SMALL BUSINESS ACCESS TO HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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SMALL BUSINESS ACCESS TO HEALTH CARE

WEDNESDAY, AUGUST 14, 2002

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

The Committee met, pursuant to call, at 11 a.m., in Room B–171, College Conference Center, McHenry County College, Hon. Donald A. Manzullo (chair of the Committee) presiding.

Chairman MANZULLO. Well, good morning. Can you hear my voice clear enough? Okay. It is my pleasure to welcome everybody to today's Small Business Committee Field Hearing on the critical issues of small business access to health care. As soon as this hearing ends, we will be going to Libertyville and have a hearing there on how the cost of medical malpractice insurance is affecting the cost of insurance premiums themselves.

Fighting health care costs is 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 60 percent of the estimated 43 million uninsured are small business 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 health care for small businesses. One of the reasons small businesses cannot afford health coverage is that they are unable to achieve the economics 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 purchasing their health care products.

Large corporations use their purchasing power of thousands of employees to offer affordable health care insurance to workers. Small business owners 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 health care to small businesses. Why must insurance companies charge the most to those least able to pay these high prices?

I was very heartened to see President Bush's 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 businesses, 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. It calls for 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 coverage.

I look forward to the testimony of the witnesses. Now, they are not all going to agree. Some are in favor of associated health plans, and some are opposed. And the purpose here is to get a fluent discussion going to see what ideas are bouncing around Congress and tell us for your perusal. I am joined by my excellent mentor. I met Phil a long—well, I know you got more years than I do. I am not as graceful and distinguished as you are. Before I was elected to Congress, Phil Crane represented all of McHenry County, and then because of the redistricting in 1992, I became the blessed beneficiary of McHenry County, and had the privilege to represent you in the past 10 years. As you know, redistricting occurs every 10 years, and we came to a situation where we went from 20 members of Congress, down to 19, and so the areas had to get bigger.

The Congressional District that I represent, we, unfortunately, lost the northeast corner of McHenry County, which is cities of Richmond, Hebron, Johnsburg; and the city of McHenry itself, and Scott, also Rinkley. I've been thinking about the cities that we lost in there. So, I lost that northeast corner, and the redistricting map, I picked up the western half of Global County, all of Carol County, the top halves of DeKalb and Whiteside County. So the new branch of the district I represent runs from Fulton on the Mississippi, all the way over until Algonquin on the Fox, and then all the way to the Iowa and Wisconsin borders to the northeast corner.

Phil Crane, in redistricting, we had to figure, he had to expand his area, he couldn't go into Lake Michigan, and he couldn't go into Wisconsin, and so, he had to come into McHenry County. And as we looked at the map, we tried to make it as square as possible. One of the townships got split, unfortunately, but at least he kept the cities intact. So, Phil, is again, reclaiming that northeast corner, and when we sat down and talked about redistricting, Phil and I had to agree that we are going to treat this county as a whole. So you now have two members of Congress that are looking after the interest of McHenry County, and I can't think of a finer partner, and a friend, and a mentor, of so many years, and with that, I'll go to you. Thank you.

Mr. CRANE. Thank you, Don. I deeply appreciate that. It is a pleasure to have the opportunity to be back in McHenry, and I maintained a lot of friends over here, even after the loss of our dis-

trict. But my district in geographic area is roughly the same. I lost a big chunk down in Cook County to guarantee that our colleagues over there stay in their districts, and they moved into mine, and I've been here eight years.

Chairman MANZULLO. Okay.

Mr. CRANE. At least we didn't send you down to Kentucky.

Chairman MANZULLO. That's correct.

Mr. CRANE. Well, I want to congratulate you for holding this important hearing, and inviting me to have the opportunity to participate. And I would like to commend your leadership efforts on access to affordable health care for small businesses. You've been a great ally in our fight to expand and remake, or make permanent medical savings accounts, and your work on establishing association health plans is to be commended as well.

Let me just say that I believe all Americans should have access to quality health care, and that is the best health care system in the world. According to the U.S. Census Data two years ago, there were around 39 million uninsured. Of that 39 million, 60 percent, I believe are owners or employees of small businesses.

One of the main reasons that individuals go without health insurance is the cost of the premium. Since 2000, insurance premiums have continued to increase. This year, premiums rose an average of 19.3 percent, and it said that for every one percent increase in health insurance premiums, 100,000 individuals will lose their health insurance coverage. That's 1.9 million more individuals on the uninsured rolls this year alone. And, Mr. Chairman, if I could just point out that I recently read that insurance companies across the country are seeking rate increases of 22.5 percent for next year. If that is correct, that would be the highest annual percentage increase in the last four years, and it would result in 2.3 million more uninsured next year.

There are also other reasons that Americans find themselves uninsured. Some are unemployed workers who have the option to continue coverage under their former employer's plan, as long as they pay the premiums, but do not have the money to do so. Other unemployed workers and some working families are uninsured because their employers do not offer any coverage. Still others, generally low-income workers, may be offered employer-based insurance for themselves or their families, but cannot afford the premiums.

All responsible lawmakers want some form of action to help the uninsured. The argument is how best to do that. And, although most members of Congress believe that the employer-sponsored insurance system should continue as the basis of coverage for most working families, there has been a gradual recognition that, in today's economy, the traditional employer-based system cannot serve all families effectively. In particular, that system does not assure stable, continuous coverage for all. Two factors demonstrate this problem.

There are very high rates of uninsurance among employees of small firms. According to a Kaiser Family Foundation Survey, while 99 percent of large firms offer health insurance, only 55 percent of firms, with fewer than 10 employees do. Among low-wage

workers, those who earned less than $7 an hour in 1996, 45 percent are not even offered insurance.

This is probably due to the fact that employers who try to offer coverage to very small groups tend to face high administrative costs. According to data collected by the Congressional Budget Office, overhead costs for providing insurance can exceed 30 percent of the premium costs for firms with fewer than 10 employees, compared to about 12 percent firms with more than 500 employees. Also, small employers may lack access to resources to assemble good and affordable options for their workers. Consequently, many small businesses adopt a competitive compensation package that emphasizes cash income rather than health benefits.

Because I am the vice chairman of the Committee on Ways and Means, as so indicated, I'd like to focus for just a brief moment on a role of taxes. The Federal Tax Code blocks employees from obtaining coverage from anyone other than an employer or former employer; The current tax system excludes from taxable income, federal and state income taxes, and payroll taxes, all compensation provided to a worker in the form of employer-sponsored insurance. But workers who do purchase insurance for themselves rarely can claim any tax relief or receive any other assistance toward the cost of coverage.

There is one section in the tax code that provides for some tax relief medical expenses. Since 1942 taxpayers who itemize, have been able to deduct health care costs that are in excess of a statutory percentage of their adjusted gross income. The current threshold where deductions of medical expenses are allowed is after 7.5 percent of the adjusted gross income. However, few taxpayers who itemize can reduce their taxable income through the existing deduction, because their unreimbursed medical expenses are unlikely to exceed 7.5 percent of the AGI. That is why I have introduced legislation to help make health care more affordable by allowing taxpayers to deduct most of their medical expenditures to exceed two percent of their adjusted gross income.

Let me give you an example of how this legislation would help. Under current law, a family with an income of $30,000 would only be allowed to deduct medical expenses in excess of $2,250. Under my proposal, that same family would be allowed to deduct all health care costs exceeding $600.

Let me just end by saying that providing access to affordable, quality health care is an issue that will be with us for some time. But the longer we wait to pass legislation to help improve access to health insurance, means that millions of Americans will continue to lack affordable protection against the potentially catastrophic costs of an illness or accident. And I look forward to hearing some of our local small business owners, as we work towards a solution for this issue. Thank you again.

Chairman MANZULLO. Thank you, Phil. Most of you have never testified before a Congressional Committee, and the first thing I want to tell you is to relax, don't be nervous, this is not the stuff that you see on C–SPAN and nobody is going to ask that you get up and swear under oath. We conduct our small business hearings formal enough to comply with the House of Representatives Rules, but informal enough so that we are goal orientated. We have a

time clock of 5 minutes, and when we get to 4 minutes, does a bird come out of the wall? What is going to be our signal on that?

Mr. THOMAS. I'll wave my hand.

Chairman MANZULLO. You will wave your hands? What if I don't see you?

Mr. THOMAS. I'll make sure.

Chairman MANZULLO. You will make sure you see me? Okay. So, when we are at 4 minutes, I will let you know, or maybe I will go like this, okay. And if you run over a little bit, that's fine. But I do want to—after testimony, we have plenty of time for questions by Congressman Crane and myself, and also you might question each other, that is also permissible. And Mary, you look the most nervous up there. I'm going to start with you. Either you are first, or you are going to be last. So I'm going to start with you. You are going to be first. And then, go ahead, before any testimony, I just want to state that your written statements will all be made part of the record. And if you want to do the preliminaries, that's fine.

Mr. CRANE. I understand, ladies first, but you mean Isabella is next to last.

Chairman MANZULLO. Oh.

Ms. WILSON. That's okay.

Chairman MANZULLO. That's all right? You are okay Isabella, all right. Thank you for reminding of that. Make sure you tell us a little bit about your business, if you're self-employed, and employ employees, et cetera.

With that, Mary Blankenbaker, you can go now.

STATEMENT OF MARY BLANKENBAKER, CO-OWNER OF BENJAMIN'S RESTAURANT

Ms. BLANKENBAKER. Thank you. Good morning. My name is Mary Blankenbaker. I am co-owner of a family owned and operated restaurant in Galena, Illinois. I have about 12 full-time employees and about 22 part time.

On behalf of the restaurant industry, I would like to thank you for this opportunity to speak to the Committee on Small Business about the important health care problems that are facing small businesses today.

Small business owners can tell you that any changes to the Patient's Bill of Rights must include explicit limits on employer liability and provision for association health plans.

Of the approximate 43 million uninsured Americans, 60 percent live in a family, employed by a small business. Many restaurants cannot afford to provide health benefits because of costly state mandates and lack of purchasing power.

For each of the last two years, health insurance premiums have gone up an average of 23 percent for table service restaurants. Benjamin's has the best rating an insurance company can provide. As of August 1st, our renewal date, our premium increased 28 percent.

Many more small businesses in a variety of industries are seeing this as well. Over 172 million people in the United States receive health coverage through their workplace. Yet, it is becoming increasingly difficult to offer health coverage incentives to employees as a result of higher premiums.

Prior to August 1st, we were already under great financial burden to provide health insurance to our employees, while paying $745 a month for just four people.

I continue to hear from my fellow restaurateurs that some premiums have risen even higher than ours. From 30 to 40, and even up to 50 percent, association health plans would provide employees greater access to better and more affordable health coverage by allowing small businesses to group together to purchase health insurance.

This would reduce the premiums and greatly expand the benefits we could offer our employees at Benjamin's, and the thousands of small businesses could offer their employees.

The insured deserves better than more mandates. Adding new laws and expanding liability will only serve to increase insurance costs and undermine employer's ability to voluntarily offer this valuable benefit.

Help us to achieve proper legislation that will make it possible for associations to pool their members and resources so they can afford suitable coverage.

Association health plans are a win-win-win-win situation. The insured's companies win because they lower sales costs and write more policies. The employer wins because they can afford the health insurance and they can add another benefit for their employees. The employees now benefit because they are insured and the government benefits because many more citizens are insured without costing the government a penny. Thank you.

Chairman MANZULLO. Thank you, Mary.

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

Chairman MANZULLO. Our next witness is Ryan Brauns. Ryan is a senior vice president from Rockford Consulting and Brokerage. And we look forward to your testimony, Ryan.

Are you doing okay, Mary?

Ms. BLANKENBAKER. I'm fine.

Chairman MANZULLO. Well, you did just fine.

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

Mr. BRAUNS. Thank you, Congressman Manzullo, and good morning to you and Representative Crane. My name is Ryan Brauns and I am the senior vice president at the firm called Rockford Consulting and Brokerage, home office in Rockford, Illinois.

I would like to thank Chairman Manzullo for all of his good work and efforts 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 of you and Representative Crane, I'm sure efficient solutions will be found.

When starting this, thinking about the testimony today, a call from—let me paraphrase, Francis Bacon came to mind. "For the want of understanding causes, operations fail."

1776, man, what a good year for the United States. What a great year for the world, not only did we have Jefferson in the beginning of this country creating an ethical framework for political freedom,

but a cost upon being as Smith, creating an ethical framework for economic freedom, it is to be used of all the nations. The outline in there, what a free market, is how it could work? What it means to the surviving, and fried, and what its loss of power is.

And the point of my testimony today is that there is something going on in health care today. A revolution so-to-speak, something that gives us great cause, great cause I should say to be optimistic about what is going on in health care. And I had college days that would constantly remind us that the plan for the long run is that we die in the short run. So clearly, a lot of things that you are discussing today, tort reform, association plans of Patient's Bills of Rights, and things of this nature, certainly have a role, they are important issues. But I assert today, that they are not necessarily long-run solutions, that certainly would help people like we just heard from, now in the short run, but what accountable solutions are systemic? And that is where the role of consumers comes into play. Our health care system is the greatest in the world. It reflects our values and that's why it's different than any other system in the world. We use a fee for service system. Everybody else matches to allocate these scarce resources, except in the country of Singapore and South Africa, the only free countries that have any type of fee-for-service in free market health care.

But the system that we have developed, really since the twenties, the day when Blue Cross came around, they institutionalized the third-party payer system has taken the consumer out of the equation by large. Taken all the power that the free market group consumerism can break, and removed it from the equation. I can give you two quick anecdotes, as to how this power, we might save our daily lives. I see people wear glasses, as do I and some of the panel. How often have you heard a radio commercial advertising laser eye surgery? I think about it. The next thing you hear one of those commercials, you know the commercial, when the surgeon talks about the quality, because we are certainly interested in that in health care, but he also talks about the price. I will do it for eight hundred an eye, I take Visa, MasterCard. The RAM study, that anecdote, shows us that people make health care decisions engross by price.

Let's take a look at the pharmaceutical industry for a moment. In 1991, they spent $55 million marketing to you and me. When you go home tonight and turn on the television, you are going to see a lot of ads for drugs. It is not a coincidence that over this last 10-year span, direct-to-consumer drug advertising has gone from $55 million to $2 billion, and a large component of the rate increases that we are seeing are driven by rising pharmaceutical costs. I don't begrudge the pharmaceutical industry, it's a free market, but it does prove to us the power of consumerism, consumers making choices, making decisions based on their own wants and desire, and price is certainly a part of that. Now, bring us to, I guess the IRS ruling that came out on June 26, greatly expanding the role of medical savings accounts, and what that can do. I am going to assert today that just didn't go quite far enough. That if we could see in your redirect, if we can see if Congressional discussion, and so forth, an expansion consumer types of model, the primary reason, it empowers their employees, it bolsters the doctor-

patient relationship, which, by the way, would have great effects. In that situation, but also the downward shift, the trend curve, we move up and down the trend curve, meaning increases year-by-year, but we haven't ever come up with anything to shift it. And that's the excitement that consumers brings to the market, the average rate of increases than you have seen in consumer driven products, it has been half or less than what we are currently seeing, and I could go on, but I welcome your questions.

