sure, you know, the cost savings that we saw ten years ago or the controlled cost increases that we saw ten years ago as a result of managed care, that was not a legislative fiat. It was the ability of people to negotiate terms and conditions of payment, and we need to make sure that we keep those safeguards in place.

Another innovative approach and the one that Chairman Manzullo is so interested in is the pooling concept, and there is a bill in the Illinois House, House Bill 5963, which is sponsored by Karen May from Highland Park, which would allow employers with 25 or fewer employees to opt to participate in the state health insurance pool.

Illinois has 66,000 state employees that are covered by the state health insurance plan, and it is our thought that to give those small employers the purchasing power they need, they should be able to opt into that program. They should pay the premiums. They should pay the increased administrative cost that would be associated for running it, but that would allow them some of the purchasing power that larger companies enjoy.

Under the provisions of the bill a company that opted to participate would not be able to select only certain employees. Every employee of the company would have to participate, and we just find that as one of the innovative approaches to try and solve this problem.

We believe in a private sector solution to this issue. We do not think that a government mandate is going to answer or solve this particular problem, but we need to find ways in which we can incent, if you will, employers to go ahead and offer health insurance to their employees, which is going to benefit all of society.

[Mr. Reljic's statement may be found in appendix.]

Chairman MANZULLO. You finished early. Great.

Mr. RELJIC. Time is always of the essence.

Chairman MANZULLO. Okay, great. Our next witness is Vondie Woodbury, Director of Muskegon, Michigan Community Health Project and Vondie came all of the way down here just to be with us today.

STATEMENT OF VONDIE WOODBURY, DIRECTOR, MUSKEGON COMMUNITY HEALTH PROJECT

Ms. WOODBURY. Yes. Thank you.

Chairman MANZULLO. Thank you very much. I look forward to your testimony.

Ms. WOODBURY. And, again, I want to thank you for the opportunity to present testimony on the work we have been doing in Muskegon County to address health care issues for our small business community.

My name is Vondie Woodbury. I am Director of the Muskegon Community Health Project. We are located almost directly across the big lake from Milwaukee, Wisconsin. So we are right there on the shore.

I am going to be speaking today about a program that community volunteers in our project developed called Access Health. Access Health is not an HMO, nor is it an insurance product. Access Health is a community owned health coverage plan that is sold to eligible small businesses in Muskegon County to provide health care coverage to the working uninsured and to their dependents. It was intentionally designed to fill the gap between public insurance programs, like Medicaid, and commercially available products.

Access Health was developed following extensive quantitative and qualitative research within our community. Some of the numbers have been touched upon by other speakers. I do not think we reflect any differently than other parts of the country.

What we did find is a group that has tended to be very small businesses who were insured, less than four employees for the most part. They tended to have very low profit margins. They were not members of our Chamber of Commerce.

When we asked them why they did not participate in commercial coverage, 69 percent of them told us it was too expensive. They had high rates of employee turnover, which for us became the carrot because it was very clear to us as we got into this market that they needed something to stop the hemorrhaging that was going on, the churning in their employees.

As we looked at the market, 95 percent of these employers told us they could afford to pay something, but it had to be less than $50 per employee per month. The people who worked for the business sector, the same type of a profile, but we found that the majority of them tended to be women under 40 with children. We found a good number of people who had moved from welfare programs into small business.

Sixty-four percent indicated that they valued health care. They wanted coverage. Most made between $6 and $10 an hour, and 65 percent of us or 65 percent of them told us again that they could afford to pay something, but it had to be less than $50 a month.

It is important to underscore when you look at this part of the month that the popular press keeps referring to them as the working poor. These are not people that self-identify as working poor. They are working. They are helping pay taxes. They are helping to support government programs like Medicaid and Medicare.

No one that we went to asked for a handout. They were all willing to pay something, and I think that is one of the most important things that need to be said about this market.

To insure that our Access Health Program only served that portion of our population who were unable to pay for commercial products, we took special steps to limit the type of business we serve. Eligible businesses must be located in Muskegon County. They cannot have offered commercial insurance for the previous 12 months.

They must have a median wage of $10 an hour or less to participate, and we wanted to make sure that these were businesses that were not in the commercial coverage market.

Any business that is found falsifying information and dumping existing coverage is dropped from Access Health for life. We have targeted 500 businesses, and we hope over time that we will grow the pool to 3,000 full or part time individuals. At present we have 300 businesses who are enrolled, and we have served nearly 1,500 people.

We work very closely with our Chamber of Commerce who sells the Blue Cross/Blue Shield program in Michigan to small businesses. We work with local insurance agents. We wanted to make sure that our part of the market was exactly that, a niche. We weren't going to pull from either.

So we have actually gotten to a point where Access Health is sold by insurance brokers for no commission, and they go back after a year and try to trade people up to commercial coverage, and so we have worked out a very good relationship with our commercial group.

Access Health is only offered in Muskegon County. Members who have medical incidents or seek treatment outside of Muskegon must pay the full cost of this out-of-pocket care. By limiting our coverage area to our own county, we insure that our product does not compete, again, with commercial products. It is not intended to do that.

Within the restrictions, we are able to provide a substantial benefit. We enter into contracts with all of the providers in our community. When I say "all," it is 97 percent, both of our hospitals, almost every primary care physician.

We pay them on a fee for service basis. They donate ten percent of those fees back to help administer the program. I have included a brochure that is on the table that describes the medical benefit package. We cover everything that is available in Muskegon County, which means if you have cancer, you will get care. If you have heart disease, you will get care.

To make it affordable, Access Health funding comes from three sources: employer contributions, employee contributions, community contributions. This type of structuring is commonly referred to as a three share model.

Three share models are different from traditional entitlement programs in which the public assumes the full 100 percent of the cost. In public policy terms, what it means in our program are that taxpayers are liable for 60 percent less of the cost than a traditional entitlement program.

In Muskegon county today an eligible business can buy Access Health for an employee for $42 a month. The employee will pay $42 a month, and the remaining part of our cost, $55, is paid for by our community. The community accesses federal dollars that were already in the system called disproportionate share hospital dollars.

A state may redistribute these dollars to states or to hospitals who serve a disproportionate share of indigent people. We directly draw down those dollars and use it for the third share of our program.

So, again, what we have managed to do is to keep it budget neutral. We have not created new funds to finance our program.

Access Health provides Muskegon County with shared wins for all the participants. The community reduces its level of uninsured as much as one third by the time we get our program up to 3,000 people.

Those covered get improved health care access, and our providers reduce the level of uncompensated care they must otherwise cost shift to insure appropriate patients.

Finally, businesses benefit by reduced employee turnover and absenteeism and enhanced competition to provide benefits to workers.

Chairman MANZULLO. How are you doing on time, Vondie?

Ms. WOODBURY. I am just about there.

Chairman MANZULLO. Okay.

Ms. WOODBURY. We think our approach is pretty common sense. Rockford has been looking at it, and I am delighted to announce that Huntington, West Virginia just got legislation through their state legislature, and they are about to kick off.

We have also been to States like Utah, Idaho, Delaware, and Beaumont, Texas before the end of this month.

So with that, sir, I thank you very much.

[Ms. Woodbury's statement may be found in appendix.]

Chairman MANZULLO. Thank you very much. We appreciate it.

Our next and last witness is Johanna Lund. She is the Chairwoman of the Rockford Health Council, and Johanna's mother and my father went to grade school together. So we go back a few years, don't we Johanna?

STATEMENT OF JOHANNA LUND, PH.D., CHAIRWOMAN, ROCKFORD HEALTH COUNCIL

Dr. LUND. We certainly do, and it is really a privilege to be a part of this.

Thank you, Chairman Manzullo.

Chairman MANZULLO. Thank you, Johanna.

Dr. LUND. And your entire committee, Congressman Kirk and Ryan and Congressman Weller, whom we met earlier in the day. Thank you so much for coming to Rockford.

I am actually here in a dual capacity as Chairperson of the Rockford Health Council and a small business owner.

Rockford, like other parts of the country, is facing a crisis in the ability of small business owners to obtain and keep affordable health insurance. This fact was documented three years ago by a study in 1999, the Rockford Healthy Community Study, which identified 16 issues, major health care issues, and certainly affordable health insurance care was one of the major issues.

The Rockford Health Council is a community based health policy and advocacy group of 54 organizations representing health care, business, education, social services, and government in Boone, Ogle and Winnebago Counties, our immediate area.

Since the release of the health of community study, we have been working collaboratively to address this issue of access to medical care. For most of our residents currently, access to care is through employer based insurance or Medicare or Medicaid.

But for a sizable number of residents, access to timely and appropriate health care is impaired due to lack of insurance. We have estimated that as much as 44,200 residents, or 16 and a half percent, of our Winnebago County population is uninsured and another 11,000 uninsured in neighboring Boone and Ogle Counties.

We estimated that a large portion of the uninsured are currently employed in the private sector. Among minority populations, the estimates are that 23 percent of African Americans and 33.5 percent of Hispanics are currently uninsured.

Our efforts began with at least two premises. One, we want to assure access to health care to those who do not currently have access, and it is not our intention to compete with the commercial insurance market.

Our desired result is improved health access and outcomes, and we also do not want to do it on the backs of doctors and hospitals.

In September of 2000, we sent a team to Muskegon, Michigan, to examine their innovative program developed for their small business community, and it is one we feel worthy of replication, but we do not intend to exclude any other workable model.

We were granted a federal community access program grant last September and have been working diligently to develop a workable model of coverage for small business owners and their employees. We believe that small businesses are having difficulty obtaining affordable coverage from the private market, in part, due to the high cost of mandated benefits and, in part, due to adverse selection based on group size.

The federal CAP grant has provided funding for a concentrated effort to develop new options for our small business community. Through a comprehensive study of 4,700 small business owners with fewer than 25 employees in Winnebago County, which was completed in December by Health Systems Research, what we found were the following:

The average small business in Winnebago County employs just under nine persons. Forty-seven and a half percent of the respondents do not offer health insurance. Even when companies offer coverage, only 69.2 percent take the coverage, with 10.7 percent not eligible at the time of the survey.

For those individuals who do not take the health insurance offered, 59 percent are thought to be using their spouse's plan. Twenty, point, four percent say that such employees cannot afford their portion of the premium.

Small employers in Rockford reported rapidly accelerating health plan premiums, an average increase of 26 percent last year. Ninety percent of the respondents not offering coverage cited high cost as the reason.

We have retained Health Management Associates of Chicago as our principal consultant in the development of a plan appropriate to our needs and the laws and regulations of Illinois. We have met with area legislators, hospital CEOs and interest groups to inform them and to seek their support. We have engaged the Illinois Department of Insurance in high level discussions about how to create a new model of affordable coverage for the 4,000 employees we estimate could benefit from an initial plan.

I commend the State Department of Insurance. They are working to help us facilitate our plan. Two weeks ago, we had a small group, focus group, of nine employers, asking their input in helping design a coverage product and further meetings are planned.

We are currently working through the details of a plan that would offer basic medical, pharmaceutical and limited hospital coverage for working adults employed by businesses of two to 25 workers with a median wage of $12 per hour who have not offered coverage for the past year.

We hope to develop a model of community coverage like the third share arrangement with employers, employees, and the community sharing the costs. Our actuary is currently pricing this model, which we expect to be able to offer to eligible small businesses at no more than $75 per month or less per employee share. The $75 was arrived at because that seemed to be the participation break point documented in our survey.

Our goal is to develop a marketable product to bring to small business owners before the end of this year. If we are successful, this approach could be a model for other Illinois communities.

We appreciate the recognition that this Committee is providing for locally developed solutions to the need for affordable coverage that have potential applicability on a community-by-community basis.

Again, I thank you and look forward to your comments and questions.

[Dr. Lund's statement may be found in appendix.]

Chairman MANZULLO. Thank you, Johanna.

Mr. KIRK. Mr. Chairman, I have got to meet with our first responders in Riverwoods.

Chairman MANZULLO. Okay.

Mr. KIRK. So I have got to take off.

Chairman MANZULLO. Well, thank you for coming.

Mr. KIRK. There is not a day goes by that this subject does not come up. So you are right on target.

Chairman MANZULLO. We held a hearing in your district what, last year?

Mr. KIRK. That is right, and I just want to applaud your leadership.

Chairman MANZULLO. Thank you.

Mr. KIRK. Your committee is right on target here.

Chairman MANZULLO. Thank you for coming.

Mr. KIRK. Thank you.

Chairman MANZULLO. Mr. Ryan, did you want to ask some questions?

Mr. RYAN. Sure. Did you want to go first, Mr. Chairman?

Chairman MANZULLO. No, go ahead.

Mr. RYAN. Okay. Well, thank you.

This has been really enlightening. Ryan, I wanted to ask you a couple of questions. I notice you have a lot of Ryans in Illinois. [Laughter.]

Mr. LEVIN. You would think we were in Ireland.

Mr. RYAN. I am intrigued with your actuarial background academically, and your model that you prescribed is one, and correct me if I am wrong, that is individual based where you make sure

that you have informed consumers making decisions. And would you agree that in the current system you do not have informed consumers and that is a source of the big problem with the cost increase that we have?

It is really not a competitive environment. Would most of the panel agree with that?

Mr. RELJIC. Absolutely.

Mr. RYAN. What do you think, and, Dr. Lund, you said something that I thought was very interesting, which is we are not trying to preclude other workable models. It seems like what you have heard with these two panels are different ideas on how to achieve the goal of getting access to affordable health insurance so that there are different workable models.

What is your, and I would like to ask the panel, all of the panel, what is your impression of basically what the President outlined on February 11th in Wisconsin when he gave his big health care speech? What the President outlined was basically this:

A refundable health insurance tax credit, $1,000 for individuals, up to $3,000 for families to purchase health insurance, association health plans so that small businesses and individuals can get access to pools, and then unlimited medical savings accounts, which for those who do not know what medical savings accounts are, are like an IRA for health care.

Right now, as Ms. Jensen said, it is deeply regulated. It is capped to the amount of people that can participate in it. In the Ways and Means Committee we are advancing legislation to unlimit the amount of MSAs that can be used in this country and reduce some of the regulatory barriers.

What do you panelists think of that model, tax credit with pooling plans across the country and with unlimited MSAs? Do you believe that each of the models that you are calling for, that you are developing could thrive in this environment?

