HEALTHCARE AND SMALL BUSINESS: PROPOSALS THAT WILL HELP LOWER COSTS AND COVER THE UNINSURED

HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT & GOVERNMENT PROGRAMS

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

WASHINGTON, DC, APRIL 27, 2006

Serial No. 109–49

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

28–599 PDF WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON SMALL BUSINESS

DONALD A. MANZULLO, Illinois, *Chairman*

ROSCOE BARTLETT, Maryland, *Vice Chairman*
SUE KELLY, New York
STEVE CHABOT, Ohio
SAM GRAVES, Missouri
TODD AKIN, Missouri
BILL SHUSTER, Pennsylvania
MARILYN MUSGRAVE, Colorado
JEB BRADLEY, New Hampshire
STEVE KING, Iowa
THADDEUS McCOTTER, Michigan
RIC KELLER, Florida
TED POE, Texas
MICHAEL SODREL, Indiana
JEFF FORTENBERRY, Nebraska
MICHAEL FITZPATRICK, Pennsylvania
LYNN WESTMORELAND, Georgia
LOUIE GOHMERT, Texas

NYDIA VELÁZQUEZ, New York
JUANITA MILLENDER-McDONALD, California
TOM UDALL, New Mexico
DANIEL LIPINSKI, Illinois
ENI FALEOMAVAEGA, American Samoa
DONNA CHRISTENSEN, Virgin Islands
DANNY DAVIS, Illinois
ED CASE, Hawaii
MADELEINE BORDALLO, Guam
RAÚL GRIJALVA, Arizona
MICHAEL MICHAUD, Maine
LINDA SÁNCHEZ, California
JOHN BARROW, Georgia
MELISSA BEAN, Illinois
GWEN MOORE, Wisconsin

J. MATTHEW SZYMANSKI, *Chief of Staff*
PHIL ESKELAND, *Deputy Chief of Staff/Policy Director*
MICHAEL DAY, *Minority Staff Director*

SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT AND GOVERNMENT PROGRAMS

MARILYN MUSGRAVE, Colorado *Chairman*
ROSCOE BARTLETT, Maryland
BILL SHUSTER, Pennsylvania
MICHAEL FITZPATRICK, Pennsylvania
LYNN WESTMORELAND, Georgia
THADDEUS McCOTTER, Michigan
JEB BRADLEY, New Hampshire

DANIEL LIPINSKI, Illinois
TOM UDALL, New Mexico
DANNY DAVIS, Illinois
RAÚL GRIJALVA, Arizona
MELISSA BEAN, Illinois
GWEN MOORE, Wisconsin

JOE HARTZ, *Professional Staff*

CONTENTS

WITNESSES

	Page
Shadegg, The Honorable John (AZ-3), Congressman, U.S. House of Representatives	5
Carroll, Mr. Robert J., Deputy Assistant Secretary for Tax Analysis, U.S. Department of the Treasury	15
Lawler, Mr. Ed, ReMax Alliance, National Association of Realtors	27
Wilson, Dr. Cecil B., M.D., Chair-Elect, Board of Trustees, American Medical Association	29
Matthews, Mr. Merrill, Ph.D., Director, The Council for Affordable Health Insurance	30
Hense, Mr. Paul, Hense and Associates, National Small Business Association	32
Perrin, Mr. Dan, The HSA Coalition	34

APPENDIX

Opening statements:	
Manzullo, Hon. Donald A.	43
Velazquez, Hon. Nydia	47
Bean, Hon. Melissa	49
Prepared statements:	
Shadegg, The Honorable John (AZ-3), Congressman, U.S. House of Representatives	50
Carroll, Mr. Robert J., Deputy Assistant Secretary for Tax Analysis, U.S. Department of the Treasury	53
Lawler, Mr. Ed, ReMax Alliance, National Association of Realtors	68
Wilson, Dr. Cecil B., M.D., Chair-Elect, Board of Trustees, American Medical Association	83
Matthews, Mr. Merrill, Ph.D., Director, The Council for Affordable Health Insurance	92
Hense, Mr. Paul, Hense and Associates, National Small Business Association	101
Perrin, Mr. Dan, The HSA Coalition	104

HEALTHCARE AND SMALL BUSINESS: PROPOSALS THAT WILL HELP LOWER COSTS AND COVER THE UNINSURED

THURSDAY, APRIL 27, 2006

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT,
ANDGOVERNMENT PROGRAMS
COMMITTEE ON SMALL BUSINESS
Washington, DC

The Subcommittee met, pursuant to call, at 10:30 a.m., in Room 2360 Rayburn House Office Building, Hon. Marilyn Musgrave [Chairman of the Subcommittee] presiding.

Present: Representatives Musgrave, Lipinski, Udall, Davis, Barrow.

Chairman MUSGRAVE. Well, thank you for being patient this morning. We are waiting on our ranking member, who is very conscientious. I assure you he will be here just as soon as he can. And Mr. Shadegg, we want to be very respectful of your time.

So I will call the meeting to order, and I thank you all for being here, and thank you especially for those who have traveled long distances to be with us here this morning. And we are going to examine health care choices for American small businesses, their employees, and for working families in this country.

All Americans deserve and want reliable, high quality, and reasonably priced health care that will be there when they need it. One of the most stressing statistics that we see each year is the rising number of Americans who live without health insurance, currently estimated at 45 million people. Of those without health insurance, about 60 percent are small businesses—are small business owners, and they employ a number of people, and they are very concerned about them and their families.

As health care costs continue to rise, fewer employees and working families will be able to afford the coverage that they need. Clearly, we in Congress must look at this pressing problem, and we must find solutions that will create an environment, so those that need health insurance cannot only find the coverage that they need but they can afford it.

We need to be working toward a health care delivery method that works best, not just what we have done before. A simple look at the current health care landscape shows that our system is clearly not working.

So the focus today in the hearing will be on four proposals that Congress has begun work on to help Americans get the coverage they need at a price they can afford. These proposals are the establishment of association health plans, AHPs, increasing the availability, use, and ease of the health savings accounts, or what we refer to as the HSAs. We also want to reform the medical liability system and examine Congressman John Shadegg's common sense legislation, H.R. 2355, the Healthcare Choice Act.

I admire Mr. Shadegg very much, and you can always depend on him to come up with a common sense approach that will really work.

On July 26, 2005, the House of Representatives passed H.R. 525, the Small Business Health Fairness Act of 2005, the legislation that would establish federally regulated association health plans. And there was strong bipartisan support for this legislation. That was the seventh time the House had passed it.

I am confident that real progress on this legislation will be made, I am hoping, on the other side of the Capitol this year, so we are looking to the Senate.

AHPs would allow small businesses to band together across state lines through their membership in an association to purchase more affordable health insurance. Unions and large corporations already have this ability, and it makes sense to me that small businesses should have the same opportunity.

HSAs are a new way for people to pay for medical expenses not covered by insurance or other reimbursements. Eligible individuals can establish and fund these accounts when they have a qualifying high deductible health plan and no other health insurance with just a few exceptions. The accounts have significant tax advantages. The contributions are deductible. Withdrawals can be used for medical expenses and are not taxed. The account earnings are tax exempt, and the unused balances can accumulate without any limit.

President Bush has proposed several improvements to HSAs, such as allowing Americans who purchase HSA qualified insurance policies on their own to have the same tax advantages of people who obtain insurance through their employers and eliminating all taxes on out-of-pocket spending through HSAs.

There is an additional area that Congress and the President have worked on, and that is tort reform in the medical community. American patients are losing access to care, because the nation's out-of-control legal system is forcing physicians in some areas of the country to retire early, stop practicing medicine, or they give up the performing of high-risk medical procedures. And it hurts people in the area that need health care.

Right now there are 21 states in full-blown medical liability crisis, and in 2002 it was estimated that there were 12 that were in that situation. So in crisis states patients continue to lose access to care, and in some states obstetricians and rural family physicians no longer deliver babies. Meanwhile, the high-risk specialists no longer provide trauma care or provide complicated surgical procedures.

Excessive litigation and high medical malpractice rates have added to employer's health care costs and spurred some providers

to err on the side of caution. That comes at the expense of both health plan dollars and patients receiving unnecessary service. And we know that this issue just isn't about the physicians. Its effects cut across the whole health care sector.

Hospitals need physicians to admit patients. Companies that manufacture medical devices and pharmaceuticals need physicians to use and prescribe their products.

Similar to the AHP legislation, the House passed H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare, or HEALTH Act, of 2005, on July 28. The Senate is continuing to debate this critical legislation right now, and there is another proposal to help Americans find and purchase affordable health care insurance, and that is the legislation introduced by Congressman John Shadegg from Arizona, H.R. 2355, the Healthcare Choice Act of 2005.

Under this legislation, consumers would no longer be limited to purchasing policies dictated by their state's regulators and mandated benefits. Instead, they could decide among a variety of insurance policies qualified in one state but for sale in multiple states.

I am very pleased to have you here today, Congressman Shadegg, to give us the details on this legislation.

And as we all know, there is no one solution to this complicated and very serious issue when we talk about 45 million people in the United States without health insurance. Small business employers and employees are in critical need of new ways to be able to increase health insurance coverage, and we will look at these proposals today as responsive solutions to the problem.

I am eager to hear the testimony. Before I do that, though, I would like to recognize our ranking member, Mr. Lipinski, for an opening statement.

[Chairman Musgrave's opening statement may be found in the appendix.]

Mr. LIPINSKI. Thank you, Madam Chairman. I would like to thank you for holding this hearing on such a critical issue, especially critical for small businesses.

Every small business owner I speak with, whether here or back home in my district, no matter what type of business they operate talks about one overriding issue that they face in running their business: how to provide affordable health care for their employees and for their own families.

Over the past five years, health insurance premiums for employers have increased by 60 percent. Small businesses that have been able to offer health care simply cannot continue to absorb these dramatic increases. This has forced many to greatly increase the cost of health insurance for their employers—for their employees or for the employers to stop offering health insurance at all.

A failure to address this crisis has created a situation where millions of working Americans have no health insurance. And while large businesses have a coverage rate approaching 90 percent for employer-based health insurance coverage, small firms have a coverage rate of only about 50 percent. In fact, 6 out of every 10 uninsured Americans are in families headed by self-employed workers or small business employees. This is simply unacceptable.

I look forward to hearing today's witnesses discuss a variety of solutions they believe could help bring down the cost of health care and provide better access for small businesses.

I supported the AHP legislation we passed last year in the House, and I am hopeful that the Senate will do the same this year. But that clearly is not enough. Because of the depth of this problem, I believe that all options should be considered, but we must make sure that in covering more Americans we do not significantly undermine the coverage or treatment that Americans currently have. Health care that is inadequate or risky cannot be accepted.

One of the issues I have been particularly focused on is addressing the skyrocketing costs of health care at the source, specifically at hospitals. Most of us would never consider getting our car repaired at a shop without first getting an estimate, but this is exactly what we do when we go to a hospital.

Lack of information prevents families from making well informed, cost effective choices. In addition, lack of information means that hospitals do not have to compete at all in their costs. When California passed a law to require hospitals to disclose their entire price list, it was revealed that there was a great disparity between hospitals in what they charge for common procedures and medications.

One hospital charged $120 for a chest X-ray while another charged more than $1,500 for the same X-ray. And while one hospital did not charge for a Tylenol capsule, another hospital charged $7 for the same capsule.

When California passed the law and required disclosure, disclosure helped to change the situation. This is why I introduce last year, along with Representative Bob Inglis, H.R. 3139, the Hospital Price Reporting and Disclosure Act, a bipartisan effort to require every hospital to give consumers clear, concise information about what they charge for common procedures and medications. A companion bill has also been introduced in the Senate by Senators Durbin, DeMint, and Cornyn.

Now, unfortunately, the people who are hit hardest by prices not being disclosed are the uninsured, including millions who work for small businesses. They are the ones who have to pay the full price for often unknown and unexpected charges. The Hospital Price Reporting and Disclosure Act would require hospitals to regularly report to the Department of Health and Human Services the amount they charge for the 25 most commonly performed in-patient procedures, 25 most common outpatient procedures, and the 50 most frequently administered medications.

More than a half a dozen states have passed some form of hospital price disclosure, including my home state of Illinois, and at least 10 states currently are considering such legislation. States such as Wisconsin and Oregon already have this kind of information available to the public on an easy-to-access website, similar to what would be required by H.R. 3139.

This information is essential to the 46 million uninsured Americans, and especially for those millions who work for small businesses. A recent report on 60 Minutes demonstrated the high impact that undisclosed hospital prices have on uninsured Americans.

While we work to get coverage for the uninsured, we should give them information that will help in their health care choices.

Obviously, though price is not the only factor that families should take into account when making their health care choices, this is an important point to consider not only when looking at H.R. 3139 but when considering all our options.

Quality information is also critical, and I am happy that the Centers for Medicare and Medicaid Services is beginning to make some quality measures available, but more is certainly needed. And the advice of health care professionals will always be essential when making care decisions. But these are not reasons to oppose making price information available.

Clearly, tackling the cost of health care is a very complicated issue. Protecting small businesses and the self-employed should be a top priority, especially as health care costs continue to skyrocket.

I look forward to hearing from our witnesses today about their ideas to provide more small business owners, their workers, and their families with health care coverage. This is clearly a problem critical to millions and millions of Americans, especially those who are small business owners, employees, and something that we need to get to work on. We cannot let this continue to go on, and I look forward to hearing today from all of our witnesses.

Thank you.

[Ranking Member Lipinski's opening statement may be found in the appendix.]

Chairman MUSGRAVE. Thank you, Mr. Lipinski.

Mr. Shadegg, we will start with you on the first panel. We appreciate so much your testifying before the Committee today, and please proceed.

STATEMENT OF THE HONORABLE JOHN SHADEGG (AZ-3), CONGRESSMAN, U.S. HOUSE OF REPRESENTATIVES

Mr. SHADEGG. Thank you, Madam Chairman, and members of the Committee. I greatly appreciate this opportunity to appear before you today and to discuss the Healthcare Choice Act. I have had a passion for health care reform since I joined the United States Congress. I believe it is incumbent upon this government to make health care more affordable and to assess the problem that many Americans have with being able to find and to purchase affordable health insurance coverage.

With your permission, Madam Chairman, I will submit my written testimony and just direct my remarks to some of the highlights of this issue.

The Healthcare Choice Act is a simple and straightforward proposal which I believe could have a very profound impact, but it requires that we set the stage first. And I think members of this Committee understand these points, but perhaps not all people listening to this hearing or perhaps reading about it will understand.

I support the Committee's efforts on association health plans, health savings accounts, the possibility of reform of medical liability. I think all of those are critical. But as you stated, Madam Chairman, this problem—the high cost of health insurance, the lack of access to affordable of coverage—is a problem that cannot be solved in a single way with a single solution.

We know, for example, that people who work for large employers and get their health care through those employers often have access to affordable health care, though listening to Mr. Lipinski discuss well informed, cost effective choices, I would argue that choice is a key factor in bringing down the cost of health care, and that many of those employees who work for large employers don't have enough choice.

Right now many of them are offered only one plan to choose from. They can't pick that plan or reject it. Once they are in the plan, they can't pick their doctor or reject that doctor. And all too often, if the plan harms them under our current law, ERISA, they can't fire the plan or even hold them liable. So that is the situation that governs many who work for large employers.

AHPs go directly at the problem of small businesses, and I enthusiastically support AHPs and the efforts of this Committee to make AHPs available to smaller employers and their employees, so that they can buy the kind of affordable coverage that employees of big companies get. I also strongly support HSAs.

But there is a segment of our market—and I think this goes at the issue of the 45 million uninsured, Madam Chairman, that you mentioned who are not able to get insurance through an employer and who are buying health insurance in the individual market. And it is that segment of the population, which I submit includes many of the 45 million uninsured, who have to go into the individual market to buy their health insurance that would be helped by the Healthcare Choice Act.

Let me explain what the Healthcare Choice Act does. Right now, if you are in the individual market and you are buying a policy for yourself, you are self-employed or your employer doesn't offer you health insurance, you have to buy a policy that has been qualified in your individual state—that is to say, that meets every single dot and title of the laws of that state, not only with regard to financial solvency of the company but with regard to every single mandated coverage that the state dictates.

And we will talk about these benefit mandates in a moment, but they drive up the cost of insurance immensely. An insurance company wanting to sell in an individual state has to then go to that state, qualify to do business, and write an insurance policy for that state unique to that state. If it wants to go to the state next door, it has to do it again, qualify to do business in the state next door, and write a new policy that meets every dot and title of that state's laws. And they must do that on and on in all 50 states if they want to sell in all 50 states.

The Healthcare Choice Act says there is immense inefficiency in having to meet every single one of those requirements, including all of the benefit mandates of those states. And so what it says is that you would be able to, as an insurance company, go to one state and to meet all of the health insurance requirements of that state and write a policy that meets that state's benefit mandate laws.

You could then go to any other state and file your health insurance policy with the State Insurance Commissioner and then sell the policy in the second or third state, and the state Health Insurance Commissioner of that state could enforce that contract, that

health insurance policy, on behalf of the individual consumer who bought the policy.

Let me explain why this came about. We have talked about mandates. The State of New York, for example, requires that every insurance policy sold in New York cover podiatry. Acupuncture, which I doubt if anybody in this room has used but may have, is mandated in 11 states. Massage therapy is mandated in four states. Hair replacement coverage is mandated in many states. Substance abuse treatment coverage is mandated in many states. Chiropractic care is mandated in 47 states.

The Council for Affordable Health Insurance, CAHI—and I believe you have a witness coming this afternoon or in your second panel to discuss this—estimates that these individual state mandates can hike or increase the price of insurance by somewhere between 20 and 45 percent. For example, a health insurance policy for a single individual in Pennsylvania costs roughly $1,500 a year. Simply cross the Delaware River into New Jersey and that identical plan costs about $4,000 per year.

And I would like to then point to this chart, if I might. This is a chart of a study that was done which shows the monthly cost of family health insurance coverage with $500 deductible in four different states. As you can see, that policy for a family of four in those four different states—in Trenton, New Jersey, the policy costs $3,881 a month. In Portland, Maine, it is $1,781 a month. In Arlington, Virginia, it is only $548, comparable policy, same coverage, same family, same pre-conditions. Madison, Wisconsin, that policy costs only $484.

If I could relate kind of a story of how this issue came to us. In point of fact, as you know, Trenton, New Jersey or New Jersey is just across the river from Pennsylvania. There are consumers in America who are literally shopping with their feet. They discover that they live in New Jersey, and to buy an insurance policy for their family it costs almost $4,000 a month.

They chat with their best friend who lives right across the river in Pennsylvania, or their sister or their brother or their father or their uncle, they are at a Sunday night barbecue, and they are discovering that the same essential coverage across the river in Pennsylvania costs anywhere from one-sixth of as much, a few hundred dollars a month, versus several thousand, $4,000 a month.

And so people are actually renting post boxes or asking a relative to—if they can say, "Well, look, I often get my health treatment across the river in Pennsylvania. The insurance company doesn't really care whether I go to a hospital or a doctor in Pennsylvania or New Jersey. The cities cross the line. What I will do is, if you wouldn't mind, I will list my home address as your home address in Pennsylvania, rather than my home address as being my home address in New Jersey, and I can save thousands of dollars a month." The reason for that: our benefit mandates and the nature of the New Jersey law.

What the Healthcare Choice Act would say is, "We can produce dramatic savings for people in this individual market in two ways." One, you allow the insurance company to qualify the plan in one state, and then to market it in 50 states, but to be held accountable

to the consumer in the state where the consumer lives. And the bill has been carefully written to ensure that.

So if you buy a policy that is, say, qualified under Illinois law, and you buy it in my home state, Arizona, and you have a problem with the insurance company in living up to the terms of the contract, the Arizona Health Insurance Commissioner can represent and protect you as a consumer.

We also have certain minimal consumer protections that apply across the board, including provisions that require, for example, an independent review of a denial of care. There is a minimal threshold that is placed in the law. But the big savings, we believe, would occur in these benefit mandates.

I will conclude by pointing out—and I would be happy to answer any questions—as Mr. Lipinski noted, well informed, cost effective choices are critical here. And I think his point about being able to make a choice about a hospital with very high costs for the procedure you need versus a hospital with very low costs is a very critical power that an individual consumer needs.

But if you step back from that, if a consumer can say, "Look, I might like to have coverage for podiatry, or I might like to have coverage for acupuncture, or I might like to have coverage for massage therapy," but, quite frankly, each of those coverages that I demand in my policy runs the cost of the policy up. I can barely afford it. Then, they might want at least the opportunity to be able to purchase a policy that has fewer mandated benefits.

And just to conclude, as you mentioned, Madam Chairman, 45 million Americans are uninsured. Statistics show or surveys show that two-thirds of those have incomes below 200 percent of the federal poverty level, and they cite unaffordability as the top reason why they are uninsured. As a nation, we want—we encourage them to become insured. It is incumbent upon us to do everything we can to make that health insurance affordable.

I believe for those in the individual market, the Healthcare Choice Act, giving them many more choices of policies to pick from, ending kind of the monopoly status that many insurance companies have in states where they are the only individual policy sold, or one of only two or three that is sold in that state, giving them many more choices would help bring down the cost of insurance, and, thus, make it more affordable for those who can't currently afford it.

With that, Madam Chairman, I would be happy to answer questions at the end of the panel.

[Congressman Shadegg's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you, Mr. Shadegg. And before we go to Mr. Carroll, I am going to ask for questions for you first, out of respect for your time, not that your time isn't valuable, but he has got other Committee things to do.

I would just like to comment that having served in a state legislature I saw in Colorado mandate after mandate added. And there was always a very persuasive group that came in to ask for the mandate. There were, quite frankly, many times other than those individuals who had suffered enormously that wanted this kind of mandate put on, because they felt it was the appropriate public

policy decision. There were also other times there were just turf wars going on, and certain groups that wanted to make sure that whatever they provided was covered.