Mr. CRANE. Thank you.

Chairman MANZULLO. Thank you.

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

Chairman MANZULLO. Our next witness is Scott Shalek, Mr. Crane's new constituent in Brainwood.

Mr. CRANE. He used to be yours.

Chairman MANZULLO. Yes, that's correct. I guess technically until January 4th, whatever it is, the—well, I have gotten to know Scott over the last several years, and Scott is an insurance broker. And we had some very, very interesting discussions on the products that are offered, and uniqueness of products that are out there, and Scott, we welcome you to the Small Business Committee to share with us your background, your experience, and your thoughts.

STATEMENT OF SCOTT SHALEK, RHU, SHALEK FINANCIAL SERVICES

Mr. SHALEK. Thank you, Congressman Manzullo and Congressman——

Chairman MANZULLO. Scott, can you please move the mike closer to you? Thanks.

Mr. SHALEK. Congressman Manzullo and Congressman Crane, I want to thank you for the invitation and opportunity to testify before the Committee on the issue of affordable health care for small businesses.

My name is Scott Shalek; I am with Shalek Financial Services in Ringwood, Illinois, and I am Regional Vice President for the National Association of Health Underwriters. Shalek Financial Services specializes in employee benefit, consulting and financial planning for individuals in businesses ranging in size from one to five hundred.

Our mission is to provide comprehensive solutions to help individuals and businesses set and achieve financial security and success, while providing a level of service above expectations.

The National Association of Health Underwriters is an association of highly qualified health insurance professionals with over 18,000 members throughout the United States and Canada. The mission of NAHU is to serve the public by promoting the activities and ethical conduct of insurance professionals through communication, education and legislative representation. Members are trained and experienced in guiding individuals and employers through the complexities of choosing appropriate and affordable health plans.

Many members hold advanced designations from the American College such as Registered Health Underwriter. We are the agents and the brokers on the front line of health care every day helping millions of individuals and businesses get the most from their

health dollars. To demonstrate the value of the agent and broker, in my written testimony, I have said three bases for my files.

Last meeting in Rockford you had, there was much discussion given to using association health plans as a way for small groups to receive lower rates, similar to those of union plans or large groups. I realize that concept, that volume discount to purchasing quotas as endorsed by business groups such as the NFIV and the IMA to be sound as an innovative solution to reducing health care costs to small employers. In other words, these have been tried in several states with disastrous results.

Last month a big MEWA called Indiana Construction Industry Trust, became insolvent and left 21,000 members with approximately $8 million in unpaid claims. As you can see, there are major problems when considering using AHPs. First, healthy groups tend to drop out after a year or two to find coverage elsewhere at more affordable rates. Second, AHPs do not have sufficient state regulatory oversight, which limits important consumer protection. Both of these factors can cause premium rates to rise and lead to more uninsured Americans.

Indeed, a vehicle has long been available to create group purchasing opportunity for small businesses. These are called Multiple Employer Trusts (METs). The difference between METs and AHPs is significant, and METs generally comport to state laws.

Another suggestion that was discussed is union plans get better rates over small groups. I have studied major union programs in Lake and McHenry County, and this is not true—proved to be true. Union plan groups vary from a low of $631 a month to a high of $832 per month, with an average cost around $756 per month. We compared these groups to the groups that I have studied previously, there is going to be substantially higher rates, almost double to some cases.

In 1965, there were only eight mandated health insurance benefit laws in the United States. Today, there are over 11 hundred and the number is escalating. These range from the trivial, to the serious. In fact, in Minnesota, hairpieces are coming; Georgia, heart transplants. In Illinois, we have in vitro fertilization, which is a multibillion dollar cost to the insurance industry, and passed on to the consumers with more in premiums.

Mandated benefits drive up costs and increase the number of uninsured. It is estimated that mandated benefits account for between 20 to 25 percent of all uninsured Americans. In Illinois alone, mandates have increased costs over 20 percent.

One idea in reducing health care costs is the elimination of exemption of mandated benefits for small businesses. The states and federal governments allow insurers to sell no-frills policies, which would compete in regulated insurance. Small employers and consumers of health care would have the freedom to choose the coverage that best meets their needs.

The health insurance industry has always been in the forefront in reducing health care costs. Programs such as PPOs and HMOs were designed to curb rising health care costs. Administration costs in private sector insurance is substantially less than government-run programs. Compared to Medicare and Medicaid, administration

costs and private sectors is about 66 percent less than what the government spends per dollar of benefits paid.

Electronic claims processing with health care debit card or Internet processing administration, would also help to reduce costs by around five times the amount required over paper claims. Expansion of medical savings accounts and elimination of burdensome regulations can substantially assist individuals and businesses to reduce cost and make coverage more affordable. Countries such as Singapore and South Africa have had great success with MSAs. Since their introduction in 1994, MSA plans in South Africa have captured about half of the private insurance market.

One plan might be ideal for making health care insurance more affordable, which the federal government has begun to seriously consider is a refundable health tax credit. The refundable health tax credit for low to medium income Americans would substantially reduce the number of uninsured, while reducing costs, and allow more small businesses the ability to offer health insurance programs to their employees at affordable rates. Properly designed health tax credits will provide a real solution to the problem of the uninsured America by addressing affordability, than most basic component of access to health care.

In conclusion, there is no doubt that we have the finest health care system in the world. Yet, we are our own worst enemies when it comes to the issue of affordability. Government regulations and mandates continue to be a driving force in rising health care and insurance costs, forcing many individuals and small businesses out of the market. As an advocate of the health insurance plan consumer, the role of the agent or broker is key to the individual and business health care solutions. But they can't do it alone. We need to work together as a team in educating the consumer and exploring sensible reforms to make health care more affordable, predictable and manageable. We need to consider responsible mandate laws, adverse selection, tort reform, and removal of political agendas. We need to work to find ways to encourage more consumers to purchase private sector health insurance. This would expand markets and increase the number of carriers. We need more choice for the consumers. Working together for a common goal, we can make a difference.

Mr. Chairman and Congressman Crane, I want to thank you for allowing me to testify today and share some common sense solutions for reducing the cost of the quality of health care. I look forward to working with you in the future, and look forward to the good work that Congress will do to make health care more affordable for all Americans.

Chairman MANZULLO. Thank you, Scott.

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

Chairman MANZULLO. Our next witness is Brad Close, representing the National Federation of any kind of Businesses. Brad is the manager of Federal Public Policy and he went on to newly greater pastures because—for whom did you work before NFIB? And who set up the hearing in Rockford, that was you, uh?

Mr. CLOSE. Yes, sir.

Chairman MANZULLO. The NIFB's great gain and our great loss, but I guess we trained you right.

Mr. CLOSE. Yes sir, you did.

Chairman MANZULLO. We sure did. And prior to working for my office, Brad worked with Congressman Ewing, and your home is there.

Mr. CLOSE. Yes.

Chairman MANZULLO. At least. So with all of those ties and connections and great credentials, we look forward to your testimony.

STATEMENT OF BRAD CLOSE, NATIONAL FEDERATION OF INDEPENDENT BUSINESSES (NFIB)

Mr. CLOSE. Thank you, Mr. Chairman. Nothing is more important for NFIB members than solving our current health care problems in small businesses. We firmly believe that association health plans and removing the restrictions on medical savings accounts, are necessary steps to create more affordable health care options for small businesses across the country.

As Mary stated earlier, over 60 percent of our uninsured population consists of small business owners, to families and their employees. The high rate of the uninsured in the small business community is due to the lack of available options for small businesses, and an increasingly shrinking small group insurance market.

We know that the smaller the business, the less likely it is to provide health insurance. Our members are the smallest of the small. We have 6,000 members across the country and over 50 percent of them have less than five employees. Sixty percent of businesses that have three to nine employees offer health care benefits. While most large firms are able to offer coverage. Even the best of times, the small business health care plan covers only about 57 percent of the employees in small businesses. Many even go without coverage due to the cost.

In fact, a recent business journal of Jacksonville, Florida article stated that skyrocketing health premiums are leading young professionals to opt out of employer-sponsored health plans, mainly because the monthly premium is no longer affordable to them.

We at NFIB can substantiate that the high cost of health care is the number one problem of small business owners today. NFIB survey shows that 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 have also told us that they believe providing health insurance is the right thing to do for their employees. Right for their employees and right for their business. However, the high cost of health insurance often prevents them from doing this.

Many of our members have experienced double-digit increases over the past few years. 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, in McKenna County experienced nearly a 100 percent increase. On average, a worker in a firm with less than 10 employees pay 17 percent more for health insurance than a worker in a firm with 200 or more employees.

In today's society, when it comes to purchasing health care, the rules of the game are definitely stacked against small business owners. 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. The 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.

Small businesses under today's laws cannot have any of these advantages. Association Health Plan legislation like H.R. 1774, in the House of Representatives, the Small Business Health Fairness Act, levels the playing field by enabling small businesses to purchase their health care like big businesses and union plans through association health plans under ERISA. Association health plans are a private market solution to our nation's health care coverage and cost problems. It builds upon what has been proven to work. If small businesses purchase health care in the same manner and under the same rules as big businesses, premiums would decrease and coverage would increase.

Allowing small business owners to purchase their health care through association health plans will allow them to save on administration costs and bring to the market a great amount of bargaining power with sufficient numbers to absorb risk without substantially increasing premiums.

Small businesses currently must pay the highest marketing billing and claim processing costs. Some pay from 20 to 25 percent of their premiums towards such expenses compared to about 10 percent of the larger employers. The H.R. 1774 would become law, administrative costs would be spread over thousands of members in association health plans instead of just a few workers in a small businesses resulting in significant cost savings. The bill would also allow association health plan to operate without having to comply with the 50 individual state laws on benefits, premiums, and solvency, and the 50 individual state mandates. This would best expand opportunities for small businesses which cannot afford coverage right now. Association Health Plan Bill also requires that the plans put up and maintain capital surpluses before they can be certified and maintain sufficient claim preserves, stop loss insurance, and indemnification insurance to guarantee the claims will be paid even in the event the financial difficulty for plan termination.

The bill also gives clear and strong regulatory authority to ensure that the Department of Labor and partnership of state regulators are able to ensure that Association Health Plans will meet the very strong certification reserve departments that the legislation provides for them.

We strongly believe that if Association Health Plans become law, our health care system will be fair and more choices will be available to small business owners, which is what we think is the ultimate solution. More choices for small business owners, free market choices, and we urge the committee to assist in moving the Association Health Plan legislation to the President's desk issue. Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you, Brad.

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

Chairman MANZULLO. Our next witness is Ken Koehler. Ken is the, I guess the CEO, President, probably both, Chairman of the

Board, of Flowerwood, Incorporated. And a very popular nursery, flower store, all kinds of equipment for gardens and lawns. We used to have those trains, LGD trains. You don't sell those anymore, but I like your type of trains.

Mr. KOEHLER. I still love trains.

Chairman MANZULLO. You still love trains. I look forward to your testimony.

STATEMENT OF KEN KOEHLER, FLOWERWOOD, INCORPORATED

Mr. KOEHLER. Thank you, Chairman Manzullo, and also Representative Crane, for giving me the opportunity to address you today with a subject that I really feel needs serious attention, and that being, affordable health care.

My name, as you stated, is Ken Koehler. I am president and co-owner of Flowerwood, here in Crystal Lake. Flowerwood is a family owned and operated florist, nursery, garden center, wholesale greenhouse, that has served McHenry County and its surrounding communities since 1948. Since our beginning with four employees, Flowerwood has grown to its present staff which is—ranges in size from 75 to 100 full- and part-time employees, as well as many seasonal employees.

We have many ethnic—different ethnic groups that are represented by the employees that we have and very many different educational backgrounds. Our employees range from ages of 16 years old starting out on their first job, to many retirees that are supplementing their income with part-time employment, and we have wages ranging from about $5,000 a year up to $75,000 a year.

Our work force includes retail clerks, floral designers, landscape designers, installers, horticultural growers, mechanics, delivery drivers and office personnel. And most of our management team we are proud to say has been with us from over 10 to 35 years, and are proud to be in service with our company.

We value these employees, and we have tried to offer comprehensive benefit packages, which include health coverage, life insurance, 401(k) plans, Cafeteria Section 125 plan. The benefits are offered to all full-time employees and currently we have 20 that have elected to be part of our health benefits package.

Flowerwood has felt health insurance coverage for its employees to be very important, it is a safeguard to their every day lives and their families' security. In the early years, Flowerwood was able to fund most of the cost of the insurance, thus minimally impacting the employees out-of-pocket exposure. Today, that has changed dramatically with the company covering 40 to 45 percent of the cost and the employees bearing with 55 to 60 percent cost.

For most of the years prior to 1998 and '99, the cost increases that we experienced were less than 10 percent, in many cases around five to six percent. For the most part manageable and the impact of both Flowerwood and the employees was moderate. But since then, increases have become double digit, and now have put our health insurance program in a crisis. In the years 1999 to 2000, we were faced with a whole 20 percent increase. At that time, we made a major change in the plan, and began to offer

choices between HMO and PPO, and at this time greatly changed the deductibles.

This change and increases in the deductibles kept the increase to about 13 percent, rather than 20 percent increase. In the year 2000 to 2001, we experienced a 17 percent increase, and in the years 2001 to 2002, was a 18 percent increase. And then just this July, for the years 2002 to 2003, we had the pleasure of experiencing in the 43 percent increase.

Since 1999, our per employee health care coverage has increased between 85 to a hundred percent, and I provided a table to show you the differences in the single and family coverage on the PPO and HMO. We are still trying to evaluate other options, but the bottom line is these cost increases significantly impacted both Flowerwood and our employees.

The pay increase that we were able to give our employees in May has been completely eroded by the increased rates in weekly insurance. And in many cases, the increases and costs double what they made in increased wages. We are concerned that these huge increases will lead to our—to help fund some of the employees' health cost, as well as total lack of ability for any of them to find their own affordable health insurance.

