THE RISING COST OF HEALTH CARE FOR SMALL BUSINESS

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT & GOVERNMENT PROGRAMS

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

CHARLESTON, SC, AUGUST 25, 2003

Serial No. 108–31

Printed for the use of the Committee on Small Business

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

92–794 PDF WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

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THE RISING COST OF HEALTH CARE FOR SMALL BUSINESS OWNERS

MONDAY, AUGUST 25, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT,AND
GOVERNMENT PROGRAMS,
COMMITTEE ON SMALL BUSINESS,
Charleston, SC

The Subcommittee met, pursuant to call, at 1:45 p.m., in the Magnolia Room, Charleston Place Hotel, 205 Meeting Street, Charleston, South Carolina, Hon. Todd Akin [Chairman of the Subcommittee] presiding.

Chairman AKIN. Good afternoon. If I could please have your attention. The Committee on Small Business and Workforce will come to order. Those of you in the back of the room, if you would like to grab a snack or a beverage or whatever, if you could do that please, and make yourselves comfortable.

One of the things that I have tried to do as Subcommittee Chair is to try to run our meetings, get them going on time and try and get them out in a reasonable period of time. I think some of you are probably pleased to hear that. So we are going to go ahead and proceed.

The general format is going to be I will make an opening statement. I do believe Congressman DeMint may have an opening statement as well, then we will hear from our different members of the panel, five minute statements from each, and then we will proceed to some questions at that point.

I would first of all like to say to all of you, thank you so much for coming today. I was pleased to be able to come here and to be able to come here with Jim DeMint. It might be a surprise to you, but the Congress has these different Committee hearings, and most of the time they are held in Washington, D.C., but we have the authority to hold Committee hearings anywhere in the country that we want to, wherever it makes sense logically. This seemed to be a very appropriate place for our topic today. Our topic is going to be, from a small business point of view, the rising cost of health care and people who are uninsured. Now that is important to us because of the fact that of the people in America who are uninsured, about sixty some percent of them are, in one way or the other, connected with small business. So that is very much down the lines of things of interest to our Committee.

So why would we choose to come here particularly for an official meeting of the House? Well, the reason is that to really find out what is going on, it is necessary to get into various states and to

see what is going on and be able to have witnesses such as yourselves. So we are very thankful to have you coming and joining with us.

I was looking around at different opportunities and talking to Congressman DeMint, who is very, very well respected, first of all on the subject of health care, but just generally speaking in the house. It was really an opportune time for us to be able to come and join you here, even though I am new to this city and wish I had a little longer to stay and visit.

Jim has been on the front lines of the small business world with his own market research company and he has not forgotten some of what it is like to be a small business owner. So he combines that interest in small business but also he has been involved with legislation that connects to the health care business. And in fact, that is to some degree his hallmark, is being involved with health care kinds of issues. He particularly caught my attention this year when he got through the idea that you could provide employees with a $500 rolling over option, so in other words at the end of the year, you did not have to spend all the money that was in your particular account, but you could roll that money over in your health savings account or these different flexible spending accounts for the end of the year. This is a significant step. It does not sound like a lot perhaps to us, but in Washington, D.C. where things tend to move slowly, that was quite a significant advance and Jim made that break-through. We are thankful to have him here.

So first of all, thank you all for coming but before we proceed and take the five minute statements, I would like to turn over the microphone if Congressman DeMint would like to make a statement or say a few words. Certainly, as I emphasized before, he has the qualifications that we need for this hearing today and we are very thankful to the people of this state for sending him to Washington, D.C. and for his expertise.

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

Chairman AKIN. Jim.

Mr. DEMINT. Mr. Chairman, thank you for coming to South Carolina, welcome to Charleston. We very much appreciate your work on the Committee. The Chairman is very involved with small business, particularly oversight of SBA and other government programs related to small business, so he is very instrumental in things that affect a lot of us.

As he has mentioned, this is an official meeting of the Committee, it's not just the two of us listening. The lady here who appears to be on a respirator is actually taking down everything we say, it will be part of the official Committee record and we use that and Committee staff uses that as we put together the case for changes, reform, for legislation. So our intent is to use this to develop solutions.

The Committee's work, while not official with jurisdiction over tax code and some other areas, it does have a lot to do with regulations that affect small business. we find ourselves very much as advocates for development government contractual arrangements with small business, whatever we can do to grow small businesses in this country, which make up about 99 percent of all the employers. So it is a big part of the American economy. Most of the new

jobs are coming, or at least a whole lot of them, from small business. So I think what we do is pretty important.

This issue of health insurance today is huge. It is a hard issue for major employers, it is an even harder issue for small businesses.

I have been traveling the state like wildfire over the last three weeks and I have not talked to one employer who has not mentioned this as a major issue. It is an issue that even makes them consider locating subsidiaries offshore. It is another reason that American businesses are having difficulty being competitive, and then as increasingly as we on the government side reduce reimbursement for Medicare/Medicaid, that cost is being shifted on the private insurers. The rates are being forced up. We have got to do something to change our health care system or to save our private insurance market and to make sure that we do more to help people get insurance rather than what we are doing now and we are making it harder for them to have insurance.

My hope today is that our witnesses will not only make us aware of the problems, which a lot of us are aware of, but to help us identify examples of things that might be working or ideas they have on how we can fix things to save the private insurance market, which is where we need to go.

So Mr. Chairman, again, thank you and I look forward to the testimony and the questions that you and I both have later on.

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

Chairman AKIN. Thank you very much, Congressman.

I think now that what we will do is we will just proceed right down the line up of our witnesses, go for five minute statements from each of you and then we will have some questions we would like to ask afterwards, if that will work.

Do we have a timer specifically?

Mr. BEZAS. Yes, I have it.

Chairman AKIN. Okay, he will make some kind of a signal when you are starting to get close to the end of your five minutes.

So our first witness, and I am very thankful to have Ernst Csiszar, who is the Director of Insurance for the State of South Carolina. We had a chance to have lunch together and Ernst has shared a couple of thoughts with me. I am just fascinated by what your comments are going to be Ernst, and thank you so much for taking time to join us here.

STATEMENT OF ERNST N. CSISZAR, DIRECTOR OF INSURANCE, STATE OF SOUTH CAROLINA

Mr. CSISZAR. Thank you, Congressman and again, I extend my welcome to the State of South Carolina, what may be the first time, I hope will not be the last time. We can use to tourist dollars, by the way. And Congressman DeMint, welcome to your home.

I am delighted to be here today and what I would like to start with is just sort of a view, at least from a regulators standpoint, of what some of the basic problems are with our health care system, and perhaps suggest maybe not entire solutions because this is a complex, very, very complex field, but perhaps some of the answers that are worth considering. I have heard some of those di-

rectly from Congressman DeMint at lunch time. I think those were great ideas.

To begin with, I would describe the problem to start with as what I would describe or call a flawed business model. And the flaw starts with the very basic proposition that we have a third party payer system in which the end customer is in essence entirely desensitized from the price. Doctors and patients incur the cost and employers and insurance companies pay for that cost. So there is not much incentive, shall we say, to have any degree of exercise by those who are actually consuming the health care.

I would add that that fundamental flaw in the business model is compounded by other flaws that I would attribute to that same business model. I would say there is weak corporate governance that we face in the sector. I will give you an example. Most public hospitals, as you know, are run by a board of trustees. Private ones also board of trustees or board of directors. They tend to be staffed with political or business cronies and oftentimes they do not do the job they are designed to do. So corporate governance is weak.

I would also say that weak management teams quite frequently are associated with the health care field, not least because the skills of a doctor are not oftentimes the skills that are required for management. No offense to the doctors, they are wonderful, they are great in terms of their own skills in practicing medicine, but I would suggest that management skills sometimes are of a different nature and do not often coincide with the profession that doctors engage in.

I would add another component, weak capitalization of the business model. We heard this morning, for instance, that in at least one state of the union—and I do not think this is untypical necessarily—you can form an HMO with $1.00. So there is overall, generally speaking, a weak capitalization.

Interestingly enough, it is also a business model that turns the laws of economics upside down. In most other places, demand drives supply. In the case of the health care system, supply I think sometimes drives demand. If you build a hospital, they will fill it for you, sooner or later it will be filled.

I would add one other component to this business model because it is a highly—and I would describe it as an over-regulated business model in fact, it has high administrative costs. The businesses incur, from what we estimate—I saw one estimate quite recently—about 25 percent in overhead costs, essentially paper shuffling kinds of costs, and that is exceedingly high for an industry that has to live on very thin margins, if there are any margins at all.

So fundamentally, I think the problem starts with the problems with the very nature of the business. You add to that the fact that this model, because of this removal of the pricing decision if you will, from the end user, from the patient, really brings about utilization issues. I sort of shrink when I hear things coming out of Washington that suggest we put cost controls on this, for instance. Cost controls do not work when your price is not an inflationary kind of price. If we are talking about spending, then the only way to control the spending is through rationing, for instance. And that is an unpalatable kind of solution I think politically or economically for most Americans, but it is indeed spending. The inflationary

costs, if anything, have gone down. The costs of actual medical procedures I think has gone down. The cost of pills tends to go down as well, even though over time we have seen increases in that.

The other problem we have of course is that over 40 percent, close to 50 percent, is already paid for by government and it is really unaffordable from a governmental standpoint and ultimately I can say that you add all these problems together, together with the cost shifting out of Medicare and Medicaid, and we have got what is certainly a bit of a mess.

In terms of solution, I would say address the fundamental problem and the fundamental problem I think you have already identified. It has to hurt the purchaser's pocketbook in some shape or form, whether it be through a medical savings account, whether it be through a voucher system, whether it be through some other means, the fact of the matter is that unless you bring a significant portion of the cost out of the purchaser's pocket, you are not going to be able to control consumption.

Thank you.

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

Chairman AKIN. Thank you very much, Ernst, that was very much on target with what we are looking for—specific in terms of where the problems were and then you give us a number one solution for what you do about it. Thank you.

And we will take our next witness is Larry Marchant and I believe that Larry is the Executive Director of the South Carolina Managed Care Alliance, but also with experience in the medical insurance business as well; is that correct, Larry?

Mr. MARCHANT. Yes, sir, thank you.

Chairman AKIN. Good. Thank you very much for coming and joining us.

STATEMENT OF LARRY MARCHANT, EXECUTIVE DIRECTOR, SOUTH CAROLINA MANAGED CARE ALLIANCE

Mr. MARCHANT. Thank you for letting me be here, Mr. Chairman, Congressman DeMint, it is a pleasure to represent the third party payers today at our Congressional hearing. I also have a little bit on the Alliance I would like to leave with you, I have got an annual report I would like to share as part of the record as well.

Chairman AKIN. Without objection.

Mr. MARCHANT. From the insurer's standpoint, I think the one thing that we would like for you to help us do as we form partnerships to address this situation—I was happy to hear Congressman DeMint's remarks at lunch about getting everyone to the table because we want to make sure we are part of the solution and we have some ideas.

If you will help re-empower us from the private sector standpoint to help solve this affordability issue as well, I think that as unpopular as managed care has been in the public with some of our politicians and with the media, the fact of the matter is, there was a time when managed care did help control cost in the health delivery system. Honestly, there are really only two ways we can control costs in the delivery system. One is you lower the reimbursement level or you lower the commodity which you are purchasing, that price, that unit price, or you control the utilization of how much

you are going to purchase. And in health care, that is what we attempted to do, and honestly, we thought we were successful in managed care on trying to control those costs and still deliver a quality product.