And then at the end of the day, would we or would we not be able to have a healthy competition of ideas and models at work for the people in this country to try and achieve better health care savings?

And then would that not provide us with not just putting our bank on one good idea, but releasing a bunch of good ideas to get at the goal of affordable health insurance?

And I will start with you, Ryan.

Mr. LEVIN. I think you are right on in that there is no one solution. There are clearly a number of solutions and some are more applicable in some circumstances than others. The proposals that the President put forward, I think, have a lot of merit. Specifically, the tax breaks, that will certainly increase affordability.

Increasing the ability to use medical savings accounts I strongly support. My view is that that should not be restricted to opening them up to larger employer groups and more participants, but should also include moves to increase the flexibility of the product designs within that structure.

Regarding association health plans, I have some strong reservations, and in a nutshell, my view is that unless they're implemented very, very carefully, they are a recipe for disaster because of the selection issue. As soon as you offer an opportunity to a

number of individual decision makers to participate or not to participate, they will make their decision as to whether they should participate based on the benefit it provides them personally or their organization.

What that means is that you tend to find those who cannot get a better deal elsewhere participating, and you get into that risk spiral where the cost for those in the group continues to increase because those who can get better deals elsewhere go elsewhere.

Mr. RYAN. Now, that is the topic of adverse selection that we debate constantly in our committee, and it is important to note that association health plans do not necessarily mean that they are going to offer one health insurance package to participants in the plan.

They could function like, I assume, your state health insurance plan does, Wisconsin's state health insurance plan or the federal employee health benefit plan, which is a laundry list of access to different products you can use.

I chose the Blue Cross PPO, but I think you mentioned you are, Don.

Chairman MANZULLO. Most members have because it covers the family both in Washington and——

Mr. RYAN. Yes, and we have many choices. So it seems that, if the AHP is structured correctly with the right solvency standards and those kinds of things and with the wide variety of choices, that the adverse selection can be dealt with.

But it is an important thing. Does your model that you articulate in your testimony with Discovery fit with what we just discussed as being the President's plan? Can that be furthered?

Mr. LEVIN. Absolutely, absolutely, yes.

Mr. RYAN. Ms. Jensen.

Ms. JENSEN. We were thrilled with the President's package, and as you so eloquently put it, I think it is essential to have different interchangeable parts that work together.

The three things that our members tend to look for, and we ask our members before we get involved in any issue, is they do not like the government telling them what to do. They do not like mandates, and they like competition because that is the kind of environment that they work in as a small business owner.

So those three components of the President's package are essential, and our only concern about tax credits is if you do them alone, they are great because they provide you with money and resources, but they do not provide the competition that brings premiums down.

So we think it is important that all three work together.

Mr. RELJIC. I would agree. I would also add that the issue of this adverse selection is one that is debated not only in Congress, but in state legislatures around the country as well.

But I think we need to take a look at, and I certainly do not know the answers to this, but we really need to take a look at what is occurring right now because an insurance company really has a motivation to find the healthiest people possible, and so it becomes an actuarial game that whoever has the best actuaries to determine what those losses are going to be is to be the most profitable.

We really should take a look at what is being done to share the cost overall as opposed to having a motivation or an incentive to find the most healthiest group or the most healthiest customer. I think that is where we really—the President's package certainly goes a long way at helping get more affordable coverage, but I think we also need to take a look at that aspect because as you look at it right now, it is completely an incentive to have the best.

The company with the best actuary is the most profitable insurance company as opposed to one that is managing the care better and sharing those risks.

Ms. WOODBURY. If I look at my community and I think about tax credits, I think about the people down the block at the Chamber of Commerce because our Blue Cross/Blue Shield product has been skyrocketing, and every time it goes up they lose members.

And I think tax credits probably have a bigger impact on their part of our local market because it stops businesses then from sort of getting themselves out of the market altogether and just dumping coverage. I think a tax credit really helps businesses that are already there.

It does not help very much with that part of the market that we work with, which is a fairly low income group. If ten percent of the businesses that we currently have in our program are child care businesses, the average child care worker makes $15,000 a year. There is not the expendable income up front to wait for a tax credit at the tail end.

Mr. RYAN. Well, If I could jump in, the President's proposal is an advanced refundable tax credit.

Ms. WOODBURY. Okay.

Mr. RYAN. So you do not wait until the end of the tax year. You get it every month when it comes through.

Ms. WOODBURY. Okay. That would be critical because these folks just do not have the money.

Mr. RYAN. No, it is a good observation.

Ms. WOODBURY. I would like to point out though I would like to see an insert there in terms of community innovation because I think that while we debate these issues and we have debated them for a long time now in terms of what we are going to do about an insured in the country, that some of the best innovations are coming out of communities. It is not just mine, but communities across the country have just sat down, like Rockford, and said, "Let's get our own arms around it. This is affecting our own hospitals, our own doctors."

We have always talked about all politics being local, and so is health care. And I think there comes a point where it would be good maybe. We have innovation types of programs for all sorts of things, certainly in research. Why not some innovation money to allow communities to also explore options?

Because we always tend to think we have invested everything that is inventable, and that is not true.

Mr. RYAN. Well, and that is what the market does.

Ms. WOODBURY. Yes, it does.

Mr. RYAN. One thing I wanted to add is that there is a big debate right now in Washington and Congress about whether or not the tax credit goes to people with employer-sponsored health care

or not. So there is a concern that if you offer just the individual market a health care tax credit, you will peel away from employer-sponsored health care.

Some of the proposals have a smaller credit available for those enrolled in employer-sponsored plans. So it would cover out-of-pocket costs and then a higher credit for those outside of it so that you do not carve out or shift away from one of the two models and so that you truly do present a level playing field so that ideas can compete, the market can work, and that incentive structures, as you said, Ryan, can be firmly put into place. Then let's see the good ideas flow and see what works the best way.

And that is hopefully what we will end up doing at the end of the day.

Dr. LUND. I certainly cannot add a great deal to what the rest of the panel has said. I like the idea of the advanced refundable, provided that that is not used for other expenses.

Mr. RYAN. It would not, no.

Dr. LUND. It would have to be limited. I understand that is where the President wants it to go. I am concerned that as it goes through its normal processes, that that might be changed. So that would be a concern.

The other thing is we can be as innovative as we want in communities, but if we do not have some sort of equality among the states, for instance, we cannot do in Illinois what Muskegon has done because of our legislative process, because of our legislation currently in place.

So I would like to see some equity, and then we can change and perhaps fund not only innovation, but forms whereby we can exchange this information. Right now we pretty much have to seek that out for ourselves.

But I think the President's plan was a very good one. I was very happy to see it.

Mr. RYAN. And I think the concern you mentioned about whether the tax credit goes to health care or something else is very well founded. One of the ideas that we are kicking around to prevent that from happening, prevent it from being spent on something else, is to do it through the employer model. Do it through withholding so that the HR person at the company, if you're at a business that doesn't offer health insurance or does offer health insurance, sends it right to the insurance company.

You could do it through other reimbursement ways, through the government, through a FICA tax withholding where it goes straight to the insurance company without having to have the individual deal with it, and then have the chance for fraud like we have had in the earned income tax credit and things like that.

So it is just food for thought.

Dr. LUND. Right.

Mr. RYAN. I can tell I have gone way over my five minutes.

Dr. LUND. Just one quick comment. On the MSAs, we are taking a look as a possible alternative. I said we are not excluding any model. It is something we are calling MSA-lite. That would be one opportunity for us to perhaps be able to get up and moving more quickly than having to wait for legislation.

Mr. RYAN. I appreciate that.

I just want to mention I want to thank the Chairman. I have to head back up to Janesville as well.

Chairman MANZULLO. Thanks for coming.

Mr. RYAN. So thank you very much for this hearing. I appreciate it.

Chairman MANZULLO. I appreciate your input.

Oftentimes I like to find out what associations people belong to to see if they could somehow, say, within an association health plan—do we have any people from the Farm Bureau here?

What about the Association of Building Contractors? Okay.

Any other NSIB? All right, okay.

Any medical professional groups, AMA, ADA?

So these are aiming my question. I ask that for your benefit.

Who is fighting AHPs and why?

Ms. JENSEN. Well, we have got a variety of opponents, largely state regulatory folks, state insurance commissioners, and insurance companies. Those tend to be the largest opponents, and our bottom line concern, for insurance companies we cannot understand why they oppose it because we think that largely they would be a partner in an AHP, that they would help offer the product.

So the only reason we can assume they oppose it is a purely competitive one, and for State Insurance Commissioners we have gone a long way to address any of their concerns about adverse selection, cherry picking, as they call it, and we feel that we have got a very substantial product that is very safe.

And, frankly, you know, we have got an uninsured population, small business, that is 60 percent. So it is not that they are going to be cherry picked out of another health plan. They do not have anything right now. So we do not understand the opposition, frankly.

Chairman MANZULLO. What I——

Mr. LEVIN. Can I?

Chairman MANZULLO. Go ahead, please, Ryan.

Mr. LEVIN. Perhaps I can answer that at least my own personal perspective. I do not oppose association health plans from a business or competitive standpoint. I simply believe that they will not work.

And if as an insurance company I would be forced to participate from a risk perspective, then I believe that would be loss making to my company, and that clearly would not be in our best interest.

But the existence of association health plans as you clearly point out would not harm our business unless we were forced to participate in a way that we believed was not sustainable.

And, therefore, my personal reservations are based on my belief that it is not a sustainable solution to the problems that we are facing.

Chairman MANZULLO. But won't you agree that the larger the pool of prospective insureds, the greater the sharing of the risk, the spreading of the risk, and the lower the premium?

Mr. LEVIN. Not exactly, no.

Chairman MANZULLO. Let me ask it another way. If a Ma and Pa company with five employees tried to get insurance, isn't their insurance a lot more than a company with 1,000 employees or 5,000 employees?

Mr. LEVIN. The answer to that depends on their health status. If that Mom and Pop company of five employees has a healthy group of employees, they may well be able to get health insurance for less cost than a larger group.

Chairman MANZULLO. So that is called cherry picking; isn't that correct?

Mr. LEVIN. It's called risk assessment. [Laughter.]

And appropriate pricing.

Chairman MANZULLO. But in the large corporations you do not require a profile as to every employee's medical condition; isn't that correct?

Mr. LEVIN. And the reason for that is because you have a captive participation audience.

Chairman MANZULLO. Right.

Mr. LEVIN. I agree with your statement that the larger group in general should have lower costs than a smaller group because of administrative efficiencies, et cetera.

From a health risk perspective though, the two do not go hand in hand. From a health risk perspective, it depends on the choice to participate or not participate in the pool.

If that choice exists, then you get into the adverse selection issues, and if the choice is made by employers——

Chairman MANZULLO. But you have adverse selection now with Blue Cross/Blue Shield who will say, "I want five healthy employees." But with the 1,000 people over here where they do not get the health background, no health check, and give a lower premium, there is no cherry picking going on.

Mr. LEVIN. Well, with the 1,000 employees, the risk——

Chairman MANZULLO. The universe is complete.

Mr. LEVIN. Yes.

Chairman MANZULLO. All right. So if you took these five employees for this one company and let them just figuratively be part of 1,000 employees, just treat everybody the same as they come into this so-called pool, which I still do not understand what you are doing that Blue Cross/Blue Shield was trying to establish, I mean, then can't you treat those people in multiples of fives and say, well, you can treat 1,000 people?

Mr. LEVIN. Here is the issue. If you have a population of 1,000 people and you have mandated participation of those 1,000 people in the risk pool, then you have a sustainable solution.

As soon as you say we have got this population of 1,000 that are all being treated the same way, each of those people can decide to opt in or opt out. Then you have a greater likelihood of the unhealthy opting in, and the healthy opting out.

Chairman MANZULLO. My brother-in-law is IBEW. He is a lineman. You could not pay me enough dollars per hour to do what Brad does. His insurance is carried by the union regardless of who his employer is. He gets great coverage. He has lots of choices, and he is an electrician.

Mr. LEVIN. But there you have mandated participation because all members of the union are required to participate in that.

Chairman MANZULLO. Does anybody want to touch that?

Dr. LUND. Don, just from a personal experience, Mr. Chairman——

[Laughter.]

Chairman MANZULLO. Yes, Dr. Lund. Does that make it easier for us?

Dr. LUND. When we sold our company, we had 31 employees. So that got us just over the 23 employees. Our premium for my husband and myself was about $240, $250 a month.

The day that we changed from that, we were the same two people, the same risk factors, the very next day our premium went to almost $700 a month because now we were only two.

Chairman MANZULLO. And AHPs would love that, too, be part of 2,000 or 20,000.

Ms. JENSEN. Can I make one quick point, Mr. Chairman?

Chairman MANZULLO. Sure.

Ms. JENSEN. All we are asking for is essentially to be allowed to participate in what is, as you mentioned, already going on with large employers and unions every single day right now. I mean, it is working very effectively for those plans.

If you look at the Caterpillar model or the John Deere plan, they provide a high level of health care, and it is much cheaper. As far as cherry picking goes, unfortunately our members are cherry picked every day. Depending on the laws of the state, whether the insurance company chooses to underwrite them is a big question.

So the insurance company essentially has the power to say, "Yes, you will participate," or, "no, you will not," and under AHPs, the association does not have that ability. They say, "We must offer to every single person who participates in an FIB."

Chairman MANZULLO. Okay. Maybe I am missing something here, but I started off with the premise, and I still believe, that the larger the group, the more you spread the risk. It brings down cost shifting in the end, which makes insurance premiums cheaper for people who already have insurance.

And yet we find this continued opposition from Blue Cross/Blue Shield on a flawed CBO report that has been discredited by I do not know how many economists and coming from the labor unions.

I mean, AHP's are nothing more than the model for the labor unions, they have been out front on this issue for 50 years. Because my dad belonged to 792, the local carpenters union, and Dad floated from place to place to place before he went into the restaurant business. Our family always had insurance because the insurance was not employer based. It was based upon the pool that existed, and he paid so much into the pool and with the labor union dues, et cetera.

And that has been one of the most seamless plans. You could go from an IBEW probably to another craft and transfer your insurance. If you decided to go, you know, from electrical work to plumbing work, you would probably have a transition period, but the family is continuously covered there.