And, you know, we were invariably told, Mr. Shadegg, that we were actually going to save money in the long run. I heard that time after time after mandates were added. And can you tell us anything about the trends in state that are many mandates in place and states that don't have as many in regard to how many uninsured there are? Do you have any idea how these mandates have impacted individual states?

Mr. SHADEGG. Madam Chairman, they have exploded. And there are, according to CAHI's calculations, 1,800—and these are numbers that are just a little bit out of date, they are several years out of date, so there may be more now. Across the 50 states, there are more than 1,800 separate types of mandates. And when you look at, for example, massage therapy or acupuncture, I don't know yet—I believe there may even be aromatherapy mandated in some states now subsequent to this—there has been an explosion of these mandates.

I certainly agree that some of the basic coverage should be included in any policy. No one would want to go out and buy a policy that didn't cover, for example, heart—cardiac issues or cancer treatment or emergency room treatment. But informed consumers, as I think Mr. Lipinski noted, can look at these and make those kinds of choices.

And I think that in many instances it may be true that some of the mandates put in place procedures that do save costs. But it is hard for me to understand how, for example, mandating massage therapy or perhaps mandating acupuncture is going to produce a savings.

One of the things that we believe this legislation would do would tamper down—that is, cause there to be a slowing—of the demand for some of the more extreme mandates. But the important thing to remember is that no state would be precluded, and no insurance company would be precluded, from continuing to offer policies with all of the mandated coverage. The consumer would have the right to pick from that.

And another important thing to think about is survey data shows that people—consumers—buy the most comprehensive policy when given the choice that they can. So if—or that they can—and when I say "when they can" it means that they can afford. When there are multiple policies in a market, one may cover very basic things, one may cover slightly more comprehensive things, and one may cover the most comprehensive. Consumers tend to buy what they can afford to buy.

The problem with mandates—and Speaker Hastert I think addressed this rather well—is that with these mandates, when you are mandating massage therapy or acupuncture, in a way because every single mandate adds to the cost of the good, you are saying, "Well, you may want to buy a KIA, because that can get you as a young person to and from work, but we are going to mandate that you buy a Mercedes, because we have decided a Mercedes is better for you and safer."

And that is a part of what the problem is, and this would just give consumers that ability to choose amongst more options than they have now.

Chairman MUSGRAVE. I think we also need to give consumers a little credit. And perhaps if mammography wasn't covered, I would, I would still have a mammogram, and I believe that people that are health care conscious, the gentlemen will go in for prostate cancer screening.

You know, it was almost like if the mandate wasn't there, no one would go in for those tests or do those things. But I think it is, you know, a consumer choice, being able to buy the type of product that fits their need that they can afford.

Mr. SHADEGG. Right.

Chairman MUSGRAVE. And you have really emphasized that very well.

Mr. SHADEGG. Well, I think it is very important to look at the statistics about who this would appeal to. The reality is, sure, we wish that every single American got mammography screening, every single American had the most comprehensive coverage. The reality is we have 45 million uninsured Americans. The choice for them is not between a policy that does cover mammography and one that doesn't; it is the choice between no health insurance or some health insurance.

And, clearly, the kind of basic things that most Americans need are going to be covered in all of the policies that we marked, enabling them to get at least initially, and perhaps as their income grows or as they go to work for a bigger employer that can offer them health insurance, the opportunity to get a more comprehensive policy. But what we need to do is get them into some level of coverage, and I believe this will offer that opportunity.

Chairman MUSGRAVE. Thank you. Mr. Lipinski.

Mr. LIPINSKI. I just wanted to thank Mr. Shadegg for his testimony, and I have no questions. Thank you.

Chairman MUSGRAVE. Mr. Davis.

Mr. DAVIS. Thank you very much, Madam Chairman, and I just have one question. I must admit that I don't have much confidence in any of these piecemeal approaches to providing the kind of health coverage that we need. And every time I get an opportunity I emphasize the fact that I believe that we need a national health plan that covers every citizen without regard to their ability to pay. And I think eventually we will get to that. I don't know when.

But, Mr. Shadegg, I am intrigued a bit by the creativity that you have used to put together your concepts and ideas, and I just want to understand. You are saying that, for example, if I live in Illinois, I may be paying more for the same plan that someone in Indiana or Colorado are paying, and under your legislation I could then purchase that same plan in Illinois, and it would be governed by my state laws and health commissioners or whoever or plan administrators, and someone else would actually be governed by what takes place in Colorado.

But I am able to save money as a result of your legislation.

Mr. SHADEGG. Yes, sir. The way it is designed is that you could buy that policy that had the coverage mandated by, say, the Colorado law, you could buy that in Illinois and it would—and because

it might not have the same—well, number one, it would not have gone through the same qualifying process in all 50 states.

And there is a parallel here to, for example, as I mentioned in my written testimony, the interstate banking. We enable people to get into interstate banking, and it has caused a decrease in the overall cost of banking. But the answer to your question is: yes. The important thing we wanted was for you—for the consumer, you the consumer in Illinois, to be able to rely on the local insurance commissioner to enforce the policy and protect you.

And there are also minimal financial guarantees that are covered in most of the 50 states. This is not unlike—and I do not know, sir, if you served in the legislature. But as you know, there are many uniform state laws, and much of insurance law in the 50 states with regard to the financial solvency of these insurance companies is governed by uniform laws.

This takes this one step further and says, "We are going to have uniform law with regard to the basic things that cover an insurance policy." But with regard to those other variables we are going to, number one, allow you to get into the business more readily; and, number two, limit the number of mandates based on the policy that was chosen to be sold, and then you, the consumer, would get to make that choice of which policy you wanted to pick. That is where—it is the second way that you get some savings.

Mr. DAVIS. Thank you very much, Madam Chairman. I appreciate the creativity, as I indicated. And, unfortunately, I did not serve in a legislature. I came out of the Chicago City Council, and there were times when we had to convince people that there was something called Illinois.

[Laughter]

Thank you, Mr. Davis.

Mr. Barrow.

Mr. BARROW. Thank you, Madam Chairman. As a former local government man myself, I want you to know we need more folks up here who have had a little experience at the local level, at the bottom of the food chain.

I want to thank you, Congressman, for your initiative here. I want to make a couple of observations, though. First off, I think it can skew the discussion a great deal to take some of the extremes and the wacky stuff out there and treat that as if that is the norm. But I do want to point out that mandated benefits that aren't widely used cannot drive up the cost in a large risk pool very much to begin with, by definition, because they are not widely used.

And the concern I have got is with the stampede on the part of folks up here to say to basically the states, "Stop me before I protect the consumer again. You know, stop me from doing what we are doing." And I am a little concerned about that.

I want to express some reservation about that, because it has been federal policy to leave regulation of this matter to the states. And if the Federal Government is going to say, "We are going to start mandating and protecting the consumer," we need to do it in a comprehensive manner, rather—because the worst possible situation is for the Federal Government to say, "We are not going to protect the consumer, but we are not going to let the states protect

the consumer either." It seems to me that that is a road we don't want to go down.

The starting point that I begin with, which I think is key to the jurisdiction of this Committee, is it still makes no sense to me why 50,000 employees working for 10,000 employers should have to pay a higher cost per capita for the same insurance product that 50,000 employees can get at the same—at a different cost working for one employer.

The secret, of course, is that you are pooling large numbers of people as much as possible, you are building the risk pool, so that you have the largest number of lucky people subsidizing the unavoidable number of unlucky people. Rather than approaching the statement of the problem as too many people getting wacky services mandated for them, the problem is we don't have the optimal balance of lucky people subsidizing the unlucky, which is what insurance is all about, certainly what we are doing when we insure our homes.

And our approach as the Small Business Committee ought to be to try and direct policy in such a way as to build risk pools, not to Balkanize and break up the risk pool. What I am concerned about is, with the efforts we have got here, a back door deregulation or creating an unregulated market inside a regulated market competing side by side.

That is, to me, the worst of all possible worlds, because you won't be able to connect the dots between the increasing cost in the good insurance that is out there, the more comprehensive insurance, as a result of people being drained out of that risk pool, taking their premiums and going into products that are—you know, have less bells and whistles on them.

So it seems to me that, you know, some of these mandates, they may not be needed by many people very much. But if it is needed, it is needed badly.

The concern I want to address, I want you to help me understand, the idea that I get from you is that some insurance is better than none. That is, at bottom, what I think you are saying. Something is better than nothing. The trouble is, if you have a whole bunch of people either exiting the current system, or entering the new system from the ranks of the uninsured who can barely afford to—who can't afford to pay in the present system, if you have got so many folks buying some kind of insurance, you are going to drive up the cost of the good insurance.

Let us just say the adequate comprehensive insurance for the rest of us, and what is the answer to that? It seems to me that it is, at bottom, a policy of Balkanizing and breaking up the risk pool, creating so many options, you walk down the shelf you have got 1,000 things to choose from. That really cuts against what insurance does to begin with, which is taking those risks that can't be avoided and spread them as far and wide as possible.

This seems to be going in the other direction. How do you answer the problem of the cost of the good insurance going up for the rest of us when you drain out so many folks from the risk pool?

Mr. SHADEGG. Excellent points, and I would like to address them all. But let me start with the—kind of your final question. There

is no motivation on the part of this legislation to encourage anyone to exit who has never had a health insurance plan.

Mr. BARROW. My point is those who want to stay in have got to pay more.

Mr. SHADEGG. The reality is that if you have health insurance through your employer, or if you can get into a group policy—and you weren't here when I began this discussion.

Mr. BARROW. I know. I apologize for that.

Mr. SHADEGG. That is all right. I know what it is like to try to make two hearings.

Mr. BARROW. I was in Ag dealing with gasoline this morning.

Mr. SHADEGG. I have been there, done that.

[Laughter]

We began with a discussion of association health plans, HSAs, and the issue of medical liability. And the Chairman said, "Look, there is no one solution." I agree with you completely. Getting people into large pools is the best mechanism to give them the most affordable health insurance.

Indeed, one of the problems that—one of the biggest criticisms I have, I imagine that I have a passion for health care reform, is that we have the notion in America that the only pool you can use is an employer pool. I think that is a false notion, and I have argued in other legislation which I introduced that we should be giving people more pooling mechanisms, so that they could get in—have the opportunity to get into other pools.

For example, why not allow the Daughters of the American Revolution to offer a health insurance pool and create their own pool? Why not allow the University of—I happen to be from Arizona—Arizona Alumni Association offer a health insurance pool? I completely agree with you that the motivation is to get as many people out of the individual market and into a larger pool. They can get a better health insurance policy.

And my passion in health care reform is to then work at that end of the specter. However, this bill is designed solely to look at those Americans who are forced to buy individual health care coverage. That is to say, they are either unemployed—

Mr. BARROW. I recognize that.

Mr. SHADEGG. —or they work for an employer who can't get them in a plant, point one. Point two, I completely agree with you that it is outrageous to say to American consumers, "Oh, you are one employee working for a large employer that"—your example of 10,000 and 50,000. If you happen to work for a large employer, you get a very good health insurance coverage, because the Federal Government made it possible through ERISA. but if you work for a small employer, but there is many of you, you just described AHPs very accurately, sorry, you don't get the same policy.

I think that is a huge flaw, and one way of addressing that flaw is AHPs. And that is a much better way to address the flaw for people who have a job with a small employer.

Mr. BARROW. Except to the extent that the only inducement would be to give the insurance industry—to get into the business of creating pools, large pools, out of small—out of large numbers of small groups—is preemption of state law.

Mr. SHADEGG. And that is the next point I wanted to go—

Mr. BARROW. That is the only inducement. Again, you are going to have a regulated carrier and an unregulated carrier playing in the same marketplace. How is that going to help the cost of insurance for those who are trying to stay with a good product?

Mr. SHADEGG. And I guess that is kind of where I go, and that is I—as much as ERISA enabled large employers to offer low cost health insurance, it, quite frankly, leaves consumers without protection. I began my talk by discussing about the fact that for that employee of a large employer they come under ERISA. Now they are getting their health insurance plan—they didn't pick the plan, their employer picked the plan, and they didn't have much voice in whether the—in the plan the employer picked.

Mr. BARROW. ERISA's concern is not with the definition of this, but protection of the solvency of the plan that you buy.

Mr. SHADEGG. Well, let us keep going, because let me finish my point. Number one, they didn't get to pick the plan. Number two, once they are in the plan, they can't pick their doctor. Number three, if they don't like the plan or the doctor, they can't fire it. And if you follow the decisions on ERISA, if the plan wrongfully denies them care and it kills them or harms them, under current law they are granted immunity. And so the plan—

Mr. BARROW. I am glad you realize it. That is sort of tort reform that doesn't work.

Mr. SHADEGG. It is a serious problem, and granting anybody immunity, absolute immunity, as ERISA does for these large plans encourages them to abuse people and deny care that they need. So you and I can get on my bill that says we are going to end that ERISA immunity any day.

But the point of that is, when the Federal Government offered large employers that option, it essentially took away from consumers state regulation. And when I drafted this bill, at least I was looking at the narrow market of those who must buy individual coverage. You could solve that by moving them into a federal pool and taking them out from under the protection of state health insurance regulators.

I argue, no, that is not a good way to do it. I don't believe that the Federal Government is a good regulator as a general proposition. I don't want the citizens of Phoenix, Arizona, or much less Baghdad or Winslow, Arizona, to have to come to Washington, D.C., or for that matter to even have to travel down to Phoenix, to go to the Department of Labor to get help.

I want them to be able to use the Arizona Commissioner of Insurance, whose job it is. So the way we wrote this bill was not to make them unregulated. It was to say, "We are going to allow more insurance products into the market, but we are going to leave the regulation at the state level." So that consumers can keep going to the place they have been going to in the past.

Mr. BARROW. I hear you, and I think I understand your point very well, but you are still Balkanizing the risk pool, creating smaller—a larger number of smaller plans, and I am trying to think how we can—how we can go towards trying to keep larger risk pools. You want to put more risk pools, some way to get into—

Mr. SHADEGG. I will join you in addressing moving people into larger risk pools. However, there will I believe always be, absent

the passage of universal health care, a group of people that buy their health insurance through the individual market. They simply are no longer in a pool.

The last point I want to make is that—and you make a good point. My testimony, for emphasis, focused on things like massage therapy or acupuncture, but the CAHI study said that these benefit mandates increase insurance prices between 20 and 45 percent. Just a 20 percent cut in an individual health insurance policy would make a dramatic difference for at least a number of consumers.

And I think you are right. My argument is, in fact, that some level of health insurance for those 45 million, at an affordable level so that they could get it, beats no health insurance, beats putting them in an emergency room asking for us to give them ERISA care.

Chairman MUSGRAVE. Mr. Barrow, I thank you.

Mr. BARROW. Thank you, ma'am.

Chairman MUSGRAVE. And I happily let you gentlemen go on. I have never enjoyed abusing the clock so much.

[Laughter]

Mr. Shadegg, if you will just indulge me for one more question. Do you have some thoughts on what is going on in Massachusetts? Mitt Romney is talking about, you know, every citizen having coverage, and would you just indulge me and give us an opinion on that before you go?

Mr. SHADEGG. Well, I think the Founding Fathers intended the states to be laboratories, and to try different experiments in health care. I am not convinced that the Massachusetts experiment will work out to produce lower cost insurance, but I would not criticize any state for making the attempt.

I personally think they would be better off, and The Wall Street Journal has joined me in this, in embracing a concept like this and making more different policies at lower costs available to the people in their state. But I applaud anybody who goes after this issue.

As I began my testimony, I am impassioned about health care reform. I think we can do better, and I think we must do better, and I think it is intolerable that we would have 45 million uninsured Americans.

Chairman MUSGRAVE. Thank you so much, and we really appreciate your time before this Committee today.

Mr. SHADEGG. Thank you.

Chairman MUSGRAVE. Mr. Carroll, you have been very patient, and I want to respectfully say there was a reason for all of that, delaying your opportunity to testify, and we look forward to hearing from you now.

STATEMENT OF MR. ROBERT CARROLL, U.S. DEPARTMENT OF THE TREASURY

Mr. CARROLL. Well, thank you very much. I would like to submit my written testimony for the record and to highlight some issues in my oral statement.

Mrs. Chairman, Ranking Member Lipinski, and distinguished members of the Subcommittee, I really do appreciate the opportunity to discuss with you today the health care proposals included in the President's fiscal year 2007 budget in the tax area. I will

focus my remarks on both the problems in health care and how the President's proposals helped to address those problems, namely by making health care more accessible, affordable, and—

Chairman MUSGRAVE. Could I just ask you to move the microphone a little closer, so everyone can hear you? Thank you.

Mr. CARROLL. —thus enabling Americans to obtain health care and retain their health care when they change employment. Health care costs continue to rapidly—to rise rapidly in the United States. Growth in health care costs have been exceeding GDP growth by two percentage points annually since 1940, comprise 16 percent of GDP in 2004, and are projected to grow to nearly 20 percent of GDP by 2015.

Higher insurance premiums pose a challenge for employers and burden workers. The burden of rising health care costs is particularly problematic for small businesses which often must choose not to offer any health insurance to their employees. At the same time health care costs are rising, the number of uninsured also continues to grow. As health care costs grow faster than incomes, an increasing number of individuals are unable to purchase health insurance.

Also, those higher and ever-increasing costs mean that the self-employed and employees of small businesses are far less likely to have coverage. A significant number of the uninsured work for small businesses.

A substantial portion of rising health care costs is due to the effects of our insurance system itself. Health insurance gives people valuable protection and peace of mind that they will have help paying their medical bills should a major illness arise.

However, because third parties such as insurance companies, employers, and the government finance the majority of health care spending, most insured do not know or feel the full cost of health care services they consume. The direct expenditure for health care by an insured person may be only a small portion of his or her total health care costs.

This is characteristic of low deductible and first dollar health insurance. The prevalence of this type of insurance is rooted in the tax treatment of health care generally. The Tax Code reduces the cost of health care when financed indirectly through employer-provided insurance rather than when purchased directly by the consumer.

The greater reliance on first dollar coverage may lead the insured person to receive medical treatment that the person may value at less than its true cost, leading to inefficient and overconsumption of medical care. First dollar coverage in effect dulls the incentive for consumers to shop carefully for cost effective health care, and the tax bias that favors this coverage is an important piece of the puzzle explaining the rapid growth in health care costs.

With the appropriate reforms, the U.S. health care system can become more efficient at supplying cost effective health care to consumers, while continuing to lead in innovation.

The President's Health Care Initiative would address rising health care costs through a series of proposals designed to improve the functioning of the health care market. At the core of this initia-

tive is a set of tax proposals that puts the health care consumer more in control of his or her health care and places health care purchased directly by individuals with high deductible health plans on an equal footing with employer-provided health insurance.

When consumers have more at stake, when they have more skin in the game, they can be expected to make better decisions. Greater reliance on competition and market forces, coupled with less reliance on third parties, such as insurance companies, employers, and the government, in making health care decisions, will lead to more efficient use of resources and help stem the excessive rise in health care costs.

The President's Health Care Initiative builds on the early success of HSAs by making high deductible health plans more attractive and expanding HSAs. Just a couple of years after the enactment of HSAs, 3.2 million people are now covered by high deductible health plans. Moreover, there is broad use of these plans by important segments of the population. Early evidence indicates that over 40 percent of those covered by these plans have incomes below $50,000, and roughly 50 percent are age 40 or over

The President's Health Care Initiative allows those with high deductible health plans to deduct insurance premiums and out-of-pocket expenses and to claim refundable tax credits to recover payroll taxes paid on these premiums and out-of-pocket expenses. The initiative also includes a refundable tax credit to cover the cost of high deductible health plan insurance premiums that is targeted to the lowest income Americans.

The result is a policy that provides the same tax advantage available to those with employer-provided insurance to health care purchased by all Americans with high deductible health plans. Providing consumers with a larger role in health care decisions will help bring market forces to health care. Where market forces are prevalent, there is evidence that health care costs have grown slower, or in some cases even decreased.

The President's Initiative also helps make health care more portable. In today's economy, employees frequently change jobs, and these changes are often for the better. Each year 56 million employees are hired, while 53 million leave their jobs. The average American between the ages of 18 and 38 has held 10.2 jobs. Seeking out and testing different jobs may generally lead to a better matching of workers to jobs and contributes to skill development and wage growth.

Americans also tend to change jobs much more frequently than workers in other major industrialized nations. In some cases, twice as often, which then allows our economy to adapt more quickly to changing economic circumstances.

Our dynamic labor markets are an important contribution to our higher economic growth and our higher living standards. Tying employees' health insurance to their workplace, however, is a source of job lock and an impediment to fluid and flexible labor markets. HSAs have the distinct advantage of being owned by individuals regardless of their employer. When workers change jobs, they take their HSAs with them.

The President's Health Care Initiative reorients HSAs, and in many circumstances lower income Americans would receive a larg-

er tax subsidy than those with higher incomes, and is in stark contrast to current law, where lower income Americans often receive little benefit from the existing tax subsidy for health care.

In summary, the lack of appropriate pricing incentives in the health care market has contributed to rising health care costs and the uninsured. At the root of this problem is the tax bias for first dollar coverage, and the diminished role of the consumer in health care decisions. The President's Health Care Initiative addresses these problems by putting the consumer more in control of their health care decisions and injecting market forces into the health care market.

The Treasury Department estimates that the President's Initiative would increase the number of HSAs by some 50 percent by 2010. Building on the early success of HSAs, this initiative can contribute to health care that is more affordable, accessible, and affordable.

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

[Mr. Carroll's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you very much, Mr. Carroll. We know that the growth in health savings accounts has been significant. Could you give me a little more specific information on how many people use them now? And can you give a prediction for the future on the use of HSAs?