What concerns us, however, is regardless of what model we end up doing—and we are supportive of a lot of different options for employers and individuals. We, Congressmen, agree that MSAs or those type of plans have a place. I think what we fear is we do not want them necessarily to take the place of another. We would like to have a lot of choices for individuals and employers to choose from, whichever best fits their ability to purchase that insurance. But when you boil it down to the lowest common denominator, and the Director hit on it a little bit on the inverse economics, and that is the health care equation is very simple. You take the total number of dollars that we spend in health care delivery, and let us say here in South Carolina, put it all in the pot—doctor's salaries, hospital costs, hospital administrators, insurance executives, premiums, everything—put it all in the pot, divide it by the population of South Carolina. And if the top line is higher than the bottom line, you have medical inflation.

In my hometown of Columbia, 100 miles up I–26, we have a quarter of a billion dollars in new hospital construction going on just in my hometown. Somebody is paying for that construction. I am not saying it is good or bad, it is needed, I suspect you could probably line up the folks clear out to King Street to give you all the reasons why we need every—all four hospitals in Columbia need all this technology. But the fact of the matter is those are the dollars that are added to the top line and the industry is concerned that regardless of how you are paying for it, whether it is a third party payer or individual, some entity has to stand over someone's shoulder and control excess capacity because we will still pay for that no matter what model that we use.

Of course, my doctor friends will agree with me on this statement, I think the only other construction project going on in Columbia right now is a high rise for a new law firm.

[Laughter.]

Mr. MARCHANT. And that may tie in to his remarks on medical malpractice.

But you know, we laugh and we are joking, but if you sit back and think about it, somebody is paying for those costs. And again, we have to make sure we have a system that is looking at those costs and making sure when you go in to purchase, that you are not over-paying or that you are not accidently being over-utilized.

I do want to brag about one particular thing that the Alliance for Managed Care worked with hand-in-hand with the NFIB, Chairman Dan Tripp, I think who is in the audience, and Chairman Thomas from the Senate, and the DOI, as a matter of fact, and that is a mandate moratorium bill that we passed in South Carolina last year. We were the first state to do this. I think our General Assembly was wise enough to understand that until we decide what the final answer is going to be on health care delivery and how we are going to pay for this, at least we can say okay, that is it, we are going to put a lid on government mandates, we are going to put a lid on forcing employers to pay for this and that.

And while this is definitely not the solution, we can do that until we can get to those answers, Congressman DeMint, down the road and I would ask the Chairman and the Committee to seriously look and see if there are ways that we can kind of at least just put a stop to any government intervention until we can come up with a plan for the future, because you know there is a mile long of mandates and HIPAA and privacy and reform that we did back in the 1990s that we feel like maybe have hurt more than it has helped.

I'm looking forward to questions from the Committee, and I will do my best to supply the answers. And thank you for allowing me to be here.

Chairman AKIN. Thank you very much, Mr. Marchant, for your perspective, and we will look forward to getting back with some questions too.

Our next witness is Ms. Evelyn Perry and I believe that you are a small business owner I am told, but also are you connected with NFIB as well?

Ms. PERRY. I am a member.

Chairman AKIN. Member of the NFIB and also a small business owner.

Ms. PERRY. Correct.

Chairman AKIN. And what was the nature of that business again?

Ms. PERRY. I will be glad to tell you about it.

Chairman AKIN. You are going to sell me something.

STATEMENT OF EVELYN REIS PERRY, PRESIDENT OF CAROLINA SOUND COMMUNICATIONS, INC., AND NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

Ms. PERRY. I wish you good afternoon, Mr. Chairman and Mr. DeMint. Thank you for inviting me today to talk about the important issue of affordable, accessible health insurance for small business. I am pleased to be here on behalf of the National Federation of Independent Business, representing 600,000 members who face a similar challenge.

My name is Evelyn Reis Perry and I am President of Carolina Sound Communications and Georgia Sound Communications, family-owned firms that provide a wide range of communication products and services to over 2000 clients.

We are based right here in beautiful Charleston, South Carolina and we also have offices in Myrtle Beach and recently Savannah, Georgia.

At Carolina Sound, we are both low voltage contractors and the MUZAK franchise in over 30 counties in South Carolina and Georgia.

We design, install and service sound and video systems for industry, schools, health care, the hospitality industry, military installations and other businesses. Recently, we have begun to work with the medical profession to help them comply with the HIPAA Act.

The MUZAK business has been in Charleston since the early 1950s and has continued to grow appreciably. It is established as a premier sound and video contractor in South Carolina and now Georgia.

As President, I manage the day-to-day operations which includes administering our employees' benefit package. At Carolina Sound and Georgia, we have 17 employees.

Like many entrepreneurs, I learned early that if I want to remain competitive in hiring, I must offer an attractive benefit package. Since we started the company, we have provided comprehensive health care to all employees.

I spent 20 years in the private non-profit world including government before I became a business owner, and social responsibility is important to me. However, recently, two experiences forced me to stop and rethink health insurance and what role an employer should play.

In January of this year, we acquired the MUZAK franchise in Savannah, Georgia, which consists of 13 counties in Georgia plus Hilton Head and Beaufort in South Carolina. The five employees there were covered by health insurance provided by a larger corporation which previously owned this property. The company provided 50 percent of the premium cost to the employee.

In investigating what this group would cost our company to cover, we found that the premiums in Savannah were almost triple the premiums in Charleston. This penalty was for no other reason than the zip code of the Savannah office. It would be impossible for us to cover these new employees at 100 percent, as we have done for years in Charleston. We have them presently covered under a temporary policy while we investigate what other options are available. Additionally, one of our principals is now a diabetic, making it a risk to change insurance companies in Charleston, even though we might wish to look at competitive bids.

The government has provided that insurance companies must cover all employees, but no one has guaranteed that it will be at a rate which is affordable.

Our company offers a quality plan—medical, dental, pharmaceutical coverage—with a wide network of doctors. Every year that passes, to remain affordable, I have to either raise the deductible or raise to copay. In past years, we have taken competitive bids just to remain even. However, the reality is that being insured is critical to our employees. We have in the past paid 100 percent of the premium cost for them.

In addition to being a socially responsible company, it is to our benefit to have healthy employees and we know that if we did not supply this benefit, some would never visit the doctor even for preventive care.

As you know, affordable health care is a problem that stretches from coast to coast. A colleague of mine in Wisconsin just went through the renewal process for her employees. She shared with me her employees will be paying a larger share of the premiums and they may delay coverage for new hires. One agent told her, "Small businesses can expect double digit increases every year in the foreseeable future no matter what their group's medical history is and no matter who the provider is." Every year I hold my breath when that renewal notice arrives. Our average increase has been almost 20 percent every year for the past four years.

Knowing that providing health insurance is necessary to me for both business and social reasons and knowing that I cannot in-

crease prices to my customers an extra 20 percent in order to absorb the cost, I continue to offer health insurance benefits despite the growing cost to our business. We have absorbed the cost every year and have not passed it on to our employees. Sadly, we now have had to rethink that policy and thus, I take the risk of losing good employees and dramatically increasing my turnover rate.

We have a 30-year old male employee, happens to be a family member, for whom our premium is about $200 a month. When he got married and had one child, he had to shoulder over $550 a month for two dependents, even after we paid his personal premium.

Those of us in the small business community are struggling each year to afford the cost of increasing premiums. It is for this reason that I support legislation endorsed by NFIB and others that would create association health plans. AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a larger group, thus ensuring greater bargaining power and lower administrative costs.

Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privilege as their counterparts in labor and big business. It will also spread the risk for the insurance companies. In the end, they win as well.

We all know that small businesses employ the vast majority of employees in this country and create the lion's share of all net new jobs. Yet this economic engine that drives our economy, small business, is the very group hurt by the inability to form AHPs. This needs to change.

I know that the AHP legislation has already passed the House of Representatives and I thank you for your leadership on this issue. I would urge our Senate to follow the House's lead.

There are several other things that Congress can do. I support and encourage the expansion of Medical Savings Accounts and Flexible Spending Accounts.

Currently, there is no rollover provision. NFIB supports legislation before Congress to allow $500 in unspent balances in FSAs to be rolled over.

Further, MSAs without the current restrictions would give employees more control over their own health care decisions. I also support the concept of having a tax credit for the purchase of individual health insurance.

I am a business owner, not a health policy expert, but I do know that there is a lot of debate about how to insure more Americans and how to help those currently insured continue to afford their coverage. We need common sense solutions to controlling the cost of quality health insurance.

Mr. Chairman, thank you for allowing me to share my experience with you and the members of the Committee. And I am happy to answer any questions that you might have.

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

Chairman AKIN. Thank you, Ms. Perry. We are going to go ahead to the questions afterwards, after we have heard from the other witnesses, but thank you very much for sharing with us.

Our next guest is Dr. Vince Degenhart. I believe you are an anesthesiologist and we really appreciate you coming in. Please proceed.

STATEMENT OF VINCENT J. DEGENHART, M.D.

Dr. DEGENHART. Thank you, Congressman Akin and Congressman DeMint and staff for enabling me to be here to speak with your Committee.

I have been practicing anesthesiology in Columbia, South Carolina for over 20 years. In those 20 years, I have seen an escalation in the number of malpractice cases and the amount of jury awards against physicians and hospitals. These rises in number of cases and jury awards have added greatly to the health care bill of America. Last year, of the 10 awards of over a million dollars in the state of South Carolina, six were against physicians, according to South Carolina Lawyers Weekly.

Ironically, this comes at a time when health care, technology, medical education are all improving. Health care in the United States is at a pinnacle and we try to get better and better and better. Life expectancy in the United States today, if you are born today, is 75 years. By the year 2010, it is expected to be 80 years. This is not because Americans are taking better care of themselves, as obesity and sedentary lifestyles have only increased the problems we see in medicine. But medical care is getting better, in spite of what our trial lawyer friends want to make America think. In other states, such as Pennsylvania, Nevada, West Virginia, they have had terrible crises in medical malpractice with doctors leaving the state, doctors quitting neurosurgery, physicians stopping delivering babies at ever increasing cost of malpractice insurance and the constant threat of being sued.

Not every decision we make in medicine is going to be the right decision, but even with the best education, the best drugs, the best surgeons, things will go wrong. The human body is a living marvel, yet we are all going to die. But that does not mean that someone made a mistake or that there was malpractice involved. But somehow in America, we have gotten to expect that perfect results are the only way.

The typical wage earner in America earns $25,000 a year, in South Carolina it is closer to $20,000 a year. As previous speakers have said, the premiums monthly are about $200 to $220 per month. That is over 10 percent of the salary. Each year, premiums go up by 15 or 20 percent, so now you pay more than 20 percent of your salary in premiums, so pretty soon, you cannot afford health insurance; therefore, we have 41 million Americans who are uninsured. These increases are incredibly high, yet if we look at malpractice insurance increases, they are staggering.

In Florida, the average OB/GYN premium is $143,000 to $203,000 per year. It is no wonder they are leaving Florida. Why when millions of Americans are without health insurance are we spending more and more on malpractice insurance and legal costs? $10 billion a year in the United States.