But I see something so simple as the AHP getting hammered. Congresswoman Velázquez, who is the ranking minority member of our Small Business Committee, has a lot of labor support, and she is a co-sponsor of a bill for AHPs, and members of Congress are standing out.

But if I am wrong, that the larger the pool, the lower the insurance rate, then the AHP is for naught. Is that correct?

Well, let me ask you one last question. The bill to which you made reference in the house, do you know what the status of that is?

Mr. RELJIC. It is going to pass today. Who knows? I mean the house and senate are in session right now. It passed out of the House Health Care Committee with a substantial number of votes in a bipartisan manner.

Chairman MANZULLO. So it has bipartisan support?

Mr. RELJIC. Yes. In sessions past it has passed the house and stalled in the senate.

Chairman MANZULLO. Who is opposed to the bill? Do you know? Any groups?

Mr. RELJIC. Mostly insurance groups and agents as well.

Chairman MANZULLO. Okay.

Mr. LEVIN. Can I just make one point?

Chairman MANZULLO. Yes.

Mr. LEVIN. That my reservations are with no vested interests. It is a professional opinion and a professional recommendation I am making that risk pooling only works or community rating only works with mandated participation. That is why it works for large employer groups and unions.

As soon as participation is not mandated, the model falls over.

Chairman MANZULLO. Do you disagree, Amy?

Ms. JENSEN. I do not believe that union members are mandated to participate in the union plan, but we would have to discuss that separately.

Chairman MANZULLO. Does anybody know the answer to that question? Yes.

AUDIENCE MEMBER. Maybe I am older. Association health plans have existed for generations, and what everybody seems to be missing is why would they all fall apart. Why don't we have them anymore?

And the reason we do not have them is exactly what Ryan is saying, because the choice factor drives the healthy out as soon as premiums start going up.

So what happens is you get the awful spiral where you are stuck with the sick and the healthy go elsewhere because they can go elsewhere for coverage. And then union model does not work because basically when you join the union, that is your health plan.

Now, you can obviously, I suppose—I am not even sure you can do this—but I suppose a union member can opt out of the union plan if he so chooses to buy individual coverage.

Chairman MANZULLO. But what if his spouse or her spouse is covered elsewhere?

AUDIENCE MEMBER. Well, then he would have a choice.

But the point is though that you are not going to get the adverse selection in a union plan. You are not going to get the adverse selection in a General Motors plan.

Chairman MANZULLO. Because they are all healthy working people.

AUDIENCE MEMBER. No, because it is a preexisting pool that is large enough to sustain the illness of the participants. Whereas when you are talking about a small business or your group, the de-

cision making mechanism is totally different. It is driven almost uniquely by cost.

So as soon as that small employer finds himself in a plan that becomes expensive and he can find coverage elsewhere more cheaply, he opts out immediately.

You do not have the same phenomenon. If I end up a General Motors employee, that is not the same model. If I am a union member, it is not the same model.

Now, you are absolutely right when you say, you know, the larger the numbers, the better the risk and the lower. You are absolutely dead right. The problem is that you cannot fit small employers into that larger pool unless you mandate it, and that is the problem.

We are not making this up. This is historical.

Chairman MANZULLO. No, I understand. There is another issue here. There is a First Amendment issue of right of association. I mean, I have a big problem with laws that say small business people cannot band together and buy insurance in groups. There is a constitutional issue that no one is even talking about.

You know, I have an appointment at two o'clock. So what I am going to have to do is to, Ryan, give you the last word on it.

Mr. LEVIN. Can I just make the point?

Chairman MANZULLO. Go ahead.

Mr. LEVIN. In states like Illinois, there actually are rules designed specifically to protect small employers from an insurance perspective. Those laws have restrictions on how insurance carriers can write a small employer group based on their health status.

In states where these laws are more restrictive, what happens is the number of uninsured has increased because the model is unsustainable. So the more restrictive these small group models become, and what you are talking about with association plans where there is community rating within the plan is essentially a very restrictive small group law.

The tighter those laws, the lower participation becomes and the higher health care costs become, and that has been proven time and again.

Chairman MANZULLO. I want to thank the panel for coming.

The basic problem is this. Small businesses cannot afford 20, 25, 27, 30, 35 percent increase in insurance premiums every year.

Mr. LEVIN. Absolutely.

Chairman MANZULLO. And so we are trying to do something innovative. Every time the small business people try to do something innovative, somebody comes in and says, "Your model does not work."

Well, my comment is the present model is not working. We have got small business people that are closing up their doors and going to work for larger employers. It is destroying the spirit of entrepreneurship.

And the cost of increase of insurance premiums on a small business is much greater than it is on the cost of a bigger business. We had a hearing in Washington about three weeks ago. I could not get Blue Cross/Blue Shield to admit that.

If premiums go up, usually premiums for the small business person are doubled than they are for the larger corporation. But we

are at the point now here where the system is broken. The system is broken. I mean, no one wants to come in with any type of socialistic scheme or anything like that, but we are looking for some solutions.

And the only thing I see out there besides the tax credit that goes even to people that do not pay taxes, which is called the refundable tax credit, is to somehow allow all of these small groups of people out there the ability to form an association to be able to come together to try to buy insurance for themselves.

That is an AHP. You know, let's think past and try it. If it breaks, it breaks. Because the present system is broken now, and at this point we do not have much to lose.

Well, listen. I want to thank you all for coming. It has been tremendous testimony. The purpose of these hearings for the person doing the recording is to gather all of this information, and I have heard of some innovative plans.

Ryan, you know, that South African plan, that is a great model. And the quality of the different plans, I have never heard this type of diversity before in all of my years on Capitol Hill when it comes to different approaches to helping to insure small business people.

Somewhere along the line each of the things that you have testified to may find its way into some type of legislation. The insurance industry has raised, in my opinion, some red flags that are cautionary signs that should be used in setting up these AHPs, and that has been extremely valuable because they have seen not only their experience rating, but worked with other AHPs, that there are giant holes in the way these things work.

And I will trust somewhere along the line the insurance companies, the labor unions, and the small business people can sit down and come up with a workable program that will address each of these deficiencies, and that is the reason why we have hearings like this.

This meeting is adjourned.

[Whereupon, at 12:40 p.m., the Committee was adjourned.]

OPENING STATEMENT OF CHAIRMAN DONALD A. MANZULLO

Good Morning. It is my pleasure to welcome everyone to today's Small Business Committee field hearing on the crucial issue of small business access to health care.

Exorbitant health care costs are one of the biggest expenses small businesses and the self-employed incur as they struggle to provide coverage for their employees. As Congress continues to examine our nation's health care problems, we need to remember that sixty percent of the estimated 43 million uninsured are small businesses owners, their employees and families.

Small business owners are unable to absorb spiraling health care costs and find themselves priced out of the health insurance market. Many owners are faced with the choice of staying in business or providing their employees with insurance.

I personally know of a small business owner who pays $700 a month and has a $5,000 deductible to insure both himself and his wife. He and his wife are considering selling their business and taking jobs that would pay considerably less in order to receive health care benefits.

Our current health care system does not provide equal access to affordable and quality healthcare for small businesses.

One of the reasons small businesses cannot afford health coverage for their employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions. Small businesses suffer from unequal treatment—what they want most is a level playing field when it comes to health care.

Large corporations use the purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other

hand, have to find their insurance on an individual basis, making it very difficult and expensive to find affordable health coverage.

I can't help but wonder why insurance companies cannot offer affordable healthcare to small business? Why must insurance companies charge the most to those least able to pay these inflated prices?

I was very heartened to see President Bush issue his plan for helping small businesses prosper in our economy. The President is aware of the health care access and affordability problems facing small business, and his plan includes concrete steps to increase health security for employees of small businesses. His agenda calls for Association Health Plans to be available for associations that want to provide health coverage for their members, and it calls for a permanent extension of Medical Savings Accounts, including a significant reduction in the required deductible for these health accounts.

Congress needs to ensure that there are many different health insurance options for small business owners to utilize. We need to help our businesses attract and keep employees, and nothing helps more than the ability to provide health insurance.

I look forward to the testimony of all the witnesses here this morning and I want to particularly thank those who have traveled a long distance to be with us here today.

PREPARED STATEMENT OF MICHAEL HOLOKA

My name is Michael Holoka. I am an attorney in Rockford, Illinois. I am married to a physician and have a twelve year old daughter. We had a traditional medical plan through my practice which covered my family. Since I am a sole practitioner with only one employee, this was the most economical way for my family to go. We have had our traditional insurance plan with Guardian Insurance since 1995 with no additional claim experience. I was paying about $5,000.00 per year. By the year 2000, we were contemplating going without any insurance because of the cost of the premiums being $21,000.00 per year for our traditional program still with Guardian Insurance. This was based on the fact that we had no claim loss, that is we had not made any claim against Guardian for medical insurance purposes since 1995.

Realizing that we could not afford to continue an insurance program which was going to continue to rise, at a minimum, twenty percent each year. We considered picking up a catastrophic insurance policy and basically self-insuring. While health care services had diminished and physicians were being paid less for their services, health insurance premiums continued to rise. One day my wife received a facsimile concerning something called an MSA insurance plan. I was not aware of nor had I heard of such a plan. However, the plan turned out to be a blessing. In fact, it had sounded too good to be true.

Some of the main features of the plan were that we could pick our own family deductible between $3,100.00 and $4,800.00. We also had the opportunity to save up to 75% of the deductible each year, which meant we could put into an MSA account an amount just over $2,300,00. If we chose not to use those funds for the deductible, they would just continue to build in the account which we have with Merrill Lynch. The best part of the plan however was the premium. While looking at a premium of over $21,000.00 per year with Guardian Insurance for a traditional medical plan, the medical plan we chose with Fortis Insurance was approximately $3,600.00 per year. This included maternity for my wife. If we chose to not include maternity coverage, the premium would have been considerably less.

It was amazing to me that we had heard very little about MSA insurance, particularly in view of the insurance crisis. When I attended a small business breakfast with Congressman Manzullo, I explained how this plan worked. It was amazing to me that none of the small business owners in attendance had heard of this plan and there had to be over 25 businesses represented at the meeting.

It is my understanding that there are any number of variables that go into the premium. Obviously the higher the deductible you choose, the less your premium will be. One quote I received for a $4,500.00 deductible was less than $2,500.00 per year. If we chose dental, the coverage would have added less than $1,000.00 to our plan.

It is not difficult to see how vital the MSA program is for small businesses so that they can provide the proper benefits for themselves and their employees for an extremely reasonable cost. There is even a term life insurance feature available up to $50,000.00 under certain MSA programs.

The MSA account itself is a tax favored account set up to pay for medical care and to allow for a build up of savings to pay for future medical expenses. The MSA

itself is a high deductible plan with extremely low premiums compared to traditional insurance. The premiums are of course deductible for the business and the amounts contributed to the medical savings account also have special tax treatment. When you use the providers participating doctors and hospitals, one hundred percent of the eligible charges are picked up after deductible. Plans vary as to what percentage is picked up if you use out of network care. The bottom line is that the MSA plan certainly will allow small businesses to affordably provide medical coverage to the owners as well as to their employees.

We are extremely pleased with this plan. Without it, we would probably not have any insurance coverage, would be self-insured for health coverage and would probably be maintaining a catastrophic insurance policy which, premium wise per year, would probably equal or exceed the amount we are paying for the MSA program. It is my hope that the MSA program will continue and be of great benefit to small business and allow many small businesses to remain soluble in the current economic market.

PREPARED STATEMENT OF DR. BILL KOBLER

I am pleased to be here to present a medical perspective on the rising cost of health care, which is a logical contributor, among other factors, to the rising cost of health care insurance. This is a very complex and multi-faceted problem, and I surely will not be able to present a complete picture today, but I hope I can provide some insight into the problems we face as health care providers. First, a little background.

An article in the New York Times in January states the government reported that in 2000, national health spending shot up 6.9 percent to $1.3 trillion in 2000. This was the largest one-year percentage increase since 1993. Hospital and drug costs were the main factors in the latest increase. (NYT 1/8/02)

Growth in health spending outpaced the 6.5 percent growth of the economy as a whole in 2000. Health care now accounts for 13.2 percent of the nation's total output, up from 13.1 percent in 1999 and 12 percent in 1990. As a physician, I could argue that this is not enough, but I'll leave that alone for now!

What are some of the factors leading to these cost increases? There is an old problem which is again rearing its ugly head. In the 1970's, there was a crisis for physicians when all the major professional liability insurers in Illinois pulled out of the market. St. Paul and CNA again stop providing coverage.

Kenneth S. Abramowitz, of the Carlyl Group states "The rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services."

In many hospitals, insurers are not only increasing premiums but are also sharply reducing amounts of coverage and raising deductibles. A Chicago hospital paid the St. Paul Companies $1 million for $40 million in coverage in 2000 with a deductible of $15 million. In 2001, St. Paul raised the premium for the hospital, to $1.8 million, but cut the coverage to $10 million and more than doubled the deductible (NYT, 9/10/01). Insurers say the increases are due to large awards by juries and large settlements.

Some research suggests that the average jury award rose to $3.49 million in 1999, up from $1.95 million in 1993. (Jury Verdict Research, Horsham, PA)

According to the Liability Monitor in Chicago, professional liability premiums are rising at an annual average of 30%.

Because of the rising medical malpractice premiums, medical costs are rising in another way: Physicians are practicing more defensive medicine—ordering extra tests and choosing procedures that limit their risks.

Another item is the explosion in the availability of very good, but very expensive prescription drugs. This is a serious problem for all recipients of health care. The proposal to provide these drugs under the Medicare program is a wonderful concept, but frightening when one pauses to consider the source of the funds for this population who consume a very large percentage of pharmaceuticals.

Medicare managed care and other private insurance plans have cut drug benefits in the last few years. The average senior spends about $500 annually for medications, plus hundreds and even thousands more for private insurance policies to cover some of the cost of prescriptions. I saw a patient just the other day with a $7,000 tab for medication in the year 2000!

There are a number of other factors I would like to briefly list, which also drive up health care costs. The people of this country have an insatiable appetite for health care services. They are bombarded with story after story of medical miracles, advertising of prescription pharmaceuticals, promises of unlimited access to health

care made by their managed care company. Yet there is very little incentive for them to utilize these services wisely.