We realize that there are many small businesses, such as ourselves, facing the same crisis. We have heard some of that here today. I hope that some affordable options become available soon. I have heard some good suggestions here. We are at the breaking point with our margins and our business is shrinking every day, like every other retailer and restaurant, entrepreneurs facing. And then when we have these unpredictable and controllable costs putting us against the wall, I don't know where it is going to end up. Mr. Chairman, thank you for the opportunity to share our company's experience with you and address the members of your committee. I hope that there are some good solid solutions to employee-based health care on the horizon. There is no easy—this is no easy task, and I commend you and the committee for your diligent work on this very important issue. And I thank you again for the opportunity.

Chairman MANZULLO. Thank you very much, Ken.

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

Chairman MANZULLO. Our next witness is Brad Buxton. Brad is the vice president of Networks and Management of Blue Cross and Blue Shield of Illinois, and Brad, tough job. We all have tough jobs, it is very difficult, I mean to use the word Medical Management, okay. Just like calling the House of Representatives, but we look forward to your testimony.

STATEMENT OF BRAD BUXTON, VICE PRESIDENT OF NETWORKS AND MEDICAL MANAGEMENT, BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Mr. BUXTON. Thank you very much. I'm not even popular at that home. My name is Brad Buxton, and I am vice president of Health Care Management for Blue Cross and Blue Shield of Chicago. And thank you, Congressman Crane and Congressman Manzullo, for inviting us today.

Blue Cross and Blue Shield of Illinois's mission is to try to provide its members with quality and affordable accessible health care in Illinois. And we do insure about one in four Illinoisans, and we worked very hard over the years to try to put together programs where we actually pooled for as many small businesses as we can. Both are HMO and PPO, to try to keep the cost down, as low as two members per group.

It is a very challenging and daunting task, as you know, because mandated benefits, as it has been mentioned here before today, have grown from eight, back 10 or 12 years ago, to now over a thousand mandated benefits. So, it is very hard, even when you are dealing with small groups in any pool, to try to do things to drain the cost down to the small group employer, that you have to add the mandates.

So, in our programs, in our HMO and PPO, we've added high—low-cost, high-deductible alternative plans. Our small groups get the same deals that our large groups get, so we try to keep them on the same playing field, and at the same time, we worked very hard in the last six years, we have actually lowered our administrative costs, that passed on from the mid-20 percent, to under 10 percent. So, we are working very hard.

But in any business, there are many things that are going to challenge you. When you look at health care, and when you look at, let's say the ideology, what we try to do, is we always try to get to the, where the problems really come from. What is really driving the cost. Why are we sitting here today talking about what legislation we need to pass for small employers? And when it comes down to it, we really get down to the cost issue. And the cost issue is great. Just a few years ago, and the law we passed, the Patient Protection Act, and while the meaning of it was very, very good, one of the things it said was, "Insurers will pay all emergency room charges, no matter what." And that means no matter whether they were emergency or not. That cost our HMO $57 million a year. Those costs had to be then passed on. And I will tell you that increase in 57 million, were not all emergency room procedures.

We do have one of the best health care systems in the world. But there are problems with it and there are issues with it. And what we have to do is figure out how we balance what we fixed in controlling the cost, to ensure that the accessibility is still there. And the quality is there. Today, it is a part of our economy. If you look at where our health care system is today, and what it has, to the local economies, it's incredible. So, if we don't do the right things, and we end up hurting the employers of people that, whether it would be health insurance, hospitals, physicians groups, et cetera, they are going to hurt multiple economies. So what do we do? We have to be very careful, and we have to get the costs that are affordable, yet, at the same time, not cut down on advances that are going to make people live longer and be healthier, and more productive in their life.

So, what we know today, is that when the medical costs are going up, they are going at a higher rate than a CPI. And they are going up on higher rate premiums, and actually the medical index is going up. Why is that? What is happening and what is one of the reasons for that? Well, one of the main reasons, and we talked

about it today, is drugs. I brought a list, a little bit of information here, which isn't in my presentation, that is written down, but our drug costs, in all lines of business went up from $463 million in 1999 to $701 million in 2001. And the average cost of a brand drug was $77 to $78 and the average cost of a generic similar was $15. That's an incredible difference, yet we don't have—we don't have a lot of businesses adapting plans that will force, or at least in generics.

But we go into three-tier types of programs to drive formally, there are a lot of things that stand in the way of having businesses go to that, and that's problematic. Three comparisons, you take Prilosec, the brand drug, versus a generic, Zantac, $153 versus $21. I can go down a long list of that. You talk about drugs are now turning at over 20 percent per year, whereas, regular hospital cost inflation is somewhere probably around four to five, but lower.

If you go back in time, and you look at health care costs back in the 1980s, we had an average length of stay of eight days. Average days per thousand are close to 900. Out-patient visits per thousand are somewhere in the mid-300s. Doctor's visits thousands were around 850.

Today, average length of stay is less than four days, and admissions per thousand are down to about 220; doctor visits are still around about 850 to 900; and out-patient is now somewhere close to 800 visits per thousand. So, when you start to look at where the costs are growing, you look at that as one of the issues, and cost continues to escalate there and most insurance companies don't have contracts which control the unit cost inflation here.

You look at—now, you go to and you look at what's happening with malpractice reform, nothing. Today, it's not only doctors, some doctors are leaving communities. And, actually, I know a doctor who is traveling from New York City to West Virginia to practice, because he is getting a better health insurance rate. He can't afford malpractice in New York. You can't afford it sometimes in Chicago. They are moving to other places, there is good and bad in that, by the way. But, that's a real problem. We have no protection for that. Health insurance companies today will offer managed care products which are now being told by their carriers that they may not carry them anymore.

We are not talking about a cost issue here, we are talking about the fact that the liability of insurers who has a HMO or point of service program may not be allowed to have coverage anymore. That's a huge problem, that's a cost problem that won't go away, we need some reform there.

Other types of things that we have seen that have come out, last year the Illinois legislature, a bill which was called the Fairness and Contracting Bill came out. That bill would have added, by the state's calculations, to the state program itself, the State of Illinois employees, almost $500 million. Blue Cross and Shield by our own calculations, by our actuaries, there are no actuaries, you know, it was very precise, thought it would cost us over $1 billion that we would have to pass on to our members, and this bill, I won't go through all of the particulars of it, is not just a bill, it is inherently a problem in Illinois. Just go look at other state legislatures, and what they are doing in anti-management care legislation. In 1999,

stated in the last person's presentation is when things went haywire. That's when anti-managed care legislation started to come in. You look at the biggest bumps in health care over time, and that care was one of them, and then when we went to payments in Medicare, and there were bumps that actually leveled out the cost of care for some time. Managed care, when it came in, to the eighties, to the late nineties, actually was leveling out the cost of care, anti-managed care legislation came in, and it went by the border.

So, we need to do a few things to take care of that, we need to look at reimbursement, we need to reimburse for health outcomes, not just generally reimburse based on what you paid in the past, we really need to figure out how we reimburse in a way that pays for care, that's quality, just like we do in our products. Thank you very much, and I appreciate your time.

Chairman MANZULLO. Thank you very much.

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

Chairman MANZULLO. You know, that's a story. Brad, the scenario that you painted, that society of the insurance company, that story is where we are really at now. The cost of health—the cost of liability insurance for health insurance providers, it is very interesting. Uhm, the next witness is Isabelle—Isabella; is that right, Isabella?

Ms. WILSON. Correct.

Chairman MANZULLO. Isabella Wilson, chief financial officer of Illinois Blower, Incorporated and out of Cary. In fact, I think that I visited your facility.

Ms. WILSON. On Industrial Drive?

Chairman MANZULLO. Yes. In Cary, with a group of other companies, and, is that correct?

Ms. WILSON. In our building we have one.

Chairman MANZULLO. Okay. Were there other shops that are nearby in that area?

Ms. WILSON. Yeah, it is an industrial area.

Chairman MANZULLO. Right. And, I think we visited that part two years ago, and now that you are here, we look forward to your testimony.

STATEMENT OF ISABELLA WILSON, CHIEF FINANCIAL OFFICER OF ILLINOIS BLOWER, INCORPORATED

Ms. WILSON. Thank you. Chairman Manzullo, Congressman Crane, I appreciate the opportunity to testify before you and this committee on such an important matter. And as you stated, my name is Isabella Wilson, and I am the chief financial officer of Illinois Blower. Which is a small, privately held manufacturer of industrial fans located in Cary. Right now, we are at about 56 employees. The rising cost of health care has several implications for a company the size of Illinois Blower and its employees.

Chairman MANZULLO. Isabella, can you pull that mike a little bit closer to you? Thank you.

Ms. WILSON. Direct and monetary costs are only part of the story. Overall, our cost for employees has increased by 56 percent from 1999 to 2000; 30 percent from 2000 to 2001 and we did manage to contain it to 13 percent to 2001 to 2002. To contain last

year's increase to only 13 percent, our employees did have to make some sacrifices. Out-of-pocket prescription drug costs increased 750 percent for our employees.

Many, in fact, had to switch doctors. In the last four out of five years, we had to switch carriers to contain our costs. Which has an impact on the quality of care, and greatly increases the company's administrative burdens and costs. Our new HMO plan is extremely limited to participation in McHenry County, forcing employees to either travel 30-plus miles to a participating hospital and doctor, or to absorb the increased cost of PPO coverage, which many just can't afford.

Financially, the impact of the company is extensive. Average gross margins in our industry are only 30 percent. Which means that for every dollar increase in health care costs, we have to increase sales by $3.31 to cover the additional costs. Over the past several years we have been very lucky. Our business is tied to the power generation industry, and we have enjoyed the boom in the creation of electrical power generation capacity since 1998.

Unfortunately, that industry has taken a severe hit since September 11th, and the collapse of Enron. As the company faces more difficult times, managing health care costs is both imperative and increasingly difficult. If the economic downturn continues, and we are forced to reduce our work force, the options available to us from the number of insurance companies who write policies for groups our size, and the number of plan designs available decrease.

Unfortunately, we are also seeing dramatic increases in all areas of our business insurance. With this year, renewal increased in our cost by seven percent, these dramatic increases and non-productive costs will have a direct impact on Illinois Blower's ability to compete in today's global marketplace.

These rising costs directly impact our ability to afford, implement capital projects, which would allow us to improve and speed up our production process. This directly affects our ability to compete with companies located in less developed countries where labor costs are significantly lower.

In summation, rising health care costs not only directly impact the company's bottom line, it can also negatively affect employee morale and less productivity; reduce employee's quality of life and medical care, and lead to a decrease, and employee's consumer spending as they have a shift in income, to cover the ever increasing out-of-pocket costs, also impacting the overall economy.

Finally, I really want to reiterate the plans that impact rising health care costs, have a major impact on our ability to compete in today's global marketplace. As an example, we are currently faced with our largest customer moving 37 percent of what was historically a product we produced for them to Chinese manufacturing companies in 2003. Our customers are looking for greater cost savings than we are able to provide, as our cost structure is continually being hit by the rising costs of such non-productive expenses as health insurance premiums.

Again, thank you for the opportunity for me to testify before this committee on this important matter. Thank you.

Chairman MANZULLO. Thank you, Isabella.

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

Chairman MANZULLO. Our last witness is with the Illinois State Medical Society, I'm sorry, is representing the Illinois State Medical Society and, Dr. Jim, is it Milam? Milam is an OB/GYN from Libertyville. But you won't be testifying about what we were hearing a minute ago.

Dr. MILAM. No. Sometimes clinical care has to take precedent over——

Chairman MANZULLO. Is that right, you take care of patients.

Dr. MILAM. I'm in the office this afternoon.

Chairman MANZULLO. So, we only need you for one half, and I'm sure you know something about the way the cost increased in medical malpractice insurance, Doctor, and we look forward to your testimony.

STATEMENT OF JAMES L. MILAM, M.D., ILLINOIS STATE MEDICAL SOCIETY

Dr. MILAM. Thank you, Mr. Chairman. It is exactly five minutes after 12, so good afternoon Mr. Chairman, and Mr. Crane. As stated, my name is James L. Milam, M.D.; I am an OB/GYN in solo practice in Libertyville. I currently serve as the First District Trustee to the Illinois State Medical Society. I represent the Lake County, McHenry County and Kane County. On behalf of our 14,000 physicians, medical student members, I appreciate having the opportunity to testify.

I am pleased to present a medical perspective on the rising cost of health care. This is an extremely complex problem, but I hope I can provide some insight into the problems we face.

National health spending shot up 6.9 percent to $1.3 trillion in 2000. Health care now accounts for 13.2 percent of the nation's total economic output, up to 12 percent a decade ago. Clearly, many factors are contributing to this unprecedented rise. One of the most pressing, is medical malpractice insurance rates. Insurance premiums are soaring in the highest rates since the mid-1980s. Also, alarming is the high number of insures that have left the medical liability market. Many physicians are forced to limit service, retire early, or move to other states where premiums are more stable. It is not unrealistic to ask the question, "Will my doctor be there?"

Many states have been categorized as seriously threatened. And, I am sure you have seen the list in the newspaper. In Illinois, the crisis is looming. The primary cause is the unrestrained escalation in jury awards that are part of a legal system that, in many states, is simply out of control. The average jury award goes to $3.49 million in 1999, up from 1.95 million in 1993.

The soaring cost of malpractice premiums drive up the cost of health care which encompasses everyone, especially small business owners. The other cost is a loss of service to patients. Emergency departments are losing staff and scaling back on many services including trauma units. Many OB/GYNs and family physicians have stopped delivering babies, and neurosurgery is being postponed, because surgeons cannot find or afford insurance.

The critical rise in malpractice premiums, medical costs are rising in another way. Physicians are practicing more defensive medi-

cine, where ordering extra tests and choosing procedures that limit their risks.

There has been an explosion in the cost of prescription drugs. Medicare, managed care, and many private insurers have cut drug benefits in the last several years. The average senior now spends $500 annually for medications. In addition, government regulation from CMS, one of the HCFA and EMTALA and COBRA, just to name a few, are burying physicians in paperwork and documentation. It tends to follow this regulation and are often at the risk of prosecution, fines and imprisonment. Soon we will have to face the daunting HIPAA statutes.

There is a shortage of well-trained nurses, as you know, and many medical students, to say many applicants are not applying to medical school, because there is a huge debt, declining income and loss of respect. Without a doubt, it is clear that legislative action is taken immediately to address the soaring costs that limit services and that passed on to many, including our small business owners.

In order to effectively stabilize medical liability insurance rates, while continuing to ensure that patients who have been injured are fairly compensated, I believe Congress must pass fair and reasonable reforms to our medical liability litigation system, that such as the ones that have been proven effective in other states.