Mr. CARROLL. Sure. According to some research in the private sector, about 3.2 million individuals are currently covered by high deductible health plans. That represents a dramatic growth in the number of people who are covered in just one year. It has tripled. In 2004, the IRS released some data that showed that a relatively small number of people had HSAs or were covered by high deductible health plans, and there has been a dramatic growth in the number of individuals covered by high deductible health plans since that time.

By 2010, as I indicated, under the President's policies we expect the number of individuals covered by—who have HSAs to increase by 50 percent. In 2010, we forecast that about 14 million people—14 million taxpayers will have HSAs. A 50 percent increase would increase that to 21 million.

Chairman MUSGRAVE. How about small businesses? What are the opportunities with HSAs for small businesses?

Mr. CARROLL. Well, I think that is a very important contribution that HSAs make to a comprehensive solution to the health care problem. I don't think—I agree with the Congressman, and the members of the Subcommittee as well, that one particular policy isn't going to solve this very complicated problem. But one of the things that we do see in the data is that an awful lot of the uninsured are—either are small business owners or work for small businesses. That is a fairly important source of the uninsured problem.

HSAs are very helpful for small business owners, and to—and the employees who work for small businesses, to provide them essentially the same tax advantage that large employers and individuals who work for large employers currently have.

Chairman MUSGRAVE. We always are concerned about people that don't have a very high income being able to afford health insurance. Could you specifically comment on what hope HSAs give for low income individuals who desperately need health care coverage?

Mr. CARROLL. Sure. What is particularly interesting about the early evidence on HSAs is that a fairly substantial fraction of those who have HSAs, or high deductible health plans that qualify for HSAs, are low income. As I mentioned, over 40 percent of those with HSAs, according to some recent preliminary evidence, have high deductible health plans. That is a very significant—that is a very significant finding. HSAs already, as they are currently constituted under current law, are helpful for the low income.

In the very early data that the IRS released a month or two ago for tax year 2004, which is taking a very early glimpse at the HSA market, again, it was kind of a prelude to the industry data released earlier this year. A large fraction, a significant fraction of those with HSAs were lower income Americans.

And what is interesting and what is important about the President's policy is it really reorients HSAs and high deductible plans. The series of refundable tax credits for payroll taxes paid for insurance premiums, payroll taxes paid for out-of-pocket expenses, and the tax credit for—the refundable tax credit targeted to the lowest income Americans to help make insurance more affordable for them, all make this system, this web of tax preferences, more progressive than they are actually currently constituted today.

In my written testimony, we present—I present a chart for an illustrative example for a family of four, age 35, and what it shows is for kind of the typical level of insurance premiums, the typical out-of-pocket expenses for a family of four, age 35, that lower income people under the President's policies actually would get a larger tax subsidy at the low end of the income distribution than at the middle or at the high end of the income distribution.

And it is because of this set of refundable credits for payroll taxes paid on the insurance premiums, the out-of-pocket expenses, and the refundable tax credit targeted to low income Americans. And what is interesting about the payroll tax credits is, you know, it is a credit for payroll taxes paid on the premiums. Of course, when individuals reach the wage cap for Social Security taxes, they stop paying those taxes, and the benefits of these credits are ratcheted down. And that is one of the features of the proposal that explains its progressivity.

Chairman MUSGRAVE. Thank you very much. Mr. Lipinski.

Mr. LIPINSKI. Thank you, Madam Chairman. I want to in a way go back to what Mr. Barrow was so eloquently stating and asking about earlier I won't have the eloquence of Mr. Barrow, but I want to—I want to ask specific questions about HSAs and what impact they are going to have on the health insurance market in general, because in a way it very much appeals to me the idea of having the marketplace work to better provide, have a more efficient system of providing health care, but I have very serious questions about it.

Looking at myself, I am diabetic. I know that every year I am going to have certain costs associated with my disease. But if those

costs are paid if I take care of myself, I can live a normal healthy life. It seems to me that an HSA would never make sense for someone such as myself who knows they are going to have such costs, that it would be much better for me to be in the regular insurance market.

And unless you can, you know, convince me otherwise, that is the way it looks to me. In that case, in the regular insurance market, young healthy people will go into—will have HSAs because it will be cheaper for them, and we are going to Balkanize—as Mr. Barrow was saying, we are going to Balkanize the market. We are going to have the sick people in one market, the healthy people in another market.

Now, can you disabuse me of this belief?

Mr. CARROLL. Well, you know, I think the issue you are raising is the issue of adverse selection. HSAs are a new product. They have been around just for a few years, and it will be some time before we do get a complete picture of HSA enrollment.

But so far I think there is little to suggest that this problem is going to be significant. The preliminary data that I referred to earlier does suggest a few important things. One, lower income Americans are benefitting from HSAs. That is a group that tends not to have insurance, that tends to perhaps have some of the concerns that you mentioned.

Older Americans are much more—a significant number of older Americans have HSAs. Over 50 percent are over 40 years old, over 20 percent are over 50 years old. Those groups are often associated with those with a health status that might not be as good as the average.

So I think when you look at the very early evidence on HSAs, it doesn't appear to be an issue, and the preliminary indications are is that some of these—some of the groups correlated by income and age, to the extent health status is correlated by income and age, it tends to be particularly helpful for some of these groups. So this tends not to be a problem.

And another thing to kind of focus on—and perhaps this is—I think this is another important issue, is that when you look at the employer market, which broadly provides benefits, 174 million people currently get their insurance through employer—the employer market, and that is an extreme—it is just central to our insurance system. But the employer market tends—is much more likely to cover middle income and upper income Americans as opposed to lower income Americans.

A chart I have in my written testimony based on some data from the current population survey released by the Census indicates that for those with incomes of $75,000 or more, there are—81 percent of that group gets their insurance through the employer market. But when you look at those—the group who have incomes below $25,000, only 23 percent of those individuals—

Mr. LIPINSKI. Okay. I just want to interrupt you, because I am running out of time here. It would seem to me, though, that in the long run you have this what you say is evidence, and it seems to suggest you are picking up with HSAs people who otherwise wouldn't have insurance, and that is great.

But it seems in the long run, if you are looking at this from an economic perspective, it makes a lot more sense if people are making the economically wise choices that healthy people are going to choose HSAs, and people right now who are more likely to be covered, as you said, with the—with health insurance coverage.

In the future, though, if HSAs become more available and businesses—employers are going to be offering HSAs because those are going to be cheaper probably for the business and for the individuals, you know, that situation is going to change with, as you said, those who are more likely to have insurance now are—you know, are in that category who work for the bigger employers.

It would seem in the long run it only makes economic sense that the people are going to pull out of the—those who are healthy are going to pull out of the insurance. And that is just looking—that is just looking at the people who are making, as I see, wise market decisions, that is the way in the long run it is going to work.

Chairman MUSGRAVE. Just answer briefly, if you could, Mr. Carroll.

Mr. CARROLL. Okay. Well, you know, one of the features of HSAs is they have a deductible, and above that deductible they cover—your insurance costs are covered. What we found—you know, I think it is the case that HSAs have been attractive to the chronically ill. I think that is reflective in the data that we have seen to date with older Americans and lower income Americans.

Chairman MUSGRAVE. Okay. Mr. Davis.

Mr. LIPINSKI. Thank you.

Chairman MUSGRAVE. Thank you, Mr. Lipinski.

Mr. DAVIS. Thank you very much, Mr. Secretary. Can you tell me how an HSA actually benefits a low income person?

Mr. CARROLL. The way the President's initiative—looking at it in its totality—benefits low income Americans in a number of different ways. First, a low income American would typically pay payroll taxes on their first dollar of wages, and the individual would receive a—under the President's proposal would receive a tax credit through the income tax for the payroll taxes paid on insurance premiums.

The individual would also receive—and that credit would be refundable. The individual would also receive a refundable tax credit for out-of-pocket expenses paid on—by that individual. And there is also included in the proposal another refundable tax credit that is targeted to the lowest income Americans. It is a 90 percent—it would cover up to 90 percent of the costs of premiums. It would be up to $1,000 for single individuals, up to $3,000 for families.

And what you see in the chart I referred to—I think it is chart 7 in the written testimony—if you have a chance to look at it, what it shows is that relative to current law where individuals—low income individuals tend to receive a fairly small, actually very small benefit from the current set of tax preferences in the tax system relative—whereas under the President's proposal they receive a much richer set of tax—a much richer tax subsidy.

Mr. DAVIS. What do we call "low income?"

Mr. CARROLL. Well, the low income—the refundable tax credit I mentioned, that is targeted to the lowest income Americans. For

singles, it is fully phased out I believe at $30,000 for singles, and $60,000 for families.

Mr. DAVIS. Do these people need any additional tax credits? Do they need something else?

Mr. CARROLL. Well, I mean, the broad structure of the proposal is not only to provide—you know, in part it is trying to make insurance more affordable. It is also trying to level the playing field between insurance provided in the employer market as well as in the non-group market. And it is also, importantly, trying to place individuals—the health care consumer at the center of health care decisions, so that they will have more at stake.

When individuals have more at stake in decisions, they typically make better ones. And by giving individuals a larger role in health care decisions, we expect this proposal to have positive effects on the—on health care costs.

Mr. DAVIS. Would it not make more sense for the government to just pay for the health insurance for these individuals than to talk about a tax credit that they may not meet or can't benefit from?

Mr. CARROLL. Yes. The broad structure of the proposal increases reliance on individual choice. As was mentioned earlier, well informed, cost effective choices is—you know, is something that is extraordinarily helpful in controlling costs. In some elements of the health care market, where the procedures typically aren't covered by insurance, we have seen a fair amount of competition.

We have seen a fair amount of price and quality information provided by the health care industry, by doctors, hospitals, and others. In vitro fertilization is an example. Eye laser surgery is another example where we have seen health care costs—not only the rise in health care costs diminished, but we have actually seen health care costs come down. So in the case of routine procedures, I think there are probably some very real benefits that can be gained by greater individual choice, by giving individuals more at stake in health care decisions.

Mr. DAVIS. While I have still got a second, let me just ask, have we really seen anything that has—I know I have been engaged for about 30 years I guess in public discussions. Cost containment has always been a big issue in health care, since I have been engaged. I have never seen anything yet that has actually brought the cost down.

It seems to me that the cost has simply been going up all the time. I have never seen anything that has brought the cost down.

Mr. CARROLL. Well, again, I think one area in the health care—in health care where you do see costs coming down is where market forces are more in play. Where they are more in play, the health care costs are either not rising as rapidly or falling, where individuals do not feel the kind of what economists would call the true marginal cost of health care, where they are not paying themselves directly a large fraction of the health care costs, you know, they tend not to be as involved in the decisions. Third parties are much more involved in the decisions. Market forces are a lot less at play.

Mr. DAVIS. Thank you very much.

Chairman MUSGRAVE. You are very welcome. Mr. Barrow.

Mr. BARROW. Thank you, Madam Chair. Mr. Carroll, I was struck by your observation that there are lots and lots of folks out there who are eligible to take advantage of the benefits of HSAs because they are already covered by essentially catastrophic coverage, high deductible policies to begin with.

The problem is, at least the problem—one of the problems that I start with is one of the reasons that folks got catastrophic coverage is they can't afford more comprehensive coverage. They can't afford coverage that covers stuff at the front end, so all they can afford is stuff that covers things out of the back end. Of course that covers you. It is cheaper because it doesn't cover most of the stuff most of the folks deal with most of the time, so I can understand why they are eligible.

The reason why they are eligible to take advantage of benefits is they ain't got the money to save. And it seems to me that if you do have enough money to save, and thereby actually get the benefit of any HSA type of legislation, it seems to me that you can't win for losing. If you don't have enough to save to begin with, you are bare. If you do have enough money to save, then you are either going to get lucky, in which case you will get the benefit of your savings account, you can do with that as you will, or you are going to be unlucky.

And if you are unlucky and get sick and have upfront costs that you aren't insured for, you lose there. You might as well be bare. You are no better off. But if you are actually lucky enough to be able to pocket some of the money you would otherwise spend on premiums covering upfront coverage you didn't need, you are pulling that person out of the risk pool.

They are not contributing to that extent to that pool of people who are taking their luck and mixing it with those folks who are unlucky, so that the lucky end up subsidizing and supporting the unlucky. Since we don't know who those folks are going to be, everything you are doing is fundamentally opposed to the whole notion of insurance. We are not insuring. It is just pushing folks to go more and more bare.

Now, how do we get folks insured if the objective—if the consequence of our policy is basically to say every man, woman, and child for themselves? If you can afford to save, do you want me to use—you know, you are either going to win or you are going to lose. But even if you are winning, you are pulling out of the risk pool.

Mr. CARROLL. Right. I think this is one part of a more comprehensive approach to health care. It is one of the elements of the problem in health care is—is the reliance on first dollar coverage. The first dollar coverage basically takes the consumer out of the decisionmaking and leads to less and less—

Mr. BARROW. I am going to leave the consumer in there for reasonable deductibles and stuff like that there. Everybody else who has paid in and is getting comprehensive coverage has got some kind of role to play in making sure you are not overutilizing the system.

But, you know, the concern I have got is folks overutilizing the system at the other end, at the emergency room, because they ain't got no coverage. And I just don't see HSAs increasing the number

of people who are pooling their risk and thereby trying to achieve the optical level, the largest number of lucky people subsidizing the unavoidable number of unlucky people. I just don't see that happening.

The arithmetic just don't add up. You can say it is part of a comprehensive package, but this does not add to that solution at all. It rewards people for being lucky, but it penalizes the community as a whole by taking those folks out of the risk-sharing formula.

Mr. CARROLL. I think when you look at the package in its entirety, its positive effects on health care costs will lower health care costs generally and be very helpful to the market generally.

Mr. BARROW. Well, I know a guy who says the national sales tax is the optimal, ideal health care solution, because it is going to raise the tax for everybody and chase all of those slackers and those hypochondriacs out of the system, reduce the overall demand of those folks who really need it. And that is going to more than offset the amount of the 33 percent national sales tax on premiums, and the 33 percent sales tax on doctors' bills. I don't believe that either.

I just don't see this part of it. I just don't see that part of the comprehensive package doing any good.

Mr. CARROLL. And another element of the proposal is that—for the initiative is that it extends to individuals purchasing their health care directly. The same tax advantages that are commonly—

Mr. BARROW. I am all for that. I am all for that. I just don't—I just see risk segmentation, breaking up the risk pool—

Mr. CARROLL. There is a large segment of the population that is not covered by the employer system.

Mr. BARROW. Fair enough.

Mr. CARROLL. They tend to be lower income. They tend to work for small businesses.

Mr. BARROW. I am for tax equity, as far as that is concerned. This just doesn't seem to get it there. Thank you.

Chairman MUSGRAVE. Mr. Udall.

Mr. UDALL. Following up on Mr. Barrow here, the HSAs, don't they really work well if you have money? And if you are living paycheck to paycheck, I mean, you don't have the ability to put the money into HSAs.

Mr. CARROLL. Well, something I mentioned earlier is the preliminary evidence on HSAs suggests that a lot of—a significant number of lower income Americans are using HSAs. Roughly over 40 percent, actually 42 percent, of those with HSAs, of the 3.2 million with HSAs have incomes below $50,000, suggesting that a very significant number of lower income Americans are finding HSAs to be useful.

That general statistic is going to be confirmed by some earlier IRS data for—released for 2004 a few months ago. It is—so I think the early evidence is that HSAs, you know, are kind of consumer choice. Lower income Americans are choosing to take up HSAS.

Then, an important aspect of the President's proposal is that it very much refocuses HSAs through the series of—as I mentioned earlier, the series of tax credits, refundable tax credits for payroll taxes paid on premiums and out-of-pocket expenses and refundable tax credit for lower income Americans. That really shifts the bene-

fits of the tax subsidy received by Americans, it provides very significant tax subsidies to lower income Americans.

There is a chart I have in the written testimony I mentioned earlier that illustrates for an individual with pretty much an average—the average out-of-pocket expenses and the average insurance premium, individuals in the $10-, $20-, $30,000 range actually will receive a larger tax subsidy under the President's proposal than higher income Americans.

Mr. UDALL. Mr. Carroll, where is the evidence that people earning under $50,000 are using the HSAs? You said it is preliminary evidence, is that correct?

Mr. CARROLL. It is—there is an IRS—the IRS released some statistics off of tax year 2004 returns a month or so ago. I can get that to you. That data, when HSAs were just starting out and there weren't all that many people with HSAs, that data nevertheless indicated a very significant fraction of those with HSAs were lower income Americans.

More recently, in January of this year, AHIP released some data that indicated that—I believe it is the AHIP data that indicated that more than 40 percent of Americans with HSAs had incomes below $50,000.

Mr. UDALL. Well, I suspect what is going on here is people may have been forced to shift into these situations. Can you tell me how many of those switched from comprehensive plans through no choice of their own?

Mr. CARROLL. I don't have that information.

Mr. UDALL. Would you be able to get that for us and give us an indication as to what is happening there? I mean, if we made some policy decision and we are forcing people to do that, I think that would be very important to this equation, wouldn't it?

Mr. CARROLL. Yes, I don't believe that the data are split out in a way in which we could kind of directly answer that question. But I would simply observe that it often may be in the interest of consumers to move towards a high deductible plan, because their premiums will in fact be lower. And that is—so, you know, to characterize it as people are being pushed into high deductible plans is not something I would necessarily agree with.

Mr. UDALL. Thank you. Appreciate it. Thank you.

Chairman MUSGRAVE. Thank you, Mr. Udall. Mr. Carroll, I did receive a note that Mr. Perrin, the last panelist on our second panel, says that he can answer the last question that Mr. Lipinski asked. And so I would like Mr. Perrin to come up and join you, Mr. Carroll.

Mr. Lipinski, could you—would you like to restate that question for us?

Mr. LIPINSKI. Does Mr. Perrin need the question restated?

Mr. PERRIN. No.

Chairman MUSGRAVE. Okay. Let us just—he is eating. That is what the deal is. Go ahead.

Mr. PERRIN. The question about diabetes or any other serious illness is one we get all the time. And for you, Congressman, I could make a pretty clear argument that you would be better off with an HSA, even if you spend every dime in the account every year.

There are two reasons the sick or the less healthy choose an HSA. The first one is financial. If you take a traditional family plan that now costs $11,000 a year, what you have is usually a $500 deductible, 20/80 co-pay up to $5,000. So you, as somebody who is less healthy, is going to spend that $500, you are going to spend the $1,000. So you are now talking about $12,500 that you are spending.

If you move to an HSA and you take that $12,500 and you get a $3,000 deductible, and you put $3,000 in the account, your health insurance policy is not going to cost you $9,000. It is going to cost you about $6,000. So you have got $3,000 in the account, you have got $6,000 for the insurance, let us say, depending on what state you live in. That is $9,000. You immediately have a savings of $3,000 instantly. So there is a financial incentive on the part of some less healthy to choose an HSA.

Now, on the non-financial side, you get complete choice, control, treatment options, because you are paying cash. And for somebody who is less healthy you have obviously a large amount of experience with the health care system. You know your condition better than most. You are perfectly happy being in charge of your health care. And you are probably the best person in the world qualified to be in charge of your health care, which is exactly what HSAs do.

We have a financial incentive, we have a non-financial incentive. That is why the sick choose an HSA, and that is why there isn't going to be adverse selection.

Now, the final point that I would add is when you move $3,000 into a savings account you are increasing your buying power by your tax rate. Right? That $500 deductible, that $1,000 to get to the 100 percent coverage on the co-insurance, really is after-tax money. We are talking about pre-tax money. So there is an additional financial kicker.

Now, the problem is that if somebody says, you know, the sick have to pay this $3,000, therefore, they won't choose an HSA. It really is a pretty simplistic analysis of what is going on on the ground with HSAs.

Now, you don't have to take my word for this. There are a number of studies, including from McKinsey and Company, that show that the less healthy when they have a high deductible plan become much more engaged in their health care. And the reason is really quite simple. If their condition gets worse because they don't take care of themselves, they are the ones that pay. It comes out of their pocket.

So you have a financial—an added financial incentive for the less healthy to become more compliant with their treatment, which is exactly precisely what the McKinsey study and others have shown. And I would be happy to provide that to the Committee.

Chairman MUSGRAVE. Mr. Lipinski, did you want to comment?

Mr. LIPINSKI. Well, I think probably right now I just want to leave it at that. I would very much like to see that study, but I think maybe we should wait. I think I have some questions and my colleagues have questions, but why don't we wait until Mr. Perrin gives his testimony.

Chairman MUSGRAVE. Thank you so much.

Mr. LIPINSKI. Thank you.

Chairman MUSGRAVE. And we all would like to be eating, so no criticism there. Just grab when you can.

Okay. Mr. Carroll, I thank you and thank you for your patience as I let Mr. Shadegg talk longer than the five minutes. I appreciate that, and we are glad you are with us today.

And I would call up the second panel. And at this point, I have seen the light, so we are going to get back on the strict time schedule. So if the second panel would come forward, I am going to introduce you as you are coming.

We have Mr. Ed Lawler, ReMax Alliance, National Association of Realtors from Fort Collins, Colorado; Merrill Matthews, Dr. Matthews is the Director of The Council for Affordable Health Insurance from Alexandria, Virginia; Mr. Dan Perrin that you just heard from is from the HSA Coalition here in D.C.; Dr. Cecil Wilson, he is the Chair-Elect of the Board of Trustees, American Medical Association, from Orlando, Florida; Mr. Paul Hense, Hense and Associates, National Small Business Association, from Grand Rapids.

Welcome. And, Mr. Lawler, we will start with you. Happy to have you in the hearing today.