There is an overwhelming burden of government regulation, which is choking the medical profession in its attempts to provide care. Many of you know the alphabet soup as well as I, but the provisions of COBRA, CLIA, HCQIA, EMTALA, HCFA, now affectionately known as CMS, are burying us in needless paperwork and documentation. We attempt to follow the regulations, at the risk of prosecution, fines and imprisonment under a system so complex, that it is impossible to meet all of its requirements. And now we will soon face the absolutely terror provoking HIPAA statutes!

We are facing a serious shortage in well-trained nurses. Medical school costs are becoming so large as to discourage our best and brightest from applying to medical school, knowing they will face huge debt, declining incomes and loss of respect for the time they spend and dedication they demonstrate in their career choice as physicians.

As a doctor, my job is to investigate problems and solve them. It would be easy to become discouraged, but medicine is still the most rewarding of professions, one worthy of fighting for and defending. I am pleased to see this forum, attempting to understand the problems of medicine and its availability to small businesses. After all, physician practices have traditionally been counted among the ranks of small business. If we work together, keeping the patient as the center of our focus, I am confident we will find a solution to our problems.

Thank you for your time and attention.

Testimony of

Phil Bartmann, President & CEO
RADICOM, Inc.

before the

U.S. House of Representatives
Committee on Small Business

Affordable Health Care Options for Small Business

April 4, 2002

Good morning Mr. Chairman and Members of the Committee. Thank you for inviting me today to talk about the important issue of affordable, accessible health insurance, especially for those owning or working for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing 600,000 members who face a similar challenge and the McHenry County Economic Development Corporation.

My name is Phil Bartmann, President and CEO of RADICOM, Inc, the only full-capability communications service provider in McHenry County. We offer sales and service assistance on two-way radio systems, business and emergency telephone systems and cellular mobile telephone service.

RADICOM, Inc.. has been serving the public safety community for 35 years. Our foundings in Libertyville, Illinois was the beginning of a long relationship with many Police and Fire Departments in northern Illinois and southern Wisconsin. I started working for the company in 1969 and then bought the business outright in 1978. We have three store locations, two here locally, and one in Appleton, WI.

We employ twenty-eight full-time workers. Some of them have been with the company for over twenty years. Our employees range in skill level, from high school to college

graduates, in age, from twenties to mid-sixties, and earn salaries ranging from $15,000 to $60,000. Their roles include salesmen, field service technicians who provide "on location" repairs, and inside technicians, retail clerks and administrative personnel. RADICOM, Inc. offers medical benefits, life insurance, a 401 (k) plan, and Cafeteria 125 plans. We feel this is a competitive benefits package and a way to hire and maintain qualified employees, especially since Motorola and other high technology companies are in our backyard.

We value our employees, which is why RADICOM has offered employee-sponsored health insurance since I can remember. The company pays most of the employees' cost, asking them to contribute $10 per week, or $40 per month toward their health plan. We also pay 100% of the $250 annual deductible for each employee.

Because we try to keep my employees' health care costs reasonable, I'm proud to say that nearly all of them have elected coverage. The one or two workers who don't participate in the company's health plan are covered through their spouse's place of employment.

The cost problem has been ongoing for some time but became serious with our most recent renewal, March 1, 2002. We presently use Nipon Life Insurance with a Preferred-Provider Option (PPO). I changed insurance carriers to Nipon a year ago because our old insurance company priced us out of the market. We chose Nipon because they offered a more comprehensive prescription drug plan and their overall price was somewhat lower.

But, this past March the cost of our premiums skyrocketed nearly 100 percent. In February, my company was paying $8,600 in monthly premiums for our employees. And, by March, the month of our renewal, I was shocked to see our total monthly costs skyrocket to $15,000! Since then, I've learned first-hand the struggle many small business owners face in trying to secure affordable health coverage.

Since 1995 our per-employee health care coverage has increased over 250%. For example, in 1997, it cost $2,433 to cover a typical employee, in 2001, it cost $3,378, and most recently, in 2002, it cost the company $6,128.

Because this increase happened so recently, we are still looking over options on how to best handle the situation. Right now, we're thinking of increasing the deductibles to see if the company's premiums would be more reasonable. I've never considered asking my employees to pay more of their share and I don't anticipate asking them to contribute more of their paychecks.

In my new capacity as Chairman of the Economic Development Corporation (EDC) for McHenry County, I found my peers are experiencing the same problem of finding affordable health care. The EDC has 350 members from the largest employer in the area to businesses smaller than my own and it seeks to attract new and retain old business in the area. This gives me a large pool of experience to compare.

For example, Sandy Piece, who owns Phoenix Woodworking Company and employs nine workers, just began offering health insurance coverage two years ago. In the two years that she offered group health insurance, her premiums have gone up every six months. She just got a notice last week that premiums for the next six months would increase by 24%! Six months ago it was raised 19% percent. It's no wonder that small business cannot provide health insurance; the costs are unpredictable and uncontrollable. If you shop the plan, you may get a "teaser" rate," then it just goes up as high as the rate the former carrier offered within the same year.

Such large increases make me very worried about RADICOM's and other McHenry businesses' ability to absorb more cost increases in the future. It's for this reason that I support legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from costly state insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business. In addition, AHPs will introduce into the market place much needed competition and diversity. Without the ability to shop for more affordable options, we are left with shifting cost or dropping coverage. Association health plans would be a health care purchasing dream come true and would ensure more choice for rural areas.

Eliminating the regulatory burden on medical savings accounts (MSAs) would also benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees by giving them control over their own health care dollars. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business. Tax credits for individuals would also be a welcomed option.

Now, I'm not a health policy expert, but to me, AHPs, MSAs, and tax credits seem like good, common sense solutions to controlling the cost of quality health care.

Mr. Chairman, thank you for allowing me to share my experience with you and the Members of the Committee. I look forward to following the good work that Congress will hopefully do in relation to employer-based health care, and I am happy to answer any questions that the Committee may have.

Testimony for

The United States House of Representatives
SMALL BUSINESS COMMITTEE

Hon. Don Manzullo, Chairman
Hon. Nydia Velazquez, Ranking Member

Field Hearing

April 4, 2002

By

Ryan C. Brauns
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Good Morning Chairman Manzullo and distinguished members of Congress. My name is Ryan Brauns and I am the Senior Vice President of Consulting at the firm Rockford Consulting & Brokerage, Inc. home office in Rockford, Illinois.

I would like to thank Chairman Manzullo for all of his good work and effort in the area of small business needs particularly that of Medical Savings Account expansion and increasing access to insurance for uninsured working Americans. Thank you Congressman Manzullo. There is much work to do and with your leadership and free market vision efficient solutions will be found.

Rockford Consulting & Brokerage is a firm specializing in employee benefits specifically strategic plan design, funding analysis, employee communications and regulatory compliance. Members of the firm have, collectively, worked with hundreds of employer groups ranging in size from 2 to 60,000 employees solving many complex cases. We appreciate this opportunity to present our comments regarding the health insurance industry, the vital role of the insurance broker, and the powerful engine of consumerism.

To begin, the words of Dickens fill the mind when reviewing the state of health insurance in America:

> It was the best of times,
> it was the worst of times,
>
> it was the age of wisdom,
> it was the age of foolishness...
>
> Charles Dickens,
> A tale of Two Cities, (1859)

And, although no one is speaking French, we are fighting a battle nonetheless. With the finest health care system man has yet devised, thousands of people from all over the world

traveling to our system every year, other countries desperately trying to copy, we threaten our own wondrous creation.

Where Are We Today

There are several possible points of insertion into a discussion of the status quo: the state of managed care, the outstanding quality of modern medicine, or the need for structural change that will yield behavioral change. Today, let us begin with government regulation.

Regulation

Business is the conduit to health insurance for Americans. Depending on whose study you see the breakdown is usually close to the following table.

7%	Self-purchased
11%	Medicaid / Public
18%	Uninsured
64%	Employer Provided

Employee Benefits Research Institute, 1999

Yet, business has been awash in a sea of government regulation: COBRA, OBRA, ADEA, ADA, ERISA, Public Health Act, TEFRA, DEFRA, Tax Reform Act of 1984, and not the least of which is the Internal Revenue Code including sections 162, 264, 79, 101, 2042, 61, 83, 106, 22, 105, 125, 120, 501, 127, 74, 132, 129, 212, 132, 119 just to identify a few.[1]

I offer these not to be ridiculous but to clearly make the point that business is not just awash, it is drowning in regulation. To be sure, much of these rules involve needed reforms and have done some good; however, many have not. In fact, many foisted unintended consequences upon the system. One such law is the Health Insurance and Accountability Act formerly known as "Kennedy-Kassebaum" and commonly called HIPAA.

[1] Group Benefits: Basic Concepts and Alternatives, 6th Ed., Burton T. Beam, Jr.

HIPAA was created with the intent of providing greater access to insurance yet it has had the opposite effect overall. It was not created in a vacuum. The law was applied to an already complex and difficult legal structure. There was little room for the private sector health care market to absorb the new burden. The market becomes more inefficient, cannot clear and moves farther away from the equilibrium we want. In turn costs go up and social good goes down.

HIPAA passed in 1996 as the last best chance to implement at least a portion of the failed Health Security Act. It really took effect the next year as it began to propagate throughout the market. What did we get—a concomitant rise in premiums as well as a several million person increase in the ranks of the uninsured. This was not a coincidence nor was it the intended effect.

The "guarantee issue" portion of the law moves closer to a national health care, single payer model and created more uninsured persons. The states of Kentucky and Washington and New Jersey are well known for the deleterious effect "guarantee issue" had. Once Kentucky forced insurers of individual health policies into "guarantee issue" many of the carriers withdrew from losses due to underwriting as rates jumped 60%. The result, fewer insurance companies, reduced competition, higher prices, more uninsured.

HIPAA stifles innovation and forecloses on solutions. Because the law makes bright line delineation between employer sponsored plans and individual plans, there is little chance to develop hybrid plans involving employer and employee contributions particular in the mode of "defined contribution" where they may be different plans for different employees depending on individual need.

The greater the role of government in this market, the greater the chance for harmful rent seeking and sub-optimal behavior as the players devote resources to look for loopholes and stop profit seeking. The market becomes inefficient and leads to more dissatisfaction. HIPAA has demonstrated a positive correlation between regulation and uninsured increases. Carry this forward to a much ballyhooed solution—Purchasing Pools.

I know that the concept of purchasing pools and "volume discount" is very attractive and even endorsed by well meaning business groups; but, I do not understand why. Certainly the idea deserves review however it is most likely the pyrite last mined by the former First Lady during the days of the Health Security Act. At best it is a short term answer.

Managed care provided some stability by doing what it promised to do—keeping the lid on claims and attacking the trend line. The savings were eventually rung out and long term gains were unsustainable. The same will hold true for the purchasing pools. Let's look at a simple example. If twenty persons want to go to the coffee shop the same amount of coffee will be served whether the persons arrive one at a time or as a group. For the insurers, the risk is still the same whether they cover a thousand groups of two persons or one group two thousand. You can see that even though some economies of scale may be attained on the administrative side, the gains are small and not long lived.

Now add the component of adverse selection to the purchasing pool and you have the makings of a disaster. Each group will make its own decision as to whether the association plan is better or worse for them. As the businesses that can do better outside leave the pool, the pool begins to implode: Rates go up and more businesses on the margin exit thereby forcing rates up again and the pool enters a death spiral.

By and large, a successful association plan is an anomaly. It is feared then, that the federal government will attempt to shore up collapsing association pools through subsidy and consolidation. Making the pools very large does not remove axiomatic adverse selection. Large pools do put the nation one step closer to a single payer, national health care model and maybe this is the goal of some. Again it is understandable that the government should hear the cry of business and look for solutions to the out of control cost increases; yet, in the end, the evidence of failed associations should prevail.

Vital Role of the Insurance Broker

The insurance market place is not easy to shop in for the small employer especially. The cost of information is high and onerous regulation provides friction. Smoothing things out is the insurance broker. Not only do brokers bring buyers and sellers together, they provide access to information as well as advocacy. Just as a business need a company attorney and accountant, so to do they need an insurance professional. Large employers have this talent in house most of the time; small employers do not. This places the small employer at a disadvantage in the market which could translate to higher rates and dissatisfaction were it not for the insurance broker.

The broker is a trained professional licensed by the state and required to maintain continuing education. The broker can be fired by the employer or the broker's license could be suspended by the state. Insurance companies can chose which brokers they will accept. The broker works for the consumer and not the government or the insurance company.

The broker is the only real advocate for the employer in the system as well as the expert intermediary to the market. As the insurance companies and the government attempt to remove the broker as a distribution channel to the small employer, it is the small employer most harmed. The creation of homogenous plans offered through collectivist purchasing pools runs counter to American demands for choice. The broker is an efficient catalyst in the market and needed by the small employer.

Consumerism

Attempts at reform have always taken aim at the supply side of the equation. HMO's, PPO's, pharmacy managers, these are supply side issues. Yet, the greatest resource which stands to reshape the entire market lies largely untapped—consumerism.

We now bear witness to the power of consumerism as we realize large premium increases based on escalating drug utilization. In 1991, drug makers spent $ 55 million on

direct to consumer advertising such as TV and radio spots. In 1999 the number climbed to $1.8 BILLION and is now well over $2 billion. This is significant for two reasons: 1) it represents over twice what the drug industry spends on research and development and 2) it proves the power of consumerism.

From 1974 to 1982 the RAND Corporation conducted a now famous study. By tracking 2,500 families with different deductibles, they demonstrated a direct link between the cost and amount of health services provided. The families with $0 deductible had 30% greater hospital costs and 67% more office visits. The study also revealed no decline in health status or healthy behaviors.

In today's market the employee is not financially engaged as in the RAND study. Over 80% of the health care dollar today comes from someone other than the patient.[2]

Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990

Hospital	Physician	All Services
1965 - 83.2%	1965 - 38.4%	1965 - 48.4%
1990 - 95.0%	1990 - 81.3%	1990 - 76.7%

The only way to effect a behavioral change is to reward the employee for healthy behavior. We must allow the employee to create a fund be it a personal health account or an unrestricted MSA. But, most importantly, the change must be made from the current model of "use it or lose it" to "use it or KEEP IT"!