Currently H.R. 4600, the Health Act of 2002, as well as with benefit patients, by awarding injured patients unlimited economic damages yet cap non-economic damages up to $250,000. This would also address a fair share rule that allocates damage awards fairly and in proportion to a party's degree of fault. These reforms are necessary and urgently needed.

Earlier this summer, the House passed a Medicare bill which the Senate, however, did not pass. To me this is very disheartening. Speaking as a physician, I can tell you that we all just want to treat our patients and deliver the highest of care. However, in the current environment, this is becoming difficult, and in some cases impossible. Many physician practices, including my own, are counted among the ranks for small businesses. If we work together keeping the patient as the focus, I am confident we can find a solution to the problem. Thank you for your time and attention.

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

Chairman MANZULLO. Thank you very much, Doctor, for the really quality testimony. What a range of opinions and backgrounds. I've got a—I've got many questions, I'm just going to take one at a time and we will rotate between the two of us, Mr. Buxton, you talked about a couple of things, and one is reimportation of drugs, and I think Blue Cross/Blue Shield is in favor of Congressman Emerson's bill; is that correct?

Mr. BUXTON. That's correct.

Chairman MANZULLO. Could you explain to the folks exactly—I'm an original co-sponsor on that bill. And could you explain to the folks how that works?

Mr. BUXTON. Not exactly. No, I can't. Uhm, actually, I am not as familiar with the bill. I know we are in favor of it, and unfortunately what I can tell you about the whole situation is the fact that, you know, the grand situation has gotten to a point, where

because of the patent abuses, that we are seeing—where the drug goes off patent, and then they put it back on under a new name, has become to be unbearable in terms of the cost. Uhm, we have seen the—actually, the pharmaceutical companies are now beginning to control the generics. And when you talk about the reimportation, the ideas that you can get these drugs for less in another country, because they don't have the same patent cost on them, and they sell them actually cheaper out there. And the idea with the legislation, is that we would be able to get those drugs at the same rate. I am not sure exactly how that works. But to be quite frank, if we could increase the use of generics, and the incentive to use generics, we really wouldn't need the whole reimportation issue. And so, if we were able to actually put some regulations on the use of generics and incentives, I think we would actually be able to bring down cost. As you can see, there is a $60 difference between brand and similar generic.

Chairman MANZULLO. So, you are talking about the—let's see, Waxman——

Mr. BUXTON. I'm looking at Mr. Keye for a little help.

Chairman MANZULLO. Hatch. Hatch-Waxman, that was the past 20 years ago, the law was passed 20 years ago, and its purpose was to speed up of the issuance of generic drugs, but something has gone haywire with that bill.

Mr. BUXTON. Right. Like, for instance, Prilosec is getting ready to go off brand. When Prilosec goes off brand, it would become a generic. Generic would take it over, or maybe multiple generics, and sell it as a generic at probably $60 less. What happened is that the pharmaceutical company made—Gateway came out with Nexium. Nexium is the same thing as Prilosec. They are selling it more than Prilosec, and what they are doing is they are gaining market share, very fast, and what they will do then is they will control the generic Prilosec by ideally, maybe the company that will do the generic. So, they are officially keeping the rate high, and you still continue to pay for a patent which, as part of the cost has been taken care of years passed. So the whole patent, I think—we think the whole patent law should be looked at in terms of, when a drug really needs to go off patent, in terms of have they recovered the cost of inventing that drug. That is something that is very important and really has never been looked at.

Chairman MANZULLO. Well, once it was when the prescription drug bill came before the House, there were three provisions in there, one being the reimportation, the other being, and making sure that everybody that provided an area that show drugs can really get at the same original discount. And the third one dealt with generic reform. And none of those were a volume plan bill. So, that's why any bill that comes through the House, really gets to address those issues. But what is it that's causing this spike in the cost of drugs? In the last two years—I really can't——

Mr. BUXTON. I think the doctor—I couldn't be able to answer that, but I really believe over-the-counter advertising, you know, has some direct consumer, and that's how they do it.

Dr. MILAM. That's exactly correct. This schizophrenia economy, if you will, because we all know drug companies stock on 401(k)s and we want them to make a profit. But, yet, we want the drug costs

down. So when a company brings a drug to market, it may cost $20 million as an average to bring the drug to market, because there may be three or four drugs of Zantac, so the company is trying to reduce the cost, and then obviously doing a patent, so another company who didn't sell it might be able to sell that drug for cheaper, and manufacture it more cheaply. Also, you might have colors, there might be a difference between a white pill and an orange pill. But the theory is that we also—they have liability. The companies have lawyers that have to look at all their liability for adverse outcomes and side effects and things like that. So the notion is that it can be sold in Canada cheaper, because there isn't the same liability laws up there, and so many patients can go across the boarder, and liability isn't the same.

Chairman MANZULLO. Like prices on the Internet?

Dr. MILAM. Yes. And then bring them back over here, and I'm not certain in the drug industry, so I don't understand totally, but it—as far as how much it costs to bring the drug to market and other significant research——

Chairman MANZULLO. It's about $100 million now. Mr. Buxton——

Dr. MILAM. One more thing, another thing that is problematic is rebates. And we have PPMs that basically are——

Chairman MANZULLO. Explain what distribution is today.

Mr. BUXTON. As if an insurance company has a covenant, or a PBM, a Pharmaceutical Benefits Management Company, manages a drug coverage for you. Okay, they have a formula, and on that formula there are brand and generic drugs. Every time one of those brand drugs are sold, the PPM has a deal with the pharmaceutical company, to get in a sense, a payment for that. Some people might call it a kickback, but it is called a rebate. That rebate then, the higher—the more people that use that drug, the more the rebate is. Now what insurance companies do, who use PPM to do their own, some of them may do their own rebate, they take that and pass it back, all of or some, to the customer. When it goes through a PPM, the PPM will take back a piece of that rebate and give it to the insurance company, who will give back some of it to the customer, or none of it, and put it back into the price, and there are different ways to do that. The problem is, rebates are inflationary. If I am paying you a dollar for every time you sell Nexium, let's say. Well, you want to sell a lot of Nexium. Okay. And it may not net out to the bottom line to the customer in the long run because some of those rebates are withheld. So, quite frankly, I think there needs to be rebate reform, if we are going to get to the bottom line, cost of the drug, to get it back to the individual.

Chairman MANZULLO. In the State of Illinois under the Circuit Breaker Plan that is provided for seniors, that rebate goes to the State of Illinois and the PBM acts in the purist capacity, maybe that's not correct—well, it is, the purist capacity to negotiate the lowest price and the savings are passed on ultimately to the consumer.

Mr. BUXTON. Right, that is the whole rebate, and there are other things like information that is sold on, what doctors prescribe what drugs, and do they get a rebate for that. So, there are a number of hidden rebates that don't come back to the state or anybody else.

And rebates still, even though the state gets the net amount, it is still inflationary practice, because you are sending people to more popular brands and not move to generics.

Chairman MANZULLO. Congressman Crane.

Mr. CRANE. Thank you, Don. And thank you all for your testimony and being here today. You know, this is a very important subject, and it's one that—we had a town meeting yesterday, and the day before, and many of these issues came up at our town meeting. I pointed out that to the folks last night that one of the ways you get around this is to make sure that you have one of your kids get a medical degree. With all kidding aside. My dad got a medical degree, and we never thought about health care, that's what your father was for. And before he got his medical degree, though, my mother went into labor and the OB was out of town that weekend, and so we put papers on the bed and boiled water, and the dog came in and sat on the floor watching, and I said to my father afterwards, "Weren't you a little unnerved about delivering me?" He said, "No, I delivered pigs and cows at the farm, it was no big deal." And—but, the fact is that he had his medical degree then, and he purposely delivered my sister and my two kid brothers at home. And we always relied on him for everything, and he produced—well, one of my brothers is a physician, and I had a nephew who is a neurosurgeon down in Downers Grove. And having members of the family that went down that path gives you comfort, as well as an emergency you get a hold of a dentist, no big deal.

But it is something that is a big deal, and you folks have all touched upon component parts of it that is a big deal facing our country today, and potentially impacting in a negative way, if we don't take some action here. So many millions of Americans—Mr. Brauns, in your testimony you dedicated a significant portion of your discussion to the power of consumerism in the free market. Given the employer-provided health care structure that the majority of these people seem to rely on, how do you propose that we begin to change the current practice, and move toward a health care market geared toward individual consumer?

Mr. BRAUNS. Thank you for the question. Uhm, I think first of all, it starts with understanding. I think we have to understand that all of us in the industry, the employers, the brokers, the physicians, the government. In fact, there is tremendous power in consumerism to begin with. Once we can get people to understand that we can take the patient, inject that patient back into the process so that when he confers—that he or she confers with their doctor, there is only a 800 number that has to be called. There is no supervising authority that has to say, "Yes, Doctor, please go ahead and do that, or don't go ahead and do that." And the way you do that is by allowing people to generate some fund of funding that they call their own.

In this country we've evolved into this medical savings account, and what I am talking about is the next evolution. And the IRS ruling that came out on the 26th, has had the ruling, has had tremendous impact in the industry already. And as I have said since then, our last—we had 50 employers that have already gone to implement something like this. So communication has to be part of

it. Things like this, but we also do call on government to? To include this in your letter, to include this in your potential solutions, and I certainly do not diminish any of the solutions that have been talked about here today, like tort reform, or association health plans, and so forth. They are controversial, I think we would have been back. But if we could find a solution that would move those or at least make them as compared to what consumers can do. We can be interested in pursuing it, and in the consumer's philosophy has that potential power. For decades, we—I shouldn't say decades. But in the late eighties, we saw what 401(k) did to the retirement market. When people got their own that they control, it vastly changed the way we used to reflect its tool, saving pension, and government. That same concept could happen here. So the IRS read the ruling now and it also makes it still very complicated. But what would be great is that government would include this in its revenue and say to perhaps House Ways and Means of the way of this, in the respect that let the money that accumulate in those funds be used by the consumer for his or her own purpose. If he wants to take that money at the end of the year and buy a fishing pole with it, then he could do it. Currently it is restricted to just health care type expenses, as we see outlined in previous bills like 125 and 105, and so forth.

But financial engagement, and by the way, consumers want this. They are clamored for it. We have not seen an employer yet that hasn't said send us more information on this. Large employers for a long time have been talking about the—defining contribution health. How can we do it? It is kind of a Holy Grail, but we haven't really been able to—the system isn't quite there yet. That's probably the last step on the journey. But we are moving in that particular direction. So, directly to answer your questions, getting information out, letting government say, Hey, we have recognized the power of this, and we want to get that information out, crafting rulings like the recent medical ruling, and expanding upon that, so that consumers can use that money as they see fit. That's what—to answer some of the things that came up here at the end of the table. You know, most consumers have no idea what drugs costs. They get their EOB, their special Benefits, say, $10, $50. They have no idea that it was a $80 or $100 bill. But if all of a sudden that 80 or 100 bucks comes out of their fund of money, they are very interested in whether they are going to take Claritin or Clarinex. One way or another, one is off brand, whether its generic or whether it's not. Because if they can take that money and go to dinner with it, or buy a fishing pole, or whether it's for the tires, or the living room. Really engaged, the last time I will ask you this, if I gave you $1,000, Congressman, handed it to you today, and said, "It's yours, do with it what you will." You would love me, you would be very happy with that. But if I gave you $1,000 and said, "Congressman, you can only use this for automobile repair." Okay, you're happy, but it doesn't have the same effect. So the revenue ruling is going in the right direction, but it's not quite there yet to really empower this thing.

Chairman MANZULLO. You haven't seen my car; a 1994 Buick Estate Wagon. A hundred thousand miles. But if you had two teenage boys driving, you wouldn't want five thousand pounds of steel

wrapped around them. So they have to drive that tank. And you made your point, but a lot of safety on that. Uhm, Ken, you mentioned in your previous, about 46 percent last year?

Mr. KOEHLER. An increase in 43 percent.

Chairman MANZULLO. Forty-three percent. Can you put the mike a little closer?

Mr. KOEHLER. Oh, sorry.

Chairman MANZULLO. Was there a reason for that? Was there an illness of one of the employees?

Mr. KOEHLER. We have had some illness within the group, so it did increase. But we experienced the same thing at the county this year, and, you know, I am a county board member, and our rates were going to increase to 37 percent, and we were able to negotiate them down to 31 percent. So, I mean, there are dramatic increases that have taken place throughout the entire industry.

Dr. MILAM. I also had the privilege, for over several years as serving on one of the boards for one of the major hospital groups in the northwestern part of this area in the State of Illinois. And some of the things that we found there, obviously tort reforms make it. This is critical. If there isn't something done about that. There is no control as far as the cost of hospitals and commissions are going to be great. And see, we are going to lose people, just good people that don't want to practice anymore because they just can't afford it. I think that is important. The other thing that we found from a hospital perspective is the fact that there are a lot of costs that are never paid back in the form of Medicaid and Medicare. And the hospitals have to absorb those costs, but of course who ends up paying for it, it's every other patient, certainly the patients that are covered by insurance, are impacted with that and it is passed on to insurance companies, but is also passed on major to the people that just don't have any insurance at all, but the people who take full bulk. And then in the past, probably three years, one of the more interesting dilemmas that have come into the health care really just begins to scratch the surface as far as health care costs, and that's called agency providers for nursing. And we've seen the cost go up, I mean incrementally, it's astounding, and it has taken a hospital to run efficiently, and in one year turn around running in the red, and putting them in jeopardy of being able to deliver good health care. And I don't know what the answer to that one is, because I mean it is a fact of life, that over the years, nurses were not paid very well for the type of work and the hours that they put in, and they realize that and then somebody that was very cute came up with the idea that, well, come and work for us as an agency nurse, and we will get you the better money, and the price went up from—and to use an example, maybe $20 an hour to $60 an hour overnight, because these people could get better jobs, better pay, uhm, by just working through an agency, and this is epidemic. And you talk about major cost is incredible.

Chairman MANZULLO. Doctor. Thank you, Mr. Chairman——

Mr. BUXTON. And I have a couple of comments, I want to be clear, I would like my testimony to reflect the fact that I am not interested, we are not interested in reforming the tort concept. If someone is injured, they should be made whole again. It is just af-

fecting the liability issue, and the cost involved, and frankly what has happened with nurses, in nursing schools, in the old days if you were a female you went to nursing school. Now if you are a female you can go to medical school. So why should you necessarily become a nurse, when you can become a doctor. That being said, we have also gone to the extreme of consumerism, if you will, we now have free agent nurses. Baseball players can be free agents and go to team to team, nurses are either finding that there is not necessarily they are instituted——

Chairman MANZULLO. That is a serious problem.