STATEMENT OF ED LAWLER, NATIONAL ASSOCIATION OF REALTORS

Mr. LAWLER. Thank you. Chairman Musgrave and Ranking Member Lipinski, and members of the Committee, my name is Ed Lawler, and I am a realtor from Fort Collins, Colorado. And I am speaking on behalf of roughly 1.2 million members of the National Association of Realtors.

NAR is the nation's largest professional trade association. Our members include real estate professionals engaged in every aspect of the real estate industry. I appreciate the opportunity to share our thoughts on the challenges that face small businesses and the smallest of the small businesses—the self-employed—in finding affordable health insurance coverage.

Unlike other issues on which NAR has testified in the past, NAR members' interest in this topic is personal rather than professional. Real estate sales is a prototypical small business. Real estate firms typically have fewer than five salaried employees, and real estate agents, as independent contractors, are not employees of the firms with which they are affiliated, but are in fact the smallest of small businesses, a firm of one.

As a consequence, real estate agents are typically forced into the individual insurance market, a market where you basically take or leave whatever coverage is offered. There is no negotiating, and there is no leverage.

Today, 28 percent of the realtors, more than one in four, of the nation's 1.2 million realtors do not have any health insurance. In seven years, the percentage of uninsured NAR members more than doubled, going from roughly 13 percent of its membership in 1996 to 28 percent in 2004. By comparison, the percent of U.S. population without health insurance was estimated to be 15.7 percent in 2004. The percentage of uninsured realtors is almost double that of the nation as a whole.

To further put these figures into light, 28 percent of our membership is 336,000 individuals. If each of those individuals is uninsured, it is likely that their family—spouses and children—are also uninsured. Therefore, we would expect that as many as 873,000 members and their dependents are uninsured.

When asked why they are uninsured, 74 percent say the cost of the coverage is their biggest barrier rather than uninsurability. It is not surprising, then, that the number one question members who call NAR information central ask: what can NAR offer me in the way of affordable health insurance?

Unfortunately, the answer to that question right now is very little. Not what the typical caller wants to hear from our association, representing them as one of the largest entities, as big as some of the largest corporations in America.

Madam Chair, our members believe the powers granted to a trade organization should be equivalent to those granted to large employers or trade unions when it comes to negotiating for a quality, uniform national health plan for their constituents, regardless of where they live. As a result, NAR members strongly support small business health plan legislation, including H.R. 525, S. 406, and, more recently, S. 1955. And we are not alone.

A March 2006 survey of likely voters done by two nationally respected polling firms, public opinion surveys, and research partners found that the American public shares NAR's support for small business health plans with 89 percent of the participants responding favorably. Even when presented with the arguments against small business plans, including both pollsters indicated using the harshest criticism lodged against AHPs and SBHPs, support for the plans remained extremely high with 86 percent of the national voters still favoring the concepts.

The result also showed that support crosses party lines with approval levels for voters of all parties greater than 86 percent. Americans understand that the current insurance delivery system is broken and that the following firms to join—and that allowing firms to join together to negotiate will make a difference, creating another large pool.

Last year, testifying before the Senate Small Business Committee on S. 406, NAR's then-president Al Mansell admitted that small business health plans are by no means the silver bullet that will solve all the nation's health insurance plans. But he pointed out that it was time for all parties, supporters and opponents, to sit down together and figure out how to address the issues that were contentious.

We are heartened by the fact that this is exactly the approach that Senators Enzi and Nelson have taken this last year in developing their compromise SBHP bill, S. 1955, the Health Insurance Marketplace Modernization and Affordability Act, which passed the Senate Health, Education, Labor, and Pensions Committee last month. Once their bill had been drafted, the Senators asked the major stakeholders—insurers, insurance commissioners, and the small business community—to submit their concerns with draft language.

Those concerns were then discussed over the course of several months, and acceptable alternatives were found. Additional

changes were also made as others weighed in on the issue. The end result of this process is a bill that addresses most of the concerns that traditionally have been raised, including state regulatory oversight, mandates, and financial solvency.

Are there still those who have objections? Yes. But it has been our experience that the bill's co-sponsors have been open to concerns and are continuing to work on addressing them. We believe that an acceptable compromise is possible. NAR is committed to working to advance what we believe can be a very effective insurance delivery system.

If SBHPs are approved, we will be one of the first to be in discussions with our insurers to craft a quality health insurance package for our realtor members.

Once again, thank you for giving NAR a place at the table, and for giving me the opportunity to share our thoughts and my thoughts. I am happy to take any questions.

[Mr. Lawler's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you. We will come back to questions after everyone testifies. Dr. Wilson.

STATEMENT OF DR. CECIL WILSON, AMERICAN MEDICAL ASSOCIATION

Dr. WILSON. Good morning, almost good morning, and thank you. Chairman Musgrave and Ranking Member Lipinski, we appreciate your holding this hearing on common-sense reforms to reduce health care costs and expand health care coverage. I am Cecil Wilson, a physician internist from Winter Park, Florida, and Chair-Elect of the Board of the American Medical Association.

My testimony focuses on medical liability crisis, but first I would like to briefly comment on health savings accounts and association health plans.

Like any small business, physician practices are grappling with the rising cost of providing health insurance to our employees and their families. The AMA believes that health savings accounts and association health plans, if properly crafted, could expand affordable health insurance options for small businesses.

Now, the AMA also believes that Congress must address the high medical liability insurance costs and the burden they place on physician practices and patient access to care. My practice employs one physician—myself—and three staff. In fact, nearly 75 percent of practice-based physicians in this country either work or own small practices of less than nine physicians. And escalating jury awards and the high cost of defending against lawsuits, including meritless claims, are the primary drivers of increased medical liability insurance premiums.

These premium costs are part of our overhead expenses, and when expenses increase physicians must either raise revenue by increasing fees or cutting other expenses to sustain their practices. And covering these costs is more challenging as Medicare, Medicaid, and managed care plans limit physician compensation for treating patients.

The resulting need to cut expenses forces physicians to face the difficult choices of laying off staff, dropping or reducing health insurance benefits for their employees, foregoing the purchase of new

medical equipment, or limiting certain aspects of their practice that are too expensive to insure.

In addition, we are all aware of the human costs that the liability crisis exacts from patients any physicians alike. We have heard sobering stories of patients who could not find trauma care in time and of pregnant women who had difficulty finding a physician to deliver their babies.

Viewed on a broader perspective, we all pay the price of a broken medical liability system. A medical liability adds $-70 to $126 billion to the cost of health care each year, and these costs translate into higher health care costs for everyone. These are the reasons we support proven reforms to the medical liability system. The AMA worked hard in supporting the passage of H.R. 5, the HEALTH Act. And, as you know, that provides reforms that have proven effective at keeping medical liability insurance premiums stable.

This Act allows patients to recover unlimited economic damages and includes a $250,000 limit on non-economic damages, also known as pain and suffering. As discussed in my written statement, a $250,000 limit on non-economic damages has worked in California. It will work nationwide.

Texas enacted effective reforms in 2003. These include limits on non-economic damages—that is, a $250,000 cap for physicians—and a limit of up to $500,000 for health care facilities such as hospitals. That new law works. What we have seen already is an increase in new physicians going to Texas, and in 2005 Texas physicians saw an average cut in their premiums of 13.5 percent. This will result in a savings in 2006 of an estimated $49 million.

Not only do these reforms work, the public supports them. An April 2006 Harris poll shows that three-fourths of Americans support comprehensive medical liability reform. Seventy-five percent believe the crisis affects their access to health care, and a majority believe that medical liability lawsuits are the primary driver of increased health care costs.

Madam Chair, federal legislation based on proven reforms that stabilize medical insurance premiums, and preserve patient access to care, is the solution to the crisis. AMA looks forward to working with Congress to continue to work to enact common-sense medical liability reforms this year.

Thank you.

[Dr. Wilson's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you, Dr. Wilson. Dr. Matthews, we will hear from you at this time.

STATEMENT OF MERRILL MATTHEWS, THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Mr. MATTHEWS. Thank you, Madam Chairman, and Ranking Member Lipinski. I appreciate your taking the time to have this hearing on a very, very important subject. I am Merrill Matthews, Director of The Council for Affordable Health Insurance, which is located in Alexandria.

CAHI is a research and advocacy organization. We have members, health insurers, doctors, third party administrators. We have been around since 1992.

We at the Council believe that all Americans should have access to affordable health coverage. And by taking just a few steps, we think Congress can move us much closer to that goal. Let me identify three issues.

People need access to affordable health insurance plans. State laws often impede that access, and Congress can take a few steps that will ensure a vibrant and competitive health insurance market. Let me start with creating affordable health insurance plans. Everyone knows that health insurance premiums have been going up, and that is largely responsible for the growing number of the uninsured.

A recent survey by Deloitte of 152 major U.S. employers found that preferred provider plans, PPOs, were going up an average of 7.2 percent, HMOs 8 percent. That is lower than it has been, but it is still significantly higher than the consumer-driven plans that were going up by an average of 2.8 percent annually.

This is why the Council believes that expanding access to consumer-driven plans such as health savings accounts and health reimbursement arrangements is one of the best ways to keep health insurance affordable. HSAs have been operating now for two years. We have seen a lot of criticisms of them, but it is remarkable how wrong the criticisms have been.

Even with the criticisms, the growing dynamics, we think that Congress can do a couple of things to make HSAs and consumer-driven plans even more attractive. The non-self-employed, people who work for an employer who does not provide health insurance, do not get a tax break for that insurance, the ability to be able to put money into an HSA and to be able to get their health insurance premiums tax deducible, tax-free for those health insurance premiums would help make health insurance more affordable for that population.

In addition, Americans spend a lot of money out of pocket on health care, allowing them to be able to pay that money out of their HSA for the wide range of health care costs, would help make health care more affordable.

Second, not everyone has access to affordable health insurance plans. In large part, the affordability of health insurance depends upon the state that you live in. Many states—Congressman Shadegg talked earlier about the mandates that are out there. The Council, we track these on a state-by-state basis. According to our figures, you have got about 1,843 mandates out there.

If you had the ability to be able to bypass some of those mandates, you would be able to have access to more affordable policies. For instance, Minnesota has 62 mandates, Maryland 60, Virginia 54. Washington, D.C. has only 17. Alabama has 18, and Idaho 13. There are no stories in the press about people falling dead in Idaho because they only have 13 mandates. You can get affordable policies out there with fewer mandates and still have quality coverage.

In addition, one of the biggest problems we have is guaranteed issue in community rating. Eight states passed those laws. Kentucky backed off from them. All the states that have done that have ended up destroying their health insurance markets by making health insurance virtually unaffordable. Congressman Shadegg

talked about New Jersey. That is our sort of prime example of how not to reform the health insurance system.

Ensuring a competitive market for health insurance—we think Congressman Shadegg's bill would allow people to be able to buy health insurance across state lines. He talked at length about it. Let me just mention one thing about it. There is some discussion about, doesn't this allow people living in one state to be able to have health insurance in another state? And isn't that a problem?

Council for Affordable Health Insurance based in Virginia provides insurance. I live in Texas. I could have the Council's plan. I choose not to do that. I have a plan in Texas. If I did choose the Council's plan, I would be a person living in Texas with a Virginia regulated health insurance policy. I can do that right now.

My daughter, who is from Texas. goes to school in New Jersey. She is a graduate student at Rutgers. She is under my Texas plan. She could choose to go under New Jersey, but we can't afford that. She is a Texas resident living in New Jersey with a Texas-based plan.

You already have that going on now, and it seems to work just fine. Incidentally, if you live in Pennsylvania, and you decide to move to New Jersey, you live in Pennsylvania, you have the individual policy there, you move to New Jersey, you can keep that individual policy living in New Jersey. You will pay lower premiums than somebody who actually goes through the insurance department there in New Jersey. But under current law, you can carry your insurance policy with you to another state.

Chairman MUSGRAVE. Could you just wrap up, please?

Mr. MATTHEWS. Yes, ma'am. In summary, let me say that just with a few steps Congress could dramatically improve Americans' access to affordable health insurance, especially for those living in states that have virtually destroyed their health insurance market.

I encourage you to look at some of those provisions, and we will be—we look forward to answering your questions. Thank you.

[Mr. Matthews's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you, Dr. Matthews. Mr. Hense, we would hear from you at this time, please.

STATEMENT OF PAUL HENSE, NATIONAL SMALL BUSINESS ASSOCIATION

Mr. HENSE. Yes. I am pleased to be here. I want to thank Todd McCracken and the National Small Business Association for having me here. I am a humble CPA from Grand Rapids, Michigan, so this stuff to me isn't statistics and numbers; it is people, because this is what I do. I don't study these bills as much as maybe some people who live in Washington, but I do see the results.

I am a University of Detroit graduate, not a Harvard or Ivy League school graduate, inner city school. This is real to me, not theoretical or statistical.

There is a term called a BFO, blinding flash of the obvious, that I think applies to what I want to present to you, because I just don't understand. And I use the example of Michigan is imploding. We are kind of looking forward to having Ford and General Motors join the National Small Business Association or Small Business As-

sociation of Michigan, because we are going through, you know, a real meltdown.

And, of course, most of you know, if you do follow Michigan issues, that it is health care that is driving what used to be the Big 3 down, not just the Medium 2.

But the situation that I look at is people—we are almost exclusively a small business CPA firm. It is what we do. It is what we are—our total involvement is. So if somebody comes to me and says, "I want to start a business. I have just been downsized by one of these giant corporations," or because we have a reputation for helping people with startups, we get people who don't have a business background, their family doesn't have a business background, and they say, "Well, what do we do?"

So we go into this, we are going to hire somebody. So you take two people, say you have one person that says, "I want to start a business, I am going to hire somebody." so you—tell me how I explain to this person who is going, "I can do it, I want the American dream, I want to own a business. How do I do this?" And I say, "Look, you hire this person, you get health care on both of you."

By the way, the employee gets 100 percent scot-free, tax deductible health care. You don't. Well, why don't I? Because you are the owner. You have just become a capitalist. And here is what we do. I am going to—say $10,000 a year you pay in health care, you are going to pay a 15 percent premium that the employee doesn't have to pay. Well, why? Because you own the business.

You had the initiative. You went out and started this business, you had the guts to do it, and, by God, the government is behind you 100 percent. They want your down payment right up front, how much they are going to get out of you over the years. Hardly understandable.

The same thing applies to pension Section 125 plans. You want employers to set up a 125 plan, have health care for the employees, set up a pension plan. Who do you exclude? The employer. From the Section 125 plan and from the health care 100 percent deductible. Hard to understand.

There is, by the way, a good side to this. There is all this negative talk. In order to avoid self-employment tax on small businesses and their health care plans, we have to usually set them up in an entity. And what do you suppose that does, an S Corp or a C Corp? That drives up accounting costs. So there is a bright side to everything.

The other point is, I had just—again, people, not numbers, nor statistics, real people—I have a young woman working for me, wonderful young woman, 15 years with me, raised three kids, just got through a bout of bone cancer with a son, finished college while her son was being treated for bone cancer, got her degree, passed the CPA exam, and we are talking about bringing her on as an owner.

And what is our hurdle? Well, she loses her—the health care becomes a problem, because she has to pay self-employment tax on the health care. But she loses her Section 125 plan. I mean, what is the message? So when I look at this, like I say, I would like to somehow someday have somebody explain to me why you would differentiate between the person who says, "I will not be on welfare, I will not be a statistic, my job went away with General Mo-

tors' downsizing, I am going to own a business, and I am going to hire somebody." Well, you can do that. This is America. That is what we want you to do.

But when you start that business, your friend or your neighbor or the person you hire, you don't pay self-employment tax on their health care insurance but you do on your own. And I have never had an explanation of that that satisfied any rational bone in my body. So basically, I think that if it is good for General Motors it is good for Ford. Obviously, it hasn't been, but if it is good for big business it is good for small business.

If it is good for government employees, let us level the playing field. If you own a business, you should have the same health care, you should have the same availability of health care with the same tax, same pension plan, same Section 125. There is no reason to prejudice the owner in these programs. We should actually be thrilled that they are doing it, because they are helping solve our employment problem.

Thank you very much for having me. And I just want to throw one thank-you out, Representative Musgrave, for your extending the Section 179 deduction. That is a big issue for small business, extend that a few years. And, Representative Lipinski, your bringing things out into the light with the hospitals--I don't remember the numbers on the bills. I know the concepts. Anything that brings the cost out in light gets—allows people to say, "This is what the problem is."

I ask continuously, why does this keep going up? Nobody ever answers. The problem we are talking here about who is going to pay. Well, that is a problem. The bigger problem is: why is it so much? And thank you very much for shining a bright light in that dark little corner of the world.

Thank you.

[Mr. Hense's testimony may be found in the appendix.]

Chairman MUSGRAVE. Appreciate your comments. Mr. Perrin.

STATEMENT OF DAN PERRIN, THE HSA COALITION

Mr. PERRIN. Thank you, Madam Chairman, and members of the Committee, Mr. Lipinski. I want to echo my colleagues' comments on your hospital bill. Trying to explain consumerism in health care when there are no prices is a kind of rough road. And it is a real problem; we salute you for your leadership in that regard.

Let me just go back to basics a little bit on HSAs. You know, people have a lot of ideas about what they are, and one Congresswoman was asking me, you know, how are you supposed to explain an HSA to people? I said, "Congresswoman, let us say I give you $2,500, and once you have spent that money your insurance kicks in." That is an HSA. She said, "Where does the $2,500 come from?" Which is the obvious question.

It comes from reducing your premium. And that is why Congress mandated that an HSA-qualified plan have the characteristics it does, to create that money available to people to fund their account.

And I have a little vignette to share with the Committee. I took my kids to one of these amusement parks where you pay the fee, the rides are free once you get in the park, except for the souvenirs

and the games and the arcades and the food. And I have five kids, and my older kids wanted to go off on their own, so I said, "Okay. Here is your money." I gave them $40 each, because I, frankly, didn't expect to see them until sundown, but they sought me out about two, three hours later, and, "Dad, we don't have any money."

So they are standing there, they have no large stuffed animals or hats or T-shirts, any noticeable thing that they have spent the money on. And I said, "What happened to the money?" and they proceeded to list this long list of things including telescopes that take quarters that were on top of a tower. They basically just wasted the money instantly, almost instantaneously. So I said, "No, I don't have any money." So we went to the waterpark and spent the rest of the day there.

Now, my wife then tells me our cousins are visiting, and I have been elected to take the kids again to the amusement park. This time there are three more, and they are teenagers. So when I handed out the money this time, I said, "Look, what you don't spend you get to keep." Okay? So some of the kids were literally jumping up and down they were so excited. They thought they hit the jackpot.

And the behavior changes were substantial. My son said, "Well, Dad, you know, the arcade is too expensive, and so is the souvenir shop." My daughter skipped lunch and had an ice cream cone. They actually argued with the clerk about the change; something I have never seen them do.

There was a huge discussion about the fact that I had brought 20 SPF sunscreen, but the teenage girls wanted 40. But it was $15 at the park, so they spent 15 minutes trying to decide how to divvy up that cost. And what that really illustrates is that when an employee, either the employee gives them the money or they finance it when they are in individual insurance, when they are spending their own money they spend it a lot differently.

And that is at the core of why HSAs—as my colleague Mr. Matthews pointed out, the Deloitte study showed only a 2.8 percent increase year or year. We have another study from United Benefit Advisors, largest private sector study ever done, 3.4 percent year-over-year premium increase. And this is what is killing business. These price increases are unsustainable. Unsustainability means you can't afford it.

When you can't afford it, it means you don't have any. And for the first time, ehealthinsurance, who has about 60 insurers on their website, sells exclusively to the individual market, showed a 15 percent premium decrease, a double-digit premium increase between 2004 and 2005. I don't know about you, but it has been a long time since health care costs have gone down, insurance costs have gone down.

So there are a lot of dynamics that HSAs bring to the table, but really it starts with reducing the premium cost and using those savings to fund the account, which then changes behavior.

So, Ms. Musgrave, I appreciate your allowing the Coalition to be represented here today, and thank you.

[Mr. Perrin's testimony may be found in the appendix.]

Chairman MUSGRAVE. Well, thank you, and maybe you could have a second job with parenting classes. I like the analogy with the amusement park.

The testimony has been especially good. I really appreciate it, and I would just like to start out with a question for Mr. Lawler. I think a lot of people when they hear ReMax or Century 21, you know, they see this big company. You know, we have seen the signs all over the country and everything, but would I be correct in stating that you are more like an independent contractor? And tell me if that is true, and, if so, what kind of challenges do you face with—

Mr. LAWLER. Absolutely. I am glad you brought that up. In my testimony here, so often that is a confused assumption, large companies we hear have market share across the whole United States. But the vast majority of these agents are independent contractors, and, as such, they are a sole person, one-person entity. They are not employed by ReMax in this case. I am not employed by ReMax. I work as an independent contractor and have to provide my own health insurance as an individual.

Of those agents that do have health insurance, approximately 30 percent get their own health insurance as individuals, and it is very limited and it is costly.

Chairman MUSGRAVE. You know, you see those ubiquitous signs, and you really do have this concept that this is a big company, and I think it is very easily overlooked, what kind of challenges you face as an independent contractor.

Dr. Wilson, I was elected my freshman class with some doctors, and they have very eloquently spoken about the challenges that much of my district faces being a remote rural area. And you talked about the challenges that in some areas you can't even get docs to deliver babies.

Could you dwell on the tort reform issue a little bit for me? And put a picture on what that does to someone who lives 75 miles from a major city, and they live in a farming community of 10,000 people, and help us out with that a little bit.

Dr. WILSON. Thank you, Madam Chair. And maybe I can approach that from my personal experience, which is actually in the greater Orlando area, which is urban. And let me just say the bottom line is that what happens in urban areas is magnified by the challenges you just described of geography. I mean, if you only have one physician in a community, and that physician decides because of the challenges related to viability to retire earlier, or to move to another state, then all of a sudden you go from one physician to zero physicians.