The average jury award in the last five years has gone from $500,000 to $1 million in medical malpractice cases. Insurance companies are stopping selling malpractice insurance. The biggest

one in the country, St. Paul Fire & Marine, stopped selling malpractice insurance in South Carolina and nationally last year, as their loss ratio—for every premium dollar they collected, they lost a $1.50. Well you cannot make money doing that. So they got out of the malpractice business, and they were the second largest insurer in our state. In this state, we are insured now primarily by the JUA and PCF, which are quasi-state agencies, non-profit with all volunteer boards. Yet, we have even seen dramatic increases in our insurance costs. This year in 2003, our increase is 24 percent on average. For my practice, it was 34 percent. We are paying this year $104,000 more than we were a year ago in malpractice insurance costs. We have gone from $301,000 to $405,000 in one year. Now you just cannot sustain those kind of increases in any type of small business.

So many people look on malpractice and physicians and hospitals as a pot of gold or their chance at the lottery, when it is not. That money comes from somewhere, it comes from each of you, all of us pay for it. That money comes out of the system. So now you have raised the bar, somebody gets a $20 million award, now somebody else cannot afford health insurance. It is estimated now that physicians, hospitals due to the cost of malpractice and runaway jury awards along with defensive medicine costs $50 to $100 billion a year in health care dollars.

What can we do to solve this problem? We need drastic solutions. Now H.R. 5 is a great start, we need to limit non-economic damages to $250,000; we need to do something with the contingency fee system. We are patterned after the English system of law and yet there is no contingency fee system in England. The loser pays and the judge is the judge and jury. So I think that we are on the right track with H.R. 5, unfortunately the Senate has voted against it and our own Senators, Hollings and Lindsey Graham, have voted against tort reform. A lot of money has gone into financial contributions, but I think that if we keep pushing, keep pushing, keep pushing, we can do something to solve this problem and get that hundred billion back into the health care system and out of these runaway jury awards.

Thank you.

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

Chairman AKIN. Thank you very much, Doctor.

Our next witness is Mr. Doug Moreland and I believe Doug, you are in the software business?

Mr. MORELAND. That is correct.

Chairman AKIN. Thank you very much for joining us. You can proceed.

STATEMENT OF DOUG MORELAND, CHIEF TECHNOLOGY OFFICER, BENEFITFOCUS.COM, INC.

Mr. MORELAND. Good afternoon, thank you.

There are a number of factors that are contributing to the high cost of health insurance. One of them that is significant I believe is the cost of the administration of health-related services. The cost of administering membership, determining eligibility, adjudicating claims is a significant contributor to the cost of insurance and this

is a burden that the health insurers and life insurers are all very familiar with.

About three and a half years ago, I and two other gentlemen co-founded a business here in the Charleston area, originally targeting a need that large and small employer groups had. Those groups were suffering under the burden of paperwork, paperwork associated with enrolling all of their employees in health-related services as well as other benefits such as 401(k) dental and vision insurances. Our intent was to capture that information, to unify it, on line so that it would be quick and easy for employees to enroll and transfer that information electronically to the health insurance carriers and the other related benefit providers.

Well, we learned very quickly that there was a substantial need in the insurance industry for these services and that led very quickly to partnerships with a number of large health insurers including Blue Cross-Blue Shield of South Carolina. From there, we began to learn what their exact needs were, how we could capture benefit enrollment for them, how we could transfer that data to them electronically and how we could reduce errors that were produced through latency in billing systems and in claims, a substantial number of claims that were being rejected because of miskeyed data.

From there, we began to work further and we became involved with the small group business, and we learned that the cost of administering small groups was substantially higher than the cost of administering large groups. Small groups turn over insurance quicker and the cost of selling and underwriting small groups is substantially greater.

Further, from there, we began to learn that consumer-driven health plans could be a significant contribution to the administrative costs because health insurers' cost was very high, but in addition to that, the employer groups' cost is very high. They are experiencing, you know, 15, 20, 25 percent rate increases every year and they are looking for some relief. The small group consumer-driven health plans would allow potentially for the configuration of health insurance on a family-by-family basis, in particular, co-payments, deductibles, co-insurance. Those types of features, if configured, would allow a family to purchase health insurance that would be substantially tailored for their needs, combined with a medical spending account, it could be a great advantage, because this would allow the employer to provide a fixed amount of funding to a family's insurance and thus allow families to spend their money more wisely. It also would introduce responsibility to the consumer.

Currently we have an environment where consumers have a tendency to use insurance if they have it and if they had more responsibility in purchasing the insurance, then we would probably see reduced costs—I would expect to see reduced costs from that.

So in summary, what Benefitfocus has been able to provide is administrative simplification, which of course is one of the chief tenets of the HIPAA Act and I am here less to tell you my opinions or what I think should be changed in the health industry, but more to inform you what our experiences have been these past years. And I give all of the credit to the health insurers for educating us

and inviting us into their business to add administrative simplification.

Thank you.

Chairman AKIN. Thank you very much for your perspective.

Dr. John Kulze, you are providing laser kinds of eye operations, if I understand that.

Dr. KULZE. Exactly. Thank you.

Chairman AKIN. Thank you.

[The statement of Mr. Moreland follows:]

STATEMENT OF JOHN KULZE, M.D.

Dr. KULZE. I am a Charleston physician in a small group practice with one other doctor and 10 employees. We provide comprehensive eye care including Lasik surgery and other eye surgery.

As a small business, we have experienced first-hand the difficulties of providing health insurance as an employer with skyrocketing costs also. We treat patients in need of health care without health insurance coverage also.

Lasik is one segment of eye care that has emerged in the last decade and is generally not covered by insurance. Subsequently, we have seen the cost of this procedure drop substantially over the last several years due to competitive pricing. Pricing varies greatly from high volume, low priced laser centers to more moderate costs from individual providers with personalized treatment. Medical offices, laser centers, banks, financing companies have all emerged that have created financing opportunities for almost any individual desiring the treatment. So it has opened the doors to almost everyone.

As a small business owner and physician, we recently changed our health insurance to a high deductible plan where the employee/employer contribute to the deductible cost. This returns the majority of the patient's outpatient care to a health care and financial transaction between doctor and patient. The third party does not stand in the middle and the doctor and patient are forced to weigh the cost of the treatment. This also allows the patient to control more of their health care costs and direct costs toward preventive care if they choose. Hopefully, changes such as these will continue to help relieve this insurance cost burden.

Thank you.

Chairman AKIN. Thank you very much for your testimony, Doctor.

My understanding is that you have business here that you have got to attend to fairly quickly, so perhaps I might start with a question or two for you.

Dr. KULZE. Okay.

Chairman AKIN. I will just start with first of all, how are the third party payment plans affecting your practice and how do you feel this practice can be improved?

Dr. KULZE. Well, quite often, the third party payment plan is, as I said in my testimony, in the middle. So a patient comes to see me and the patient and the doctor are together, yet they cannot maybe continue treatment or provide treatment until it is okayed by a third party payer and then possibly the treatment, depending on what it is, may not be covered by the third party payer. So it

adds a whole other layer between doctor and patient, where, you know, treatment and payment is done.

Chairman AKIN. Thank you very much. Congressman, did you have a question you wanted to———.

Mr. DEMINT. Yeah, Dr. Kulze—Kulze is right?

Dr. KULZE. That is correct.

Mr. DEMINT. I often use the example when I am speaking of laser eye surgery, so I am glad you are here. Because after years of working in health care myself and dealing with process improvement in many other business categories, I have found that because of the payer system on the medical side of health care, that it was very difficult for them—physicians, hospitals—to constantly change the way they deliver, to look for more efficient ways to do things, to look for new technology, to cut out steps, because of the coding system and really because of third party fixed payer systems. Not necessarily insurance in general, I want to make a distinction there.

But it looks to me that Lasik eye surgery is kind of an example of what could happen if not only the consumer was involved, but the physician was not tied down to the code system that is a part of all other medicine. You can deliver the service in the way that you think is best and you can pull out as many steps as you want and it is competitive, like you said, but it is my understanding that Lasik eye surgeons do just fine as far as what they are making, the price is getting lower and lower, the quality appears to go up, consumers making the decision.

Sometimes people will say well consumers really are not smart enough to buy health care. I would like you to maybe just comment on the code system, the consumers, how you do business directly with them. Do you think the American consumer can buy health care?

Dr. KULZE. Well, first, the code system is quite complicated and it seems to constantly change. So in a small practice like myself, I mean I even have to have someone designated or hired to keep up with correct coding. It would be completely impossible for me to code everything myself and know correct codes and file subsequently. I would not have the time.

Mr. DEMINT. But you do not have to do that for Lasik.

Dr. KULZE. Yes, Lasik, you do not. Lasik is—there is not a third party issue there to file. It is a transaction between patient and doctor simply, like most any other thing purchased in the world. So doctor and patient are going to sit down and discuss the procedure and decide the best route to go. There are varying price levels emerging with advancements in Lasik. Prices may very according to the patient's desires. If you want to take the Cadillac version, then you can have the Cadillac version and pay for it too. But there is some pricing in that manner. But competitive pricing between physician and physician has really brought the price down I think.

Certainly it is not going to go lower than the physician can stand. So it is at a level that is accepted I think to physician and patient.

Mr. DEMINT. Do you find the patient able to make—I mean there is a concern that if patients ever do business directly with you, that you are going to take advantage of them. How would we make sure

that did not happen if we tried to allow a lot of other medical services to be delivered in the same way? How do we know doctors would not take advantage of us?

Dr. KULZE. That is a good question and obviously like any business person—physician, lawyer, whatever—it comes down to when you are making the purchase, the transaction, the treatment, there has to be some trust obviously. I think physicians work hard to train themselves, to keep certification, to know what goes on from one physician to the other. I think patients see the quality of their care. I think what you see in the majority of private medicine is that doctors gain their business from referral from other patients. So patients that have received appropriate care and quality care, they tell their family members and friends who they think they should go to. So that system alone promotes quality care.

Mr. DEMINT. Okay. I yield back, Mr. Chairman.

Chairman AKIN. Thank you. I very much appreciate your coming in.

Let me see if I can summarize what I think I was hearing you say, to make sure I understand.

First of all, you are saying that at least in the Lasik side of your business, it is basically a free market in the sense that there is a product that is available and customers can come in and purchase it and they can negotiate what price they want, depending on which doctor they want to talk to or what procedure they need. And what you are saying is that that free enterprise is working well. It is producing—maybe I am putting words in your mouth, but tell me if I am. We are producing a good quality product, the costs are continuing to come down and yet the doctors and everybody is content with the result of the transactions, nobody is starving to death and people are getting good service. Is that the bottom line of what you are saying?

Dr. KULZE. That is generally so, I agree.

Chairman AKIN. But your practice also includes a much broader spectrum of work other than just Lasik, and so in those other categories, those are where you have the government set up and essentially it is a de facto price control type of thing and you also do not have the consumer that involved or immediately involved in the cost of what they are purchasing.

Dr. KULZE. True. I do probably the majority of my practice not Lasik and I strongly agree with the first gentleman that talked that I think the answer in my view, from the doctor's standpoint, is bringing this transaction back between patient and doctor, so that at the same time that you are discussing treatment, you are discussing the cost of the treatment. I think that is very, very important.

Chairman AKIN. Thank you very much for joining us, we appreciate you coming in, especially with I know that you have got other business waiting. So if you would like to be excused and want to slip out, that is fine. We have got some questions for the other gentlemen here as well.

Dr. KULZE. Thank you.