Mr. BUXTON. Yeah, there is a 120,000 right now, and projected to be about a quarter of a million by 2024. Most of it is the lack of respect, long hours, and the work force is not here, because the people who go into medicine or health care do it because they have an inner drive. They want to do it. Now, they can become a business, then they are getting paid just as any other business, so why should they work nights and weekends, and be exposed to bodily fluids and potentially come down with hepatitis or HIV when they can make the same amount of money in the business world, unless they really want to do it, in which case——

Chairman MANZULLO. But that is the consumerism.

Mr. BUXTON. Yes. Also, the fact that——

Chairman MANZULLO. And I might add, please, we are all in this together, so what I want to know—well, no, what I mean is, we have to have the nurses or the doctors are affected.

Mr. BUXTON. But we have shifting cost for so many years from one person to another person, as a society that's what insurance is. Shifting the cost. If I don't have a claim, I'm paying for the person who is sick, and, frankly, most people cannot afford out-of-pocket medical care. I could not go pay for a gallbladder surgery in the next week or long-term institutional care for my folks, next month or something. So I suppose part of what I think we should come to grips with is the fact that, as a society, we need to decide how much we are going to spend on our health care. We know how much a burger is worth, we know how much a gallon of gas is worth, and we know how much we are ready to go pay for a Cubs ticket, but how much do we want to pay for our health care. And we have to come to grips with that notion.

Chairman MANZULLO. Well, you threw in the Cubs analogy, but I won't touch that. Scott, on tort reform we might want to look at structures. So much in the state of Nebraska, which has probably the lowest malpractice and medical insurance rates in the nation. In Nebraska, they sent punitive damages to the state educational system instead of a plan. Now, after all, no plaintiff has the real right to penalty judgments—they have a real right that penalty judgments, actual damages—in fact, no plaintiff has a right to penalty judgments, but they do have a right to actual damages, pain and suffering and legal costs. But punitive judgments really don't serve the purpose, except for enriching the plaintiff's pocket. And why do we need to give the plaintiffs a motive to sue insurance companies, or doctors or hospitals? You know, it's a big thing. We can make $93 million if we sue the doctor, who, on a 77-year-old man who had eye surgery and they did it wrong.

Mr. SHALEK. In the state of Illinois, are punitives a consideration of medical malpractice?

Mr. BUXTON. I think so.

Dr. MILAM. What's the question?

Chairman MANZULLO. Are punitive damages——

Mr. BUXTON. A consideration of malpractice?

Chairman MANZULLO. I don't think they are in the State of Illinois, are they? Do you know of any awards of punitive damages in Illinois?

Mr. BUXTON. There was a 77-year-old man that received $90-some million——

Chairman MANZULLO. Was that in Illinois, the judgments?

Mr. BUXTON. I know it was a loss.

Chairman MANZULLO. Okay.

Mr. BUXTON. It was finalized, it was reduced down, but still those kind of settlements, all it does, $93 million, who is going to pay for it? Punitive, excuse me. Punitive, we are going out and punishing Exxon for adding this bill in Alaska, but punitive in the sense that the jury is instructed to use their best judgment of what they think.

Chairman MANZULLO. All right, it is covered under pain and suffering.

Mr. BUXTON. Yes.

Chairman MANZULLO. Congressman Crane.

Mr. CRANE. Uh, yes. Mr. Shalek, you have discussed a number of solutions for more affordable health insurance, and I would like to ask you if we were able to help control over utilization of health care services by making consumers more aware of health care costs, do you think that would result in lower utilization and lower costs?

Mr. SHALEK. Education of the consumer is a big factor. Now, if we can see it by what the drug companies are doing on TV, they are educating the consumers to buy brand name drugs. They go to the doctor, they have the symptoms, they see everything else on TV. We need this drug, doctor; the doctor gives them the prescription for it, and lays the cost. The biggest thing is education of consumers, and we need everybody to get involved, agents have tried, doctors tried, but insurance companies direct, what we need is a greater effort, maybe on behalf of the government to get involved in educating the consumer on health care and what the actual costs are and how to do so affordably.

Mr. CRANE. You mentioned that there should be more emphasis on individually purchased health insurance, and, frankly, I am amazed at how many people I have talked to that has stated it is just too complicated to process the work through and they would rather not bother. Can you tell me how we can work to educate consumers to make that less intimidating from their prospective?

Mr. SHALEK. That is probably a role of the agent. But medical savings accounts work, the health tax credit could be a great success story, with the government, people don't understand their health care coverage in a big—in a lot of ways. You talk to most employees, they have no idea they have this benefit. They go to the doctor, they know they got a $10 co-pay, that's it, that's all they care about. They don't understand what everything else costs. How

to access a doctor, how to ask for discounts from the doctor. An example: My chiropractor does not charge me the deductible on insurance. Because he knows after the deductible they are going to pay, that's all he settles for, he is basically paid on assignment from my insurance companies. There are doctors out there that will do that. But people are, like doctors I guess, they don't know how to ask for discounts, like the insurance companies are asking for discounts, they don't understand their benefits. They get this book that is this thick (indicating) and they are not going to read it. So, if we don't go with MSAs and a health tax credit, a refundable health tax credit for all lower income to middle income Americans, we will increase the number of uninsured, people will start understanding their insurance better, because the government is involved with the education process.

Mr. CRANE. When I listen to this, I keep reflecting back on the experience of when I grew up as a kid. I had a great grandmother who was in her 90s and she had cataracts, and so my dad laid her out on the dining room table, and he made us little kids go into the other room, and he had glass doors that had little shades on them, and my older brother and I would climb up on the backs of the chairs and look over and watch, whatnot. And my mother was in there, and an aunt of ours was assisting, as they did surgery on one of her eyes and restored her vision to that one eye.

I mean, it was that whole attitude about any of the needs that you might have in drawing that out, makes the climate we live in today something that is bewildering. Because I still have tendency to think that, you know, I'm going to call all the medical experts in the family if I have a problem and that's no big deal. But it is a big deal. It is a big deal in educating people in understanding what their options are and things to do with and likely important in educating us as to what we can do to help with this. Don.

Chairman MANZULLO. Thank you. You don't operate like that, do you?

Dr. MILAM. Oh, no. Uhm, with regards to what the gentleman's chiropractor does, let me just say that, most of the PPOs and contracts that I belong to and HMO contracts, require that I collect the deductible from the patient. If I don't collect the deductible, they can kick me out of the plan. That being said, in addition with Medicare, we are obligated, because the Medicare fee is already set. That I have to collect a deductible in a co-pay for Medicare patient, or else then I have just changed my rates, so there are contractual, and, in fact, government restrictions to being kind, it's almost like we are in a double bind. We want to be nice to our patients and forget the co-pay, but, in fact, if you forget the co-pay, there are some jurisdictions, where doctors have not charged their friends or there other associates for medical care, and that's been considered kickbacks in some jurisdictions as well. So this is all about the contracts, and we are talking about businesses. It's difficult, and it is still burdensome.

Mr. BUXTON. Just a moment, Representative Crane, one quick fact. Last year, we run our data all the time and look at where our costs are generated from. Twenty percent of our members last year did not generate a claim, twenty percent. Seven percent drove 72 percent of the cost. And most of those were chronic care conditions.

So, when you begin to look at what's driving the cost, chronic care really shows through, especially when you get down to asthma, diabetes and complications of heart and hypertension. Those are the major things. And obesity and smoking are the two greatest causes of health care problems. And if we could solve those two issues, we could cut our health care problem. And that's true. That's not something that is made up. And everybody agrees with that. It is just that it is so hard to make that change and this is why disease management—disease management is going to save money per se. Disease management help people manage their disease better and might save somebody that cost, like an emergency room here and there. But over the course of the disease like diabetes, it is going to be very expensive, and then the most expensive is the last two or three months of life. And that is where we spend the most money. So, when you put things in perspective, your grandfather, your father was right. A lot of people who don't need care, they get care, and the most terrifying thing you can do is get care, and be in a hospital too long, because of hidden infection. And we know for a fact that a lot of people who are coded as dying of pneumonia, aren't dying of pneumonia, they are dying of salmonella, and other bacteria. And that's not even reported to the CDC, because the CDC doesn't require it. So when you talk about medical errors, you got to start to talk about what's going on in terms of how we are going to control these rates with people who are severely ill and in hospitals, and what are we going to do about that. And that's a huge issue. So, anyway, I just thought I would bring this up.

Mr. CRANE. You know, in that context, my dad used to write in a syndicated newspaper company called the "Great Medic" and he was arguing 70 years ago that smoking caused lung cancer, and I never ever smoked in his presence, but I was the only one of his kids that took up that bad habit, and I did it for 50 years. I quit five years ago, cold turkey.

Chairman MANZULLO. Good for you.

Mr. CRANE. But, I have a grandfather who lived to be 98 and grew his own tobacco, and his wife never thought it was—it was that serious. And he made his own beer, and he grew his own tobacco, and he lived to 98 in his peaceful business. But, which is part of the reason why, again, you know our family environment there. You've got emergency Dr. Pop, you know, it's a broken bone, he'll fix it. But at any rate, these are legitimate concerns that I was brought up to be more aware of than I obviously was, or I wouldn't have taken that path of 50 years of Camel cigarettes. Uhm, let me ask a question of you Mr. Buxton, can you comment on whether Blue Cross and Blue Shield are trying to incorporate more emphasis on prevention in order to keep health care costs down?

Mr. BUXTON. Yes, we are actually—most of the products now, are standard benefits, include preventive care, and we feel very strongly that preventive care administered correctly will actually create a healthy new population. So, we have done things most recently in our HMO product where we actually reward physicians to do things in preventive care, whether it be immunizations. But one of the most recent ones was in preventive care for doing mammograms. We found that our physicians and our HMO weren't doing mammograms at the level we felt they should be, or that healthy

2000 dictated they should. So what we did was, we said anytime we find it in the record, we will give you an extra $1,000. And we have done that with mammograms, pap smears, we've done it with diabetic and asthma programs, so when we find that the program, the five-point program to the individuals documented in the medical record, that way we know the individuals know what they are supposed to do to take care of themselves. We give the physician an extra thousand dollars. So the idea is that so the beginning of us getting into the payments for outcomes, because that is a good outcome, you can actually measure it, you see it, it's there in the record and then you pay for it.

The idea is you can tie cost effective care to quality care, but you are paying more for that. And the rationale in looking at doing that within hospitals in terms of beginning to look at as you lower infraction rates, as you lower mortality rates, and those types of things, we are going to actually increase payments to hospitals who do that, because we feel then we get a healthier population, and in a sense they practice better. So I didn't get to that in my little deal today, but we feel that outcome-based reimbursement is one of the keys here. You wouldn't pay to have your car fixed twice for the same thing.

Chairman MANZULLO. I have. You haven't seen my car.

Mr. BUXTON. At the same time, and we think that those types of business principles, we need to begin to get into health care. So, that's a great question, and, yes, we do reimburse extra for good preventive care.

Chairman MANZULLO. There is a bill that was introduced several months ago, there are ten thousand bills a year, to allow an employer, an employer to have a gym on-site with the ability of the employees who come in there, for weight loss, for continuity, for almost anything. But if there is a gym next door, that is a separate business and the employer can't contract with them to provide those services without the benefit being considered to be included as income to the employee. And so that is it in the whole wellness-thinking based upon prevention. That is some of the things that we are trying to do. But, Scott, I want to ask you a question and that is, in terms of innovation, you come up with some pretty interesting scenarios and one of those is on page three of your testimony, you talk about the Injection Molding Company in Woodstock. One of the things that I want the folks here to hear, and maybe you can help Ken in his application, how did you go about saving that company that tremendous amount of money?

Mr. SHALEK. We reviewed their current programs and looked at their costs and I worked for almost every single insurance company selling insurance through the State of Illinois, and make recommendations on looking at an alternative plan that they had most of their people on HMO, some of them PPO; I said, "Look, they were complaining because the HMO was not that well available to people out here," like Illinois Blower has the same problem. I said, "Why don't you go all PPO with a completely different design?" Go with a $1,000 or $2,000 deductible and then the company offers $1,000, the insurance company gets $1,000 to $2,000 or $5,000 deductible, with a 100 percent coverage, thereafter. Including prescriptions, and you also get a prescription discount card up-

front. And when you start comparing the cost, I said, "give your employees all a two-hundred and fifty to $500 deductible, let them understand the cost. What their benefits are. But once they hit this cap of $1,000 to $2,000, everything is paid 100 percent. Lower the costs by about 50 percent." I lowered their costs from $23,000—$24,000 basically, to——

Chairman MANZULLO. Per month?

Mr. SHALEK. Per month. To $14,000 per month. Big, big, difference in cost deductions. And, you know, as was said, seven percent of all claims or 90 percent of all claims come from 70 percent of the people. Well, you get $1,000 or $2,000, after that you are covered 100 percent. We are getting rid of the small claims, let the employer pay the first $500 themselves on the little stuff, let the company self-insured from $500 to a thousand at 70 percent or 90 percent, or whatever percent they want, but the employer's self-insure that. It is going to cost them not that much more money, but the savings they are saving is dramatic.

Chairman MANZULLO. So you were able, through global innovation, to actually lower their health care costs——

Mr. SHALEK. Their costs reduced $112,586.52 a year.

Chairman MANZULLO. And that's for 40——

Mr. SHALEK. Forty-five employees.

Chairman MANZULLO. Ryan, we are going to wind up here pretty soon? You have had similar experiences in your book, isn't that correct?

Mr. BRAUNS. Yeah, definitely. Especially recently, with the consumer concept. And the concept is very similar in a lot of ways to what we have been talking about. Although some of the things, kind of nibbling on the edges. And one of the insurance companies we use is one of the South African companies, and——

Chairman MANZULLO. Is that a South African company?

Mr. BRAUNS. Yeah. And by the way, I think all of the major insurance companies in this country are working on developing consumer-type products. This just has to be one of the first companies that is out of the box with a quality product. And what is interesting about that particular product is that it couples with it a health—a preventive healthy behavior-type of program. The difference is, though, that the compensation for the healthy behavior isn't going to the doctor or the hospital, which is really a good idea, however, the conversation here goes directly back to the person, if the person engages in health behavior, smoking cessation, weight loss, jogging, working in a gym, and the whole list of things, and then they get something for it, they get money or they get airline miles, or they get dinners at a restaurant, and things like that. It sounds a bit hokey, I understand, but if you think about it, that is what we all do. If you say we got a gym on the premises, build a gym on the premises of this business for the concept of lowering health plans, nobody wins. Except for the people who go to the gym anyway, nobody wins. But as soon as they say, "Tell you what, if you don't go, I'm going to take $25 out of your paycheck." That's financial engagement.