Let me just say that my experience—and I have been in practice for a fair number of years now—and a surgery group that I have used for some 25 years in one of the hospitals at which I have privileges two years ago lost their liability insurance because in Florida at that time companies were fleeing the State. Two members of that group left the State, one member retired, and the remaining members of that group decided not to provide coverage at that community hospital.

So the group I had used for my patients in Winter Park Hospital was no longer at that hospital, and since they were the only gen-

eral surgery group for nine months that hospital had no general surgeon. So if one of my patients or any patient in Winter Park came to that hospital with an acute abdomen, with appendicitis, or a gall bladder problem, they had to be transferred. And that's the reality of the liability crisis, which is—does not solve the problems in terms of recompensating people who are injured, but results in these effects.

So as I said to begin with, those kinds of things are multiplied many fold, not only in rural settings but also in the urban high density population settings as well.

Chairman MUSGRAVE. I believe you mentioned 21 states in crisis. Are there states where docs are literally fleeing? They just don't want to practice there anymore? How bad is that crisis that you are referring to in your testimony?

Dr. WILSON. The 21 states—and that is an American Medical Association designation—and we designate states based on our understanding of the challenges to access to care for patients in that state relating to the liability crisis, the value of awards, the excess awards, the difficulty of getting insurance, and that is how we categorize those states.

I will just give you the example from my State of Florida. It is very difficult to recruit physicians to come to Florida. One of the other groups that I use is an orthopedic group who has for the past three years tried to recruit a physician to come to their practice. One of my brothers who is a general surgeon in the panhandle, a group of five general surgeons, took them three years to recruit two general surgeons to come to the panhandle, and it was because of the liability crisis.

My brother, who was hoping to retire, kept saying, "I am hoping to retire." And I said, "Well, you know, Ted, you keep promising that," but it was the challenge. So that is the personal experience.

The other final observation which I alluded to is Texas. And prior to Texas reform in 2003, you could pick any particular high risk specialty and find that the numbers—actually the numbers were decreasing in the State. And just in the three years since passage of that legislation, that climate has changed such that physicians are now coming and we are seeing increased numbers coming to Texas.

Chairman MUSGRAVE. Thank you. Mr. Lipinski.

Mr. LIPINSKI. Thank you, Madam Chairman. We have been here for more than two hours already, but I could probably go on for at least two hours myself here. I will try not to do that.

I would like to first thank Mr. Hense and Mr. Perrin for their comments on my bill, H.R. 3139, Hospital Price Disclosure Act, and hopefully maybe I can get the Chairman of the Committee to sign on to that bill.

But I want to move on to a couple of questions that I have. First I want to talk a little bit—Dr. Matthews had talked about mandates and the problems with mandates, and it is certainly easy to pull out ones that—most of us would say, "Well, that is kind of ridiculous, that that needs to be covered."

I just wanted to make a statement about my concerns. Right now, it is not a problem if you live in one state and for some reason or another you could have insurance through—from another state.

My concern is that, though, if you can have an insurance company just following the—whatever the requirements are in one state, what it is going to lead to with every insurance company is going to be going to one state. What state is that?

The state that has the fewest regulations, the fewest mandates, and is going to be in the interest of the states to fight against each other to get to the bottom, so that they have insurance companies there, so they are getting in the money from these insurance companies. I mean, that is my concern about that.

One thing, this is going to violate probably all kinds of norms in etiquette, but let me pull something out from my shoe.

[Laughter]

This is an orthotic. I have had orthotics now for four or five years. I was having knee pain. I was a runner, and I didn't have—hadn't had any problems for many years, and, you know, first I was told, well, you are just getting older, you have got to accept that. Then, I went and was told, "Well, you get these orthotics. It will make a difference. It can help to get rid of your knee pain."

Now, they were covered—the insurance I had at the time, they were covered. Moved to a different insurance, they weren't covered. I actually waited a little while until I was elected to Congress—until I started my coverage, I should say. I had been elected, but I checked the insurance I had before I started and got the insurance, it didn't cover it. So I thought, well, I could wait a little while. I waited, and, sure enough, now I have coverage, which is fantastic.

I would have bought it no matter what. But I can certainly see this isn't the best example, but it is an example. What difference does it make? On a good week, I run 20 to 25 miles in a week. It certainly helps my health. I am in much better shape because of that, and I would want to do that. However, I would be concerned that there are people who certainly simply for one reason or another didn't want to do it or couldn't afford it—to go out and spend the few hundred dollars that it costs to buy one of these.

That is my concern, getting back to Mr. Perrin on HSAs. Do we have—what evidence do we have about people's long—their decisionmaking in terms of long-term impacts? It is easy to look at all of these different things you might buy at an amusement park and say, "Well, the kid doesn't really need that or didn't really need to do that." I mean, that is one thing. But it is another thing if someone is not going to get a test or someone is not going to get something done.

Do we have any evidence that people do make good decisions for themselves in the long run? And it gets down to not whether people, you know, are smarter or not, as much as, what information do people have? Do people have enough information to be making those types of decisions?

Mr. MATTHEWS. Let me address a couple of points there. Number one, we had a group of actuaries oversee this mandate chart, and you will find in there that we did an actuarial estimate on each of the mandates. The vast majority of them are less than one percent, would affect the cost of a premium less than one percent.

Some of them have very little impact. It is when you begin to add 20, 30, 40, 50 mandates together that you begin to start having a real significance.

Another question that came up in the discussion of this is: wouldn't we think that some of these—some of the things that are in there that we look at as mandates are things that you would expect a good health insurance policy to cover anyway. But because some state or another state—for instance, prescription drugs—we mention that as a mandate, because a couple of states have a law about that.

We would think that a good prescription—a good health insurance policy would include prescription drug coverage anyway. So some of the things that we call mandates are going to be part of what we think a comprehensive policy should have. But there is no evidence that I am aware of that when deductibles rise our mandates decrease, that you have any adverse effect on health outcomes. We are not aware of that.

What most happens is that most of the mandates that you could begin to extract are things that people could pay for out of their own pocket, but because insurance covers they go ahead and do—they cover it under the insurance. And that gets to an issue of, you mentioned—the term overinsured or underinsured was mentioned here earlier.

In many cases, people have comprehensive coverage for things that they could pay for easily out of pocket. And ideal insurance would not necessarily cover everything that somebody could reasonably spend on health care. It would actually cover large unforeseen costs, things that insurance, when you talk about insurance, should actually be covering, not standard, routine, daily, or lower cost.

But there is no evidence that I am aware of that by moving people to higher deductibles or removing some of the mandates that it adversely affects their health in any shape, form, or fashion.

Mr. LIPINSKI. I know Mr. Perrin is going to address this next, but let me also throw in this other part of this question. Why do insurance companies—insurance companies—health insurance companies are not out there for people's—to look after—just to look after people's welfare. They are out there to make a profit. Why don't insurance companies encourage people to not overspend? Because the money doesn't come out of nowhere.

They money comes from the insurance company. How can insurance companies aren't themselves—they are in the business. This is their business. And if they don't want people to spend too much, if they think the way their insurance is structured that people are going to spend too much, why don't insurance companies do something about it?

Mr. MATTHEWS. That is one of the reasons why deductibles have been rising over the past decade or two. It used to be—several years ago it would be a $50 or a $100 deductible. Now it is—$500 or $1,000 is common. Also, a change in the co-pays. But as Dan pointed out, that sort of increases your cost up front. And if you have a $1,000 deductible, without an HSA or a health reimbursement arrangement, you may discourage or put off certain care that you might otherwise get if you had coverage for it.

That is why what the consumer-driven plans with the HRA or HSA are meant to do is to say there is money in an account for you if you need preventive care, if you need to get routine care, but there is an incentive for you to ask the question: where do I get value for my money? And that is what they are trying to do is to get that element back in.

Now, in the '90s, many of the insurers, especially large insurers, were moving to managed care as a way to try to control utilization. But that was just never going to work. People and physicians do not want somebody looking over their shoulder telling them what they can and can't have.

The only alternative we really have now is to give that power to patients and let them make the decisions in consultation with their physicians.

Mr. PERRIN. Mr. Lipinski, let me give you a couple of quick bullet point answers. I thought about the amusement park analogy, and if one of my kids was in pain in some way, you know, and I kept true to the—you have got $40, they would likely go and spend money to make themselves feel better. If they felt nauseous, they would buy some Pepto-Bismol. If they twisted their knee, they would get a bandage, or whatever. And I expect that they would be incented by the fact that they don't feel well to spend the money.

The HSA provides you the ability to have the cash by reducing your premium to spend the money. I have got, you know, a couple of quick vignettes personally. I used to smoke. I would get bronchitis. I go in. I had Kaiser. They would give me this, you know, 10-day, three times a day pill, which I could never take, because I can't even take my vitamin every day. And so I would get bronchitis again, and then a buddy told me about Zithromax.

So I went in and I asked for Zithromax, and they said, "It is not on our formulary." I said, "Just write me the script, and I will pay out of pocket." And so they gave me so codeine syrup as well, which for five bucks I could get at the Kaiser pharmacy. So I went down, I gave them the prescriptions, and they filled it with Z-Pak. And I said, "I thought you guys didn't have Z-Pak, you know, for patients." And she said, "Well, we don't, but the doctors take it when they get sick."

So the point I am trying to make is that with a little bit of knowledge a consumer can make decisions which benefit them, provided they have the funds to pay for it. An HSA, by lowering your premium, will give you access.

With regard to the insurance companies, you know, if you look at this chart, which is Exhibit C in my testimony, you will see that as the out-of-pocket costs for individuals has dropped, the cost of health care has increased—premiums mostly. Insurers don't insure anymore. I mean, most of these insurers are, you know, administrative services organizations that take $50 or $80 claims, plus 15 percent, and charge you for being a clerk. Okay?

And as insurance has come more to that sort of model where the deductibles get so low that everybody blows past them, they essentially become these huge, you know, electronic claims processing companies, and there is an enormous amount of waste.

Let me just tell you what happened in South Africa.

Chairman MUSGRAVE. Very quickly. We are going to have to wrap it up, please.

Mr. PERRIN. All right. You know, in 10 years in South Africa we saw 65 percent of the insured population get an MSA, almost exactly like an HSA. You know, there are some insurers who really don't want to see an HSA succeed, because their top-line profit goes from $927 a month down to $400 or $500 a month in premium.

So, you know, those companies are in this MSA market and that are pricing their plans properly, they are making money because the insurance works, the insurance science of the less healthy and the healthy combined to, you know, give them appropriate and practical coverage.

And, you know, if you look at the McKinsey study, if you look at other incentives that are in place with an HSA, the less healthy are simply not adversely affected by not getting care. And one of the reasons for that is that an HSA allows for preventative care to be a covered benefit. And that is the only covered benefit that is allowed below the deductible.

Now, notwithstanding that, Assurant, which was in the MSA pilot, found that 30—more than 30 percent of the people in an HSA got preventative care, more preventative care, when compared to their normal fee-for-service, you know, or HMO population. And the reason is really simple. It is like that noise in your car when you first get a car and you ignore it and you end up paying 10 times more than if you had just fixed the damn valve in the first place. Right?

And you learn the lesson where if you let things go, they are going to get more expensive, and you have to pay to get your car out. This is the exact same lesson that people with an HSA know intuitively, and that is why they spend more on preventative care.

Chairman MUSGRAVE. Mr. Lipinski, did you have any thing else?

Mr. LIPINSKI. I will—well, I will pass right now. I don't know if you have any more questions or you have—

Chairman MUSGRAVE. I am going to just ask one more thing, and this is a subject that we can certainly pursue more. I just have to ask my constituent, Mr. Lawler, when you talked about those realtors, those members calling and saying, "Well, what can you do about the high cost of health insurance?" do you think that we have offered some solutions today, and could you just comment on that? I would just like to hear what you think Congress could do that is really going to address this problem.

Mr. LAWLER. Well, I have to commend the House side, because you have worked diligently on association health plans, and I think that is probably the best answer or route for realtors. We need to get the Senate to come along, and at least the Senate bill—

Chairman MUSGRAVE. We agree with that.

Mr. LAWLER. —1955—Senate bill 1955 at least I think is marching down that direction. But I think, you know, we are the largest group of our type, and it is difficult for our agents to get health insurance. Roughly a third don't have insurance. Roughly a third are buying it as individuals. They have no way to be in a pool. And the other third are basically getting their insurance through their spouse or somebody else.

So I think it would be terrific if all the House members would work with their Senate compatriots to get an association health plan as soon as possible. I think the—when we asked our realtors recently what was one of their biggest concerns, within less than a week we had over 400 responses regarding associated health plans or health plans. And this is just the State of Colorado. This isn't the National Association of Realtors, just in our local area.

Chairman MUSGRAVE. Thank you very much. Some of the legislation—the legislation that Mr. Hense mentioned is Melissa Hart's Self-Employed Health Care Affordability Act. And I am a co-sponsor of that, and I certainly think that the disclosure for prices—that is going to get us in the direction that we need to go. I mean, it is incredible that we think of going into it blind so to speak and not have any idea what the prices are.

I just commend you for your testimony. This has probably been the hearing where we have gone over the most, but I feel that we got some very good information today, and I appreciate all of you for being here. Appreciate the fact that you all made the effort to get here and share your expertise with us today.

And thank you, Mr. Lipinski.

This hearing is adjourned.

[Whereupon, at 12:54 p.m., the Subcommittee was adjourned.]

Opening Statement
Marilyn Musgrave, Chairman
Subcommittee on Workforce, Empowerment, & Government Programs
Healthcare and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured

- Good Morning, this hearing of the Subcommittee on Workforce, Empowerment and Government Programs will come to order.
- Thank you all for being here this morning as we examine health care choices for American small businesses, their employees and working families.
- I would like to especially thank those of you who traveled great distances to provide our committee with testimony.

- All Americans deserve reliable, high quality, and reasonably priced health care that will be there when they need it.
- One of the most stressing statistics we see each year is the rising number of Americans who live without health insurance, currently estimated at roughly 45 million people.
- Of those without health insurance, about 60 percent are small business owners, employees of small businesses, and their families.
- As health care costs continue to rise, fewer employers and working families will be able to afford coverage.
- Clearly, we in Congress must look at this pressing problem and find solutions that will create an environment so those that need health insurance can not only find the coverage they need, but also afford it.
- We need to be working toward a health care delivery method that works best, not just what we've always done. A simple look at the current health care landscape shows that the system is not working.

- Our focus today will be on four proposals that this Congress has begun work on to help Americans get the coverage they need, at a price they can afford.

- These proposals are the establishment of Association Health Plans, or AHPs, increasing the availability, use, and ease of Health Savings Accounts or HSAs, reforming the medical liability system, and examining Congressman John Shadegg's common-sense legislation, H.R. 2355, the "Health Care Choice Act."

- On July 26, 2005, the House of Representatives passed H.R. 525, the "Small Business Health Fairness Act of 2005,"—legislation that would establish federally regulated association health plans, with a strong bipartisan vote.

- This was the seventh time the House has passed such legislation. I am confident, however, that real progress on this legislation will be made on the other side of Capitol Hill this year.

- AHPs would allow small businesses to band together across state lines, through their membership in an association, to purchase more affordable health insurance.

- Unions and large corporations already have this ability and it makes sense to me that small businesses should as well.

- HSAs are a new way that people can pay for medical expenses not covered by insurance or other reimbursements.

- Eligible individuals can establish and fund these accounts when they have a qualifying high deductible health plan and no other health insurance, with some exceptions.

- The accounts have significant tax advantages:

    - Contributions are deductible,
    - Withdrawals used for medical expenses are not taxed,
    - Account earnings are tax-exempt, and,
    - Unused balances may accumulate without limit.

- President Bush has proposed several improvements to HSAs, such as allowing Americans who purchase HSA-qualified insurance policies on their own to have the same tax advantages as people who obtain insurance through their employers and eliminating all taxes on out-of-pocket spending through HSAs.

- An additional area Congress and the President have worked on together is tort reform in the medical community.

- America's patients are losing access to care because the nation's out-of-control legal system is forcing physicians in some areas of the country to retire early, relocate or give up performing high-risk medical procedures.

- There are now 21 states in a full-blown medical liability crisis -- up from 12 in 2002.

- In crisis states, patients continue to lose access to care. In some states, obstetricians and rural family physicians no longer deliver babies. Meanwhile, high-risk specialists no longer provide trauma care or perform complicated surgical procedures.

- Excessive litigation and high medical malpractice rates have added to employers' health care costs and spurred some providers to "err on the side of caution" that comes at the expense of both health plan dollars and patients receiving unnecessary service.

- This issue isn't just about physicians -- its effects cut across the health care sector.

- Hospitals need physicians to admit patients. Companies that manufacture medical devices and pharmaceuticals need physicians to use and prescribe their products.

- Similar to the AHP legislation, the House passed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare or 'HEALTH' Act of 2005," on July 28, 2005. The Senate is continuing its debate on this critical legislation.

- Yet another proposal to help Americans find and purchase affordable health insurance is legislation introduced by Congressman John Shadegg from Arizona—H.R. 2355, the "Health Care Choice Act of 2005."

- Under this legislation, consumers would no longer be limited to purchasing policies dictated by their state's regulations and mandated benefits. Instead, they could decide among a variety of insurance policies qualified in one state but offered for sale in multiple states.

- I am very pleased that we have Congressman Shadegg here to give us the details on his legislation on our first panel and we will be hearing from him very shortly.

- As we all know, there is no one solution to a problem as complicated and complex as 45 million Americans without health insurance.

- Small business employers and employees are in critical need of new ways to increase health insurance coverage, and the proposals examined today are responsive solutions to this problem.

- I am very eager to get to today's testimony so please let me say thank you to our witnesses today, but before we begin, I would like to yield to the Gentleman from Illinois, our Ranking Member, Mr. Lipinski.

STATEMENT
of the
Honorable Daniel Lipinski, Ranking Member
Subcommittee on Workforce Empowerment and Government Programs
Hearing on "Prescriptions for Health Care Solutions"
House Committee on Small Business
April 24, 2006

Thank you, Madam Chairman, for holding this hearing on such a critical issue, especially for small businesses. Every small business owner I speak with, whether here or at home in my district, no matter what type of business they operate, talks about one overriding issue that they face in running their business – how to provide affordable health care for their employees and for their own families.

Over the past five years, health insurance premiums for employers have increased by 60 percent. Small businesses that have been able to offer health care simply cannot continue to absorb these dramatic increases. This has forced many to greatly increase the costs of health insurance for their employees or to stop offering health insurance at all.

The failure to address this crisis has created a situation where millions of working Americans have no health insurance. And while large businesses have a coverage rate approaching 90 percent for employer-based health insurance coverage, small firms have a coverage rate of only about 50 percent. In fact, 6 out of every 10 uninsured Americans are in families headed by self-employed workers or small business employees. This is simply unacceptable.

I look forward to hearing today's witnesses discuss a variety of solutions they believe could help bring down the cost of health care and provide better access for small businesses. I supported the AHP legislation we passed last year in the House and I am hopeful the Senate will do likewise. But that is clearly not enough. Because of the depth of this problem, I believe that all options should be considered. But we must make sure that in covering more Americans we do not significantly undermine the coverage or treatment that Americans currently have. Health care that is inadequate or risky cannot be accepted.

One of the issues I have been particularly focused on is addressing the skyrocketing cost of health care at the source, specifically at hospitals. Most of us would never consider getting our car repaired at a shop without first receiving an estimate of the charges, but this is exactly what we do when we need to go to a hospital for treatment. Lack of information prevents families from making well-informed, cost-effective choices. In addition, lack of information means that hospitals do not have to compete in their costs. When California required hospitals to disclose their entire price list, it was revealed that there was a great disparity between hospitals in what they charge for common procedures and medications. One hospital charged $120 for a chest x-ray while another charged more than $1500. And while a Tylenol capsule was free at one hospital another charged over 7 dollars for the same medicine. Disclosure helped change this.

This is why last year I introduced, along with Rep. Bob Inglis, HR 3139, the Hospital Price Reporting and Disclosure Act, a bipartisan effort to require every hospital to give consumers clear, concise information about what they charge for common procedures and medications. A companion bill has also been introduced in the Senate by Dick Durbin, Jim Demint, and John Cornyn

Unfortunately, the people who are hit hardest by this are the uninsured, including millions who work for small businesses. They are the ones who have to pay the full price, not an insurance company negotiated price, for often unknown and unexpected charges. The Hospital Price Reporting and Disclosure Act, would require hospitals to regularly report to the Department of Health and Human Services (HHS) the amount they charge for the twenty-five most commonly performed inpatient procedures, the twenty-five most common outpatient procedures, and the fifty most frequently administered medications.

More than half a dozen states have passed some form of hospital price disclosure legislation, including my home state of Illinois, and at least 10 have legislation currently pending. States such as Wisconsin and Oregon already have this kind of information available to the public on an easy to access website, similar to what would be required by HR 3139.

This information is essential to the 46 million uninsured Americans, and especially for those millions who work for small businesses. A recent report on *60 Minutes* demonstrated the high impact that undisclosed hospital prices have on uninsured Americans. While we work to get coverage for the uninsured, we should give them information that will help in their health care choices.

Obviously price is not the only factor that families should take into account when making health care choices. This is an important point not only when looking at HR 3139, but when considering all our options. Quality information is also critical, and I am happy that the Centers for Medicare and Medicaid Services (CMS) is beginning to make some quality measures available; but more is certainly needed. And the advice of health care professionals will *always* be essential when making care decisions. But these are not reasons to oppose making price information available.

Clearly, tackling the cost of health care is a very complicated issue. Protecting small businesses and the self-employed should be a top priority, especially as health care costs continue to skyrocket. I look forward to hearing from our witnesses today about their ideas to provide more small business owners, their workers, and their families with health care coverage.