Chairman AKIN. I think maybe what I am going to do is to kind of go back around, Ernst, to you to start off and a question which pretty much really occurred to me as I heard a number of your

other testimonies. Different ones of you, depending on your perspectives, identified things that are driving health care costs. You know, the problem of malpractice in some areas, the problem of the cost of administration and a number of different things.

Let me ask, and anybody who wants to jump in on this question, please do. If you take a look at what these different cost drivers are and you had to rate them, which one is really driving cost of medicine the most. The first question would be what do you think that would be, if you can compare administrative costs to malpractice to other things. So that would be my first question.

Mr. CSISZAR Actually, Congressman, there is an interesting study out by Price Waterhouse in 2002 that sort of identifies some of the drivers and I think they are pretty much on target, because I would agree with the fact that the number one driver is demand. The number one driver is the fact for the first time since the Egyptian pyramids, doctors are providing of value to the patients, they are not telling them to go home and take a couple of aspirins. You know, there are procedures—artificial knees, MRIs, CAT scans, so on and so forth. So there is something that the customer is valuing in this. So I think demand supplemented by demographics, we know that our aged population is roughly about 13 percent of the population, but consumes roughly 33 percent of overall medical costs. So combine demographics into this demand equation and I do not think there is any doubt in my mind whatsoever that demand is the number one driver.

Add to that then things like malpractice and I would agree entirely with the doctor here that malpractice is a contributor. I would only caution you, I keep hearing about caps on awards and that is a good start, but that is not the whole solution. I entirely agree with the comments made with respect to loser pays, with respect to choice of venue, for instance, which is significant, with respect to trial by judge alone without juries for instance. So I think a comprehensive tort reform package would make eminent sense because it is a clear, clear driver.

I would add to that———.

Chairman AKIN. Could I interrupt you just a second? Could I assume that the things that you are mentioning are in sort of economic order?

Mr. CSISZAR Yes.

Chairman AKIN. So you would say first of all demand, obviously people want health care and that is really what is driving it.

Mr. CSISZAR Yes.

Chairman AKIN. Second thing would be malpractice.

Mr. CSISZAR Malpractice.

Chairman AKIN. You pick that over, for instance, administrative costs or whatever.

Mr. CSISZAR I would pick that over the regulatory cost, for instance, because the regulatory cost I would pick as number three, just the amount of paperwork required by things like the privacy legislation. Never mind paperwork, actually changes to computer systems, for instance, at an enormous cost. So I would add regulation as number three.

Certainly fraud is in there, I would put that probably in as sort of a number four.

But by far, outstripping all of this is just the demand factor I think. And that again is supplemented by a third party payer system, by demographics, et cetera.

Chairman AKIN. Thank you very much. Did anybody want to piggyback on that one way or the other?

Mr. DEMINT. A lot of the things you have mentioned—paperwork, administration, fraud—a lot of these are a result of again the third party fixed fee system, even the fraud trying to game the system. Liability is somewhat of an issue in that the patient is somewhat helpless in the process, all the decisions have to be made for them, so they cannot share in the responsibility the way it is set up.

So what I look for is, is there a common root cause. I mean certainly not any one thing is going to change it, but a lot of the system of bureaucracy and liability is built around the fact that the patient is not a decision-maker, not a responsible participant in the process and you have certainly spoken of that.

Let me switch to Mr. Marchant. Mr Marchant, you have heard the mention of these patient-directed plans, defined contributions. And in your testimony you mentioned that someone is going to—in other words, is going to have to ration utilization. It is either going to have to be a third party or it is going to have to be the patients themselves. I think we have heard here and many other occasions, if we make it free for the patient, then a third party is going to have to restrict access, because getting back again to the idea of demand.

But my question to you and I know that a number of the companies that you represent have been involved with some of these new products, but it does not appear that the insurance industry is as active as I might think they would be at a crisis stage of the industry developing defined contribution plans, trying to work out how to make them work better for patients, for employers, and maybe there is a lot going on that I do not know. But just from an industry perspective, is the development of defined contribution, health savings accounts, HRAs, is that a priority of the health insurance industry?

Mr. MARCHANT. Congressman, the industry reacts to the market. That is the reason why we had managed care to begin with and that is why you are seeing more and more companies coming up with these defined plans, MSAs. I know of at least one, probably several health insurance companies here in South Carolina that do offer these type products to employers. The information that I have received back is that people are not jumping to buy them. They appear to be complicated and for whatever reason, I do not know if the marketing folks are not pushing them, but we are not seeing people beat down the doors to buy them. But we surely—we are at a position in the market where we want to offer an employer anything. I mean we are at the point where they are making decision to drop everything that they have, so the industry is trying to retool and put products on the market which people feel comfortable they can buy. From what I understand so far is that the marketplace has not matured yet or maybe the crisis is not large enough, I am not sure. But they are not buying them like we thought they would. But they are being offered in this state.

I want to get back though to a question about controlling the cost and utilization, you talked a little bit about that in the laser surgery that was talked about earlier. That is an elective procedure. The industry is concerned that most health care is an involuntary purchase, so whatever—I mean the laser surgery, there is probably a lot of thought put into that, that is elective and you can shop around. But whatever plan that we decide to do, we still hope that there is an ability for someone to go in and have some prearranged discounts or some look after the fact to make sure that utilization does not continue on the rate that it is right now and that costs stay level.

Mr. DEMINT. I appreciate those points. But I think most health care is elective, 70 or 80 percent of what we go to the doctor for goes away by itself within a few days. And what concerns me is the way our system is set up, it encourages people to actually over-elect. Certainly the more serious procedures are not elective, the problems that people have, and my concern is that we are over-utilizing at the primary care level and we are not getting enough money up to the chronic, more tertiary services.

But again my question goes back to you. I know following the market is one thing, but it is my opinion that we need a lot of help figuring out how to make consumer-directed products work and we need a lot of participation from the health care industry. This is not exclusive of other health care products, I believe the cash accounts can work in conjunction with an HMO insurance product, with a PPO insurance product, with all kind of alternatives. What we are trying to do though is get some of the health care decision-making made with the individual having a vested interest in what it costs, pushing the health care industry to publish prices, to get more quality information and I guess my challenge to you and the industry is to help us on that, because it is a complex product to develop and I have had a number of employers say they have talked to their insurance companies about it, the products are not developed very well, there is not marketing material and folks are really just learning about it. But we did have 10,000 federal employees this year take a health reimbursement account product without very much promotion at all. So my hope is that it is growing.

But I appreciate yours answers and response and consideration there.

Mr. Chairman.

Chairman AKIN. Thank you very much for the back and forth on that. It raised one of the questions that came up to me, Larry, in your comments. I think you said something to the effect "someone must control the excess capacity," and I guess you could say which came first, the chicken or the egg. But that does raise a question and that is if you are going to control costs, and maybe that is making the assumption that they will be controlled one way or the other, you know, who is to do that? I think that certainly the health care industry has done a job doing that, they have dropped a lot of costs in the process of trying to cut out duplicate procedures, which we had a lot of problems with in other ways.

On the other hand, at a fundamental level, I think Ernst has raised the question of who is the ultimate person that is going to

be controlling that, and do we believe, as the doctor just suggested, that that is more of a consumer base or is that something that is going to be controlled by someone else. Do you have a personal opinion as to where that should go or do you generally support the concept that it should be more of a consumer driven model that is going to help us?

Mr. MARCHANT. Well, surely we would support more cost sharing for employees. I mean we understand and we believe that the more people feel the give and take, the better off we probably are on controlling utilization, and that of course will be right back to the patient. I mean they will make that decision. You know, insurance used to operate that way and we have moved toward copays and we have moved toward the prescription cards because that was the consumer demand, that is what employers were asking for. We got into the preventive medicine is good, we need to encourage people to get physicals that may have cost $400 but it is better to let them have it on a $25 copay and maybe catch that disease.

So all of these things were market forces and the industry is supportive of going back towards more pay as you go, but we have been under a tremendous political pressure from the Congress and from our state legislators to try to put products in the market the cover all these things, make it easy for the employees to access this care. So I think the industry is prepared to go either way, Mr. Chairman, on that issue. We want to be involved in presenting options for the market.

Chairman AKIN. Thank you very much, I think you answered my question.

A follow up then, Ms. Perry, you had mentioned several different kinds of ways to move more towards a market-driven system. At least I got that impression of some of your conclusions.

And I guess maybe I would just ask if you could elaborate, what are the advantages or limitations of either, whether it is a Medical Savings Account or the FSAs. I have trouble keeping them all straight, but essentially———.

Ms. PERRY. I do too.

Chairman AKIN. —essentially variations on the theme where you create more flexibility on the part of the consumer to control how they want to get insured and how they want to cover their medical liabilities. Could you comment on that?

Ms. PERRY. Sure.

On the MSAs, from my understanding and again, I am not an insurance expert by any means, individual families and individuals can pay medical expenses from an MSA and they can contribute to this tax free and it can be rolled over from one year to the next. So if they bank the pretax money to pay for copays or to pay for the deductibles and they do not use them all this year, they will roll over and this is true of the FSAs as well, the following year. Right now, I believe it's the FSAs, if they are not used by the employee, who has been the one to put their money into it, it goes to the employer, a wonderful boon to me, but not to my employee. And they are not going to be overly excited about putting their money into a fund that disappears at the end of the year. And right now, MSAs are scheduled to end December 31 of this year. They were a demo, it was strictly an experiment and it is not going to

continue into the next year unless something happens. And there has been a limitation of 750,000 individuals who are able to participate in this product and then it cuts off.

Chairman AKIN. So it is very limited what is available right now.

Ms. PERRY. Extremely limited—extremely limited.

Chairman AKIN. Okay.

Ms. PERRY. And I guess the one that is of most interest to me right now is the AHP, the Association Health Plan, and mainly for some of the reasons that I had mentioned. I see an economy of scale, I see a spreading the risk. Instead of just in-state, across the states, across the country, using the population of the country or the population of an association to spread the risk factor for the insurance company and for us. So that when I buy a company in Georgia, I do not have to worry about paying three times what I pay in Charleston, South Carolina. If I only have 17 employees, I am competing with a General Electric, I am competing with a large company that has a very large population to spread that risk.

Chairman AKIN. Thank you. Congressman DeMint, did you have any follow up questions along those lines?

Mr. DEMINT. Well, it is more of a suggestion. While MSAs are very limited, health reimbursement accounts are now available and can be rolled over. I would hope whatever carrier you use would make you aware of those. This is where an employer can put money into an account for an employee, they can provide a reinsurance product above that and the money can roll over if they do not spend it. Now we are trying to improve that so it will be portable, so that the employee can put money in it that rolls over, that is what health savings accounts are ultimately envisioned to be. But right now, you can create an HRA style of product.

But let me move from you to Mr. Moreland for a quick question.

When you were talking about defined contribution plans, it sounded like while you were positive about it, you were—did I hear you say that the administrative costs of those were high?

Mr. MORELAND. Well, to be more clear, I would say that the delivery mechanism is a little more complex. It is difficult for an employee to configure their benefits and determine their cost on a piece of paper, which is why our organization has gotten so involved in defined contribution plans, because it is easy via computer software to provide an environment where a subscriber, contract holder can configure their benefits different ways and see the immediate impact on the bottom line, their medical spending account and their overall costs.

Mr. DEMINT. But your general conclusion is that this is a potential solution to at least some of the problems we have talked about. Is that fair to say?

Mr. MORELAND. It is.