Well, I did have a demonstrable and impartial effect on his claims in general. So, many of our cases started to go down to the consumers that we have. We already have seen a reduction, and we

are anticipating a reduction in renewals as well because the shift curves a little bit lower, and the magic of this, if I could use that word, it is kind of expenditure, as that we just heard, many people don't have claims. Many people have small claims. These people will roll money over in their funds, year after year, after year, their funds will grow, because it is much easier for the employer to have them say, I will have a $5,000 deductible plan, I'll have a $10,000 deductible plan, when the bulk of their employees are generating those funds underneath, or it is for the employer to say, "You know what, ladies and gentlemen, with my company, XYZ here, we are eliminating the company dental plan." Under today's scenario they would be wailing a national fee. But if you are able to say, "Look, most of you have a few thousand dollars in your fund, we are going to let you have a voluntary dental plan, and we will even put a little towards that." All the employees are going to be happy as clams that the company has off-loaded some of the liability and made it affixed in that respect. These are the type of solutions that are starting to come out of the free market, primarily driven by this consumerism concept. And it is——

Chairman MANZULLO. So the issue is in Illinois health care. People who buy insurance need to shop more. They need to go to——

Mr. SHALEK. I think it's not shopping, I think they need to become educated more and find out what benefits are available to——

Chairman MANZULLO. What products are out?

Mr. SHALEK. And with destiny, they can even have a week at the Ritz Carlton if they wanted to.

Mr. BRAUNS. There are solutions out there. We all know that there is a price in this, in the employer's respect, we've got lots of clients who are getting 30 to 40 percent increases. You know, you just can't sustain your business in that respect, so short-run stuff is solutions here, and actually are certainly called for. But something systemic, something long run. And there was a study done in California, and I can't recall the name of it, I will put it in my written testimony later, uhm, where a great way was put toward to developing Web-site and so forth, so employers can go to that and find out what tax rates they had coming to them. How does the IRS treat expenses and even a lot of employers, small employers in particularly, rent—they don't know that under 162 of the Code, you can deduct health care expenses of the business expenses. A lot of them aren't aware of that. You would be surprised. So what this study found is that when you made a course of the range of options that are out there, yeah, they lowered their premiums, it increased substantially from what they were, now that doesn't mean that those of us who are taking advantage of that aren't getting much of the same problems, but there are many that could use additional information.

Last point, PPOs, we talked about the rise in cost of health insurance going all the way back to July 1, 1966, Medicare, by the way the Medicare cost shift is killing us, if Congress can do something about that right away in that respect. Costs have continued to rise. We saw an inflection in that curve, an abatement in around the '80s when we started to get managed care come into the picture in earnest. But now we see that the trends, obviously this focus really increased. When everybody has a discount, nobody gets a

discount. PPOs are fundamentally consumers. If you go to doctor A, it costs you less; if you go to doctor B, it costs you more, your choice. But all of a sudden, you cannot find an employer that does not have a PPO arrangement. You can find many employers have two or three PPOs. In Rockford we have three hospitals. All have emergency care centers, all level one trauma centers and so forth, and we have many employers that have all three hospitals in their PPO in that respect. So the PPO concept proved the consumerism will work, but all of a sudden as a potential solution now that the savings have been brought out of that.

Chairman MANZULLO. Doctor.

Dr. MILAM. Thank you. And, Mr. Chairman, that is the last comment that I was going to agree with it. Everything that was just said is accurately said, and it doesn't do anything to control the cost, it just shifts from one party to another party. So shopping around doesn't necessarily lower the rates to the clients, it may lower individual rates or a group rate like the Injection Molding Company, but it still costs X to deliver the care. And we have addressed that so far, and that's what we have to get across or it will—or else we will have to accept the fact that if we don't control this, it is going to go up, so we either have to accept rising costs or accept controlled costs.

Chairman MANZULLO. I appreciate that so much. I want to thank everybody for their testimony. Our Small Business Committee actually had more hearings on health care than I think any other committee has in Congress. We held five hearings on HCFA horror stories of how physicians and medical providers, and are being abused by HCFA's 4,800 employees and 49 different Medicare contractors. We may not be in that situation where there are two Medicare contractors such as in Los Angeles and they have geographical divisions and the MRI indication for a particular virulent ailment, differs depending on which side of the street you lived on. There was a difference in reimbursement rate even though the providers were across the street. After there was a merger with the two providers, so that there was now one provider—reimbursement rates still varied depending on where you lived. This is totally one of the most inefficient systems that has ever been developed by Health Care Finance Administration. Physicians and other health care providers are hammered by provisions that do not make sense.

Let me give you an example on closing on that. We were approached by the portable x-ray providers. My mother was at an assisted living center, when she needed an x-ray, her doctor—she talked to the doctor on the phone, and he would call the portable x-ray people, they would go to the nursing home, in the privacy of her room, they would take the picture, send it over to the radiologist, who is part of that team, and usually within two hours of the phone call that my mom would make to her primary care physician, would know the condition of her lungs. Most seniors, the biggest fear, of course, is pneumonia. But Medicare got reimbursement—reimbursement rates go down so low, that that portable x-ray provider went out of business, and the next time she had to have an x-ray, guess what happens, one of those pair of ambulance units shows up at the nursing home, it is wintertime, she is pushed out there in the wheelchair, lifted up, taken to the emergency room

at the hospital, sits there in a room with people of all types of ailments and diseases, and gets her x-ray taken; four hours later she is transported back to the nursing home. And the amount of reimbursement is that Medicare has to pay for that, that obviously is much higher. Brad, you know what I am talking about.

So we held a hearing, and this was the hearing where we actually had to subpoena in the head of the Health Care Financing Administration and he blew off the subpoena. We were getting ready to have him held in Congressional Contempt of Congress. Finally he showed up, we got the parties, sat down together and said this stupid arbitrary rule not only is a disservice to seniors, that my mother was a victim of that, but also cost a lot more money. No one is leaving the room, bring your toothbrushes and your sleeping bags until we come to a resolution. Well, no one stayed overnight, but the hearing did last three hours, and now there has been a favorable resolution where HCFA has now decided to increase the reimbursement.

But that is the type of stuff we have to deal with on a continuing basis. There is a lady that was here in the audience had a device called the Mary Walker. What this is, it is a device, that is the regular walker as we know it. There is a little seat on it, and the purpose of it, is to encourage seniors to become mobile and they would walk for a period of time, then just get a little bit of a rest, and get back up on that again. Well, because it had an arm that came across and latched across, and actually much more ergonomically correct, because the seat here now places his or her hands in front, with the legs back here, and it spreads out and redistributes the weight much better. But because it had a latch on there, HCFA continues to call it a restraint. Therefore, it is not in the nursing homes, if it is used. We have been working with those people now for several months. And, Doug, I sent you an e-mail, what is it called, the therapy, this is round six now with HCFA. It is everything that we have been working with for the past two years and the Chairman of the Small Business Committee is, going to bring in the decision makers from HCFA and say, now is the time you bring your toothbrush and your sleeping bag, because no one is leaving this room. We are going to lock up until you come to an amicable decision. So we need to talk about HCFA again.

Mr. BUXTON. We are doing the same thing with dialysis right now. Kidney dialysis will become a really bad problem, if it isn't now, in many metropolitan areas, where hospitals have cut down because of the reimbursement, and now the private vendors are charging so much that nobody can afford it.

Chairman MANZULLO. Would you talk to them about that because they don't like me?

Mr. BUXTON. And I heard your reputation, and I'm proud of it.

Chairman MANZULLO. Phil, did you have any closing remarks?

Mr. CRANE. Well, the only concluding remarks that I would like to make is title of the Small Business Access to Health Care field hearing. The importance is small businesses in this country. I am Chairman of the McHenry Subcommittee and we had a hearing out here about five years ago and we got Charlie Rangel who is the Democratic Ranking Member on Ways and Means, to come with me, and Charlie is basically a free trader, and I knew that we had

giants, we in our district, like Motorola and Sears, and Allstate, Baxter Avenue, to name a few, and so I anticipated getting input from all these giants in the world market. What was revealing about that hearing is better than 90 percent of our exports in the State of Illinois, and at that time we were the fifth largest export state in the union, over 90 percent of our exports came from companies employing 500 or less. And a fellow came in to see me that was doing business in the Persian Gulf and he had a folder, and he said, "Congressman, do you know how many businesses in your district that are doing business in the Persian Gulf?" I said, "I haven't the vaguest idea." He handed it to me; it was over a hundred fifty businesses in our district doing business in the Persian Gulf and I—and these were employers of 150 or fewer. And I looked at the names and there wasn't a single one of them that I had seen before, and I thought he was conning me and I checked and they were businesses from our district, and, indeed, they were doing business over there. So, I think getting the message out so people understand that the importance of small businesses, I mean, that is the real strength of our nation.

Chairman MANZULLO. But, Phil, you can yield on that, the trade imbalance, in our country the inability of paper manufacturers to export is because of the higher cost of doing business and it's a natural sector going into—that will be the next hearing—but in terms of the higher cost of health care, makes that less competitive.

Mr. CRANE. Well, that is an important ingredient, but the other thing, Don, is that we didn't have trade negotiating.

Chairman MANZULLO. All right.

Mr. CRANE. It is eliminating in other countries very good products.

Chairman MANZULLO. Great.

Mr. CRANE. And now we have addressed that.

Chairman MANZULLO. It makes it better for the farmers. Well, we want to thank you all for coming. You have been very gracious in your testimony. I'm going to leave the record open for 14 days. I think Ryan wanted to add something to your testimony; is that correct?

Mr. BRAUNS. Uh-huh.

Chairman MANZULLO. If you can give that to Doug. Doug, why don't you give us the fax number. Uhm, it's 202——

Mr. THOMAS. In Washington?

Chairman MANZULLO. Yeah.

Mr. THOMAS. Yeah, you can send your written testimony down there, it is 202–225–3587. I'm trying to think, I never faxed to myself, 3587.

Chairman MANZULLO. Okay.

Mr. THOMAS. You can put it to my attention or Piper's.

Chairman MANZULLO. This hearing is adjourned.

[Whereupon, the Committee was adjourned.]

House Small Business Committee
Field Hearing on Small Business
Access to Health Care
August 14, 2002

Opening Statement
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 60 percent of the estimated 43 million uninsured are small business 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 businesses? 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.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS
CONGRESSMAN PHILIP M. CRANE – OPENING STATEMENT
AUGUST 14, 2002

Thank you Chairman Manzullo for holding this important hearing and inviting me here to participate. I'd like to commend your leadership efforts on access to affordable health care for small businesses. You've been a great ally in our fight to expand and make permanent Medical Savings Accounts and your work on establishing Association Health Plans is to be commended as well.

Let me just say that I believe all Americans should have access to quality health care in what I believe is the best health system in the world. According to U.S. census data 2 years ago there were around 39 million uninsured. Of that 39 million, 60% I believe are owners and employees of small businesses.

One of the main reasons that individuals go without health insurance is the cost of the premium. Since 2000, insurance premiums have continued to increase. This year, premiums rose and average of 19.3%. It is said that for 1% increase in health insurance premiums, 100,000 individuals will lose their health insurance coverage—that's 1.9 million more individuals on the uninsured rolls this year alone. And, Mr. Chairman, if I could just point out that I recently read that insurance companies across the country are seeking rate increases of 22.5% for next year. If that is correct, that would be the highest annual percentage increase in the last 4 years and would result in 2.3 million more uninsured next year.

There are also other reasons that Americans find themselves uninsured. Some are unemployed workers who could continue coverage under their former employer's plan as long as they pay the premiums but do not have the money to do so. Other unemployed workers and some working families are uninsured because their employers do not offer any coverage. Still others, generally low-income workers, may be offered employer-based insurance for themselves or their families but cannot afford the premiums.

All responsible lawmakers want some form of action to help the uninsured. The argument is over how best to do that. And although most Members of Congress believe that the employer-sponsored insurance system should continue as the basis of coverage for most working families, there has been a gradual recognition that, in today's economy, the traditional employer-based system cannot serve all families effectively. In particular, that system does not assure stable, continuous coverage for all. Two factors demonstrate this problem:

There are very high rates of uninsurance among employees of small firms. According to a Kaiser Family Foundation survey, while 99% of large firms offer health insurance, only 55% of firms with fewer than 10 employees do. Among low-wage workers (those who earned less than $7 an hour in 1996), 45% are not even offered insurance.

This is probably due to the fact that employers who try to offer coverage to very small groups tend to face high administrative costs. According to data collected by the Congressional Budget

Office, overhead costs for providing insurance can exceed 30% of the premium costs for firms with fewer than 10 employees, compared with about 12% for firms with more than 500 employees. Also, small employers may lack access to resources to assemble good and affordable options for their workers. Consequently, many small businesses adopt a competitive compensation package that emphasizes cash income rather than health benefits.

Because I am the Vice-Chairman of the Committee on Ways and Means, I'd like to focus for a brief minute on the roll of taxes. The federal tax code blocks employees from obtaining coverage from anyone other than an employer or former employer. The current tax system excludes from taxable income (federal and state income taxes and payroll taxes) all compensation provided to a worker in the form of employer-sponsored insurance. But workers who do purchase insurance for themselves rarely can claim any tax relief or receive any other assistance toward the cost of coverage.

There is one section in the tax code that provides for some tax relief of medical expenses. Since 1942, taxpayers who itemize have been able to deduct health care costs that are in excess of a statutory percentage of their Adjusted Gross Income (AGI). The current threshold where deductions of medical expenses are allowed is after 7.5% of AGI. However, few taxpayers who itemize can reduce their taxable income through the existing deduction because their unreimbursed medical expenses are unlikely to exceed 7.5% of their AGI. That is why I have introduced legislation to help make health care more affordable by allowing taxpayers to deduct most of their medical expenditures that exceed 2% of their AGI.

Let me give you an example of how this legislation would help. Under current law, a family with an income of $30,000 would only be allowed to deduct medical expenses in excess of $2,250. Under my proposal that same family would be allowed to deduct all health care costs exceeding $600.

Let me just end by saying that providing access to affordable, quality health care is an issue that will be with us for some time. But, the longer we wait to pass legislation to help improve access to health insurance means that millions of Americans will continue to lack affordable protection against the potentially catastrophic costs of an illness or accident. I look forward to hearing from some of our local small business owners as we work towards a solution for this issue.

Thank you.