More than 70% of Americans covered by insurance file less than $500 in medical claims a year.[3] For these employees, they feel that their insurance plan is of questionable value. But as they accumulate funds in their health account they perceive value. From the

[2] Patient Power: Solving America's Health Care Crisis by John C. Goodman, president of the National Center for Policy Analysis, and Gerald L.Musgrave, president of Economics America
[3] Council on Affordable Health Insurance

employer's standpoint, he or she can buy less insurance as the employees grow their funds. Less insurance equals less costs while the employee satisfaction is going up.

The power of consumerism represents our best chance to change behavior, to change the perception from entitlement to participation, control costs and create satisfaction. WOW! A major solution is at hand.

Consumer Driven health care is a private market solution to the problem. The market will answer the demand if it is left alone to operate.

Conclusion

I urge you to let Adam Smith's invisible hand guide this market. If we reduce the cost of information, eliminate the friction caused by onerous regulation, then the market will clear with all of the traditional attributes: economies of scale will be achieved, equalibria will be reached and satisfaction will be high.

So, esteemed Congressmen, when you return to the well and address your fellow members on behalf of the Nation, let "choice" and "competition" and "consumerism" be your clarion call. Dissuade the detractors that increased federal control could ever be a solution.

Despite the building pressure, which is great, this is a time to be positive about the health insurance market.

Thank you again for this opportunity to testify and I am happy to answer any of the committees questions.

-30-

Mick McCarty, Director of Sales, Blue Cross and Blue Shield of Illinois
House Small Business Committee "field hearing"
Rockford, IL
April 4, 2002

Thank you for inviting Blue Cross and Blue Shield of Illinois to testify today on the subject of small business health insurance concerns.

My name is Mick McCarty. I am a Director of Sales for Blue Cross and Blue Shield of Illinois, based at our office here in Rockford, as well as Chicago. As you know, Blue Cross is the oldest and largest health insurance company in Illinois. About one in four Illinoisian is covered by Blue Cross and Blue Shield. Today, and every day, we work closely with small businesses all over Illinois to help them with their health insurance needs. We consider ourselves to be an integral factor to the success of the small business climate in Illinois.

In your invitation, Congressman Manzullo, you noted that small business owners are struggling these days to provide health insurance benefits to their families and employees. You also pointed out that small business often seems to be overlooked in congressional debate on health insurance issues, even though 60 percent of the uninsured are small business owners, employees or their dependents.

Over the years, Blue Cross has developed many initiatives… and many products… to offer small business owners the greatest possible flexibility in health insurance programs. This includes several small business "pools" consisting of hundreds of thousands of members. These pools allow us to keep our costs as low as possible and to spread the risks associated with medical care over a large, insured population. These pools allow us to provide the same level of negotiated provider discounts to a group of 2 employees that we provide to our largest customers. In addition, we are able to offer employers benefit packages that include up to 3 benefit type options, such as a PPO, an HMO and a low cost/high deductible alternative plan so that the employee can choose the program that best fits their needs. One of our products, the Community Participating Option, was created specifically for small businesses in more rural settings where business dynamics are different than in urban areas. Another recently launched product, Blue Print, is targeted at providing employer groups from 50 employees to 150 employees with product options that focus on low costs, broad access to providers, large discounts and benefit choices and flexibility. Believe me, when we go into the marketplace with our products, no one is more concerned about costs, price, benefits and service than we are. It's our livelihood.

But there is only so much we can do in the face of rising cost and other factors. I'd like to spend just a few minutes this morning talking about those things -- things we should be doing to protect the small-group market from even greater price pressure… and things we should be doing to actively encourage that market. Congress has a role in both areas. So does the Illinois General Assembly. And so does every player in the health care delivery system.

We all know that medical costs are going up. Some of that is inevitable. Inflation is a fact of life. Science continues to produce new, more-expensive treatments and drugs. Technological advances carry a price tag. Hospitals face labor shortages. The list goes on.

But there are other cost pressures that government can address. Congress and the General Assembly must carefully examine any new "mandates," balancing the benefits against the cost. In 1965 there were only eight health care mandates nationwide. Today, there are over 1000, and the number is rising. Many people thought, for example, that the Illinois "reform" legislation enacted a few years ago was economically painless. We know better. The emergency room provisions of that legislation alone cost Blue Cross customers at least $57 million a year. I remind you, those costs ultimately are paid by our policyholders -- and fall hardest on small employers. Maybe the reforms are worth the cost. But we shouldn't fool ourselves into thinking benefits are free.

Another suggestion that surfaces in discussions is to expand coverage by subsidizing employer-sponsored insurance. This comes in the form of federal, state or local programs..... perhaps in combination. While subsidies add dollars to the equation, current and previous experiences indicate that enrollment tends to be modest unless the subsidies are substantial. Still, the concept of supporting employer-sponsored insurance is worthy. And if we are to utilize substantial sums to support small business insurance initiatives, this approach is superior to many others.

Congress is considering legislation to encourage business associations to sponsor health insurance programs for their members on a national basis. This proposal and these arrangements have their problems:

- Proposed legislation would exempt federally certified AHPs from state health insurance regulation. In fact, the AHPs could undermine state laws that are enacted to assure access and affordability for small businesses. A CBO analysis of this legislation indicated that it could cause premiums to rise for 4 in 5 small employers by unraveling state reforms.
- There is a long history of fraud and abuse with similar entities called multiple employer welfare arrangements (MEWAs). As of 12/98, the DOL had initiated 358 civil and 70 criminal investigations of MEWAs that affected over 1.2 million enrollees.
- The CBO estimates only a 1.3% increase in coverage through small firms if AHPs are made available.

Another federal threat is so-called "patients' rights" legislation that could add additional costs and liability to the list of reasons small businesses drop health coverage.

In Springfield, the Illinois State Medical Association is pushing legislation that would severely limit health plans' ability to catch and fix claims abuses. At the same time, this legislation would add literally billions of dollars to administrative costs with no benefit to patients. Again... employers would be asked to foot the bill.

Enough negative. Some good things are being done to help small business cope with insurance issues. Others can and should be done.

Governor Ryan and HHS Secretary Thompson have worked together closely on several groundbreaking initiatives. One will allow the state to expand Kid Care to the families of eligible children. As this initiative grows, it will allow small-business employees to use their benefits to add dependent coverage. That helps them AND the employer by bringing more healthy people into the small business insurance pool. Blue Cross worked with a cross-section of community groups and business organization in support of Governor Ryan's Family Care initiative and we support its extension.

While I mentioned that subsidies would have a modest impact on increasing the number of insured, tax credits to small employers for their low income workers is worth considering. I also encourage you to continue to press for an acceleration of the full tax deductibility for the self-employed. As a side note, full tax deductibility for people without employer-sponsored coverage requires review.

Expansion of Medical Savings Accounts to broader markets and segments is an item worth pursuing. This doesn't do anything to get at the roots of increases in the cost of medical care, but it does strengthen the factor of consumerism in the economic equation.

McCain-Schumer (S.812) and its companion Brown-Emerson (H.R. 1862) will have a favorable impact by removing barriers to generic drug entry.

Focus group findings by the California HealthCare Foundation support the notion that many small businesses are not well informed about health insurance. We encourage a broad based campaign to reach all non-insuring small businesses in a community with messages related to market protections, tax deductibility, and available health insurance options

Defined Contribution approaches should be studied, though William Mercer reported that half of all employers have a moderate interest and are not ready to move on the idea yet. The Robert Wood Johnson Foundation and the Center concluded similar results for Studying Health System.

At the federal level, Congress is struggling with several key issues affecting the small-group market, including how to cope with an uncertain economy and laid-off employees. We believe that the best solution is one that provides incentives that will keep these workers in the general insurance pool. Other approaches to this problem would remove these generally younger, healthier workers from the risk pool, creating significant added price pressure for employers.

We realize these are difficult issues. We commend the committee for its efforts to focus attention on the impact of health insurance issues on small business. As we have for more than six decades in Illinois, Blue Cross and Blue Shield stands ready to help in any way we reasonably can. Thank you again for this opportunity.

U.S. House of Representatives
Small Business Committee
Hearing on Affordable Healthcare for Small Businesses

Testimony of Destiny Health, Inc.
Delivered by Ryan Levin
Vice President, Product Development and Risk Management

Rockford, Illinois
April 4, 2002

Chairman Manzullo, Congressman Weller, Congressman Kirk and Congressman Ryan, thank you for the opportunity to share these remarks before the Committee today.

Destiny Health and this Committee share common goals. First, to identify the factors contributing to surging healthcare inflation and the increasingly larger insurance premiums faced by employers committed to offering health benefits to their employees. Second, to help create and deliver a new model of health insurance capable of harnessing this inflation and ensuring more consistently affordable and comprehensive insurance coverage for employees of the small businesses that are in many ways the backbone of the state and national economy.

We believe that the way to accomplish these goals is simple and, more importantly, within reach. The individual healthcare consumer is the only participant in the healthcare system with the power to affect all the decisions that drive healthcare cost and quality. Thus, to stabilize costs and improve access to affordable health insurance, all solutions must point toward empowering the consumer to make better decisions.

In describing the path to this solution, there are just a few key points that I would like to make. First, I will touch on the factors driving the increasing number of employed uninsured. Second, I will explain our perspective on the basic causes of healthcare inflation, with emphasis on how unchecked consumer demand can increase costs. Finally, I will discuss how this power of consumerism can be harnessed to drive positive changes throughout the healthcare system; changes that have proven to stabilize and even reduce costs.

Spiraling health insurance costs are increasing the ranks of the uninsured.

As this Committee is aware, a large majority of the more than 40 million uninsured Americans are in fact small business owners and their employees. We believe there are two primary reasons for this: cost and the fact that health insurance provides poor value to the healthy.

With double-digit increases projected to continue into the foreseeable future, healthcare costs are steadily becoming a more and more significant component of employers' business expenses. For many, health insurance has already become unaffordable. The only option for the managers of these companies, aside from eliminating health benefits altogether, is to shift a portion of the cost burden to their employees. Indeed, a study released this week by the Kaiser Foundation found that 35 percent of small business owners will raise premiums for their employees within the next year. In many

of these instances, **employees drop out of the system because they can no longer afford to pay high premiums**.

At the same time, while traditional insurance plans provide substantial coverage for the sick, they fall woefully short of providing any value for the healthy. **Many of the employed uninsured *can* afford health insurance, but simply choose not to pay for it.** This is because they are healthy and are therefore offered little or no value for their increasingly larger health insurance contributions.

If costs continue to rise, increasing numbers of healthier individuals will drop out of the system altogether. Health insurance relies on the participation of the healthy to subsidize the cost of the sick, so this dynamic puts further upward pressure on premiums. If allowed to continue, this scenario threatens to send costs spiraling higher even as coverage levels decrease.

Consumers are disengaged from the financial consequences of their decisions, and thus contribute indirectly to their own increasing costs.

There are numerous reasons for the well-recognized upward trends in healthcare costs, but an important one has gained little attention: consumers are isolated from the costs and disengaged from the financial consequences of their healthcare decisions. Two examples clearly illustrate the effect consumer demand can have on prices.

Drug costs on the rise

A central cause of healthcare inflation is the rise in pharmacy costs. Aside from technological advances, there is another important dynamic driving pharmacy costs: the role of the consumer.

One of the strategies on which pharmaceutical manufacturers rely is direct-to-consumer advertising. Spending by drug companies in this area has escalated dramatically over the last several years, now topping two and half billion dollars.

A study done by *Prevention* magazine found that 87 percent of patients who ask their physician for an advertised drug are in fact prescribed it. This illustrates the dynamic of consumer power – consumers driving their own consumption of health care. Clearly, providers in the healthcare system understand the power of the consumer: by inducing demand, consumers respond and use more health care.

What's key here is that, while drug companies clearly understand this dynamic, insurance plans are not structured in a way that recognizes it. only a very small portion of the cost of the drug is borne by the member, with the balance being paid by the insurance plan. So consumers are buying healthcare with "someone else's money" and have no incentive to control their demand. There is evidence that consumer behavior patterns can lead directly to higher expenses for insurers and employers.

This disengagement from the financial consequences of their decisions applies to more than just drug spend: a survey by Destiny Health found that, because consumers are accustomed to paying no more than a copay for treatment, more than

half of consumers believe the average cost of a doctor office visit to be less than $50, and one-quarter thought it was around $25. The true cost of an office visit is around $90.

Consumer backlash against managed care restrictions

HMOs and insurance carriers have traditionally contained healthcare costs through various forms of medical management, including primary care physician gatekeeper requirements, prior approval of treatment, and similar strategies. Understandably, members of these plans have felt restricted by these measures and have exerted increasing pressure on their employers and carriers to loosen these controls, in the process opening up their plans to additional costs.

In addition, members are pushing back against restrictions placed on them through the tight networks of healthcare providers historically used by carriers to negotiate deep discounts in return for driving their members to those providers and facilities. Wider networks give members more choice, but result in lower discounts provided to health insurance carriers and, thus, higher insurance costs.

The collective reaction to consumer pressures like these has resulted in a reduction in insurers' leverage and ability to control healthcare costs – and has led therefore to an increase in premiums.

These are only two examples of the power of consumers to drive the direction of their health insurance. Enrollments are already shifting away from traditional HMO plans and toward any available alternatives, which indicates that employees are fed up with the old model and are encouraging their employers to actively seek and try out the alternatives. This week's Kaiser Foundation research found that nearly one-third of small businesses have switched plans in the past two years.

The solution to reducing the number of uninsured must harness the power of consumerism and provide value to the healthy.

Reducing the employed uninsured population requires a two-pronged strategy:

Control healthcare costs by encouraging patients to act like consumers.

Small businesses and their insurers should recognize that patients are the drivers of many healthcare decisions. By providing them with the right information and the appropriate incentives to live healthy lifestyles and be more responsible about their spending decisions, patients become informed and empowered consumers of healthcare. The result is lower healthcare costs and an increase in employees' ability to afford healthcare coverage.

Introduce value for the healthy, creating a tangible reason for healthy employees to enroll in the health plan.