MELISSA L. BEAN
8TH DISTRICT, ILLINOIS

COMMITTEE ON FINANCIAL SERVICES
COMMITTEE ON SMALL BUSINESS

Congress of the United States
House of Representatives
Washington, DC 20515–1308

WASHINGTON OFFICE:
512 CANNON HOUSE OFFICE BUILDING
(202) 225-3711

DISTRICT OFFICE:
1430 NORTH MEACHAM RD.
SCHAUMBURG, IL 60173
(847) 519-3434

www.house.gov/bean

Statement for the Record
Small Business Committee Hearing, "Healthcare and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured"
Date: April 27, 2006 10:30 am
Location: 2360 Rayburn

To begin, I want to thank the Committee for holding this important hearing. Currently, 6 out of every 10 uninsured Americans are in families headed by workers who are self-employed or work in a firm with less than 100 employees. As everyone here knows, small businesses are the engine that drives our economy, and these businesses deserve our help in making sure that health care is an affordable option.

Recent reports show that small businesses are dropping health insurance coverage because they simply can no longer afford the costs. To put this in perspective, health care costs rose by 11 percent in 2002, 14 percent in 2003, 11 percent in 2004, and 9 percent in 2005. With premiums rising at these rates, small business owners need real legislative solutions.

For these reasons, I am a co-sponsor of H.R. 4961, *The Equity of Our Nation's Self- Employed Act*, which will go far in helping more small business owner's afford health insurance.

Today, Mr. Paul Hense is here to testify about the importance of this legislation. I encourage my colleagues on both sides of the aisle to listen to Mr. Hense's testimony and support this bi-partisan legislation introduced by Chairman Manzullo.

The Equity for Our Nation's Self-Employed Act would allow small business owners to deduct health care costs from their payroll taxes, which include Social Security and Medicare. The average self-employed individual pays $10,880 annually for health care coverage and would save $1,664 through this tax deduction.

Corporations are already able to deduct their health care expenses from all their taxes making current law unequal and unfair to small businesses. Thanks to a 2003 change in the tax code small business owners can deduct health insurance costs from their individual federal income taxes. However, self-employed workers pay a 15.3 percent payroll tax on top of their individual income tax.

By allowing small business owners to deduct their health insurance costs from their payroll taxes would effectively reduce costs by more than 15 percent. Correcting this inequity will help owners cope with the drastic cost increases in obtaining health care insurance. I urge my colleagues to join me in co-sponsoring H.R. 4961.

Melissa L. Bean

PRINTED ON RECYCLED PAPER

Statement of Congressman John Shadegg
Before the
Small Business Committee
Subcommittee on Workforce, Empowerment and Government Programs:
Healthcare and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured

April 27, 2006

Chairman Musgrave, and Members of the Committee, thank you for the invitation to participate in today's hearing on this critical issue for America's small business and entrepreneurial sector.

Today I will discuss a bill I have introduced, the Health Care Choice Act, H.R. 2355. The bill has been reported out of the Energy and Commerce Committee and hopefully will come up for a floor vote in the next few months.

The Health Care Choice Act is a simple bill, which will have a profound impact on health insurance in America. The Health Care Choice Act will help put individuals back in control over their health care needs and reduce costs by avoiding red tape and expensive state mandates.

How the Bill Works

Rather than going through 50 different regulatory processes, this bill will allow an insurance company to go through one process and sell to people in all 50 states. In this way, we can help people, not by setting up a massive

new government bureaucracy, but by empowering individuals to make the best choice for themselves and their families.

The High Cost of State Mandates

There are an estimated 1,800 or so insurance "mandates" across the country, and the costs add up. New York requires every insurance policy sold there to cover podiatry. Acupuncture coverage is mandated in 11 states, massage therapy in four, and chiropractors in 47. The Council for Affordable Health Insurance (CAHI) estimates that state mandates can hike insurance prices 20 to 45 percent. For example, a health policy for a single Pennsylvanian costs roughly $1,500 annually. Cross the Delaware River into New Jersey, and a similar health plan costs about $4,000, thanks to government regulations.

Lowering Costs

The Health Care Choice Act will help bring down the cost of health insurance as much as 12 percent, on average, by letting people compare insurance plans across the country and pick the one that is right for them. By offering people choices in a nationwide health insurance market we will reduce the cost of health insurance for Americans. This is particularly true for the two-thirds of the 44 million uninsured Americans who have incomes below 200 percent of the federal poverty level that cite "unaffordability" as the top reason for why they are uninsured.

Increasing Efficiency and Portability

Also, increasing interstate commerce in health insurance would remove a huge barrier to the efficient allocation of human resources in our economy. That would change if individuals were able to shop nationwide for policies

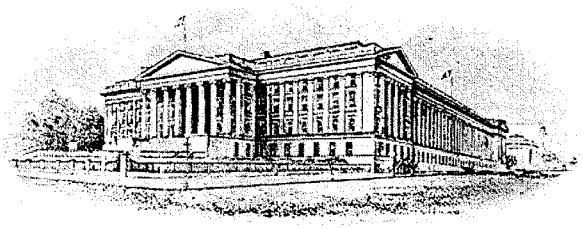
that would follow them wherever they go. Moreover, if an individual leaves a job, or is in between jobs, they will be able to maintain health insurance when they need it most.

No Race to the Bottom

Critics allege that creating a nationwide health insurance market will result in a "race to the bottom" in which unscrupulous insurers operating in poorly regulated states would be able to take advantage of consumers. But which state is so poorly regulated? The best analogy for what to expect here is probably our experience with interstate banking, which has resulted in operators moving to friendly regulatory states like Delaware and South Dakota. But, would anyone deny that this has proven a boon to consumers? A national market has allowed the growth of large, financially stable institutions that have offered more services, lowered costs and earned consumer trust. We can expect much of the same for health insurance.

I firmly believe that until consumers are in control over their health insurance, to choose the policy that best fits their individual needs, any legislative attempt won't really reform health care; we will only re-regulate it. Instead of moving toward a national health care system controlled by federal bureaucrats we need to empower individuals and families, and the Health Care Choice Act is an important step toward accomplishing this goal.

Thank you.



U.S. TREASURY DEPARTMENT
OFFICE OF PUBLIC AFFAIRS

EMBARGOED FOR RELEASE UNTIL 10:30AM: April 27, 2006
Contact: Sean Kevelighan (202) 622-2910

Hearing on Healthcare and Small Business: Proposals that Will Help Lower the Costs and Cover the Uninsured

Testimony of Robert J. Carroll
Deputy Assistant Secretary (Tax Analysis)
United States Department of the Treasury
Before the Subcommittee on Workforce, Empowerment, and Government Programs
House Small Business Committee

April 27, 2006

Ms. Chairwoman, Ranking Member Lipinski, and distinguished Members of the Committee, I appreciate the opportunity to discuss with you today the health care proposals included in the President's FY 2007 Budget. I will focus my remarks on both the problems in health care and how the President's proposals help address these problems.

The Broad Objectives of the President's Health Care Initiative

The President's initiative on health care is aimed at making health care more accessible, affordable and portable, thus better enabling Americans to obtain health care and to retain their health care when they change employment.

Individuals and families should have access to a variety of health plans so that they can choose health care based on their individual needs and preferences. Information about the range, price, and quality of available health care options should be readily available and easy to use. Purchasing decisions should be made more by consumers, rather than surrogates, such as employers, insurers, or the government. A key focus of the President's health care initiative is to put the consumer at the center of health care decisions.

When individuals are in more control of their health care decisions, we can expect those decisions to be better ones. Another component of the President's health care initiative is the recognition that the government has a responsibility to promote access to quality affordable health care for the poor. Health care should be affordable for all. Empowering consumers is essential to improving value and affordability in American health care. Our government can also provide financial assistance to low-income Americans and encourage the states and employers to help the chronically ill obtain affordable health coverage.

Health insurance should be portable. Individuals should be able to take their health insurance with them when they change jobs, move, become self-employed, or leave the labor force. They should not have to worry about changing doctors, learning a new insurance company bureaucracy, having their premiums go up or losing their insurance tax advantage when they move between employment opportunities.

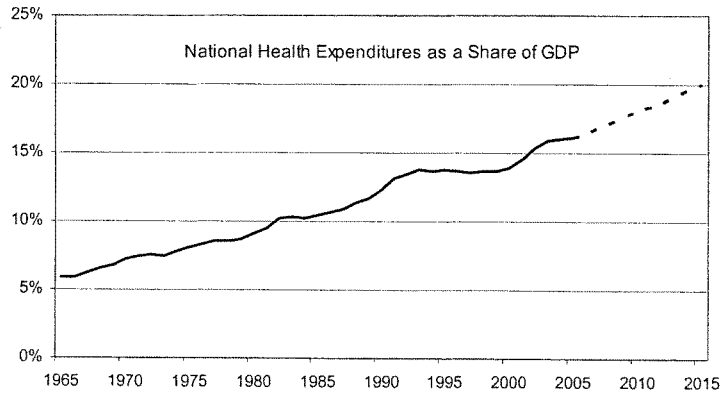
Americans enjoy the best health care facilities and medical professionals in the world, but Americans are concerned about the rising cost of health care, losing their health insurance if they change jobs, and a lack of information about price and quality. These concerns are based on real world observation and are valid. The President's health care initiative attempts to address the root problems that underlie these concerns.

Problems in Health Care

Rising Costs

Health care costs continue to rise rapidly. Growth in health care costs have been exceeding GDP growth by two percentage points annually since 1940. Chart 1 shows both actual and projected growth of national health expenditures as a percentage of GDP from 1965 through 2015. Most recently, growth of national health expenditures as a percentage of GDP rose from 13.8 percent in 2000 to 16 percent in 2004 and is expected to rise to nearly 20 percent by 2015. These rising costs impose a burden on the U.S. economy. Higher spending on public programs like Medicare and Medicaid strains state and Federal budgets. Higher insurance premiums pose a challenge for employers and burden workers with higher health costs and lower wage increases. The burden of rising health care costs is particularly problematic for small businesses, who often choose not to offer any health insurance to employees.

Chart 1: National health expenditures continue to rise as a share of GDP



Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services.

The Uninsured

At the same time health care costs are rising, the number of uninsured also continues to grow. As health care costs grow faster than incomes, an increasing number of individuals are unable to

purchase health insurance. Also, those higher – and ever-rising – costs mean that the self-employed and employees of small businesses are far less likely to have coverage. According to the Kaiser Family Foundation's annual survey, nearly 100 percent of firms with 200 or more workers offer health insurance to their employees. Yet only 59 percent of firms with between 3 and 199 workers offer insurance to their employees, a decline of 9 percentage points from 2000. Regardless of how the number of uninsured is measured, millions of Americans are currently uninsured.

Removal of Market Forces from Health Care Purchase Decisions

A substantial portion of rising health care costs is due to the effects of our insurance system itself. Health insurance gives people valuable protection and peace of mind that they will have help paying their medical bills should a major illness arise. However, because third parties such as insurance companies, employers, and the government finance the vast majority of health care spending, most insured do not know or feel the full cost of the health care services they consume.

The direct expenditure for health care by an insured person may be only a small portion of his or her total health care costs. This is characteristic of low deductible and first dollar health insurance and the prevalence of this type of insurance is rooted in the tax treatment of health care generally. The tax code reduces the cost of health care when financed indirectly through employer-provided insurance rather than when purchased directly by the consumer. The greater reliance on first dollar coverage may lead the insured person to receive treatment that the person may value at less than the true cost of the treatment, leading to the over-consumption of medical care. This over-consumption is the rational response of consumers who do not have to directly pay the entire cost of the medical services they use. A change in the portion of the cost of medical services faced by the consumer so that he or she faces something closer to the true market cost of medical services – the marginal cost of health care – would encourage him to make better decisions and examine information on lower-cost alternative treatments. This may slow the steady increase in national health expenditures.

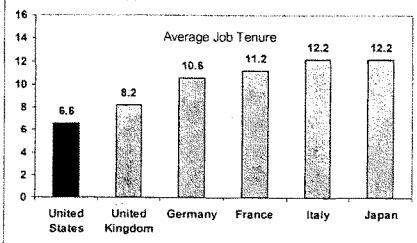
Health Insurance Is Not Directed Towards Today's Dynamic Labor Markets

In today's economy employees frequently change jobs. These changes are often for the better. The dynamism of U.S. labor markets provides important economic benefits by allowing our economy to adapt more quickly to changing economic circumstances. The fluidity and flexibility of our labor markets may generally lead to a better matching of workers to jobs and contribute to skill development and wage growth. Workers might change jobs in pursuit of better pay, to gain more work experience or broaden their skills, or possibly to attain more flexible work arrangements.

According to the Bureau of Labor Statistics' Job Openings and Labor Turnover Survey, in 2005, some 56.1 million employees were hired to fill jobs, while 53.1 million employees left their former positions, and this was a typical year for labor turnover. As shown in Chart 2, the average American between the ages of 18 and 38 has held 10.2 jobs and the young are more apt to change jobs than those who are older. About two-thirds of lifetime wage growth occurs within the first 10 years of labor market experience. Seeking out and testing different jobs appears to be an important aspect of our labor markets and an important component the economic progress for younger workers.

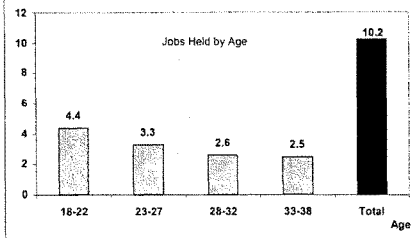
The high degree of job mobility and its role in building labor market experience and skills undoubtedly contributes to our economic vitality. As shown in Chart 3, Americans tend to change jobs much more frequently than workers in other major industrialized nations, in some cases nearly twice as often. The better matching of workers to jobs associated with the high degree of labor force dynamics contributes to economic growth and living standards by increasing the productivity of labor.

Chart 3: Labor markets in the U.S. are characterized by greater flexibility than our major trading partners



Source: International Labor Organization, "World Employment Report 2004-05," December 2004

Chart 2: Job turnover is an important part of dynamic labor markets in the U.S.



Source: Bureau of Labor Statistics, "Number of Jobs Held, Labor Market Activity, and Earnings Growth among Younger Baby Boomers: Recent Results from a Longitudinal Survey," August 25, 2004.

Tying employees' health insurance to their workplace, however, is an impediment to a dynamic labor market. Approximately 73 percent of insured Americans obtain their insurance in whole or in part through their employers. Employer-based health insurance is usually not portable when employees change jobs or stop working. People changing jobs usually must change insurance policies to receive any health benefits from their new employer. Lack of portability results in "job lock" – if anyone in the family is in poor or questionable health status, workers become hesitant to leave their jobs to work for an employer who does not offer insurance, work for themselves, or retire. Job lock has the effect of reducing the fluidity and flexibility of our labor markets and is a drag on economic growth.

How Does The President's Health Care Initiative Address the Problems

Major Parts of the Initiative

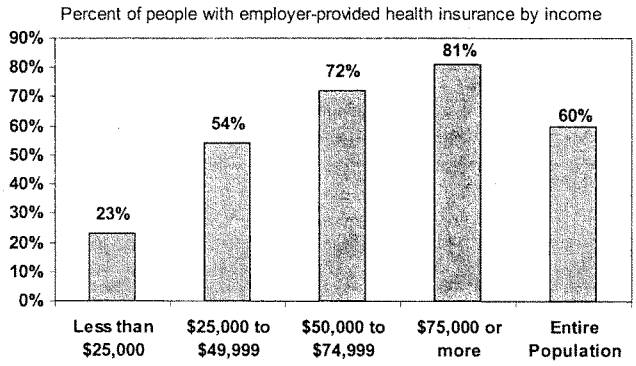
With the appropriate reforms, the U.S. health care system can become more efficient at supplying cost-effective health care to consumers while continuing to lead in innovation and the development of cutting edge medicines. The President's initiative would address the rising costs of health care spending through a series of initiatives designed to improve the functioning of the healthcare market. At the core of this initiative is a set of tax proposals that puts the health care consumer more in control of his or her health care and places health care purchased directly by individuals with high deductible health plans on an equal footing with employer-provided health insurance. When consumers have more at stake, they will make better decisions. Greater

reliance on competition and market forces, coupled with less reliance on third parties, such as insurance companies, employers and the government, in making health care decisions will lead to more efficient use of resources and stem the excessive rise in health care costs.

Currently, health insurance purchased through an employer is subject to neither income nor payroll taxes. While an individual purchasing health care on his or her own might pay one dollar for a dollar's worth of health care, an individual who obtains health care through an employer-provided insurance plan pays considerably less. Consider, for example, a taxpayer who is in the 15 percent income tax bracket and also pays 15.3 percent in Social Security and Medicare taxes (including both the employee and employer shares). For the last dollar of wages received, this taxpayer would pay 30.3 cents in income and payroll taxes. Thus, for every dollar of wages received, this individual could purchase only 69.7 cents of most consumption items. In the case of health care financed through an employer, however, the individual could purchase a dollar of health care benefits in the form of a health insurance policy for every dollar of wages received. The health care benefits received in the form of an employer-paid health insurance premium is subject to neither income nor payroll taxes. A dollar received in employer-provided health insurance would finance a dollar of insurance-funded health care consumption. Thus, the current tax system builds in a large tax subsidy for purchasing health care through employer-provided health insurance.

Many small businesses cannot afford to offer insurance and their workers are often among the uninsured. But those who work for larger companies currently receive a significant tax advantage: They pay neither income taxes nor payroll taxes on their health insurance premiums. In contrast, those who purchase insurance directly – perhaps because they work for a small business that does not offer insurance – pay for insurance after paying income and payroll taxes. The President's proposals would eliminate this inequity and thus reduce the possibility of job lock. HSAs are owned by individuals regardless of their employer. When workers change jobs, they take their HSAs with them, reducing the possibility of job lock. An individual could seek the best job possible regardless of the employer, or become self-employed and still have the opportunity to take advantage of the tax benefits provided by the President's proposals.

Chart 4: Low-income families often aren't covered by employer-provided health insurance.



Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, March 2005

Moreover, as shown in Chart 4, lower income individuals are less likely to be covered by employer-provided insurance. Policies that make health insurance more accessible and affordable to all American's by extending the tax advantages enjoyed by those receiving their insurance through their employers would be particularly helpful to these lower income individuals.

There are several parts to the proposal. First, all taxpayers could either deduct or exclude for income tax purposes health insurance premiums for high deductible health care plans (HDHP). In addition, individuals would receive a refundable income tax credit for payroll taxes paid on those premiums. These two provisions effectively place insurance purchased directly by individuals on an equal footing with that purchased through an employer, provided the insurance purchased is an HDHP.

Next, all taxpayers that have an HDHP could deduct a higher level of out-of-pocket expenses for income tax purposes through the use of a Health Savings Account (HSA) than under current law. Also, taxpayers could claim a tax credit for payroll taxes paid on out-of-pocket expenses through the use of that same HSA. The amount of out-of-pocket expenses that could be deducted would

be equal to the amount of out-of pocket exposure allowed for a qualifying HDHP. These two proposals have the effect of placing out-of-pocket expenses for those with an HDHP on an equal footing with insurance.

Once a taxpayer decides to purchase an HDHP, he or she would effectively receive the same tax advantages on his or her health care expenditures -- insurance and out-of-pocket -- as those who finance all their health care through an employer-provided health plan.

The third major piece of the initiative is a refundable health insurance tax credit (HITC) for lower-income individuals for the purchase of an HDHP. The credit would be refundable and cover up to 90 percent of the cost of the health insurance up to $1,000 for singles and up to $3,000 for families. This provision would make health care more affordable to lower-income individuals and encourage those currently uncovered to obtain health insurance.

Giving Consumers a Greater Stake in Health Care Decisions – Slowing the Growth in Health Care Costs

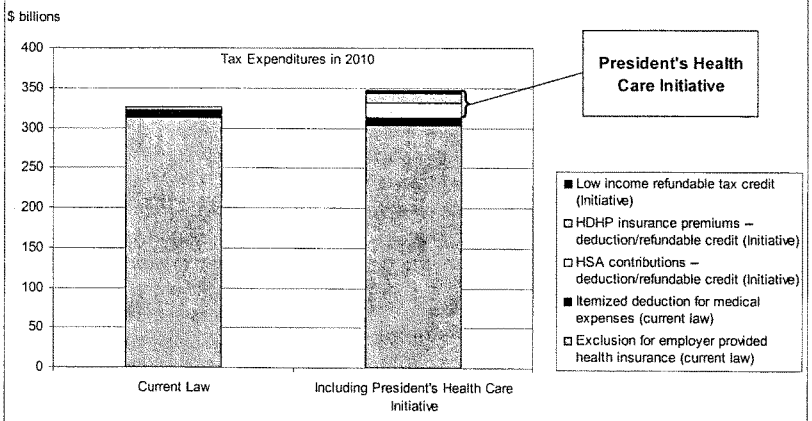
An HDHP gives consumers a greater stake in their health care decisions. With an HDHP, an insured individual has responsibility for payment of at least the first $1,050 (with no more than a total $5,250 out-of-pocket exposure) of medical costs.[1] This provides consumers with a much larger role in health care by requiring that the consumer bear a larger share of the financial responsibility for his or her health care decisions, thus bringing market forces to bear on the cost of medical expenditures. In health care markets where market forces are prevalent, health care costs have grown slower or, in some cases, even decreased. Markets such as the laser eye surgery market and the in vitro fertilization markets, where there is significant competition, have experienced price decreases. Increased market forces resulting from the President's initiative helps reduce the rate of growth in national health expenditures.

What is the Cost of the President's Initiative?

[1] These are the 2006 levels of the required deductible and total out-of-pocket exposure. These levels are indexed by the CPI-U. The required deductible and total out-of-pocket exposure for family coverage are $2,100 and $10,500, respectively.