Good Morning and thank you.

My name is Mary Blankenbaker and I am co-owner of Benjamin's, a family owned and operated restaurant in Galena, IL.

On behalf of the restaurant industry, I would like to thank you for this opportunity to speak to the Committee on Small Business about the important health care problems that are facing small businesses today.

Small business owners can tell you that any changes to the "Patient's Bill of Rights" must include explicit limits on employer liability, and provisions for Association Health Plans.

Of the approximate 43 million uninsured Americans, 60 percent live in a family employed by a small business. Many restaurants cannot afford to provide health benefits because of costly state mandates and lack of purchasing power.

For each of the last two years, health insurance premiums have gone up an average of 23 percent for tableservice restaurants. Benjamin's has the best rating an insurance company can provide and as of August 1st our premium has increased 28%!

Many more small businesses in a variety of industries are seeing this as well.

Over 172 million people in the U.S. receive health coverage through their workplace yet it is becoming increasingly difficult to offer health coverage incentives to employees as a result of higher premiums.

Prior to August 1st, we were already under great financial burden to provide health insurance to our employees while paying $745 a month for just 4 people.

I continue to hear from my fellow restaurateurs that some premiums have risen even higher than ours, from 30 to 40 and even up to 50 %.

Association Health Plans (AHPs) would provide employees greater access to better and more affordable health coverage by allowing small businesses to group together to purchase health insurance.

This would reduce the premiums and greatly expand the benefits we could offer our employees at Benjamin's and the thousands of small businesses could offer their employees.

The insured deserve better than more mandates. Adding new laws and expanding liability will only serve to increase insurance costs and undermine employers' ability to voluntarily offer this valuable benefit.

Help us achieve proper legislation that will make it possible for Association's to pool their members and resources so they can afford suitable coverage. Thank you.

Testimony for

The United States House of Representatives
SMALL BUSINESS COMMITTEE

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

Field Hearing

August 14, 2002

By

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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, a paraphrase of Francis Bacon comes to mind:

> For the want of understanding causes, operations fail.

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 now face a dilemma. Why? In that answer lie the solutions.

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 the great power of market forces.

Consumerism

Attempts at reform have always taken aim at the supply side of the equation. HMO's, PPO's, pharmacy managers, these are primarily supply side issues, although PPO's do present a distinctly 'consumer' quality. Yet, the greatest resource which stands to reshape the entire industry 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. People will and do make decisions influenced by price regarding health care. There is empirical data supporting the power of consumer engagement.

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.

Only three countries in the world use a fee for service model while the rest of the world uses some kind of rationing of health care—Singapore (to the least extent), South Africa, United States. About 10 years ago in South Africa a small health scheme called

Discovery Health emerged with a consumer driven product. In a short time, they have become the number one insurer in that country.

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.[1]

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.[2] 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 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.

What would a consumer driven product look like? Specifically: The consumer will be allowed to grow a fund of money that is his own. The fund will be used for day to day type of expenses and insurance will "kick in" when the fund is exhausted. This is not a high deductible insurance plan overlaying an MSA, Medical Savings Account. Here there is a small gap, if any, between the personal medical fund and the level at which insurance pays.

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[1] 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
[2] Council on Affordable Health Insurance

The money in the fund belongs to the employee and can be used or kept at the employee's discretion. Now the employee is financially engaged. Restricting the fund as to the type of expenses allowed will restrict the financial engagement of consumer and thus bridle the power of this mechanism.

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.

As this force propagates throughout the market, controversial issues such as tort reform, patient's bills of rights, and purchasing pools become less important. In the area or tort reform for example, lawsuits will decrease as consumers regain a position in the market because they will have better information, a feeling of empowerment and be more able to assume risk. Now, the consumer is left impotent and often has only the legal system as a tool for influence. As we have taken the consumer out of the health care equation, we have pushed the consumer into the courts.

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.

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.[3]

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.

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"

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

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. 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 needs 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 was 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.

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, equilibrium 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 committee's questions.

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Testimony for

The United State House of Representatives
SMALL BUSINESS COMMITTEE

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

Field Hearing on Affordable Healthcare for Small Businesses

August 14, 2002

McHenry County College

By

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Congressman Manzullo, and distinguished Members of Congress, thank you for the invitation and opportunity to testify before the Committee on the issue of affordable health care for small businesses, today. My name is Scott Shalek, owner of Shalek Financial Services in Ringwood, Illinois and Regional Vice President of the National Association of Health Underwriters (NAHU). In addition, I am a past president of the Chicago & Northeastern Illinois Association of Health Underwriters and the Illinois State Association of Health Underwriters.

Shalek Financial Services specializes in employee benefits consulting and financial planning for individuals and businesses ranging in size from 1 to 500 employees. Our mission is to provide comprehensive solutions to help individuals and businesses set and achieve financial security and success, while providing a level of service above expectations.

The National Association of Health Underwriters is an Association of highly qualified health insurance professionals with more than 18,000 members and over 200 chapters throughout the United States and Canada. The mission of NAHU is to serve the public by promoting the activities and ethical conduct of insurance professionals through communication, education and legislative representation. Members are trained and experienced in guiding individual and employers through the complexities of choosing appropriate and affordable health plans. We are the agents and brokers on the front line of health care every day, helping millions of individuals and businesses get the most from their health insurance.

NAHU believes that our members hold a unique position as advocates for health plan consumers. The insurance agents and brokers must be licensed by the state(s) where they practice, and in most states they must complete continuing education credits every year in order to keep their license(s). They keep abreast on new developments and standards in the health insurance industry, learn about new options that better serve their clients, and, because they usually represent a number of insurance companies, offer a wide range of health insurance options and alternatives.

As an individual or business health plan consumer representative, a professional health insurance agent/broker will:

- Evaluate the health plan needs of the individual or business.
- Explain the details of different health plans and provide cost indexes.
- Make specific recommendations and tailor plans to suit needs as well as budgets.
- Review the plan periodically to update coverage and maintain affordability.

- Communicate the facts about various benefit packages to employees.
- Serve as the consumer's advocate and advisor in dealing with insurance companies, doctors, hospitals and government agencies. This involves servicing claims, and providing advice about regulations and legislation.

To demonstrate the value of the agent/broker the following cases have been taken from my records:

Company A, is an injection molding company in Woodstock, Illinois with 45 employees covered under their group health insurance program, which included both HMO and PPO options. Renewal premium for the group was $23,999.27 per month. Current PPO had a $250 deductible in network and a $500 deductible out of network. Individual out of pocket was $1500 in network and $3000 out of network. Family out of pocket was 3 times the individual out of pockets. After review of their benefits and maximum out of pocket costs per employee and family, a PPO only plan with partial self-funding was recommended. The recommended insured programs offered a $1000 or $2000 Deductible with 100% coverage after the deductible. Cost savings were $71,798.16 per year on the $1000 deductible and $112,586.52 per year on the $2000 deductible. By having the employer self-insure, the difference between the $1,000 deductible and the amount of their current $250 deductible, a substantial savings would be realized for both the employer and employees, and the change to 100% coinsurance after the deductible considerably lowers the maximum out-of-pocket costs for employees.

Company B, is a manufacturing company in Cary, Illinois, with 57 employees. Jan 1st renewal rates increased by 40% to $33,404.79/month. The carrier stated this was due to current claims. (One employee had over $200,000 in ongoing claims, but came off the group in November when their COBRA expired) By shopping the group and explaining the claims situation, with no change in deductible, the client was able to lower premiums almost $10,000 per month to $23, 857.54. Due to this savings the company lowered their deductible from $500 to $250 and still realized a substantial savings.

Company C, is a consulting company in Barrington, Illinois with only 2 employees- (husband and wife). One employee has an ongoing condition with claims over $100,000 per year. Their COBRA was expiring. Under HIPPA, we were able to obtain quality group coverage at an affordable rate with no interruption in coverage. Under Illinois HIPPA CHIP they had another option, and could have obtained individual coverage with no interruption, but the cost would have been higher.

At your hearing on April 4, 2002 in Rockford, Illinois Association Health Plans (AHPs) were discussed as a way for small groups to receive lower rates similar to union plans or large employers. I realize that the concept of volume discounts through purchasing pools as endorsed by business groups such as the National Federation of Independent Business and the Illinois Manufacturers' Association may sound like an innovative solution to reducing health care costs for small

employers, however there have been serious problems with AHPs, other Multiple Employer Welfare Arrangement (MEWA) type plans, and some purchasing pools in the past. Texas, Iowa, Indiana, Connecticut, Florida and Colorado are just a few states where AHP's have been tried and have been unsuccessful. For example, Florida had Community Health Purchasing Alliances, which went bankrupt after being inundated with unhealthy groups. Colorado's purchasing cooperative dissolved on July 31, 2002. Indiana had a Funeral Director's Association plan, which folded up about 4 years ago. Last month, a big MEWA called the "Indiana Construction Industry Trust" became insolvent and has left 21,000 members with approximately $8,000,000 in unpaid claims. As you can see, there are major problems when considering using AHPs: First, healthy groups tend to drop out after a year or two to find coverage elsewhere at more affordable rates. Second, AHPs do not have sufficient state regulatory oversight, which limits important consumer protections. Both of these factors can cause premium rates to rise and lead to more uninsured Americans.

Indeed, a vehicle has long been available to create a group purchasing opportunity for small businesses. These are called Multiple Employer Trusts (METs). It is through MET pooling of small group medical insurance that most small employers today purchase their group health insurance. The difference between METs and AHPs is significant and METs generally comport to state laws.

Another suggestion that has been discussed that may improve affordability is union plans. After studying the major union programs in Lake and McHenry Counties this does not prove to be true. Most union programs charge a flat rate per hour, based on a 32-hour week. The same rate is charged for each employee: regardless of age; marital status; or current health insurance coverage. Depending on which union an employee is a member of; rates vary from $630.77 per month to $831.94 per month. The average cost is around $756.00 per month. If we compared average plan costs for unions with Company A, B, or C as previously discussed, we would obtain the following results:

Company A would be paying $34,020.00 more per month.
Company B's cost would increase $19,234.76 per month.
Company C with only two employees would have a cost increase of $30.00 per month.

In 1965, there were only 8 mandated health insurance benefits laws in the United States. Today, there more than 1,100 mandates and that number continues to rise. Mandated benefits vary in medical necessity such as hairpieces in Minnesota, marriage counseling in California, deposits to a sperm bank in Massachusetts, and heart transplants in Georgia. In Illinois we have invitro-fertilization, which is a multi-billion cost to the insurance industry. Mandated benefits drive up costs and

increase the number of uninsured. Experts estimate that mandated benefits have driven up cost so much that they account for somewhere between 20 and 25 percent of all uninsured Americans. In Illinois alone, mandates have increased costs over 20 percent.

One idea in reducing health care costs is the elimination or exemption of mandated benefits for small business. If the states and federal government allowed insurers to sell no-frills policies, which would compete with regulated insurance, small employers and consumers of health care would have the freedom to choose the coverage that best meets their needs. This exemption from mandates should be available for all small employer plans, not just association health plans. This would allow them to compete with ERISA plans that are offered through larger corporations.

The health insurance industry has always been in the forefront in reducing health care costs. Programs such as PPOs and HMOs were designed to curb rising health care costs. Administration costs in private sector insurance are substantially less than government run programs. Compared to Medicare and Medicaid administration costs, private sector costs are 66 percent less than what the government spends per dollar of benefit paid.(1)

Electronic claims processed with a health care debit card or Internet processing is another idea that could substantially reduce administration costs and lower premiums. It is estimated that electronic claims processing could reduce costs at least 5 times the amount that is required for claims submitted on paper.

Expansion of Medical Savings Accounts (MSAs) and the elimination of burdensome regulations can substantially assist individuals and businesses reduce cost and make coverage more affordable. Countries such as Singapore and South Africa have had tremendous success with MSAs in curbing health care costs. Since their introduction in 1994, MSA plans in South Africa have captured about half of the private insurance market.

(1) Mark Litow and the Technical Committee of the Council for Affordable Health Insurance, "Rhetoric vs. Realty: Comparing Public and Private Health Care Administration Costs," Council for Affordable Health Insurance, March 1994.

Tort reform is another factor in increased health insurance cost, and any reform should be modeled after the state of Nebraska, which sends punitive damages to the state educational system instead of the plaintiff. After all, no plaintiff has a real right to penalty judgments, just actual damages, pain and suffering, and legal costs. Punitive judgments serve a purpose, but enriching the plaintiff is not a valid purpose. Huge jury-awarded penalties ultimately become increase premiums to consumers. We need to remove the profit motive from the plaintiffs' hands.

One final idea for making health insurance more affordable which the federal government has begun to seriously consider is a refundable health tax credit. A refundable health tax credit for low to middle income Americans would substantially reduce the number of uninsured, while reducing costs, and allow more small businesses the ability to offer health insurance programs to their employees at affordable rates. Properly designed, health tax credits will provide a real solution to the problem of the uninsured in America by addressing affordability – the most basic component of access to health care.

In conclusion, there is no doubt that we have the finest health care system in the world, yet we are our own worst enemy when it comes to the issue of affordability. Government regulations and mandates continue to be a driving force in rising health insurance costs forcing many individual and small businesses out of the market.

As an advocate for the health plan consumer, the role of the agent/broker is key to individual and business health care solutions, but they can't do it alone. We all need to work as a team in educating the consumer and exploring sensible reforms to make health care more affordable, predictable and manageable. We need to work to find ways to encourage more consumers to purchase private sector health insurance. This will expand markets and increase the number of carriers, leading to more choice for consumers. When we work together for a common goal, we can make a difference.

Mr. Chairman and members of the Committee, thank you for allowing me to testify today and share some common sense solutions for reducing the cost of quality health care. I look forward to following the good work that Congress will do to make health insurance more affordable for more Americans and I am happy to answer any questions the Committee may have at this time.

Testimony of

Brad Close
Manager, Federal Public Policy (House)

before the

U.S. House of Representatives
Committee on Small Business

Affordable Health Care Options for Small Business

August 14, 2002

Chairman Manzullo and Members of the Committee, on behalf of NFIB, I want to thank you for the invitation and the opportunity to testify before the Small Business Committee.

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.

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] In fact, a recent Business Journal article stated that skyrocketing health premiums are leading young professionals to opt out of employer-sponsored health plans because the monthly

[1] Employee Health Benefits, 2000 Annual Survey, The Henry J. Kaiser Foundation

premiums are becoming unaffordable. [2] This is a trend that is particularly disturbing for small business.