Mr. DEMINT. And it can be administered efficiently if given the right software and if your company does it, right?

Mr. MORELAND. And we might. But further I would say too, just referring to what we were speaking about earlier are defined contribution system really prevalent in our industry yet, and the answer I think is no, but I think there are a number of reasons for that. One is that there is somewhat a wait-and-see environment in the industry, but also because there needs to be a fair amount of

infrastructure in the administration systems to support defined contribution plans; in particular, paying claims out of medical spending accounts. None of those systems, software systems or even processes have really been established yet. So I think we will see that in time.

Mr. DEMINT. Good, good. I yield back.

Chairman AKIN. Thank you, Congressman.

I know that Congressman DeMint has done a lot to challenge the thinking of many of us in Congress along the lines of these, particularly the MSAs, FSAs and it is helpful to hear what you are saying, it just takes time. I remember when the HMO first came along. Boy, it took a long time to drag me along, I was one of those died in the wool, get my major medical policy on the street corner and do not bother me with telling me who my doctor was going to be. It takes time to try to have a public understanding, and I am sure the medical community to understand, how these systems are going to work. So I appreciate your perspective on that.

I appreciate, Jim, that you are challenging all of us to take a look at the way to try to develop that flexibility for our consumers across the board.

Mr. DEMINT. Thank you, Mr. Chairman.

Chairman AKIN. I think maybe just in a general sense, I will go back to the starting point I think that you, Ernst, put pretty clearly and that was from a systems point of view, we have got some fundamental problems in what we have got going. And I think that is has been my sense, and part of the reason I even ran for a government office was that we do have a systemic kind of thing. And the problem is that we have separated the consumer from the product that he is using, and that just by definition is going to drive costs. And I appreciate your sort of standing off and taking a look at it at a distance and saying, you know, we kind of have to challenge some of those assumptions at the front end.

My background was big business, I used to work for IBM and other places like that, and I understand—you know, businesses, I do not think of them as being evil, they are pretty much, you show me the rules, I will play the game. And I think the insurance companies have responded to the rules to some degree the way politics and people in public office have defined them.

Maybe we need to get back to the drawing board and get back to the basics that built America, which is allowing the consumer to be one that defines the demand, and maybe that answers that question that you mentioned, in terms of excess capacity. You know, if people will not pay for it, that is a quick way to stop it, and to try to develop those products.

Unless you have a follow on questions, Mr. Congressman, I am———.

Mr. DEMINT. I think we need to reassure Vince that we have heard the malpractice argument and that is almost a no-brainer, we need to do something about that. Medicine is not a perfect science and to hold doctors to a standard of perfection is only going to make it harder and harder for people to get health care and to afford insurance.

But did you have any additional comments to make?

Dr. DEGENHART. Well, I appreciate what the House has done in that regard, and hopefully the Senate can somehow come around, it has become a very partisan issue.

But since I spoke about the malpractice issue, I think I would be remiss if I did not speak about the quality issue. Because in medicine, we have got to improve quality. I think it is good and we like to pat ourselves on the back that we all do a great job and do not want to get sued. Yet the Institute of Medicine says we make 44,000 errors a year that cause death in the United States in American hospitals. That may be high, it may be low, I do not know for sure. But in any event, we are doing things. Our new committees on quality assurance, the new leap frog group out of Washington that is instituting a partnership with hospitals to have software programs such that medical errors in medications basically cannot be made. You cannot make a medication error that you write too much for a patient or not enough, or that you write the wrong drug or something they are allergic to. Also they will have treatment protocols for different disease processes—did you think of this, did you want to do this, did you want to do that. These are some systems things.

A lot of times, I think what has been known with this with the Institute of Medicine, what they showed was that most of the errors are not errors that the physician or the nurse or somebody makes personally, it is a system error. And we can fix a lot of these systems. And yes, that takes money and it is going to take time, but I think in the next two or three years, you are going to see dramatic changes in that regard in hospitals and health care facilities in their systems that are going to be so much better. And I think that will deliver a better product and hopefully ultimately a more cost-effective product as Lasik has shown.

Chairman AKIN. I may have glossed over. As a member of the House, we passed some different malpractice legislation, I do not know how many times in the last couple of years and so I kind of took that as we have already done that, and I would just wish that we had a tape recording to pass on to some of my Senate colleagues so perhaps we could move something along in that regard as well.

Perhaps some of you can do something about that. Who knows.

Larry.

Mr. MARCHANT. Going back to the answer that I gave to you about the utilization, I cannot leave without stressing this for the Committee to remember—patients do not control utilization in the hospital setting. The providers control utilization. So again, as we go back and rethink, yes, on the voluntary procedures when you are of a sound mind and you can think about what procedures you want to have done, remember that most of cost that we incur in the health care delivery system are 25 percent of the sickest people in the United States. Most of those decisions are involuntary, the person that is paying the way does not make those decisions on how many tests to run, what procedure is done. Those are done by the provider. So again, as we go through this process of putting people in control of their health care, we have to take into account that many of these decisions are not made by the folks who actually pay the bill.

Mr. DEMINT. And that is an excellent point, if I can jump in, Mr. Chairman. As I envision defined contribution, patient driven, I see primary and secondary health care and as we get to the tertiary level which is more involuntary, obviously third parties need to be involved. But we do need, to what degree we can, keep—make sure folks have insurance, they are covered, but keep the patient, their family at least involved with the financial aspect of it. Because at whatever point health care becomes free, the demand goes through the roof. And we just need to question all aspects of it and I appreciate all of you today helping us question it and come up with a few ideas.

We want to move from talking about the problem to figuring out what the solution is. And I know some of that is on our side, some of it is on your side, and so hopefully we have challenged each other today to come up with some new ways of doing things and we will see how the health care market evolves.

Mr. Chairman, I know we need to close right now but if anyone has 30 seconds of something that has not been said that needs to be said, you have done us all a great honor to be here and I want to make sure we do not leave it unsaid. So any additional comments?

(No response.)

Chairman AKIN. Well, I appreciate that. So far I have a perfect record of bringing meetings in on time and we have got four minutes that has been redeemed for everybody.

Thank you all very much. We will be standing by for a few minutes afterwards if you have any questions or answers or thoughts. Thank you all very much, the meeting is adjourned.

[Whereupon, at 3:00 p.m., the hearing was concluded.]

OPENING STATEMENT
25 AUGUST 2003

SUBCOMMITTEE CHAIRMAN W. TODD AKIN
SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT & GOVERNMENT PROGRAMS

"The Rising Cost of Health Care for Small Business Owners"

Good afternoon and thank you for coming here today.

When my friend, Congressman Jim DeMint, approached me to join him down in Charleston to discuss the healthcare situation facing South Carolina, I was happy to do so. Ever since his first days as a Member of Congress in our nation's capital, Jim has been known as a passionate crusader for a stronger small business environment and a tireless advocate for better, more affordable health care.

Having been on the front lines of the small business world with his own market research company, Congressman DeMint has not forgotten the travails of the small business owner. To this day, he is one of the leading voices among our colleagues on the Small Business Committee. He is constantly involved with any and all legislation having to do with improving care for his constituents.

Congressman DeMint's consistent commitment to consumer-driven healthcare and the survival of the small business community are perfectly illustrated in his proposal to provide employees with the option of rolling over up to $500 in funds left over in their flexible spending accounts at the end of the year. This prevents employees from having to "use it or lose it" by Dec. 31 of each year.

Jim and his office have brought us here today to discuss a very real situation: the rising cost of healthcare and the increasing burdens being putting on you, the hard-working, tax-paying Americans who sustain our employer-based healthcare system and whose commitment and energy help make it the best in the world.

Jim's staff has gathered a wide array of voices from the community to help us develop solutions for this crisis.

I thank you for answering this call and look forward to hearing your thoughts. First, though, Mr. DeMint, would you like to say a few words?

Outline of Testimony Before the
Congress of the United States of America
House of Representatives Committee on Small Business
Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises

August 25, 2003
1:30 p.m.
Magnolia Room
Charleston Place Hotel
Charleston, South Carolina

Ernst N. Csiszar
Director of Insurance
State of South Carolina

The Rising Cost of Health Insurance for Small Businesses

I. Introduction

Chairman Akin, Congressman DeMint, members of the Subcommittee,
Good morning, my name is Ernie Csiszar, and I am the Director of Insurance for the State of South Carolina. Thank you for the opportunity to speak to you today on the topic of *The Rising Cost of Health Insurance for Small Businesses*. For the next several minutes, I will highlight the problems of health insurance affordability and availability within South Carolina for small employers. Accordingly, my comments today will focus primarily on the South Carolina small group health insurance market. I will address the following points:

- Why health insurance premiums are on the rise;
- South Carolina's efforts to enhance health insurance affordability and availability within its small group health insurance market; and
- Some general thoughts on the possible solutions.

The Problem Confronting South Carolina Small Businesses

Let me begin by saying that in South Carolina our small employers *have access* to health insurance coverage. However, as in most states, the cost of health insurance is

simply unaffordable for most small employers;[1] consequently, the cost of health insurance coverage becomes a barrier. The average annual cost of employment-based family coverage approached $8,000 in 2002, and health insurance cost is cited by small businesses as their number one issue.

The issue of health insurance and small employers is an important one because most South Carolinians, like most other Americans, obtain health insurance through their employer. Most South Carolinians are employed by small businesses, i.e., businesses with less than 50 employees. Without offering health insurance, the ability of these businesses to recruit, attract or retain employees is limited. With the rising costs of health insurance, most small employers cannot offer health insurance as an employment benefit. Those who do offer this coverage cannot do so without some cost-sharing, making the issues of access to appropriate services more acute in South Carolina's small group health insurance market. The rising costs of health insurance threaten the economic survival of some small businesses.

II. Why Health Insurance Premiums Are on the Rise

Many experts will tell you that inflationary cost increases are the primary contributor to the rising costs of health insurance. Medical inflation certainly plays a role, but I do not think it is the primary reason health insurance costs appear to be out of control.

Health insurance costs are rising, in my opinion, not solely as a result of medical inflation, but because we are utilizing health care services at higher rates than we ever have before. As health care utilization and spending increase, so do health insurance premiums. While factors such as 1) the costs of prescription drugs; 2) the expense of new medical technology; 3) medical malpractice awards; and 4) the cost of uncompensated care certainly contribute to the cost of health insurance, they are not, in my opinion, the primary reason costs are spiraling out of control. The problem is not

[1] This issue is not unique to South Carolina. Most states are confronting similar problems with health insurance.

medical inflation *per se*; it is utilization combined with a flawed business model for health care delivery.

This may be contrary to most of what you have read about the reasons for the rising costs of health insurance. Some experts cite new medical technology, government mandates and uncompensated care as contributors to the rising costs of health care. Most argue that the costs of prescription drugs are the primary culprit. Each of these plays a role. For example, out of the $1.1 trillion dollars that has been spent on healthcare, the costs of prescription drugs account for $138 billion of that amount---significant, but not overwhelming when compared to the total cost. Mathematically, that's about 12% of the problem. There is still about $1 trillion that requires explanation. The increased use of intermediaries contributes in excess of $40 billion to the costs. However, neither the cost of government mandates[2], new medical technology[3], use of intermediaries nor the costs of uncompensated care[4] account for the remaining $1 trillion.