Chart 5 shows the health care tax expenditures under current law and under the President's health care initiatives for fiscal year 2010 for both income and payroll taxes. As can be seen, the current tax subsidy for the employee exclusion for employer-provided health insurance constitutes the major portion of the health care tax expenditure, either currently or under the President's initiative. As a result of the President's health care initiative, total health tax expenditures would increase by about $21 billion or somewhat over 6 percent in 2010.

Chart 5: President's Health Care Initiative complements already existing health care tax expenditures

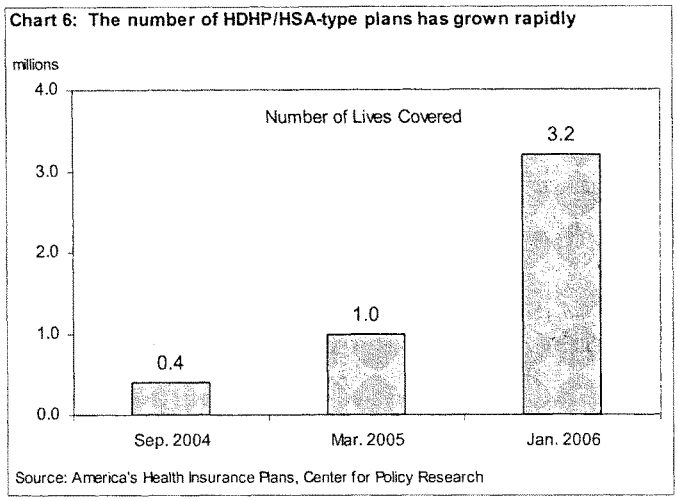


Note: The estimates include the tax expenditure related to both income and payroll taxes. The estimates also include the effects on outlays.

Source: U.S. Department of the Treasury, Office of Tax Analysis.

The Experience So Far with HSAs

The growth in HDHPs since their inception has been dramatic. Enrollment in HSA-qualified HDHPs has grown to nearly 3.2 million individuals in January 2006, according to the latest estimates from America's Health Insurance Plans (AHIP). As shown in Chart 6, this is triple the number reported in 2005, which in turn was double the number reported in 2004, the first full year in which HSAs were available.



Importantly, preliminary indications suggest that HSAs as constituted under current law appear to have helped the uninsured and are being used by many lower income and older Americans. According to AHIP estimates, roughly one-third of those who purchased HSA-eligible HDHPs in the non-group market were previously uninsured, and about 50 percent are age 40 or over. [2] Other research shows that over 40 percent of those who purchased HAS-eligible plans in 2005 have incomes below $50,000[3] HSAs provide an additional option to individuals, which helps reduce the number of uninsured and helps lower income and older individuals.

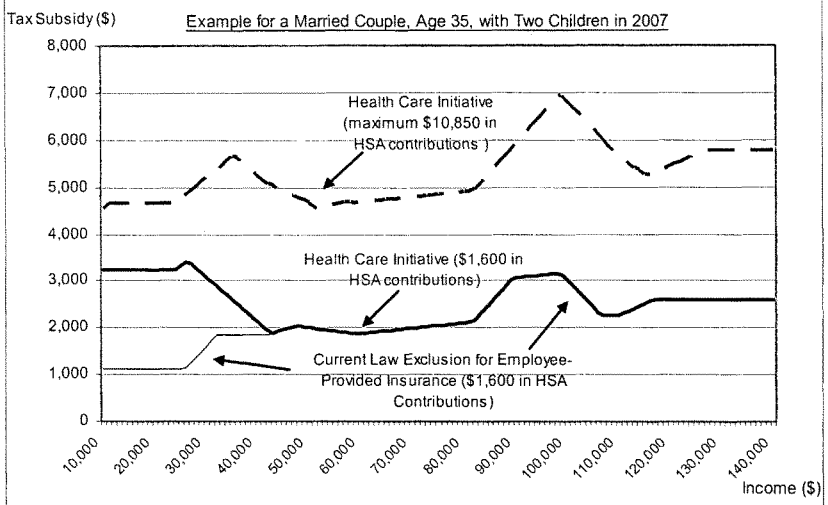
[2] America's Health Insurance Plans, Center for Policy Research, January 2006 Census of HSAs.
[3] From Health Savings Accounts: The First Six Months of 2005," eHealthInsurance, July 27, 2005.
[4] America's Health Insurance Plans, Center for Policy Research, January 2006 Census of HSAs.

Where Does the Presidents Health Care Initiative Take Us?

The President's health care initiative levels the playing field between employer-provided insurance and HDHP insurance purchased directly by an individual and also levels the playing field between out-of pocket expenditures and insurance premiums for those with an HDHP. A key benefit of the initiative is that it reduces the tax bias towards lower deductible and first dollar health insurance. As discussed above, first dollar insurance dulls the incentives for consumers to shop carefully for cost-effective health care. Placing the consumer at the center of health care decisions helps slow the growth in health care spending. Greater reliance on health insurance purchased directly by individuals, and on HSAs generally, will also increase portability and reduce the harmful effects of job lock.

The initiative also makes HSAs more progressive. Lower income Americans receive a larger tax subsidy through the refundable health insurance tax credit targeted to low income individuals and through the set of refundable tax credits for Social Security and Medicare taxes. The latter set of credits is reduced once an individual reaches the taxable wage cap for Social Security taxes. Chart 7 compares the tax subsidy from the health care tax provisions under current law to those received under President's health care initiative for a couple at age 35 with two children. When the family's income exceeds roughly $45,000, the President's health care initiative provides the same tax subsidy for a family purchasing health care directly as it does for a family purchasing their insurance through their employer under current law. Also, the tax subsidy under the President's health care initiative is higher for lower income families than under current law. For those with the lowest incomes, the President's initiative would provide a subsidy for more than half of a family's insurance premiums.

Chart 7: Health Care Tax Subsidy Under Current Law and the President's Health Care Initiative



Note: The family is assumed to pay a health insurance premium of $6,200 and make an HSA contribution of $1,600, except as noted above. The maximum HSA contribution under the proposal is $10,850 (in 2007). The taxpayer is assumed to receive all income from wages.

Source: U.S. Department of the Treasury, Office of Tax Analysis.

As shown in Chart 7, there is a significant tax benefit from contributing the maximum amount to an HSA under the President's initiative, with the tax subsidy initially increasing with income because of the graduated income tax rates. The tax subsidy declines once the taxable wage cap for Social Security taxes is reached. Thus, there is a limit on the tax benefit from the payroll tax credit for higher-income earners.

The maximum tax benefit provided by the HITC targeted to lower income individuals is available for single individuals with incomes below $15,000 and is completely phased out when a single individual's income reaches $25,000. For families, the maximum tax benefit provided by the HITC is available for incomes below $25,000 and completely phased out when a family's income reaches $60,000.

The President's initiative makes HSAs significantly more attractive to both the uninsured and to lower-income individuals. Thus, the Treasury Department estimates that the President's initiative would increase the number of HSAs by some 50 percent by 2010. This initiative would also help control the growth in national health expenditures by encouraging the use of HSAs and HDHPs.

The Larger Initiative

The tax provisions described above are part of a broader initiative outlined by the President that includes: new national Portable HSA insurance plans; a proposal to permit the purchase of health insurance policies across state lines; a proposal to allow associations of small businesses to band together to purchase health insurance; medical liability reform; and a series of health information technology actions.

- The Portable HSA proposal would allow employers to have the option to offer workers a Portable HSA insurance policy. Employees would own and control the insurance policy, just like they already own and control existing HSAs. Employees enrolled in a Portable HSA insurance policy could take the policy with them wherever they go, just like they currently can with their HSAs. Their premiums would be tax-free, whether they change employers or pay the premiums on their own. Their premiums would not go up based on their health at the time they change jobs, leave the labor force, or move.
- The proposal to allow the purchase of health insurance policies across state lines would allow Americans to buy the best health insurance for them, based on their own circumstances, instead of being limited to only the policies available in their state. This proposal would allow competition among health insurance plans from different states, which will ultimately benefit consumers.
- The President's Association Health Plans proposal would make it easier for small businesses to provide health care for their employees by allowing small businesses to join together through their trade and professional associations to provide health coverage, giving them the same advantages of economies of scale, administrative efficiencies, and negotiating strength enjoyed by big businesses and labor unions. By providing coverage for thousands of employees at a time, association members would pay lower premiums for better coverage.
- The President's strategy for addressing the cost of medical liability includes common-sense reforms such as: (1) reserving punitive damages for egregious cases where they are justified and limiting non-economic damages to reasonable amounts; (2) ensuring that old cases based on old claims cannot be brought to court many years later; and (3) providing that defendants pay judgments in proportion to their fault. Although the House has passed these reforms three times, the Senate has not followed House's example.

- The President's health information technology actions include: establishing the position of the National Coordinator for Health Information Technology within the U.S. Department of Health and Human Services (HHS); providing support for several health IT projects to assess and develop solutions to key implementation issues, and establishing the American Health Information Community (AHIC), a committee of both public and private stakeholders formed to make recommendations on how to accelerate the development and adoption of health IT.

Conclusion

I thank you for the opportunity to testify before the Committee today and look forward to your questions.

Statement Of
The NATIONAL ASSOCIATION of REALTORS®
Before The United States House
Workforce, Empowerment and Government Programs Subcommittee of the Committee on Small Business
Regarding
Healthcare and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured
April 27, 2006

Chairwoman Musgrave, Ranking Member Lipinski and members of the Subcommittee, my name is Ed Lawler and I am a REALTOR® with ReMax Alliance located in Fort Collins, Colorado. I am happy to be here today representing the NATIONAL ASSOCIATION OF REALTORS® (NAR). I would like to commend the subcommittee for holding this hearing and appreciate the opportunity to share NAR's thoughts regarding the health care challenges facing small businesses.

NAR is the nation's largest professional trade association with over 1.2 million members who belong to over 1500 REALTOR® associations and boards at the state and local levels. NAR membership includes brokers, salespeople, property managers, appraisers and counselors as well as others engaged in every aspect of the real estate industry.

Typically when we have been asked to testify before this committee or others, it has been with regards to issues or legislation that enhance the ability of Americans to own property and/or advance our members' business interests. In this particular case, though, our interest in the hearing topic is a more personal one and my reason for being here is a simple one. NAR's members have been telling the association loudly and

clearly that the current health insurance system is not working for them as self-employed individuals or small business owners. They tell us that the existing health insurance delivery system is broken.

Today 28 percent of REALTORS® - more than one in four of the nation's 1.2 million REALTORS® - do not have health insurance coverage. For comparison purposes, the percent of the U.S. population without health insurance coverage was estimated to be 15.7 percent in 2004. The percentage of uninsured REALTORS® is almost double that of the nation as a whole.

It's not surprising then that the number one question asked by members who call NAR's Information Central call center is "What can NAR offer me as a member in the way of affordable health insurance coverage?"

Right now, unfortunately, the answer to that question is that we can offer them very little more than what they can find for themselves in the individual market.

As you can imagine, that answer isn't very satisfactory to the typical caller. Their immediate response is "Why can't an organization the size of the NAR offer its members the kind of quality health insurance plans that my neighbor's corporate employer or sister's trade union offers them? With a million-plus members, NAR should be able to provide its members with access to a comparable group health insurance plan!"

The fact is that the complexity and administrative burden of offering a program that meets the requirements of the fifty states and four territories within which NAR's members reside makes it impossible to do so – even with a million-plus members.

We now work with one of the nation's largest third party administrators of association insurance programs to provide our members with access to a large number of

fine companies. Even making use of a national broker, we find the premiums offered our members are not what we believe we would be able to offer if we were able to negotiate on behalf of the membership and offer a single, uniform national health insurance program.

It is for this reason that NAR has strongly support legislative efforts to enact small business health plan legislation. We believe that a small business health plan would allow NAR to offer its members an affordable alternative source of health insurance coverage. The ability to offer a uniform national insurance program will allow NAR to effectively use the bargaining power and administrative efficiencies that having a large membership creates. We are committed to using that expertise to negotiate for and provide the type of affordable coverage package that Americans have come to expect and deserve. NAR has already demonstrated its ability to deliver a wide array of lower cost services and goods to our members. We firmly believe that NAR can do so in this arena also.

The REALTOR® Health Insurance Profile

While the current number of members uninsured just cited is problematic, NAR's leadership is equally troubled by what we have found to be (1) the reasons for the lack of coverage, (2) the types of coverage enjoyed by those who have insurance and (3) what we believe will be the future percentage of uninsured REALTORS® if nothing is done.

Reasons for Lack of Coverage. In order to determine our members' current health insurance coverage and concerns, NAR surveyed a random and representative sample of its members. As indicated earlier, 28 percent or roughly 336,000

REALTORS® have no health insurance coverage. When asked why they were uninsured, the overwhelming majority (84 percent) surveyed indicated that cost was the primary reason.

Knowing the structure of the real estate sales industry, it is not unexpected that real estate professionals would be very sensitive to premium costs. Like all self-employed and commission-based workers, real estate licensees have no employer who contributes to the cost of health insurance, no guaranteed monthly income and significant monthly business expenses that continue even in those months when there is no sale, and therefore, no income. These factors, together with the fact that in most states independent contractors are forced to find coverage in the individual market and do not have access to less expensive group plans, make it difficult for real estate licensees to afford monthly premiums that can easily reach $1200 or $1400 per couple or family per month.

I would note that only seven percent of all respondents indicated that they did not have coverage because they had been denied coverage due to a pre-existing condition that made them ineligible.

Sources of Coverage Concerns. We are concerned that this high percentage of uninsured is likely to grow in future years. Our concern stems from the typical sources of insurance coverage among those who are insured and what we know to be likely future trends in each of these insurance market segments.

Among those who have health insurance coverage, REALTORS® are most likely to obtain their coverage from their spouse's employer (25 percent). We expect this source of coverage to decline in future surveys as more and more employers reconsider

whether to continue to offer insurance coverage to employee's spouses and dependents. We anticipate that more will drop extended coverage to employees' families.

Group coverage does provide coverage for 23 percent of the membership. In the past, this type of coverage was typically held by an agent who was engaged in real estate as a second career and had health insurance as part of their retiree benefits. Today, however, outside of a few states that require insurers to group the self-employed with other small businesses, group coverage is more likely to be held by either a new agent who continues to work two jobs as they transition from a prior career or an established agent who takes a second job simply because that job provides the agent with health insurance benefits.

We believe that future surveys will show that those who hold group coverage will decline in number. Those in real estate as a second career will likely not have health benefits from an earlier job as retiree insurance benefits become a thing of the past for a new generation of workers. For those working two jobs – real estate sales and a second job that provides benefits - there comes a point when decisions have to be made as to which job offers the worker the mix of job fulfillment and benefits that are essential to a healthy life. For those who cannot do without health insurance coverage, real estate is likely not to be the final choice. We have anecdotal evidence from our surveys and member call logs that this choice is already facing many of our members.

Of those NAR members who have health insurance coverage, roughly five percent are covered through COBRA (Consolidated Omnibus Budget Reconciliation Act) policies which give workers and their families who lose their health benefits the right to continued coverage for limited periods of time under certain circumstances. Given the

rapid growth in the number of new agents who have moved in recent months into the real estate sales industry, it is not surprising to us that COBRA coverage would be a source for a significant numbers of new agents. However, these members will eventually have to find alternative coverage or go without insurance.

Most indicative of the changes that have occurred in the eight years since NAR last surveyed the member's health insurance coverages is a final statistic. Today 18 percent of REALTORS® with insurance obtain coverage through individual policies. This category was not even included in our earlier 1996 health insurance member survey – so insignificant was this source of insurance coverage.

Individual coverage is also the most problematic and unaffordable coverage option according to our members. During visits to our Colorado senators last month, the Colorado Association of REALTORS® president delivered a two-inch thick binder of emails from Colorado REALTORS® that chronicled their health insurance stories. Many report that their monthly insurance premiums now exceed their home mortgages. One Aurora, Colorado member shared his not uncommon experience – a 93 percent increase in health insurance premiums between 2003 and 2006 for his family of 5. As he put it, *"I have only been able to continue this coverage because of a nest egg and not because of the income from my fledgling business. Unfortunately, I am now in a position where I must pursue employment with a company that has group health care because I can no longer afford these healthcare expenses."*

For all of these reasons, we expect the number of uninsured members to continue to grow. In the past seven years, for example, the number of uninsured NAR members has doubled, going from approximately 13% of the membership in 1996 to 28% in 2004.

For the reasons cited earlier – lapsing COBRA coverage, changing employer insurance benefit policies, sensitivity to costs – we are most concerned that our now high percentage of uninsured members will grow larger over time as the cost of health insurance increases.

REALTORS® Support for SBHPs

As a result of the increasing challenges that NAR's members are facing as they look for affordable health insurance and our own experience in providing our members with quality member services, the NATIONAL ASSOCIATION OF REALTORS® has been a strong supporter of efforts to allow small businesses and the self-employed to join together and negotiate for health insurance coverage through their professional trade associations. For this reason, we have supported HR 525 and S. 406, the Small Business Health Fairness Act, and their underlying recognition of the important role that professional trade organizations can play in increasing the array of health insurance coverage options available to their members.

Most recently, we have also been very actively involved in the efforts that Senators Mike Enzi and Ben Nelson have undertaken in the Senate to advance their compromise small business health plan alternative, S. 1955, the Health Insurance Marketplace Modernization and Affordability Act. NAR was pleased to be able to participate along with National Association of Insurance Commissioners (NAIC), insurers, and the small business community in an incredible process that resulted in the amended version of S. 1955 that was approved by the Senate Health, Education, Labor and Pensions (HELP) Committee last month.

The amended bill addresses longstanding concerns which have repeatedly stymied past measures that have been approved by the House but which have stalled in the Senate HELP Committee. As amended, S. 1955 will:

- Require small business health plans (SBHPs) to be fully insured and avoid the potential problems created by a self-insured approach;
- Tighten the requirements for what type of association can sponsor an SBHP;
- Require insurers working with a sponsoring trade association to be licensed in every state in which the SBHP enrolls association members;
- Give regulatory oversight over SBHP insurers to the state insurance commissioners in each state;
- Make SBHPs subject to all state laws with the exception of mandate and small group market premium rating rules explicitly addressed in S. 1955;
- Preserve state consumer protection or unfair trade laws since S. 1955 does not preempt these laws;
- Subject an insurer offering an SBHP to the same financial safety and soundness laws governing any other state licensed insurer;
- Require an SBHP that offers policy options that do not comply with state mandates to also offer at least one enhanced plan option that complies either with state law or matches the coverages offered to state employees in one of the five most populous states; and
- Not force an employer to choose an SBHP but gives them the option to choose the SBHP or state regulated insurance product that best meets the firm's needs.

An actuarial analysis of S. 1955 by the Mercer Group was recently released. Using the same econometric model used in their earlier and very critical study of association health plan (AHP) legislation, the group found that S. 1955 would reduce small employers health insurance costs by 12% and increases the number of insureds in the small group market by approximately 900,000. The study concluded that *"These results indicate that SBHP legislation may be part of a multi-faceted solution to rising health care premiums for small employers".*

Small Business Owners and Public Support for SBHPs

Madam Chair, Americans believe in equal treatment and "playing fair". The current system that allows unions or large firms to offer a health insurance program unhampered by the need to comply with 50 sets of state mandates and regulations – while professional trade organization can't offer their members the same type of program - just isn't viewed as fair or right by our members.

As it turns out, our members' perceptions aren't that much different from the general public's view of the matter either. In each of the past two years, NAR has sponsored a national public opinion survey on the topics of health care and small business health plans. In 2005, a widely respective polling firm, Public Opinion Strategies, did both focus group work and a national survey. In 2006, we asked an equally respected Democratic pollster, Celinda Lake of Lake Research Partners, to work with Public Opinion Strategies on a second national survey of likely voters on the topic of small business health plans.

In the 2005 voter focus groups, we found that many people were surprised that a national trade organization like the NAR couldn't offer their members a uniform, national insurance program. They knew that large firms and unions were able to do so but were surprised to find out that large corporations and unions were subject to one set of rules and small businesses and the self employed were subject to a second, more restrictive set of rules.

The general public also perceived a disparity in the current system and believed that small businesses should be able to ban together through their trade organizations to obtain access to a single, uniform program unhampered by differing sets of rules and regulations.

Both the 2005 and 2006 voter surveys found that the American public share NAR's members support for small business health plans (SBHPs), as authorized by HR. 525, S. 406 and S. 1955.

In both the 2005 and 2006 telephone interviews, the individual was asked about their general views on the state of health insurance and their own level of satisfaction with the current system. The concept of small business health plans was also explained and discussed. The individual was then asked if this concept was something that they would favor or oppose. The arguments in favor and those against SBHPs were also shared with the individual and their level of support or opposition again solicited.

Not surprisingly, we found that across all groups and in both years, cost is a major health care concern. For consumers, costs are impacting their personal budget through higher premiums, co-pays and drug prices. For some, a decision to take one job over another or to take a job over being self-employed was driven by the need to have

affordable health insurance benefits. Small business owners indicated that they are having significant difficulties affording employee health coverage. Additionally, these same owners indicated that they may not be able to continue to offer coverage and recognize that their inability to provide benefits comparable to those offered by larger firms is affecting their ability to attract and retain skilled workers.

When the survey work turned to the concept of allowing the creation of small business health plans, both voters and small business owners were very supportive in both years. In 2006, when small business health plans are described to voters, 89% favored the concept; even after the harshest of opposition arguments were shared and explained, 86% continued to support the concept.

Also, of interest, the results show that support for the small business health plans crosses party lines with very high approval percentages for Republicans (93%), Democrats (886%) and Independents (88%).