Creating incentives to encourage broader enrollment in insurance coverage has two advantages. First, it ensures that these healthier employees have the protection

they need for unexpected, high-cost healthcare events; and second, it allows for a lower cost and more sustainable health insurance risk pool, including a greater proportion of healthy members to subsidize the higher costs of the sick.

The environment is right for this philosophy to flourish, especially among small businesses. However, the most important step is to design a plan that maintains comprehensive coverage and freedom of choice at the same time that it increases affordability and value for employers' and members' dollars.

A better model: The consumer-driven solution to health insurance.

As I've mentioned, we believe that active participation in healthcare, supported by rewards and incentives that promote wellness and smarter decisions, leads to lower healthcare costs. The insurance model that brings this scenario to life has been labeled the "consumer driven healthcare" model. There are several variations on this model, with important distinctions in benefit design and the kinds of incentive and wellness programs that we believe are crucial.

The model I describe here is based on one developed by Destiny Health's sister company, Discovery Health, an international health insurance company that has successfully enrolled more than 1.2 million members in its consumer-focused plan since 1992.

The basic idea is to divide healthcare spending into two logical categories, and to provide consumers with the means to pay for each. The model has three distinct, but integrated components.

The first component is a personal account that belongs to the member to use at their discretion for day-to-day, routine healthcare services, such as physician visits, lab tests, x-rays and other check-ups, as well as acute medications. At Destiny Health, we call this component the Personal Medical Fund™. This account can be funded by the employer, the employee or both. It is crucial that the employee always retain control of the money in this account, with the ability to keep any remaining balance. This gives them a stake not only in their insurance plan but also in their routine healthcare decisions.

Second, comprehensive insurance benefits for high-cost, often unexpected and infrequent healthcare services, such as surgery, hospitalization and catastrophic care. This suite of insured benefits protects members when they need it most. It also includes coverage for chronic medication and high cumulative day-to-day costs. These types of services are appropriately dealt with by insurance rather than the personal spending account as they are largely outside of the member's control.

Finally, the entire plan is integrated with an incentive-based wellness program that provides members with tangible rewards for living healthy and responsible lifestyles and making smarter spending decisions.

Collectively, these elements create a comprehensive health plan that is cost competitive and sustainable. It provides value for the healthy and comprehensive insurance protection for those who need it. This plan design has some very powerful consequences:

- It creates the right incentives to control discretionary healthcare spending. Thus, members become more responsible consumers of healthcare, reducing overall healthcare costs. A 1998 study of more than 60,000 families insured by Discovery Health found that discretionary spending was 47 percent lower than under traditional health plans. This same study found that there was no evidence of cost-shifting, or any resulting increase in hospitalization or surgery costs for plan members. Proof positive that employees are capable of making decisions that control cost without foregoing necessary care.

- Members who use their day-to-day benefits prudently get money back. This is very different from traditional structures where these members would perceive no value for their premium dollars paid. On the other end of the spectrum, comprehensive protection is provided for higher cost, less discretionary treatment, without penalizing the member by forcing them to use their Personal Medical Fund to pay for this.

- It enables substantially more flexibility to employers in determining their benefit options, premium cost levels, and other features, and gives plan members the freedom of choice they want over the providers and types of service they receive.

Compared to traditional health benefit programs, the advantages of the consumer-focused alternative for virtually all constituents could be substantial. Employers regain control over the costs of health plans, and are able to share reasonable levels of liability and risk with their employees. Providers regain control over what kinds of medicine they are able to practice and provide. Consumers, armed with better information and appropriate incentives, enjoy the freedom to participate in their own healthcare decisions and the benefits of improved service from every party.

These advantages would be even more powerful within a tax environment that placed products such as this on an equivalent basis with more traditional health insurance models.

In short, this product aligns incentives properly. When this happens, consumers become involved and educated and make better healthcare decisions in partnership with their physicians. Not only does this reduce the cost of healthcare, but it results in a health insurance plan design that, for the first time, is also attractive to those employees not currently anticipating treatment.

Thank you.

Destiny Health™

Company Background

Destiny Health is a healthcare insurance carrier founded on a revolutionary concept – putting its members in control of their own healthcare dollars. Destiny Health offers an innovative product that aims to change the way consumers think about and use their health insurance benefit dollars. The product uses the appropriate incentives to engage consumers to make smart healthcare decisions. The end result is that smart healthcare decisions mean healthy lifestyle decisions.

This consumer-focused strategy is patterned after that of Destiny's parent company, Discovery Holdings, a major international family of insurance companies. Discovery used the consumer driven model in South Africa to literally transform the face of the healthcare system there. Now, over 50 percent of insured consumers in South Africa embrace this model.

Discovery has 10 years of experience selling and administering the plan, with over one million participants. The primary shareholder of Discovery is First Rand Ltd, a public banking and financial services company with over $40 billion in assets under management. In addition to the foundation provided by this proven business model, Destiny Health benefits from a senior management team with great depth of experience with all models of healthcare management and financing, in the United States and around the world.

Destiny Health helps its members stay happy and healthy and provides true financial value in the midst of an otherwise value-deficient healthcare system. It does this by bringing together peace-of-mind insurance benefits with a unique Personal Medical Fund" that gives members the freedom to participate in routine healthcare decisions according to their own needs and budgets. To support active participation, the Destiny Health Vitality Program provides targeted incentives to encourage and reward healthier choices and behavior.

With offices in Bethesda, Maryland and operations located in Oak Brook (just outside Chicago), Illinois, Destiny Health offers flexible plan options that return the control of healthcare purchasing to the consumer for routine and preventive services while providing comprehensive insurance protection. This unique combination provides strong value for the individual's premium dollar and allows for sustainable costs over time.

For more information on Destiny Health please visit www.destinyhealth.com.

Destiny Health™

Industry Data and Statistics

- Americans' spending on health care rose 6.9 percent to $1.3 trillion in 2000, including a 17.3 percent boost in spending on prescription drugs.
  Source: U.S. Department of Health & Human Services

- The rise in 2001 represents the sixth straight year that the percentage increase in spending on prescriptions was in double digits.
  Source: U.S. Department of Health & Human Services

- Health care costs are expected to increase by at least 13 percent in 2002, with small businesses' costs rising by as much as 30 percent to 40 percent.
  Source: William M. Mercer, Inc.

- In 2001, the average cost to companies for each employee's health-care benefits rose 11.2 percent to $4,924 -- the largest increase in nine years, and a rate several times higher than inflation.
  Source: William M. Mercer, Inc.

- Employers will pay $5,524 per employee for health benefits in 2002, up 18 percent over 2001.
  Source: Hewitt Associates, Inc.

- According to recent government projections, health-care spending in the U.S. is expected to double over the next decade to $2.6 trillion, with U.S. businesses picking up a significant portion of the tab.
  Source: Dow Jones Business News

- The September terrorist attacks will push health care costs even higher than had been expected prior to the disaster – by as much as 13 percent to 17 percent in 2002.
  Source: Buck Consultants, Inc.

- Experts predict that double-digit health care cost increases will last into 2005, making it virtually impossible for small businesses and individuals to sustain an affordable health benefits program.
  Source: *BusinessWeek*

- 99 percent of companies are significantly or critically concerned about health care costs.
  Source: Hewitt Associates, William M. Mercer

- 75 percent of companies are concerned that employee dissatisfaction with health care benefits is impacting attraction, retention and engagement.
  Source: Hewitt Associates, William M. Mercer

- 50 percent of companies say the maximum added annual cost they can absorb over the next five years for health benefits is 8 percent or less, yet costs are expected to rise by about 14 percent each year over the next five years.
  Source: Hewitt Associates, William M. Mercer

- To control rising costs, 43 percent of employers are increasing employee contributions in 2002, and 37 percent are creating cost-sharing plans.
  Source: Hewitt Associates, William M. Mercer

- Two-thirds of employers are open to allowing consumer choices in creating custom-designed options.
  Source: Hewitt Associates, William M. Mercer

- More than 70 percent of employers are considering benefit reductions or an increase in employee co-pays this year.
  Source: Watson Wyatt

- A recent study of over 2,700 employers found that 75 percent of big companies and 42 percent of smaller companies are likely to raise premiums for their employees in the next year.
  Source: Kaiser Family Foundation

- HMOs covered only 23 percent of U.S. workers last year, its lowest enrollment mark since 1993.
  Source: Kaiser Family Foundation

- It is predicted that the number of uninsured, working Americans is likely to increase in the near future, due mostly to the prohibitive costs of health insurance.
  Source: National Academy of Sciences

- A survey of 1,000 adults nationwide found that over 50 percent of respondents believe the average cost of a doctor office visit to be less than $50, less than the average haircut. The true cost of an office visit is at least $90.
  Source: Destiny Health

For more information on Destiny Health please visit www.destinyhealth.com.

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Consumer-Driven Plans Counter Criticism
Employee Benefit News – February 1, 2002
http://www.benefitnews.com/subscriber/Article.cfm?id=37880530

Providers of consumer-driven health plans, which have been touted as a rapidly emerging alternative to managed care, have become sensitive to criticisms that they are merely an elaborate smoke-and-mirrors scheme to make the sickest patients pay more.

Many of the companies say they have already anticipated the problems of adverse selection and have built corrections for this possibility into their plan designs, premium payment methodologies, and consumer incentives.

Analysts following the issue admit it's a complex and unpredictable one, given the broad range of consumer-directed approaches on the market and the seemingly infinite flexibility employers have in implementing them.

"Five percent of the population accounts for 55% of the healthcare expenses," explains Ray Herschman, a consultant with William M. Mercer who specializes in the study of consumer-based healthcare.

"So part of the difficulty with this whole issue is there's a social contract. People who have insurance pool the risk so that, God forbid, if you're one of the 5% - and it changes from year to year who that 5% is - you don't get creamed."

The concern, Herschman says, is that consumer-driven health care will give "healthy folks" an incentive to migrate into low-cost plans while leading the sickest people into a situation where their care becomes unaffordable.

Yet it need not be so, says Herschman, if employers work together closely with plan providers to implement long-term financing strategies and not simply grasp for a temporary fix to the problem of rising health costs.

Innovation and tradition
Vendors of consumer-driven plans are eager to show that they've already grappled with the issue of adverse selection. Oak Brook, Ill.-based Destiny Health, for example, provides a spending account for members to use for discretionary, day-to-day services.
But on top of that account, which is funded by taxable employer contributions, members have an insurance component with "risk-smoothing elements, which effectively subsidize the sick with healthy peoples' premiums," says Ryan Levin, vice president of product development.

Medications for chronic conditions, such as asthma or diabetes, are covered under a traditional copayment system through the Destiny plan. Other kinds of medications are paid for by the member's spending account, however.

"The key is using the savings piece of the plan only in those areas where it makes sense to use it," says Levin. "On the other hand, it's as important, if not more important, to provide risk-adjusted, cost subsidized insurance in those areas where people have minimal control."

If employees run out of funds in their savings, they must pay out-of-pocket for their day-to-day expenses, up to a limit determined by plan design. After that, a "safety net" of coverage, which works like an 80/20 coinsurance policy, kicks in.

Hospitalizations and surgeries are also covered by a traditional insurance component under the Destiny plan, which is being marketed primarily to fully insured employers.
Plan members, therefore, only use their spending account for discretionary purposes, such as ordinary doctor visits or voluntary laser eye surgery. Members are allowed to roll the funds over from year to year. What's more, they can even take the money with them when they leave the company.

All this creates a strong incentive for members to cut back on any overutilization of services and to question the costs of services they do receive, say the company's leaders. But lest employees be tempted to forego preventive care, Destiny includes a rewards program to encourage spending in that area.

"We're convinced that our product has the incentives aligned properly in that all types of employees will choose our plan because it is truly comprehensive coverage for the sick and value for the healthy," says CEO Ken Linde.

Skewing against predictions
With one year of enrollment experience under its belt, Minneapolis, Minn.-based Definity Health has an answer to the criticism that its consumer-driven plan design would only manage to attract young, healthy, single people.

"We're not attracting the young healthies," insists spokesperson Chris Delaney. "Our first year, client average age was 42. That is right on with the average age of our member companies. At the end of the day, you see a skewing toward middle age."
Definity also skewed toward families in its first year, with family size averaging between 2.6 and 2.7 members per subscriber. That's about 20% larger than the U.S. average of 2.2, says Delaney.

The company's clients for the first year included Medtronic, Aon Corp., and Ridgeview Health Systems. Covered lives stood at 6,600 at the end of 2001. But Definity has since signed more clients, including the Pacific Business Group on Health.

Definity's plan design combines a pre-tax spending account, funded by the employer, for routine or voluntary medical expenses. After members meet a certain deductible, which is higher than the amount funded annually in the spending account, comprehensive insurance kicks in and pays 100% of pharmacy and in-network services.

Preventive care is always fully paid and does not come out of member spending accounts, which are allowed to accumulate from year to year. Because its plans are self-insured, says Delaney, adverse selection is not much of an issue. Employers are still on the hook to pay comprehensive healthcare claims of members who have met their annual deductible.

Delaney claims it would be rare for a Definity plan member with high healthcare needs to have to pay thousands of dollars each year for health care, except in cases where the employer built in such a large gap between the plan's spending account and deductible ceiling.

Some patients with high-cost needs may prefer the Definity plan even if they do have to pay more than they would have under a managed care arrangement, says Delaney, simply because the plan offers unrestricted consumer choice.

Migration witnessed
Humana rolled out its CoverageFirst plan to its own Louisville, Ky., employees last summer. Similar to other consumer-driven products, the plan features a spending account ($500) and a high deductible (either $1,500 or $2,000) that members must meet in order for comprehensive insurance (either 80/20 or 100%) to kick in. Members first reach into their spending accounts to pay for all healthcare expenses, including preventive care.

"For the most part, the very healthy people appeared to have chosen our CoverageFirst plan," says John Bertko, chief actuary. "And that was entirely as expected."

After tying its employee premium contributions to a standard PPO plan, Humana allowed employees to buy "up" or "down" from that plan depending on the level of insurance they wanted. The company witnessed an 11% migration downward into less-expensive plans.

A "total replacement" philosophy is essential to the company's ability to compensate for adverse selection, says Bertko: "We offer a bundle of six different kinds of plans, and we want the employer to encourage folks to migrate to more cost-effective plans."