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[2] It is reported that health insurance mandates contribute to the cost of health insurance. Government regulation contributes to premium growth. While this may be true in some states, South Carolina is considered a low mandate state and the cost of state mandates contributes about 5.3% to the overall cost of health insurance coverage. Yet, the costs of health insurance continue to rise.

Some insurers indicate that their costs of providing health insurance have increased significantly with the implementation of federal mandates required by the Health Insurance Portability and Accountability Act (HIPAA). These costs are passed off to the consumer in the form of higher insurance premiums. The cost of federal mandates has been cited by some carriers exiting the South Carolina market as the primary reason for their decision. Carriers deciding to exit the small group health insurance market in South Carolina have indicated that the decision is not limited to South Carolina. If an insurer decides to exit the market, it typically does so nationwide.

The number of insurers offering health insurance coverage dropped from 72 in 1997 to 32 as of December 31, 2001. The reasons cited for exiting the small group market have varied; however, 33% of these insurers cited financial losses, 22% indicated that they were focusing their business elsewhere, 6% indicated their departure was due to the guaranteed issue and guaranteed renewability provisions of HIPAA, and the remaining 39% have exited the market altogether. The overall number has further decreased to 23 as of December 31, 2002.

Additionally, the price of health insurance coverage within the market has increased while coverage appears to be diminishing. With the fewer number of insurers, competition has naturally decreased and participation in the state reinsurance pool has been lower than expected. Research demonstrates that this

Flawed Business Model

Our healthcare system is complex, and is supposed to be a private delivery system with the government as a safety net for the poor and the elderly. Rightly or wrongly, access to health care is not a right in this country as it is in others. Our system relies on *optional* employment-based coverage. Even though we do not have universal healthcare, more costs and decisions about healthcare are shifting to government purchasers and consumers. The rising costs of health insurance and the aging of the population is largely responsible for this shift. Most baby boomers will be 65 in 2010 and that will move more Americans into a government-funded system. Although our system of healthcare is supposed to be private, there is a very strong shift toward government as the primary payer.

In 1997, government programs in the United States accounted for 46.4% of health spending, a 5.9% increase from government spending in 1990. At that growth rate,

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issue is not isolated to South Carolina. Many of the carriers that have left the South Carolina market have also exited the small group market in other states.

[3] Fortunately, with the advances in medical technology, we are able to treat more illnesses and diseases than ever before. Although necessary, this new technology tends to be expensive and contributes to the overall costs of healthcare.

[4] Additionally, uncompensated care contributes to the increased costs of health insurance. We believe that South Carolinians are using emergency rooms more as the primary source of their health care services because they are either unable to afford or do not think they need health insurance. Particularly, South Carolinians with low incomes and no insurance coverage often are unable to seek or obtain timely or adequate health care, turning to emergency room or other safety net providers, such as community health centers and public hospitals, or forego care entirely. Compared to those who are insured, the uninsured tend to have more serious preventable illnesses that threaten their work productivity and ability to retain jobs. The South Carolina Office of Research and Statistics reports that in the year 2000, there were 312,076 emergency room visits by the uninsured. Emergency room visits by the uninsured for possible injuries do not include any traumatic injures but rather ill-defined and unspecified types of injuries (sprain of back, open wound of head, back disorder and symptom involving head/neck). The medical reasons involve acute infections of the abdomen, pelvis, respiratory system and urinary tract. These are illnesses that generally can be treated in a physician's office.

government will be the principal payer of healthcare by the end of this decade if it is not already. More importantly, the United States Government has taken a stronger role in the regulation of private healthcare e.g., mandated 48-hour maternity stay, mental health coverage requirements, Women's Health and Cancer Rights Act, and HIPAA. Concomitantly, in the private insurance sector, the patient and providers control the costs, but the employers and the carriers pay. This system of healthcare delivery desensitizes the consumer to the actual costs of medical services thereby contributing to the escalating costs for those services. Co-pays are generally less than $50 and have been totally ineffective in controlling the costs of health care.

Clearly, the business model for our system of healthcare delivery is flawed. We have a system where a third party payer pays most, if not all, of the costs of healthcare thus causing a disconnect between the actual users of the system and the payer(s).

Over-utilization

Our population is aging; consequently, the overall utilization of health care is on the rise. In South Carolina, health status is a major factor in utilization. South Carolina ranks 46th in overall health status—the 4th worst in the nation. South Carolina ranks 1st for deaths due to stroke and 10th for deaths due to heart disease. Complications from diabetes was the 6th leading cause of death in 1999. Moreover, half of our population is overweight or obese and the Center for Disease Control reports that nearly 80% of South Carolinians are at risk for health problems related to lack of exercise.

Adverse selection is also at work here. Our youth do not purchase health insurance when they should because they consider themselves healthy and believe they do not need it. As a consequence, people generally tend to purchase insurance when they become unhealthy. Moreover, the quality of care has improved significantly in the last two decades. Consumers have become more sensitive to the value of healthcare and are demanding more. These factors all put pressure on resources such as prescription drugs and home health services and thus increase the costs of health insurance.

It is apparent that our society is relying less on preventive behavior (balanced diet and exercise) to maintain health and more on health care services, hence, over-utilization. No one is advocating that consumers *not* seek health care. We need to seek care. However, as consumers, we need to become more responsible stewards of our own health. I do believe that more emphasis needs to be placed on primary care and prevention. Heart disease, osteoporosis, diabetes---all are diseases where the costs of care drop when the patient takes an active role in managing the illness. Over-utilization results when we constantly seek care but there is no modification in behavior or active disease management. When you combine the increased utilization of the healthcare system with a flawed business model, you get disaster.

III. Conclusion

The legislative proposals that we develop to expand coverage and stabilize rates will only be temporary fixes. There can be no permanent solution to this issue until we correct the problems with our healthcare delivery system by making some fundamental policy decisions in this country and getting control of the underlying costs.

The system must be fixed before any meaningful solutions can be fashioned. Policymakers in this country must decide whether they want to provide universal healthcare to its citizenry, and provide it. We need to stop tip-toeing around this issue and confront it.

The issue of universal healthcare is a controversial one because many people think that you are advocating a single payer system. I am not advocating a single payer system. Single payer universal healthcare systems are imperfect. Most countries with single payer universal healthcare systems are trying to develop private health-care delivery systems to supplement the governmental system. The private market competes based upon benefits in these countries.

The issue of universal healthcare is also controversial because experience shows these systems do not work unless all citizens are required to purchase health insurance. The pool must be large enough to spread the risk and measures must be in place to keep costs down.

The health insurance industry has come full circle. Healthcare inflation was spiraling out of control in the 1980's. This was addressed by managed care. Employers contracted with managed care organizations to control costs. This worked for a while, but managed care was viewed as too restrictive by the users. All of the savings that resulted from the managed care cost control mechanisms have been taken. There is little, if any, cost control now. The response has been to shift more of the costs to the consumer. Some health plans are already experimenting with different tiers of pricing in which patients pay less when they use network providers as well as providing different co-pays for drugs depending upon whether they are generic or name-brand.

I do not believe that more government involvement through price controls or cost shifting is the answer. It is simply a deferment mechanism. More government involvement does nothing to control the costs of healthcare or health insurance. If anything, costs may increase as a result of such action. Cost-shifting only increases the number of uninsured. When more of the cost of health insurance coverage is shifted, evidence suggests that employees simply refuse to enroll for coverage citing the expense of the coverage as the primary reason for their decision.

Price controls do not work. I am convinced that it is the right solution to the wrong problem. The problem in health insurance is not medical inflation *per se,* but utilization combined with a flawed third party payer system. The system needs to be fixed. Price controls on prescription drugs may yield some temporary savings, but will not correct the overall problem. Similarly, bandaid-type legislation such as the Patient Bill of Rights or legislation allowing United States citizens to import drugs from Canada are all temporary fixes to much more complex problem. Patient education focusing on prevention and incentives to encourage proper use of the system must be critical components of any solution developed.

APPENDIX A

What has South Carolina Done to Expand Insurance Availability and Affordability?

The next several pages summarize some of the things South Carolina has done and continues to do to try to expand health insurance coverage within the small group health insurance market.

Legislative Initiatives.

Pre-HIPAA Reform

Insurance market reforms were enacted across the country in the early 1990's in response to concerns about both the individual and small group insurance markets. The percentage of individuals covered by private insurance was declining. The decline was more rapid in the small group and individual markets. Additionally, the cost of insurance was rising rapidly. The market was characterized by the following activities: medical underwriting and adverse selection[5]; exclusions on pre-existing conditions[6]; lack of portability[7]; churning,[8] durational rating[9] and industry screening.

During the 1990's, the majority of states enacted small group market reforms designed to improve the availability of health insurance coverage. These reforms included rating restrictions, limitations on pre-existing condition exclusions, guaranteed issue requirements, guaranteed renewability and portability of coverage. These reforms

[5] Problems within the market first became apparent in the individual market. Generally, young, healthy individuals do not purchase insurance until there is a need i.e., the birth of a child or the onset of a disease. Therefore, these individuals tend to be more risky. This raised the price of insurance to a level that many of them could not afford. Similar problems spread to the small group market. This is generally referred to as adverse selection. To counteract adverse selection and to offer more attractive prices, insurers engaged in medical underwriting by rating applicants based upon their age and health status.

[6] Insurers included provisions within their contracts that restricted coverage for illnesses that existed 6-12 months prior to enrollment in the plan. Some insurers declined to cover high-risk individuals or excluded a designated set of health problems altogether such as cancer or asthma. This was referred to as "ridering out."

[7] The pre-existing exclusion provisions created "job-lock," where ill employees were frozen into their present position by the fear of losing insurance benefits if they were to switch jobs.

[8] Churning refers to the practice of offering deep discounts to new subscribers after extensive medical underwriting.

[9] Durational rating occurs when insurers discount premiums then subsequently raise premiums as the policies age and payment of more benefits under the policy is likely.

were expected to improve equity (prevent discrimination), expand access, decrease variation among premium levels, and prevent destabilization of the market. The reforms of the 1990's culminated with the passage of HIPAA in 1996.

Like most states, South Carolina began reforming its small group health insurance market in the 1990's due to complaints from small employers about availability of insurance and high health insurance premiums, particularly from those small employers with employees who had health problems. Prior to these reforms, exclusionary riders were not permitted and pre-existing condition limitations were limited to 12/12. However, there were generally no restrictions on rating, renewability or issuance of coverage.

In 1992, small group rating went into effect. These rating reforms implemented rating bands that imposed limits on the use of health status in rating after adjusting for various case characteristics. However the rating reforms, did not address all of the issues plaguing the small group health market and did not appear to stabilize health insurance premium rates adequately for the small group market.

In response to continued concerns from small employers about the affordability and availability of health insurance coverage, the South Carolina General Assembly enacted the Small Employer Health Insurance Availability Act[10] to improve small employer access to health insurance in 1994. The Act also attempted to promote rate stability thereby making coverage more affordable. It was intended to reform the small group market where groups with health problems faced limited coverage opportunities that were too expensive. Purchasing cooperatives were also allowed.

The law required insurers marketing to small employers to offer certain plans on a guaranteed issue basis. The law also required the use of modified community rating, which prohibited the use of health status in establishing rates, and generally required policies to be renewable as long as the employer continued to pay the premiums timely. Accordingly, any small employer that wanted to could buy comprehensive health insurance coverage regardless of the health conditions of the owner, the employees, or their dependents. The insurer's guaranteed issue plans were referred to as the basic and

[10] *See* S.C. Act No. 339 of 1997.

standard health insurance plans. These plans included hospitalization, outpatient care, doctors' visits, primary care, and preventative care. The preventative care benefits were designed to provide good health through immunizations and prescribed periodic screenings. The law also required the use of modified community rating and prohibited the use of health status in establishing rates.