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 have experienced double-digit increases. Elaine Smith from Granite

[2] *Healthy Workers Decide to Drop Coverage*, The Business Journal of Jacksonville, August 2, 2002

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.[3] Small businesses need more bargaining power so they can have access to affordable health care coverage for their employees.

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

[3] *The Uninsured,* Health Policy Alternatives, Inc., September 21, 1999

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 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 been 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 a great amount of bargaining power

with sufficient numbers to absorb risk without substantially increasing premiums.

MSAs also offer an alternative solution. Eliminating the regulatory burden on Medical Savings Accounts would greatly 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 will provide yet another vital affordable health care option to the small business community. Another important option that NFIB strongly supports is allowing tax credits for individuals who purchase health insurance.

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.[4] 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

[4] *Private Health Insurance* –U.S. General Accounting Office, October 2001

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.

In addition, the bill requires the plans put up and maintain capital surpluses before they can be certified in order to prevent fraudulent plans from forming. Also, 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 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.

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. I urge the Committee to assist in moving AHP legislation to the President's desk.

Mr. Chairman and Members of the Committee:

Thank you for giving me the opportunity to address you today about a subject that I feel needs our serious attention – Affordable Health Care.

My name is Ken Koehler and I am the president and co-owner of Flowerwood, Inc. in Crystal Lake. Flowerwood is a family owned and operated Florist, Nursery, Garden Center and Wholesale Greenhouse that has served McHenry County and the surrounding communities since 1948. Since our beginning with four employees, Flowerwood has grown to its present staff of 75 to 100 full-time, part-time and seasonal employees that come from a wide range of ethnic and educational background. Our employees' ages range from 16 year olds with their first job to retirees supplementing their income with part-time employment and earn from $ 5,000 to $ 75,000 a year.

Our work force includes retail clerks, floral designers, landscape designers and installers, horticultural growers, mechanics, delivery drivers and office personnel. Most of our management team are long term employees with between 10 to 35 years of service.

We value these employees and have tried to offer a comprehensive benefit package, health coverage, life insurance, 401(k) plan and Cafeteria Section 125 plan. Benefits are offered to all full time employees and 20 have elected our Health Benefit (10 on the HMO and 10 on the PPO).

Flowerwood has felt health insurance coverage for its employees to be a very important safeguard for their everyday lives and family care. In the early years Flowerwood had been able to fund most of the cost of the insurance coverage, thus minimally impacting the employees out of pocket exposure. Today that has changed dramatically with the company covering 40 to 45% of the cost and the employees contributing 55 to 60%.

For most years prior to 1998/99, the cost increases that we experienced were less than 10% and in many cases around 5 to 6%. They were for the most part manageable and the impact to both Flowerwood and our employees moderate. But since then the increase have been double digit and now have put our health insurance program in crisis. In 1999/2000 we were faced with over a 20% increase; at that time we made major changes to the plans and began to offer a choice between an HMO or PPO. This change and increased deductibles kept the increase to about 13%. In 2000/01, we experienced a 17% increase and in 2001/02 we experienced an 18% increase. And just this July for 2002/03, we experienced a 43% increase.

Since 1999, our per employee health care coverage has increased between 85 –100%.

Annual Coverages Cost

	Single HMO	Family PPO	Single HMO	Family PPO
1999/2000	1,673	4,256	2,339	5,939
2000/2001	1,995	5,064	2,739	6,948
2001/2002	2,309	5,698	3,317	8,186
2002/2003	3,199	7,780	4,751	11,865

We are still trying to evaluate other options, but bottom line, these cost increases have significantly impacted both Flowerwood and our employees. The pay increase that we were able to give our employees in May have been completely eroded by the increased rates in weekly insurance deductions.

We are concerned that these huge increases will lead to our inability to help fund some of our employee health costs, as well as a total lack of ability for any of them to find their own affordable health insurance.

We realize that there are many small businesses such as ourselves facing this same crisis. I hope that some affordable options become available soon. We are at the breaking point with all our margins shrinking daily and these very unpredictable and uncontrollable costs putting us against the wall.

Mr. Chairman, thank you for the opportunity to share my company's experience with you and the members of the committee. I hope there are some good solid solutions to employer-based healthcare on the horizon. This is no easy task and I commend you and this committee for your diligent work this very important issue!

Kenneth D. Koehler
President & CFO, Flowerwood Inc.
Crystal Lake, IL

testimony before the
U.S House of Representatives
Committee on Small Business
Small Business Access to Healthcare

Wednesday, August 14, 2002

DRAFT of proposed testimony
Brad Buxton
"Affordable Health Care"
Crystal Lake, IL
August 14, 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 Brad Buxton. I am a Vice President of Health Care Management for Blue Cross and Blue Shield of Illinois in 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. The Center for Studying Health System Change found that very large subsidies are needed to increase insurance coverage by even a modest amount. Their findings concluded that there are 33.8 million workers in firms with fewer than 50 workers. 16.1 Million employees are not offered insurance through their work. If a 30% subsidy were provided, only 500,000 of these 16.1 million would actually opt for coverage.

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 possible.

Thank you.

Dear Chairman Manzullo,

I appreciate the opportunity to testify before you and this committee on such an important matter. My name is Isabella Wilson, and I am the Chief Financial Officer of Illinois Blower, Inc., a small, privately held manufacturer of industrial fans located in Cary Illinois. The rising cost of healthcare has several implications for a company the size of Illinois Blower and its employees.

1. Direct monetary costs are only part of the story
    a. Even doing everything in our power for the health of the company and employees, the following increases have occurred.
    b. Employee with Family portion of costs

i.	1999	$32/week	$1,664/year	
ii.	2000	$35/week	$1,820/year	9% increase
iii.	2001	$42/week	$2,184/year	17% increase
iv.	2002	$46/week	$2,392/year	14% increase

    c. Total costs for Employee with Family

i.	1999	$359/month	$4,308/year	
ii.	2000	$479/month	$5,748/year	33% increase
iii.	2001	$616/month	$7,392/year	29% increase
iv.	2002	$709/month	$8,508/year	15% increase

    d. Overall health care costs per employee increased

i.	1999	$2,264/employee	
ii.	2000	$3,534/employee	56% increase
iii.	2001	$4,600/employee	30% increase
iv.	2002	$5,198/employee	13% increase

2. Working to contain costs produced several negative affects
    a. Prescription drug coverage is one area where we have had to dramatically reduce benefits to contain costs, which has had direct financial implications for our employees.
        i. In one example, we have a fairly young employee (35 years old), who had a massive heart attack 2 years ago. Since his heart attack, he has had to take 4 separate prescription drugs to maintain his health. Last year those drugs cost him only $160/year (through a prescription drug mail in program). This year those same drugs cost him $1,200/year. Last year his total out of pocket expense for his family, only including his contributions to the coverage and his personal maintenance prescriptions was $2,344. This year his cost is $3,592, which is a 53% increase.
        ii. All of our employees who have maintenance prescriptions have been hit hard by this plan change. Many of our employees would truly have to make a decision between spending the additional funds on prescription drug or doing without them. The decision to

forgo treatment because of cost, could lead to not only missed work due to illness (impacting productivity), reduced quality of life, and ultimately a shortened lifespan.

b. Switching insurance carriers 4 out of last 5 years.
   i. Employees have had to change doctors each year, losing history which impacts quality of care
   ii. Massive administrative and educational workload each time you have to switch, which has direct financial impact even though it is difficult to quantify.
   iii. Employee cards never arrive on time, leading to claims being filed incorrectly with the old insurance carrier, requiring administrative time to correct the payment. Often to avoid credit issues with medical providers, employees having to pay directly for services and prescriptions creating more administrative work to again correct the situation.
   iv. One year we actually had to file a lawsuit against the prior year carrier, who refused to pay claims incurred in the prior year but filed for in the current year

c. In order to mitigate the cost increases to both the company and the employees, we began offering HMO's.
   i. Unfortunately, the HMO coverage in McHenry County is less that ideal. Very few hospitals and physicians participate in the plan.
   ii. Most of our lower income employees have to use the HMO to afford healthcare coverage. The higher deductibles and copays of a PPO are not affordable for someone trying to support a family on $13 an hour.
   iii. As a result most of the employees who elected the HMO must drive 30 plus miles to reach a doctor that accepts the insurance and are limited to only one pharmacy in the area that accepts the insurance.

3. What these increases have meant to Illinois Blower.
   a. Average gross margins in our industry are only 30%. Which means that for every dollar increase in health care costs, we have had to increase sales by $3.33 to cover the additional costs.

   b. Over the past several years, we have been lucky. Our business is tied to the power generation industry and we have enjoyed the boom in the creation of electrical power generation capacity since 1998. Unfortunately, the power generation industry has taken a severe hit since September 11th and the collapse of Enron. As the company faces more arduous times, managing healthcare costs is both imperative and increasingly difficult. If the economic downturn continues and we are forced to reduce our work force, the options available to us from the

numbers of insurance companies who write policies for groups our size to the number of plan designs available decrease.

c. Unfortunately, we are also seeing dramatic increases in all areas of business insurance, including workers compensation, product liability, and property insurance with this year's renewal increasing our costs by 70%. These dramatic increases in non-productive costs will have a direct impact on Illinois Blower's ability to compete in today's global market place.

d. These rising costs directly impact our ability to afford and implement, capital projects, which would allow us to improve and speed up our production processes. This directly affects our ability to compete with companies located in less developed areas of the world where labor costs are significantly lower.

In summation, rising healthcare costs not only impact a company's bottom line, but can also negatively affect employee morale and thus productivity, reduce employee's quality of life and medical care, and lead to a decrease an employee's consumer spending also impacting the overall economy.

Finally, I want to reiterate that the financial implication of rising healthcare costs have a major impact on our ability to compete in today's global market place. As an example, we are currently faced with our largest customer moving 37% of what was historically product we produced for them to Chinese manufacturing companies in 2003. Our customer is looking for greater cost savings than we are able to provide, as our cost structure is continually being hit by the rising costs of such non-productive expenses such as health insurance premiums.

Again, I thank you for allowing me the opportunity to testify before the committee on this important matter.

Illinois State Medical Society

Statement
of the
Illinois State Medical Society
to the
Committee on Small Business
Presented by James L. Milam, M.D.
First District Trustee
RE: Small Business Access to Health Care
August 14, 2002

Good morning Mr. Chairman and members of the Committee, my name is James L. Milam, M.D. I am a practicing obstetrician from Libertyville, Illinois and currently serve as First District Trustee of the Illinois State Medical Society (ISMS). On behalf of our 14,000 physician and medical student members, I appreciate having the opportunity to testify.

I am pleased to present a medical perspective on the rising cost of health care. This is an extremely complex problem which will most likely not be solved today, but I hope I can provide some insight into the problems we face as health care providers.

A January article in the *New York Times* (1/8/02) 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. It sites that hospital and drug costs were the main factors contributing to the increase.

Growth in healthcare spending outpaced the 6.5 percent growth of the economy *as a whole* in 2000. Heath 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. Clearly, many factors are contributing to this unprecedented rise.

What are some of the factors leading to these cost increases? To begin, one of the most pressing reasons is medical malpractice insurance rates. Insurance premiums are soaring at the highest rate since the mid-1980s These premium increases threaten our ability to practice medicine. Also alarming is the high number of insurers that have left the medical liability market. Many physicians are forced to limit services, retire early, or move to other states where liability premiums are more stable. It is not unrealistic to ask the question, "Will my doctor be there?"

Many states have been categorized as "seriously threatened." These include Florida, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. In Illinois, along with Alabama, Arizona, North Carolina, South Carolina and Tennessee, a crisis is looming.

The primary cause of this emerging crisis and soaring rates is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. New data indicate that increasing medical liability premiums are being driven primarily

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by increases in lawsuit awards and secondarily by increases in litigation expenses. 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)

The soaring cost of medical malpractice premiums drive up the cost of healthcare which encompasses everyone – especially small business owners. The other cost, which perhaps may not be as obvious, is the loss of services to patients. Emergency departments are losing staff and scaling back on many services including trauma units. Many obstetrician/gynecologists and family physicians have stopped delivering babies, and some advanced and high risk procedures, such as neurosurgery are being postponed because surgeons cannot find or afford insurance. This cost is not as easily to quantify, however, could prove to be much more damaging than the monetary rise.

If you think that this is not a crisis in Illinois, you are mistaken. 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 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. This is not folklore, this was reported by the *New York Times* in September, 2001.

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 reason for the costs of healthcare, is the explosion in the cost of prescription drugs. This is a serious problem for all recipients of heath 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 amount of pharmaceuticals.

Medicare, managed care and many private insurers have cut drug benefits in the last few years. The average senior spends about $500 annually for medications, plus hundreds or thousands more for private insurance policies to cover some of the cost of prescriptions.

In addition to medical malpractice insurance and prescription drugs, there is an overwhelming burden of government regulation, which is harming the medical profession in its attempts to provide the highest quality of care. You have probably heard of many of these acronyms, but the provisions of CMS (formerly HCFA), EMTALA and COBRA, just to name a few, are burying physicians in needless paperwork and documentation. Gainful attempts to follow the regulations are often at the risk of prosecution, fines and imprisonment under a system so complex, that it is impossible to meet all of its requirements. Soon we will have to face the complex, daunting HIPAA statutes.

Another hardship impacting the cost and quality of medical care is the shortage of well-trained nurses. Medical school costs too are soaring, discouraging many of the brightest from applying to 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.

Without a doubt, it is clear that legislative action is needed immediately. Without it, there is little hope that much will be done to address the soaring costs that limit services to patients and are passed on to many, including small business owners. In order of effectively stabilize medical liability insurance rates – while continuing to ensure that patients who have been injured through negligence are fairly compensated – Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective in other states.

Currently, H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Health Care 'Health' Act of 2002," as well as its Senate companion, S. 2793, are bipartisan approaches that would lead to a stabilized medical liability insurance market and bring balance to our medical liability litigation system. The major provisions would benefit patients by: awarding injured patients unlimited economic damages yet cap non-economic damages up to $250,000. This legislation would also address a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault. These reforms are necessary and urgently needed.

Earlier this summer, the House passed a Medicare bill which would have subsidized private insurance plans that would benefit all seniors and pay most of the cost of pharmaceutical expenses. The Senate, however, did not pass the bill – this is very disheartening. Both Republicans and Democrats must come together to solve the issue that affects us all – providing quality healthcare. Speaking as a physician, I can tell you that we just want to treat our patients and deliver the highest of care. However, in the current environment, this is becoming difficult and in some cases impossible. Many physician practices are counted among the ranks of small business. If we work together, keeping the patient as the focus, I am confident we can find a solution to the problems.

Thank you for your time and attention.

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