"But we make sure the traditional plans continue to be priced correctly. Those plans will get adversely selected, because healthier people leaving them means their average cost goes up. We use some of the savings that are coming off those low-priced plans to offset the high-cost plans."

While traditional plans are designed to remain higher in cost than the CoverageFirst plan, says Bertko, companies that implement Humana's product line exclusively will be better positioned to spread the risk among all plan members.

"When you're dealing with strategies among offering plans or choices within a single plan environment, obviously the sick have to be paid for by the well," observes Mike McAllister, president and CEO. "The basic insurance premise, or the aggregation of risk, has not changed."

Risk adjustment

But Minneapolis, Minn.-based eBenX has developed a way to risk adjust premium payments among competing plans on its "health care supermarket" enrollment and administration platform, with an eye toward reducing adverse selection to a bare minimum.

In January, the company kicked off a program in Ohio that compensates insurers based on the enrollee demographics in five geographical areas of the state. Under a 32-tier risk-adjusted payment system, plans and carriers are compensated more accurately than they would be under a traditional three-tier arrangement (single, single plus one, family) for the health risks they assume.

Carriers that wish to compete for employer business on the eBenX enrollment platform must first agree to the company's risk models, which determine the ratios between different plan members' premium rates. Carriers then price their products accordingly, within the 32-tier system, under the assumption that they will attract all possible members to their plan.

The composite premium, which is the average cost per member per month (PMPM), is subtracted from the average PMPM contribution an employer wants to make. The remainder is the employee's premium share, which is converted into four tiers in order to meet compliance requirements and non-discrimination rules.

All the plans that compete on eBenX's platform are fully insured.

"Creating an environment where employees have a fair and equitable chance to enroll in any plan on a risk-neutral basis is the key to making this work," says Tom Adkin, director of financial consulting.

In such an environment, employees will have more of an opportunity to compare plans based on their quality, says Adkin, than on their price. And that's yet another way to mitigate the consequences of adverse selection

Testimony of

Amy Jensen Cunniffe
Director, Federal Public Policy (House)

before the

U.S. House of Representatives
Committee on Small Business

Affordable Health Care Options for Small Business

April 4, 2002

Good morning Chairman Manzullo and Members of the Committee. My name is Amy Jensen Cunniffe and I am the Director of Federal Public Policy (House) for the National Federation of Independent Business (NFIB). I thank you for the invitation and the opportunity to testify on behalf of NFIB.

NFIB is the nation's largest small business advocacy organization, representing more than 600,000 small business owners in all 50 states and the District of Columbia. Nothing is more important to NFIB than solving the health care problems of small businesses. We firmly believe that association health plans (AHPs) and removing the restrictions on medical savings accounts (MSAs) are necessary steps to create more affordable health care options for small businesses across the nation.

Rising Number of Uninsured

According to the most recent information from the Census Bureau, nearly 39 million Americans did not have health care coverage in 2000 - that is nearly one out of seven Americans. Since that time, a slow economy, higher unemployment and rising health care costs likely mean that more Americans became uninsured. And, two million Americans became uninsured due to job loss in 2001. Over 60% of our uninsured population consists of small business owners, workers, and their family members. The high rate of uninsured in the small business community is due to the lack of available options for small business and an increasingly shrinking small group insurance marketplace.

We know that the smaller the business, the less likely it is to provide health insurance. Sixty percent of businesses that have three to nine employees offer health care benefits, while most large firms are able to offer coverage. Even in the best of times, the small business health care plan only covers about 57 percent of the employees, many choosing to go without coverage due to the costs.[1] For the smallest of the small, offering health coverage is a constant battle.

The High Cost of Health Insurance on Main Street

We at NFIB can substantiate that the high cost of health care is the number one problem of small business owners today. NFIB surveys show that for the past decade, small business owners have ranked the cost of health insurance as their number one problem – higher than taxes, regulations, and every other problem. Our members also have told us that they believe providing health insurance is the right thing to do – right for their employees and right for business. However, the high cost of health insurance often prevents them from doing this.

As you know, Mr. Chairman, NFIB has provided several witnesses who testified before your Committee as well as Representative Thune's Subcommittee, and all of them

[1] Employee Health Benefits, 2000 Annual Survey, The Henry J. Kaiser Foundation

have experienced double-digit increases. Elaine Smith from Granite City, Illinois, experienced a 26 percent increase this year, Ron Hatch of Yankton, South Dakota experienced a 50 percent increase, and Phil Bartmann, one of your constituents, experienced nearly a 100 percent increase. On average, a worker in a firm with less than 10 employees pays **17 percent more** for health insurance than a worker in a firm with 200 or more employees.[2] Small businesses need more bargaining power so they can have access to affordable health care coverage for their employees.

Solutions

In today's society, when it comes to purchasing health care, the rules of the game are definitely stacked against small business. The small businesses with the least income actually pay the most, while Fortune 500 companies are able to offer exceptional benefits, have more modest annual cost increases, and more health plan choices for their employees. These companies have benefited from the economies of scale that come from being able to purchase health care in a large group, across state lines, under one set of rules. Unfortunately, under today's law, it's impossible for small business to be able to purchase health care in the same manner as their big business counterparts.

Association health plan (AHP) legislation like H.R. 1774, the Small Business Health Fairness Act of 2001, introduced by Representatives Fletcher and Dooley, levels the playing field by enabling small businesses to purchase their health care like big

[2] *The Uninsured*, Health Policy Alternatives, Inc., September 21, 1999

business and union plans through AHPs under ERISA. AHPs are a private market solution to our nation's health care coverage and cost problems. It builds upon what has proven to work. If small business could purchase health care in the same manner and under the same rules as big business, premiums would decrease and coverage would increase.

Allowing small businesses to purchase health care though association health plans will allow them to save on administrative costs and bring to the market, the greatest amount of bargaining power and sufficient numbers to absorb risk without substantially increasing premiums.

MSAs also offer an alternative solution. Eliminating the regulatory burden on MSAs would benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees by giving them control over their own health care dollars. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business. Tax credits for individuals would also be a welcomed option.

AHPs Will Reduce Health Insurance Costs For Small Employers

One of the most frequent complaints of small businesses purchasing health insurance today are drastic rate hikes that force them to drop or completely restructure

their employer-sponsored health care coverage. Allowing small businesses to purchase health insurance through AHPs will minimize this problem.

In fact, the only study that looks solely at AHP legislation, by the CONSAD Research Corporation, estimated that as many as 8.5 million previously uninsured workers would receive coverage if this concept is enacted into law.

AHPs Will Reduce Administrative Costs for Small Business

Small businesses currently must pay the highest marketing, billing and claim processing costs. Some pay from 20-25 percent of their premiums toward such expenses, compared with about 10 percent for large employers.[3] If H.R. 1774 becomes law, administrative costs would be spread over thousands of members in AHPs instead of a few workers in a small business, resulting in significant cost savings. The bill would also allow an association health plan to operate without having to comply with 50 individual state laws on benefits, premiums, and solvency, thus expanding the opportunities for small businesses, which cannot afford coverage to obtain access through an AHP.

AHPs Will Permit Small Firms to Purchase Benefits Similar To Those Offered By Fortune 500 Companies

If given the same tools, which large employers and labor unions use to offer

[3] *Private Health Insurance – Small Employers Continue to Face Challenges in Providing Coverage*, U.S. General Accounting Office, October 2001

health benefits, AHPs can substantially reduce the cost of health benefits through operating efficiencies. Why should working families be forced to pay 18% more for health insurance just because they work for a small business? If the cost of benefits is reduced, small business employees will get more benefits.

AHPs Are Prohibited From "Cherry Picking" Under H.R. 1774

As many of you know, some insurance companies are not fond of the competition that AHPs would bring to bear. In fact, many insurance companies raise untrue allegations about AHPs. The allegation that AHPs will cherry pick good risks ignores several facts. Current law prohibits any group health plans (including AHPs) to exclude sick or high-risk individuals, or employers with high claims experience, from the health plan. AHPs are subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA

Only bona fide associations, which are in existence for three years for purposes other than, providing health insurance, can operate an AHP. This prevents insurance companies from setting up sham associations for the purpose of excluding high risks.

AHPs Are Not MEWAs

Insurance Companies also like to refer to AHPs as multiple employer welfare

arrangements (MEWAs). However, the AHPs in H.R. 1774 are not MEWAs. A MEWA can be operated by any organization for the sole purpose of providing health insurance to multiple employers. They are not required to meet the explicit and strict solvency standards of an AHP. In fact, many of the problems that MEWAs have created are explicitly prevented by the stringent mechanics of the AHP legislation.

Solvency and Consumer Protections

To prevent fraudulent plans from forming, the bill requires the plans put up and maintain capital surpluses before they can be certified. In addition, plans must maintain sufficient claims reserves, stop loss insurance and indemnification insurance to guarantee that claims will be paid even in the event of financial difficulty or plan termination. The bill also gives clear and strong regulatory authority to ensure that the Department of Labor in partnership with state regulators are able to ensure that AHPs will meet the very strong certification and reserve requirements provided in the legislation.

The fact is that it's time to see insurance company claims for what they are and move AHP legislation to the President's desk. NFIB strongly believes if AHPs become law, our health care system will be fairer and more choices will be available to small business owners at a lower cost.

Testimony of
Boro Reljic
Vice President of Government Affairs
Illinois Manufacturers' Association
U.S. House Committee on Small Business
Rock Valley College

Thank you Mr. Chairman, members of the Committee. My name is Boro Reljic and I am the Vice President of Government Affairs for the Illinois Manufacturers' Association (IMA). Thank you for letting me share our concerns regarding health care coverage.

The IMA is the oldest and largest industrial association in the country. Since 1893, IMA has represented manufacturers' interests before the Illinois General Assembly and state regulatory agencies. We currently represent approximately 4,000 companies in Illinois that employ nearly 80 percent (approximately 800,000) of the manufacturing workforce in this state. A significant portion — approximately 70 percent of our membership has fewer than 100 employees. Nearly 98 percent of IMA members offer health insurance benefits to their employees. The IMA represents companies as large as Caterpillar Tractor and John Deere to smaller companies with less familiar names like Zenith Cutter or the Rockford Spring Company in this area.

The cost of providing health care to employees is the number one concern to Illinois manufacturers, according to the IMA's benefit report. There are 43 million people in the U.S. without health insurance. The main reason is that health insurance is becoming increasingly unaffordable. According to the National Association of Manufacturers, health care costs increased by more than 300 percent between 1980-1990 ($73 billion to $223.6 billion). Health care costs in 1999 were 470 percent more expensive than in 1980 ($73 billion to $343.4 billion). The number of uninsured will continue to rise as long as we see double-digit health insurance premium increases. To get more people covered, we must find ways to make health insurance more affordable.

One reason health care costs continue to skyrocket is due to the

ever-increasing number of legislative mandates. Illinois' Insurance Code mandates account for over 20 percent of the cost of health insurance.

Another reason for skyrocketing health care costs is the erosion of managed care. Various managed care plans allowed employers to offer quality health care coverage to their employees at a reasonable cost. Medical providers, unhappy with these marketplace developments, are turning to legislative bodies to unravel various cost control mechanisms.

These two reasons, coupled with double digit medical inflation, drive costs so high that a 15 percent premium increase looks reasonable. The increased premium pressures eventually fall on employees through the loss of coverage or increased co-pays and deductibles.

The larger the uninsured population, the greater the strain on both public and private sector budgets, the public sector through Medicare and the private sector through cost shifting for uncompensated or under-compensated care. We need to find ways to make health insurance more affordable.

One innovative approach that we support, currently under consideration in Illinois, is H.B. 5963 (May, D-Highland Park) which would allow employers with 25 or fewer employees an option to participate in an insurance pool that would have the same health care insurance options as state employees through Illinois' employees group health plan.

The bill would allow small employers another avenue, in addition to the standard insurance product, to find ways to offer insurance to their employees. If enacted, small employers would enjoy the same purchasing power as the State of Illinois currently enjoys. Employers that participate in the plan would pay the entire cost of coverage, plus any additional administrative charges incurred. Also, employers that participated in the plan would be required to enroll all employees.

Small businessmen and women purchasing group policies are constantly looking at reducing health insurance costs. H.B. 5963 would allow these individuals to join an existing pool and receive the

price benefits and purchasing power that a large group enjoys.

In addition to the already mentioned cost drivers, it is our view that legislators must be wary of the following provisions that will cause higher insurance premiums and more uninsured. Legislators should:

- Oppose efforts that place restrictions on a payer's ability to negotiate procedures, benefits and payouts to providers.
- Oppose attempts to allow physicians to collectively bargain.
- Oppose efforts that allow "any willing provider" to participate in negotiated contracts between provider and payer.

And finally,

- Oppose efforts to expand liability to buyers of health care for treatment outcomes and care denials by insurers.

In order to remain competitive, small businesses need relief from these skyrocketing costs. Members of Congress and other legislative bodies must remember that there is a direct correlation between affordability and coverage. The more unaffordable health care insurance becomes, the larger the uninsured population.

Overall, it is our belief that the private sector is better suited to provide health care than the public sector, from both a quality and cost standpoint. Managed care was the result of the private sector finding ways to hold down health care costs. Please don't "Reform" managed care by removing necessary cost constraint barriers, because in the end, higher premiums mean fewer insured.

I would be happy to entertain any questions.

"Small Business Access to Health Care"

Testimony of
Vondie Moore Woodbury
Director
Muskegon Community Health Project
Submitted to the
U.S. House Small Business Committee
April 4, 2002
Rockford, Illinois

Thank you Mr. Chairman and members of the Committee for the opportunity to present testimony on the work we have been doing in Muskegon County to address health care access and financing for our small business community.

My name is Vondie Woodbury and I am the Director of the Muskegon Community Health Project. We are located in Muskegon, Michigan. I will be speaking today about a program that community volunteers within the Health Project developed called Access Health.

Access Health is not an HMO nor is it an insurance product. Access Health is a community-owned health coverage plan that is sold to eligible businesses in Muskegon County for the purpose of providing health care coverage to the working uninsured and to their dependents. Access Health was intentionally designed to fill the gap between public insurance programs and commercially available products. It was also envisioned as a market force tool to assist small businesses in recruiting and retaining good employees through health benefits.