HIPAA Reform

In 1997, South Carolina began implementing the changes required by HIPAA. HIPAA requires insurers to guarantee issue all plans offered to small employers. The portability, renewability and non-discrimination provisions were also applicable to the large and small groups.

Effective July 1, 1997, these guaranteed issue requirements would have been coupled with modified community rating, if the rating provisions were not changed. The guaranteed issue and modified community rating requirements had a negative impact upon the market because they did not allow insurers the necessary rating flexibility to recoup some of the costs of adverse selection. Consequently, the Small Employer Availability Act was modified in 1997 to allow some rating flexibility. Group size was added as a rating characteristic. The allowable case characteristics for rating purposes now include age, gender, geographic area, industry, family composition, and group size. The legislation allows permitted use of health status for rating within certain limits.

The most significant change brought about by insurance reforms of the 1990's was rate stabilization. Rates stabilized for a time as a result of adjusted community rating and the flexible rating bands legislation introduced in 1997. However, without a formal comprehensive study, it was difficult to define or attribute all of the changes in the market to legislative reform. Although price increases had stabilized after the introduction of these reform initiatives, they are on the rise again. Some carriers attribute their exit from the small group market to HIPAA rules and their inability to make a profit in this market.

Expansion of Coverage Under the South Carolina Health Insurance Pool (SCHIP)

In 1989, the South Carolina Health Insurance Pool was created to assist persons who could not obtain health insurance coverage from any other source in obtaining health insurance coverage. Most recently, the Department recommended that the Pool be expanded to cover the disabled under 65—those South Carolinians who could not obtain health insurance but were otherwise eligible for Medicaid or Medicare.

Expansion of Publicly Funded Health Insurance Programs

The South Carolina Medicaid program enrolls low income persons ineligible for supplemental security disability income, whose net family income is less than 150% of the federal poverty level. Additionally, private organizations such as the Medical University of South Carolina and Palmetto-Richland Hospital provide care for uninsured South Carolinians. Other programs sponsored by private organizations include, but are not limited to, CommunIcare. South Carolina has tried to be creative in addressing the needs of its uninsured. Described below are some of the projects conducted in the State to provide needed healthcare or to expand coverage to the uninsured in this State.

South Carolina Health Access Program

The South Carolina Health Access Plan (SCHAP) was a federal demonstration project that provided health insurance coverage to low-income employees and employers. This was accomplished by using the Medicaid program, structured in a managed care insurance environment, with employers and employees paying premiums approximating 30% of their health care costs. The project operated in Horry and Marion Counties and was available to local small businesses that participated on a voluntary basis. Health insurance premiums were collected monthly through the employer and matched against federal Medicaid funds to pay participating health care providers. Members had the freedom of choice to select a primary care participating physician. The physicians received Medicaid reimbursement and a $4 per member/per month management fee for

accepting responsibility for the patient's care. The physicians determined the need for care, coordinated referral, ensured access to medical care 24 hours per day, and monitored all treatment provided to the patient.

Eligible Businesses. All businesses were required to be located in Horry and Marion Counties and have less than 100 employees. Additionally, 50% of the firm's employees had to earn less than 150% of the federal poverty level (family income eligibility requirement). In order to participate, a business had to enroll at least three eligible (full-time workers under the age of 65) employees. No health insurance could have been provided to the eligible population during the prior 12-month period.

Premiums. The premiums were as follows: single - $39.94/month, employee portion - $9.98. Family - $99.29/month, employee portion - $24.82. Employees with income under 100% of FPL were not required to pay a portion of the premium.

Participation. The program began in April 1995, and ran for 48 months serving 2,815 individuals. Ninety-one physicians provided 38,528 member months of care to beneficiaries. $3,086,504 was spent for direct medical care at an average cost of $80.11 per person per month. Premiums accounted for $1,313,304 of the total health care cost. The cost of the program as of April 15, 1997, including administration, totaled $5,211,398.

Administration. The demonstration project was administered by DHHS with subcontracts to the Department of Social Services (DSS) and Blue Cross/Blue Shield of South Carolina Advisory Bodies. Project staff received policy guidance from a seven-member commission from the DHHS. The project staff also received advice and guidance from the Health Access Board of Horry and Marion Counties and a seven-member Physicians' Advisory Council.

Findings. The South Carolina Health Access Plan successfully achieved its objectives of providing health insurance coverage and showing that the Medicaid program would be a

feasible means of solving the problem of the working uninsured. Based upon the South Carolina experience, the demonstration project determined that the Medicaid program can be a feasible mechanism to provide health care coverage to the low-income working uninsured. Use of the administrative structure, reimbursement systems, MMIS systems, and other infrastructure facilitated the cost-effectiveness. Through the HRSA grant described infra, we are trying to determine whether we can duplicate the success of this project.

Other Private Healthcare Initiatives

Tri-County Project Care, Inc. (TPC)

TPC was established in the Charleston, SC area to provide quality, affordable health care to all the uninsured by investing public and private resources in the coordination and delivery of a not-for-profit pilot program dedicated to those eligible tri-county residents without access to affordable medical services. TPC offers a network of community health centers and physicians located throughout the tri-county area. These providers include the Medical Society of SC, Franklin C. Fetler Center, Inc., McClennan-Banks Clinic, University Medical Associates, DHEC Trident Health District, United Physicians, Thomas Cooper and Associates, St. James-Santee Family Health, Sea Island Comprehensive Health Services, Medical University of South Carolina, Care Alliance Health Services, Trident Health System and East Cooper Regional Medical Center. The Greenville, SC and the Columbia, SC (Richland-Palmetto Hospital) areas have also established similar projects.

Expanding Health Insurance Coverage and Stabilizing Rates Within South Carolina's Small Group Health Insurance Market

The issues in the health insurance market in South Carolina are not unique to South Carolina. In light of this, South Carolina pursued and obtained a grant from Health Resource Services Administration (HRSA) to perform an in-depth study of South Carolina's small group health insurance market. Nationally, states are experiencing deterioration of the health insurance market—particularly in the small group market. The work performed by this grant represents the first comprehensive study done on South

Carolina's health insurance market. While some studies have been conducted, they have been fragmented and limited to various segments of the industry. Most of the data about the uninsured in South Carolina is based on national studies and small samples from South Carolina with high standard error rates. It is difficult to formulate health policies and solutions to the issues confronting this state without valid and reliable state specific data.

The purpose of this project is to collect data that will enable this state to develop initiatives designed to stabilize health insurance rates and expand access to health insurance coverage particularly within the small group health insurance market. Set forth below are the project goals:

1. To organize the South Carolina Health Insurance Policy Advisory Committee---a multi-disciplinary Advisory Committee that will help develop and design strategies that will reduce the number of uninsured by improving access to health insurance coverage.

2. To summarize existing data to gain an understanding of the health insurance status of South Carolinians.

3. To collect primary data that will enable us to identify who the uninsured are, the reasons for their uninsured status and barriers to access to health insurance.

4. To analyze the data collected and enhanced knowledge of the uninsured in order to determine how the state may improve upon successful public programs (e.g., SCHAP) or design new strategies, programs and/or initiatives to improve access to health insurance coverage and stabilize rates within the market so that those who have insurance do not lose insurance coverage.

5. To present the project findings to policymakers and leaders within the state in order to facilitate implementation of the initiatives and strategies identified as possible solutions to improvement of health insurance access for South Carolina small employers.

Through our date collection activities under the grant, we have determined that national statistics about the uninsured in this state are understated. The number of uninsured appear to be much higher. More importantly, the majority of the uninsured have jobs and are employed by small employers.

National Health Insurance Symposium

Finally, this National Health Insurance Symposium is a part of our efforts to develop strategies to expand health insurance coverage. National experts on health insurance policy have been invited to discuss strategies and potential solutions to expanding health insurance coverage. We hope to take some of what we learn here over the next couple of days and develop legislative proposals to expand health insurance coverage and stabilize rates within the small group health insurance market.

Testimony before the United States Congress on behalf of the

Testimony of

Evelyn Reis Perry

before the

Subcommittee on Workforce, Empowerment and Government Programs

on the date of

August 25, 2003

on the subject of

Small Business Access and Alternatives to Health Care

Testimony of
Evelyn Reis Perry, President of Carolina Sound Communications, Inc.

Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me today to talk about the important issue of affordable, accessible health insurance for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing 600,000 members who face a similar challenge.

My name is Evelyn Reis Perry and I am President of Carolina Sound Communications, Inc., Sound Communications, Inc. and Georgia Sound Communications LLC, family-owned firms that provide a wide-range of communication products and services to over 2,000 clients.

We are based right here in beautiful Charleston, S.C. and also have offices in Myrtle Beach, SC and have recently expanded to Savannah, G.A.

At Carolina Sound Communications, we are both low voltage contractors and the MUZAK franchise in over 30 counties in South Carolina and Georgia. We utilize the emotional power of music to create an experience for our clients and their customers and through audio architecture, we provide brand identification for them. We design, install and service sound and video systems for industry, schools, theaters, military installations and other businesses.

Additionally, we design and install digital security products via closed circuit camera systems; nurse-call systems to hospitals and the health-care industry; inter-com

systems and informational technology to schools; sound systems and intercoms to the fast-food industry; audio visual systems for board rooms; point of purchase advertising in the business and retail industry as well as messages-on-hold for telephone systems. We also install sound masking systems and now, we are assisting the medical field in their compliance with the HIPPA Act.

Carolina Sound was established in1984 although the MUZAK business has been in Charleston since the early 1950s. We have continued to grow appreciably and have established the business as the premier sound and video business in South Carolina and now Georgia.

As President, I manage the day-to-day operations and am responsible for the overall management of our company. My position involves various tasks from public relations and advertising to purchasing, hiring, customer contact on a daily basis, to managing the human resources activities and administering our employees' benefit packages. At Carolina Sound, Sound and Georgia Sound, we have 17 employees.

Like many entrepreneurs, I learned early that, if I want to remain competitive in hiring, I must offer an attractive benefit package. Since we started the company, we have provided comprehensive health care insurance to all employees.

I spent 20 years in the private non-profit world before I became a business owner and social responsibility is important to me However, recently, two experiences forced me to stop and re-think health insurance and what role an employer should play.

In January of this year, we acquired the MUZAK franchise in Savannah, Georgia. This franchised territory consists of 13 counties in Georgia and Hilton Head and Beaufort in South Carolina. The five employees there were covered by health insurance provided

by a larger corporation, which previously owned this property. This company provided 50% of the premium cost to the employee.

In investigating what this group would cost our company to cover, we found that the premiums in Savannah were almost triple the premiums in Charleston. This "penalty" was for no other reason than the zip code of the Savannah office. It would be impossible for us to cover these new employees at 100% as we had for years done in Charleston. We have them presently covered under a temporary policy while we investigate what other options are available. Additionally, one of our principals is now a diabetic making it a risk to change companies even though we wish to look at competitive bids.

The government has provided that insurance companies must cover all employees but no one has guaranteed that it will be at a rate, which is affordable. So we have a golden noose with our current provider.

Our company is able to offer a good PPO plan to our employees. We want to provide a quality plan – medical, dental, pharmaceutical and vision coverage, with a wide network of doctors.