Access Health was developed following extensive quantitative and qualitative research about our own community. Like many other parts of our country, uninsurance rates in Muskegon County had been steadily increasing during the mid- to late 1990's. Based upon our own observation and research, it was apparent that many uninsured people in Muskegon were working full or part time in the small businesses service and retail sectors, the fastest growing segment of our economy.

In general, these businesses were not members of our Chamber of Commerce or other recognized business advocacy groups. They tended to be very small, have relatively low profit margins. When we asked the business owners why they did not participate in commercial options, the cost of coverage was identified as a major barrier by 69%. We learned two other important things about these businesses. They had high rates of employee turnover that was being fueled in part by a lack of benefits. We also learned that these employers were willing to purchase a benefit program but could not afford to pay more than $50 per employee per month.

The people who worked for this part of our business sector had their own unique profile. In our community, the majority are women under 40 years of age with children. They admitted putting off medical care because of the inability to pay. Most indicated that they valued health care and wanted a benefit. Unfortunately, because of their low-income status ($6 - $10 per hour wages) commercial coverage was not affordable. However, like their employers, a majority indicated a willingness to pay something and again, they identified $50 a month as an acceptable and realistic ceiling.

It is extremely important to underscore the fact that both the business owner and their workers were willing to pay. This is not a sector that self identifies as "poor" even though the

popular press routinely calls them *the working poor*. This is a group of businesses and individuals who go to work, pay taxes and help support government programs like Medicaid and Medicare. No one was asking for a handout. Indeed, many of the people we surveyed indicated an aversion to "government sponsored" programs with a welfare stigma. There was a very strong sentiment around personal responsibility and independence. Access Health was developed to address this niche market of businesses and individuals – not to be an entitlement program.

To ensure that Access Health only served that portion of our population who were unable to pay for commercially available products, we took special steps to limit the type of business we will serve. Eligible businesses must be located in Muskegon County. They cannot have offered any commercial insurance for the previous 12 months. They must have a median wage of $10 an hour or less to participate in the program. In short, we wanted to make sure that businesses who belong in the commercial market stayed in the commercial market. Any business found falsifying information and dumping existing coverage is dropped from Access Health for life.

Access Health has targeted 500 businesses in an effort to accommodate what we hope will be 3,000 full or part-time working uninsured individuals. At present, over 300 small businesses have enrolled. Thus far, we have served nearly 1,500 individuals. We work closely with our Chamber of Commerce and with local insurance agents to ensure that our niche remains just that – a very specific part of the local market. Access Health is even sold by insurance brokers in our community after they ascertain that a business cannot participate in their commercial portfolio. Indeed the largest local brokerage firm in Muskegon County is a member of the Access Health Governance Board.

Let me emphasize here that Access Health is only offered in Muskegon County. And, that we are not insurance. Members who have medical incidents and seek treatment outside of Muskegon must pay the cost of this care out of pocket. By limiting our coverage area to our own county, we ensure that our niche product does not compete with the richer benefit afforded by a commercial carrier.

Within these restrictions, Access Health is able to provide a substantial benefit package – 97% of our physicians, both of our hospitals, numerous support and ancillary providers participate. As a community we created a program that emphasizes prevention and gets people into care. We created a program that gives people access to the hospital if they needed care and one which pays the hospital for that care. We offer a drug benefit that is affordable. We have done all of these things and still fit the budget of our targeted business group and the people who work for them.

We contract directly with our local physicians who provide services to Access Health members on a fee-for-service basis. These physicians donate 10% of their fees back to the program in order to support its administration. I have attached to this testimony a list of benefits along with required co-pays. Our physician network keeps these co-pays which you will note are structured to encourage the use of primary care as opposed to emergency rooms for care. For instance, a primary care visit will cost one of our members $5.

To make it affordable, Access Health's funding comes from three sources: (1) employer contributions, (2) employee contributions and, (3) community contributions. This type of structuring is commonly referred to as a *three-share* model. Three share models are different from traditional entitlement programs in which the public assumes the full 100% of the cost. In the Access Health program, the public share is only 40% of the cost. In public policy terms, this means that the taxpayers are liable for 60% less of the cost than in a traditional entitlement

program. This 60% is split between the business owner and the employee. Indeed, in Muskegon County today, an eligible business can buy Access Health for an employee for $42 a month. The employee will also pay $42 and the remaining part of our cost $55 is paid by the community. This represents a total cost of $139 per member/per month.

The community portion of the cost for Access Health comes from a mix of community donations and federal Disproportionate Share Hospital dollars (DSH). DSH funds are federal Medicaid funds that are available to states. A state may redistribute this money to hospitals who have a disproportionate share of uncompensated care. By agreement with the state of Michigan and our two hospital systems, the money that Muskegon county hospitals would have received is turned over to Access Health to fund the community share. Besides making good sense – one DSH dollar is matched by two local ones - Access Health is also therefore budget neutral. We used money already in the system. And, the people and businesses who need the service are helping to pay for it.

I want to make an important point here. While there are other community care models around the country, each type has significant drawbacks. Some only provide minimal health care services such as primary care. In these models, physicians and hospitals may balk at participation because of uncertainty of the level of care and cost of services required. Other models require special local taxes to adequately finance their programs. Only the Access Health model provides full services in a business-type structure that is managed at the local level. Access Health has its own administration and maintains its own health service data for effective, real-time medical case management.

Access Health provides my community with "shared wins" for all of the participants. The community reduces its level of uninsured as much as one-third. Those covered get improved healthcare access and our providers reduce the level of uncompensated care they must otherwise cost-shift to insured patients. Finally, businesses benefit by reduced employee turnover and absenteeism and enhanced competition to provide benefits to workers.

The common sense approach embodied in the Access Health model has moved other communities and groups across the nation including people here in Rockford, Illinois to take a more focused look at our program. I am delighted to announce that Huntington, West Virginia, has recently received approval by their state legislature and governor to implement a three-share model. States like Utah, Idaho and Delaware are also taking a closer look at our model.

We have learned that people are willing to help pay for their health coverage and that it is possible to use existing programs to maintain budget neutrality. We have also learned that communities can create a product that fits a niche part of the market without adversely affecting commercial coverage. Not all of America's uninsured need an entitlement solution. We would suggest that entitlements should serve that portion of a community's uninsured who clearly have no other resources and need the safety net and that solutions for working uninsured do not have to compromise a community's safety net resources.

Thank you for this opportunity to tell you about Access Health and the difference it is making in Muskegon County. We are a relatively small community but we believe that our experience offers opportunities and examples for those who forge public policy.

Testimony
U.S. House Committee on Small Business
Hearing on Affordable Health Care
April 4, 2002
Johanna Lund, PhD, Chairperson
Rockford Health Council

Good Morning and welcome to Rockford. I am speaking today in my dual capacity as Chairperson of the Rockford Health Council and as a small business owner. I wish to thank Chairman Manzullo and the entire House Committee on Small Business for conducting this field hearing on affordable health care here in Rockford, Illinois.

Rockford, like other areas of our country, is facing a crisis in the ability of small business owners to obtain and keep affordable health insurance. This fact was documented three years ago by the Rockford Healthy Community Study, which in June 1999 identified access to medical care as one of sixteen major health issues facing our immediate area.

This comprehensive collaborative study was funded and produced by nine Rockford Health Council members organizations, including our three hospital/health systems, Winnebago County, the City of Rockford, Rockford Park District, United Way, the Community Foundation of Northern Illinois, and the University of Illinois College of Medicine at Rockford.

Rockford Health Council is a community-based health policy and advocacy group of 54 organizations representing health care, business, education, social services, and government in Boone, Ogle, and Winnebago Counties, our immediate region.

Since the release of the Healthy Community Study we have been working collaboratively to address the issue of access to medical care. Rockford is rich in health care resources. We boast three major hospitals, a strong private provider community, a mature and full service federally funded community health center, comprehensive public health services, and well developed public and private behavioral health care.

For most of our residents access to health care is through employer-based insurance or through Medicare or Medicaid. But for a sizeable minority of residents access to timely and appropriate health care is impaired due to lack of insurance. We have estimated that as may as 44,200 residents, 16.5% of our Winnebago County population, is uninsured, with another 11,100 (12.2%) uninsured in neighboring Boone and Ogle Counties. We estimated that a large portion of the uninsured are currently employed in the private sector. Among minority populations, the estimates are that 23% of African-Americans and 33.5% of Hispanics are currently uninsured.

Our efforts began with two premises: (1) We want to assure access to health care to those who do not currently have such access, and (2) It is not our intention to compete with the commercial insurance market. Our desired result is improved health access and outcomes.

In September 2000 we sent a team to Muskegon, Michigan to examine the innovative programs developed with and for their small business community. We found their third share model appealing and worthy of replication, but do not intend to exclude any other workable model. We were awarded a federal Community Access Program grant last September, and have been working diligently to develop a workable model of coverage for small business owners and their employees.

We believe that small businesses are having difficulty obtaining affordable coverage from the private market, in part due to the high costs of mandated benefits and in part due to adverse selection based on group size.

The federal CAP grant has provided funding for a concentrated effort to develop new options for our small business community. Through a comprehensive survey of 4,700 small business owners with fewer than 25 employees in Winnebago County, completed in December by Health Systems Research, we have determined the following:

- The average small business in Winnebago County employs just under 9 persons.
- 47.5% of respondents do not offer health insurance.
- Even when companies offer coverage, only 69.2% take the coverage, with 10.7% not eligible at the time of the survey.

- For those individuals who do not take the health insurance offered, 59% are thought to be using their spouses' plan. 20.4% of respondents say that such employees cannot afford their portion of the premium.
- Small employers in Rockford reported rapidly accelerating health plan premiums – an average increase of 26% last year.
- 90% of respondents not offering health coverage cited high cost as the key reason.

Since September our Access to Medical Care Team has expanded to include members of the business community, physicians, health systems, our community health center, public health, and the brokerage community. A member of Congressman Manzullo's staff has joined our team. We have retained Health Management Associates of Chicago as our principal consultant in the development of a plan design appropriate to our needs and the laws and regulations of Illinois.

We have met with area legislators, hospital CEOs, and interest groups to share information and seek support. We have engaged the Illinois Department of Insurance in high-level discussions about how to create a new model of affordable coverage for the 4,000 employees we estimate could benefit from an initial plan. The department is working to facilitate our work. Two weeks ago we held a focus group with nine small business owners to seek their input and help in designing a coverage product. Further meetings are planned.

We are currently working through the details of a plan that would offer basic medical, pharmaceutical, and limited hospital coverage to working adults employed by businesses of 2 to 25 workers with a median wage of $12 per hour who have not offered coverage for the past year. We hope to develop a model of community coverage funded by a "Third-Share" arrangement, with employers, employees, and the community sharing in the costs.

Our contractual actuary is currently pricing this model, which we expect to be able to offer to eligible small businesses at no more than $75 per month (or less) per employee share. This was the "break point" documented in our survey at which participation would be expected to fall below half of eligible employees.

Our goal is to develop a marketable product to bring to small business owners before the end of this year. If we are successful, this approach could be a model for other Illinois communities. We appreciate the recognition that this committee is providing for locally developed solutions to the need for affordable coverage that have potential applicability on a community-by-community basis. I would be pleased to address any questions you have about our work.

DIRECT REIMBURSEMENT
An Alternative To Traditional Health Care Insurance

The traditional insurance choices to which health care insured individuals are likely to avail themselves or will have made available to them by their employers, is usually a product in which the insurance entity receives an up front fee amounting to roughly 30% to 40% of the existing dollars in the plan. Frequently, a significant waiting period exists before certain higher cost benefits can be accessed. There may be other aspects particular to each type of plan product, but in an effort to be brief, I will limit my discussion.

In the first instance, for example, an employer may decide to spend $100,000.00 to provide dental insurance for the employees. Let us assume that the employer has 100 employees, and he/she figures that this would allow a $1000.00 annual dental benefit for each of the employees. However, the employer's reasoning is flawed, because the insurance company's product probably requires that, at the front end of the plan, a conservative 30% insurance/administration fee be provided. So, the actual coverage, divided equally among the employees, is really only $700.00.

The second example considers the concept of a mandatory waiting period. With dental insurance again as the product, it is not unusual for the insurance company to designate certain higher cost dental procedures as inaccessible for a specific period of time---- possibly even one, two or three years. Such procedures might be crowns or bridges, which are more costly than silver or composite resin fillings. Some procedures, such as orthodontics (braces) for example, may not be a covered procedure at all and therefore excluded from the insurance product. Sometimes companies reserve the right to substitute a less costly approach to a treatment procedure, which essentially changes the doctor's treatment plan significantly. It is a common practice for insurance companies to secure providers who are willing to treat a group of patients for set negotiated fees, regardless of the doctor's specific fee schedule. In exchange, the insurance company agrees to restrict the covered employees to seeing only doctors in the network, thus eliminating the employee's freedom of choice to select their health care provider.

A more desirable insurance approach would include a system referred to as ***Direct Reimbursement***. Through this insurance vehicle, an employer can minimize the initial insurance/administration fee. Customarily, with this program, the only cost to the employer is a much more reasonable administration fee, as the administrating entity simply administrates the program for the employer. The cost of such programs usually falls in the range of 10% of the plan's designated assets. Therefore, that same employer with the 100 employees, can provide each employee with a plan benefit of $900.00, instead of the $700.00 illustrated in the previous model. The employees are allowed to select their own doctor, there are no restrictions as to which procedures can be performed, and no waiting periods exists. Customarily, the employee has the needed treatment completed, pays for the services at the treatment facility, brings the receipt back to the plan administrator, and is then reimbursed from the plan's assets which are customized, equally allotted, and individually based for each of the patient's health care. A slight twist to this example would be to have the plan administrator submit payment

directly to the provider, from designated plan funds specifically for this purpose. Once the employee has submitted the treating doctor's billing statement, payment is forwarded to the doctor through the proper channels.

Direct Reimbursement is an excellent approach, along the ever-winding road, to preserve insurance benefits and ensure that maximum plan dollars are made available to the insured individual for use in paying for their needed health care. It is also a small, but steady step closer in the journey to solve the very real and critical concerns of health care utilization and access.

Respectfully submitted,

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