Every year that passes, I have to either raise the deductible or raise the co-pay. In past years, we have also had to take competitive bids to remain even. Every year, it has become more and more difficult to find an affordable plan. However, the reality is that being insured is critical to our employees. We have, in the past, paid 100% of the cost for our employees.

In addition to being a socially responsible company, it is to our benefit to have healthy employees and we know that if we didn't supply this benefit, some would never visit the doctor even for preventive care.

We offer AFLAC as a supplemental plan through pre-tax payroll deductions and we have paid for a life insurance plan as well.

As you know, affordable health care is a problem that stretches from coast to coast. A friend and counterpart of mine in Wisconsin just went through the renewal process for her employees. She shared with me her employees will be paying a larger share of the premiums and they may delay coverage for new hires. One agent told her "small businesses can expect double digit increases every year in the foreseeable future no matter what their group's medical history is and no matter whom the provider is." Every year, I have begun holding my breath when that renewal notice arrives. Our average increase has been almost 20% every year over the last four years.

Knowing that providing health insurance is necessary to me for both business and social reasons, and knowing that I cannot increase prices to my customers an extra 20% in order to absorb the cost, I continue to offer health insurance benefits, despite the growing cost to the business. Our business has absorbed the cost every year. We have not passed on that cost until this year. Sadly, we have had to re-think that policy though we will try to hold it to as little as possible. Thus, I take the risk of losing good employees and dramatically increasing my turnover rate.

Additionally, I am forced by the insurance companies to provide a minimum number of people to insure or the premium goes up yet again, so we sometimes insure people who already are insured by other means (military insurance still in place or

spouses who are insured) and we are forced to pay maternity benefits for women who are long past the childbearing age or who can no longer have children because of surgery. If we have one employee of childbearing age, we have to insure them all. We have a 30-year-old employee (a family member) for whom our premium is about $176 a month. When he got married and had one child, he had to shoulder over $550 a month for the two dependents even after we paid his personal premium.

Those of us in the small business community who offer insurance are struggling each year to afford the cost of increasing premiums. It is for this reason that I support legislation endorsed by NFIB and others that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from costly state insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business.

In addition, AHPs will introduce into the market place much needed competition and diversity. It will also spread the risk for the insurance companies. In the end, they win as well. Without the ability to shop for more affordable options, we are forced to shift costs to our employees or drop coverage. AHPs would begin to end the nightmare of health care purchasing for small businesses.

We all know that small businesses employ the vast majority of employees in this country and create the lion's share of all net new jobs. Yet this economic engine that

drives our economy, small business, is the very group hurt by the inability to form AHPs. This needs to change.

I know that the AHP legislation has already passed the House of Representatives and I thank you for your leadership on the issue. I would also urge our Senate to follow the House's lead on this important issue.

There are several other things that Congress can do in this area. I support and encourage the expansion of Medical Savings Accounts (MSAs) and Flexible Spending Accounts (FSAs).

Currently, there is no rollover provision to allow individuals to keep the money for future expenses or for the funds to be distributed to the individual from one year to the next. These limitations need to be changed to allow workers to take control of health care costs and prepare for the future. NFIB supports legislation before Congress to allow $500 in unspent balances in FSAs to be rolled over.

Further, eliminating the regulatory burden on MSAs would benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees. They give employees control over their own health care decisions. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business. I also support the concept of having a tax credit for the purchase of individual health insurance.

Like most small business owners, I talk to a lot of people every day. To be competitive on Main Street, you have to. I know from talking to other small employers that AHPs, MSAs, FSAs and tax credits would be great options for small business owners.

Now, I'm a business owner, not a health policy expert, but I do know that there is a lot of debate about how to insure more Americans and how to help those currently insured continue to afford their coverage. We need common sense solutions to controlling the cost of quality health care.

Mr. Chairman, thank you for allowing me to share my experience with you and the Members of the Committee. I look forward to the relief that will come from Congress by enacting AHPs and expanding MSAs, FSAs and tax credits, and I am happy to answer any questions that the Committee may have.

NFIB CORE VALUES

We believe deeply that:

Small business is essential to America.

Free enterprise is essential to the start-up and expansion of small business.

Small business is threatened by government intervention.

An informed, educated, concerned and involved public is the ultimate safeguard.

Members determine the public policy positions of the organization.

Our employees, collectively and individually, determine the success of the NFIB's endeavors, and each person has a valued contribution to make.

Honesty, integrity, and respect for human and spiritual values are important in all aspects of life, and are essential to a sustaining work environment.

NFIB
The Voice of Small Business™

WRITTEN TESTIMONY OF VINCENT J. DEGENHART, M.D. FIELD HEARING OF THE COMMITTEE ON SMALL BUSINESS, US HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT AND GOVERNMENT PROGRAMS

DATE OF HEARING: AUGUST 25, 2003; 1:30 PM
PLACE: MAGNOLIA ROOM, CHARLESTON PLACE HOTEL, CHARLESTON, SC

Good afternoon ladies and gentlemen. My name is Vincent Degenhart, M.D., a member of the South Carolina Medical Association, and practicing Anesthesiologist. I would like to thank Congressman DeMint and his staff along with all of the members of the Subcommittee on Workforce, Empowerment, and Government Programs for giving me the opportunity to speak today. I have been practicing Anesthesiology in Columbia, SC for over 20 years. During that period of time I have seen a continual rise in the number of malpractice cases in South Carolina, and a dramatic rise in the amount of awards. Last year of the ten awards of over $1 million dollars in South Carolina, 6 were against physicians, according to *SC Lawyers Weekly.*

Ironically this comes at a time when advances in health care, technology, and medical education have improved the health care for all South Carolinians. Although we rank higher than we would like in heart disease, infant mortality, and vehicular deaths, we have made great strides in almost every area of health care. The effect of rising litigation is a great threat to the progress we have made and future access to quality health care in South Carolina. We have all read stories about how the litigation crisis has forced Doctors in states such as Pennsylvania, Florida, Nevada, and West Virginia to stop delivering babies, close trauma services, or completely shut down their practices due to the rising cost of malpractice insurance and constant threat of being sued. We are now seeing those trends in South Carolina.

It is a paradox in medicine that with each innovation, new drug, or procedure, the public has raised expectations of just what American medicine can do. Life expectancy continues to rise in America and is nearly 75 years if you are born today, expected to rise to 80 years by the year 2010. That is not because Americans are taking better care of themselves, as obesity and sedentary lifestyles have added to America's health problems. The human body is a complex living marvel. Yet something will go wrong with it, and it ultimately will fail. Sadly we will all die. Along the way we physicians try to improve the quality of life and increase longevity. Not every decision physicians and other health care providers make will be prove beneficial. However, even with correct decisions, the best drugs, the best surgeons, etc. things can and do go wrong. This is not malpractice. It is a bad or less than desirable result. How often do we take our cars to the shop only to bring it home with the same problem or a new problem? We do not turn around and sue our neighborhood mechanic. Somehow the medical profession is held to a higher standard.

TESTIMONY BY DOUG MORELAND
REGARDING OBSTACLES TO COVERAGE FOR SMALL BUSINESSES
AND THEIR EMPLOYEEES

August 21, 2003

BACKGROUND

I, Doug Moreland, am a founder and Chief Technology Officer of Benefitfocus.com, Inc. located in Mount Pleasant, SC. Benefitfocus is a provider of online benefit enrollment services. Using the Internet, employers utilize the Benefitfocus service to enroll their employees in health insurance, life insurance, and other benefit products. Using a simple web based interface, employees key in their demographics, learn about their benefits, and elect coverage for themselves and their family. Benefitfocus then formats the benefit elections into HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant transaction sets and transmits them electronically to the corresponding insurance carriers as well as other benefit providers. Through strategic partnerships with numerous health insurance carriers, including Blue Cross Blue Shield of South Carolina, Benefitfocus provides its services to employer groups all over the United States. In most instances, the Benefitfocus service is private-labeled under the brand of the sponsoring health insurance carrier.

ADMINISTRATIVE COSTS

The high cost of health insurance is certainly one of the largest obstacles to coverage. There are numerous contributing factors, one of them being the high cost of administering enrollment, managing eligibility, and adjudicating claims. Adding to this is the high cost of member services, including telephone support for the purposes of educating the consumer, reconciling bills, explaining benefits, and resolving claims. A testimonial to this fact is that administrative simplification is one of the chief tenants of HIPAA.

ELECTRONIC ENROLLMENT

Benefitfocus provides streamlined electronic enrollment services. Electronic enrollment is fundamental to reducing administrative overhead in several ways. It eliminates transcription errors caused by the misinterpretation of handwritten applications, reduces data keying errors, and efficiently loads the information automatically into eligibility and membership systems, thus reducing downstream processing costs and speeding claims adjudication. Further, the online enrollment experience improves employees' understanding of their benefits and furthers their empowerment by providing follow-on enrollment actions associated with life events such as marriage, having a child, or loss of insurance.

ADMINISTRATIVE SIMPLIFICATION

Paper trails and proprietary electronic data processes are still a major contributing factor to administrative costs. One way that HIPAA promotes administrative simplification is by standardizing on the protocols used to communicate benefits between covered entities (those organizations that must communicate benefits information). To that end, Benefitfocus was an early adopter of HIPAA transaction formats. Benefitfocus sends and receives HIPAA transactions daily to numerous health insurers and has provided consultation services to several of the Blue Cross and Blue Shield insurance carriers.

SMALL BUSINESS OBSTACLES

Administering insurance for small businesses is even more costly than for large businesses, due to the added burden of selling and underwriting small groups. Further, small employer groups are very price sensitive, changing health insurance carriers every two years on average. The sales process that includes quoting and reviewing health applications and health histories is very costly

because it consists of multiple steps and involves numerous persons including agents, brokers, and actuaries - the process sometimes taking weeks to complete. Since most insurance carriers close the sale on only a minority of the groups quoted, most groups receive several quotes, multiplying the costs of the sale.

CONSUMER DRIVEN HEALTH PRODUCTS

With the dramatic annual increases in insurance premiums that small businesses have seen over recent years, employers are looking for relief. Consumer driven health products offer hope with the promise to give employees and employers alike more control over their insurance costs by supporting configurable health benefits and medical spending accounts. Many insurance carriers are developing these plans to provide configuration and pricing options geared toward empowering the employee as a consumer. Besides empowering the employee, it enables the employer to control its costs by giving the employee the responsibility to configure and purchase his own insurance using the funds in his medical spending account. Copayment, deductibles, and coinsurance are examples of some of the configurable options available to each employee, allowing him to determine his costs and configure insurance to better suit his needs.

In summary, electronic enrollment provides the means to deliver these configurable, consumer driven health plans, keeping costs down for employer and employee alike.

ELECTRONIC BILLING

Reconciliation of group billing adds to the administrative burden. Most health insurers produce paper bills and send them via traditional mail services, sometimes delaying the delivery of the bill for two weeks. During any two week period, an employer may hire and terminate numerous employees, creating billing discrepancies that must be resolved. By delivering bills just in time electronically, the 'window' for billing discrepancies is virtually closed, reducing the cost of administration.

SUMMARY

In summary, electronic enrollment services are a viable means to reduce health care costs by introducing administrative simplification and empowering the consumer in a variety of ways. As health insurers adopt new technologies, more and more opportunities for further simplification, cost savings, and adaptation will certainly arise.