When asked if they would be likely to participate in a plan like this if available, 77% of small business owners in 2005 said they would be likely to participate in a plan like this, including 41% who indicated that they would be very likely to do so.

It is clear, however, that small business owners are very aware of the need to choose a quality health plan for their workers so as to continue to attract quality workers. In this way, small business owners and the trade organizations that represent them are in step with each other.

NAR's leadership, for example, is very aware that if we are able to provide a small business health plan to our members it will need to be the very best program possible. We're a volunteer organization. Our members can decide not to join just as

easily as they join. We can't afford to alienate our members by providing them with a second class, stripped–down coverage plan. That would just not be in the best interests of our members nor of the Association itself.

Conclusion

Finally, I would like to close by saying that we know that this bill is not the silver bullet that will solve the nation's health insurance problems. We do believe, however, that it is an approach that can provide a viable alternative source of health insurance coverage for a significant component of the nation's uninsured small businesses and our own self-employed, independent contractor members.

Last year testifying before the Senate Small Business Committee on our support for S. 406, NAR's then president, Al Mansell, stated that he believed that it was time for all parties – supporters and opponents – to sit down together and figure out how to address the issues that were contentious.

He said, *"If there were concerns that the bill's solvency provisions are too lax, then let's talk about what a more acceptable level of reserves would be. If there is confusion over the degree of oversight that the Department of Labor and the state insurance commissioners would have over self-insured versus fully insured small business health plans, let's clarify. If the definition of what it takes to be "bona-fide" professional or trade association eligible to offer a small business health plan is too open-ended, let's discuss how that definition could be modified to avoid the problems that some contend will exist."*

We are heartened by the fact that this is exactly the approach that Senators Enzi and Nelson have taken this last year. Citing his belief that Republican and Democratic opposition to the traditional AHP bill was sufficiently strong to prevent the bill from moving successfully through the Senate, Senator Enzi began work with Senator Nelson on what came to be introduced as, S. 1955, the Health Insurance Marketplace Modernization and Affordability Act.

The Senators then asked the major stakeholder interest groups – insurers, insurance commissioners and the small business community –to submit their concerns with the bill as introduced. All of those concerns - and others identified as discussions continued - were then discussed over the course of months until alternative language that each of the stakeholders could agree on was found. Additional changes were then made as others weighed in on the original draft and pointed out additional points that needed to be considered.

Obviously, there are groups who have been very vocal about their continue opposition to SBHPs and believe that SBHPs will – take your pick - "cherry pick" only the good risks, fail due to adverse selection, offer only bare-bones coverages, offer enhanced plans that are be too expensive, provide insurance coverage to too few individuals, attract too many participants from state regulated plans, cause prices to increase, cause individuals to loose their coverage, etc. despite the intentions and best efforts of the sponsors and their staffs to draft a bill that prevents these unintended consequences. These are serious charges and need to be considered. It has been our experience that the bill's cosponsors have been willing and are continuing to work on addressing these concerns.

But I think, too, that it is also important to look at who is not saying that SBHPs will do these things. Many of the most vocal and credible opponents of small business health plans – including those who have the expertise to properly evaluate the impacts of changes to the insurance regulatory system – those who have put their lobbying "muscle" and resources behind efforts to derail earlier bills – have not opposed S. 1955. They have expressed "concerns" and continue to work with the sponsors on changes that could address their concerns. But the formal oppose positions and biting letters of opposition that are part of the record in the past are not there this time.

It would be easy for those who are not insurance experts, whose staffs are not experts and who want to do no harm to be hesitant to support a measure that could have unintended consequences. That's understandable. But as we testified last year, it's simply time to take this issue seriously, do the careful analysis necessary, and ask the tough questions of the cosponsors – one of whom as a former state insurance commissioner and governor is an insurance expert.

The current health insurance system is broken. The current system "cherry-pick" those are fortunate enough to have the financial resources it takes to purchase the current state regulated insurance products. The self-employed and small business owners need someone negotiating on their behalf. We need the leverage that our combined numbers give us. We need the ability to spread the risk that we represent over a large pool than is now possible.

We can't wait for major health reform; we can't wait for yet another session of Congress to come and go without action. We need small business health plan legislation enacted this year and we are committed to working with both chambers to make this

happen. I can tell you that when this legislation is adopted, the NATIONAL ASSOCIATION of REALTORS® will be one of the first to be actively involved in discussions with the nation's insurers to work out a quality health insurance coverage package that we can work together to provide REALTORS® nationwide.

I thank you for giving me the opportunity to share our thoughts with you. I'll be happy to take any questions that you might have.

Statement

of the

American Medical Association

to the

Committee on Small Business
Subcommittee on Workforce, Empowerment and Government Programs
U.S. House of Representatives

RE: "Health Care and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured"

Presented by: Cecil B. Wilson, MD

April 27, 2006

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank Chairman Marilyn Musgrave, Ranking Member Daniel Lipinski, and Members of the Workforce, Empowerment and Government Programs Subcommittee for holding this hearing to examine commonsense reforms designed to reduce health care costs, expand health care coverage, and improve the quality of health care. I am Cecil Wilson, MD, Chair-Elect of the AMA and an internist from Winter Park, Florida and am honored to testify before you today. As requested by the Committee, I will devote the majority of my comments to medical liability reform and will comment briefly on association health plans (AHPs) and health savings accounts (HSAs) at the conclusion of my remarks.

THE HIGH COST OF THE MEDICAL LIABILITY CRISIS AFFECTS EVERYONE

According to estimates by the U.S. Department of Health and Human Services (HHS), medical liability adds $70 billion to $126 billion to the cost of health care each year.[1] These are the costs attributed to defensive medicine, which could be significantly reduced by effective medical liability reforms. These costs mean higher health insurance premiums and higher medical costs for all Americans as well as higher taxes. Taxpayers bear a substantial burden, given that one-third of the total health care spending in our country is paid by the federal government through the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability cost adds $47.5 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government

[1] Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dept. of Health and Human Servs., Confronting the New Health Care Crisis, Improving Health Care Quality & lowering Costs by Fixing Our Med. Liability Sys. 8 (2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf

programs. Data from the agency shows that reasonable limits on non-economic damages would reduce the amount of taxpayers' money the federal government spends by $28.1 to $50.6 billion per year.

An April 2002 Price Waterhouse Coopers study, "The Factors Fueling Rising Health Care Costs," concluded that litigation accounted for seven percent of the increase in rising costs of health insurance premiums. The median jury award in medical liability cases nearly tripled from 1997 to 2004, increasing from $157,000 to $439,400.[2] Overall, 75 percent of medical liability claims in 2004 were closed without payment to the plaintiff. Of the seven percent of claims that resulted in a jury verdict, the defendant won 83 percent of the time. However, physicians who are found not liable for negligence still have large fees to pay for their defense. Average defense costs were $93,559 per claim in cases where the defendant prevailed at trial. In cases where the claim was dropped or dismissed, the cost to defendants averaged $18,774. These resources would be better applied to caring for injured patients.

THE CURRENT MEDICAL LIABILITY SYSTEM DOES NOT SERVE PATIENTS WELL

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as, or more, devastating for patients and their families as injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation. This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in compensating patients. Transformed by high-stakes financial incentives, it has become an increasingly irrational system driven by open-ended non-economic damage awards. It is also an extremely inefficient mechanism for compensating patients harmed by negligence where court costs and attorney fees often consume a substantial amount of any compensation awarded to patients.

Escalating jury awards and settlements, and the high cost of defending against lawsuits, even those without merit, are driving medical liability insurance premiums to unprecedented levels.[3] As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices, or drop vital services—all of which seriously impede patient access to care. National statistics demonstrate the crisis is real. Of 3,143 counties in the nation, 1,541 do not have a practicing ob-gyn to provide needed care.[4] Because of the complexity of their practice, neurosurgeons are frequent targets of lawsuits and many have curtailed their practices to limit their exposure to liability. Of neurosurgeons limiting their practices, 75 percent no longer operate on children. The nation's medical liability crisis also

[2] Physician Insurers Association of America, PIAA Claim Trend Analysis: 2004 ed. (2005)
[3] A compendium of data supporting medical liability reform and debunking arguments against reform is available on the AMA Web site at http://www.ama-assn.org/go/mlrnow.
[4] AMA Master File, 2004.

has caused 55 percent of orthopaedic surgeons to avoid certain high-risk procedures, including 39 percent who no longer perform spine surgery.[5] The crisis may also have long-term consequences. Almost half of America's medical students in their third or fourth year of medical school indicate the liability crisis was a factor in their choice of specialty, threatening America's future access to high-risk medical services such as surgical and obstetrical care.[6]

In the past year, there were several significant developments relating to the medical liability crisis. For example, in late 2005 the AMA had identified 20 states in crisis.[7] In February of this year, however, the AMA announced that Tennessee had become the 21st state in a full-blown crisis. From 1995 to 2005, Tennessee physicians have seen liability premium increases as high as 127 to 212 percent. A Tennessee Medical Association survey found that 70 percent of Tennessee's physicians believe the state has a shortage of high-risk specialists. Of Tennessee's 95 counties, 85 percent have no residing neurosurgeon, 51 percent have no residing orthopedic surgeon, 49 percent have no residing emergency physician, and 44 percent have no residing obstetrician-gynecologist.

Tennessee's experience reflects the disturbing national trend. There have been countless reports over the last five years demonstrating the harmful effect of the liability crisis on patients and physicians alike. For instance, in January 2005, an Alton, Ohio mother-to-be had to find a new ob-gyn — her third ob-gyn during the course of her pregnancy. Her first two doctors moved out of state on separate occasions due to the adverse and costly litigation climate.[8] In the fall of 2004, a Quad-cities, Illinois surgeon moved to Maine. His liability premiums in Illinois were seven times higher than what he now pays as a resident of Maine.[9] A Chicago thoracic surgeon commutes to Tulsa, Oklahoma every week to practice medicine. It has proven to be far less expensive to commute and pay insurance in Oklahoma that it is to practice in Chicago.[10] The Finger Lakes region of New York State lost five percent of its primary care physicians, 11 percent of its ob-gyns, and four percent of its surgeons.[11] The Mohawk Valley region of New York lost 36 percent of its ob-gyns and 27 percent of its general surgeons.[12] The Southern Tier region lost 28 percent of its ob-gyns and 15 percent of its general surgeons.[13]

PHYSICIAN PRACTICES ARE SMALL BUSINESSES

In addition to being medical professionals, the vast majority of physicians are also small business people. AMA data show that approximately three-fourths of practice-based physicians work in or own small practices (businesses). Among practice-based physicians,

---

[5] Alliance of Specialty Medicine, Feb. 17, 2005
[6] AMA Division of Market Research and Analysis, November, 2003
[7] Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, West Virginia, and Wyoming.
[8] Ohio State Medical Association
[9] Illinois State Medical Society
[10] *Id.*
[11] Center for Health Workforce Studies (April 2006)
[12] *Id.*
[13] *Id.*

roughly 33 percent are in solo practice, 26 percent are in practices with 2 to 4 physicians, and 16 percent are in practices with 5 to 9 physicians.[14] In addition, self-employed physicians employ an average of 4.1 non-physicians.[15]

Physicians' vocation of caring for patients is best served when physicians are able to operate in a viable business model. As with any small business, physician practices generally do not have the ability to absorb or shift the cost of rapidly increasing insurance premiums. While there are indications that premium increases may be moderating slightly after years of rapid growth, premiums remain at high, unaffordable rates. Thus, the urgent need to pass effective reforms has not abated.

Physicians' business overhead includes high costs imposed by unfunded government mandates resulting from paperwork and other regulatory requirements. Physicians must employ specially trained professional staff to bill for their services, manage health care records, and ensure compliance with complex state and federal regulations. When overhead expenses increase, physicians must either increase fees or cut other expenses just to sustain their practices. For physicians, raising fees to offset these costs is becoming more difficult as Medicare, Medicaid, and private health insurers exert considerable market influence to dictate physician reimbursement for the care physicians provide to patients. In many instances reimbursement is set at or below the actual cost of delivering that care. In addition, physician offices are prevented from providing many ancillary services to enhance revenue by state and federal legislation such as the Stark and anti-kickback laws.

Alternatively, if physicians are forced to trim expenses, they are generally limited in their options and must make difficult choices. These include: cutting staff; limiting employee benefits such as health insurance, retirement benefits, and 401(k) plans; forgoing the hiring of additional staff; delaying the purchase of advanced medical equipment; or investing in new health information technology systems. In some cases, physicians must limit certain aspects of their practice in order to find or afford medical liability insurance. For example, numerous family physicians are no longer delivering babies because it is cost prohibitive to insure that component of their practice. Others have recognized that their business plan is unsustainable and, pushed by unaffordable or unavailable medical liability insurance, have chosen to retire early.

A FEDERAL SOLUTION IS NECESSARY

The medical liability crisis requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their ability to access health care services

[14] Department of Economic and Statistical Research, American Medical Association, The Practice Arrangements of Patient Care Physicians (2003), available at http://www.ama-assn.org/ama1/pub/upload/mm/363/pmr-022004.pdf.
[15] American Medical Association, Physician Socioeconomic Statistics (2003 edition).

that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

The premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been stripped of their most effective provisions due to state constitutions that explicitly limit reforms or the laws have been nullified by activist state court judges.

For example, in 1995 Wisconsin's legislature enacted a $350,000 cap on non-economic damages.[16] During this time, Wisconsin enjoyed a stable liability insurance market with some of the lowest medical liability premiums in the country.[17] Patients and physicians benefited from the stability created by Wisconsin's medical liability statutes. However, equilibrium in Wisconsin's medical liability insurance market was upset when the Wisconsin Supreme Court struck down the state's statutory cap on non-economic damages.[18] Shortly after the elimination of the cap, a jury awarded a $4.25 million verdict for non-economic damages in a medical liability case.[19] In response, Wisconsin has subsequently enacted a new cap.[20] State-based reforms like Wisconsin's are subject to judicial fiat in a wide variety of venues. This instability upsets actuarial models and injects unpredictability into insurance rate-making. We believe that the time is ripe for a federal approach based on evidence and experience in order to resolve the liability crisis.

PROVEN SOLUTIONS

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. In past Congresses, the House of Representatives has passed comprehensive medical liability reform legislation, including H.R. 5 last year, which the AMA supported.

Those bills contained the following provisions:

- awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);

- awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in these bills;

- awarding injured patients punitive damages up to two times economic damages or up to $250,000, whichever is greater;

---

[16] Wis. Stat. § 655.017 and § 893.55(4)(d)
[17] *Medical Liability Monitor* (Oct. 2005)
[18] Ferdon v. Wisconsin Patient Compensation Fund, 284 Wis. 2d 573, 701 N.W. 2d 440 (2005).
[19] *Wisconsin State Journal*, February 3, 2006.
[20] Wis. Act 183 (2006)

- allowing evidence of collateral source benefits (such as health insurance or workers compensation) and prohibiting subrogation of patient damage awards;

- establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and

- establishing a sliding-scale for attorneys' contingency fees, therefore maximizing the recovery for patients.

California

The reforms already passed by the House of Representatives in H.R. 5 are not part of some untested theory. They are based on successful reforms passed in California in 1975 known as MICRA (the "Medical Injury Compensation Reform Act of 1975"). They have been proven to have stabilized the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing. Data from the National Association of Insurance Commissioners (NAIC) shows that total liability premiums in California increased only 309 percent between 1976 and 2004, compared to 1,011 percent for the rest of the U.S.

Some opponents of medical liability reform have argued that California's "Proposition 103," not MICRA, is responsible for lowering medical liability premiums in California. Studies have found, however, that "The evidence shows that Proposition 103 cannot explain the relatively modest growth in malpractice premiums in California since 1988," the year Proposition 103 was enacted, and that "MICRA must be given credit for this favorable trend."[21] At the time of Proposition 103's passage, MICRA had been declared constitutional, and liability premiums in California already had begun to stabilize due to insurers' confidence that the courts were beginning to uniformly apply MICRA. Proposition 103 does not prohibit increases in premiums, it only requires that the increases are justified and are not "excessive, inadequate, or unfairly discriminatory." Under Proposition 103, the California Department of Insurance must grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance. Since passage of Proposition 103, few public hearings have been held challenging rate increases for medical liability insurers. The bottom line is that medical liability insurers writing policies for California physicians do not need to increase rates dramatically because MICRA has brought stability to the market.

---

[21] William G. Hamm, Ph.D, et al., *MICRA, Not Proposition 103, Accounts for the Relatively Low Growth in Medical Malpractice Insurance Costs in California* (2005)

Texas

Texas also provides a compelling example of how successful tort reforms reduce escalations in medical liability premiums. From 1995 to 2002, claims against Texas doctors occurred at nearly twice the national average.[22] From 1989 to 1999, the average non-economic damage award quadrupled from $318,666 to $1,379,203.[23] Thirteen physician liability insurance companies began withdrawing from this line of insurance or left the state entirely because of unprecedented losses.

In 2003, the Texas legislature enacted comprehensive medical liability insurance reform, which included a "stacked cap" on non-economic damages. To avoid possible constitutional challenges, Texas voters also passed a ballot initiative amending the state constitution allowing for the enactment of limits on non-economic damages in health care liability cases. Under the Texas law, in addition to recovering unlimited economic damages, an injured patient may recover up to $750,000 in non-economic damages in a health care lawsuit against multiple defendants. The Texas reforms created three separate caps, one for health care providers (including physicians) and two for health care institutions (including hospitals). One cap provides a $250,000 limitation on non-economic damages in lawsuits against all health care providers named as defendants in a lawsuit. For institutions, the Texas law also includes a cap of $250,000 on non-economic damages against any one institution, while also permitting a third cap of $250,000 in those instances where more than one institution is found negligent.

As a result, Texas medical liability insurance rates have seen impressive decreases. The average rate cut for Texas physicians was 13.5% in 2005.[24] Texas physicians will save an estimated $49 million on their 2006 premiums.[25] The number of medical liability insurers in Texas has also increased by 23, and Texas physicians finally have a broad choice of insurance carriers.[26] After passage of these reforms, Texas experienced an increase of physicians, particularly specialists, and there has been an influx of physicians to medically underserved communities.[27]

---

[22] 2003 Texas Medical Association Closed Claim Liability Study

[23] *Id.*

[24] Texas Department of Insurance

[25] The Doctor's Company announced an 18 percent rate cut on March 23, 2005. Since the passage of state reforms, the carrier decreased its rates by 24.5 percent. Medical Protective announced a six percent rate cut, a third reduction in the past twelve months. American Physicians Insurance Exchange implemented a 13 percent rate cut in December, 2005.

[26] *Id.*

[27] Texas had experienced a net loss of 9 orthopaedic surgeons from 2000 to 2003. Since then, the state has experienced a net gain of 93 orthopaedic surgeons. Texas had lost 14 ob-gyns from 2001 to 2003 and subsequently experienced a net gain of 91. From 1991 to 2002, Texas experienced a net loss of one neurosurgeon. Since the enactment of the 2003 reforms, the state has experienced a net gain of 24. The number of physicians serving the state's most populous county, Harris County, has grown by 762. Among the additions to the Houston medical community are 65 emergency physicians, 8 orthopaedic surgeons, 16 neurologists, 8 neonatalogists, 6 pediatric cardiologists, 22 kidney specialists, and 9 rheumatologists. (Texas Medical Board, May 2005 reports)

FURTHER SUPPORT FOR LIMITATIONS ON NON-ECONOMIC DAMAGES

When liability insurance premiums are lower, more physicians are able to remain in practice, and the access to quality care is improved. A July 3, 2003, study from the Agency for Health care Research and Quality (AHRQ) looked at the distribution of physicians across states with and without caps on non-economic damages since 1970.[28] After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps.

In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[29] The study points to California, praising MICRA as "perhaps the most successful example of reform at the state level," and noting its slower rate of growth in medical liability premiums.[30]

An April 2006 Harris Interactive Poll demonstrates that Americans overwhelmingly support comprehensive medical liability reform, including reasonable limits on non-economic damages. Three-quarters of those surveyed support reforms, and 74 percent believe their access to affordable, high-quality health care is threatened because medical liability costs are forcing physicians out of medicine. Of those surveyed, 76 percent of those surveyed strongly support full payment of lost wages and medical expenses, and reasonable limits on "pain and suffering" awards. In addition, 67 percent also favor a law to limit the fees personal injury lawyers can take from an award or settlement. A strong majority of poll participants also believe that medical liability lawsuits are one of the primary drivers of rising health care costs.[31]

HEALTH SAVINGS ACCOUNTS

Longstanding AMA policy supports a pluralistic health care system in which patients and physicians have freedom of choice in coverage and delivery of care. As a result, the AMA was an early, visible leader in developing the Health Saving Account (HSA) concept and promoting such plans as options in the health insurance marketplace. In addition to developing extensive policy, the AMA lobbied for legislative enactment of HSAs and Health Reimbursement Arrangements (HRAs); we published and disseminated over 3,000 copies of the AMA brochure "Health Savings Accounts at a Glance"; we coordinated continuing medical education programs on HSAs and HRAs; we have delivered numerous speeches at conferences and medical society meetings; we have offered HSAs and HRAs to physicians through the AMA Insurance Agency; and we offer an HSA to our own employees. In

---

[28] Fred Hellinger & William Encinosa, U.S. Dep't of Health and Human Servs., "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians" (2003).
[29] Joint Econ. Comm., 108th Cong., Liability for Med. Malpractice: Issues & Evidence 19 (2003).
[30] *Id.*
[31] Health Coalition on Liability and Access (April 20, 2006)

addition, the AMA Council on Medical Service has published nine reports on issues related to consumer-driven health care.

ASSOCIATION HEALTH PLANS

The AMA is supportive of efforts to enhance the flexibility of the health insurance market by facilitating options for increasing the number of insured individuals through Association Health Plans (AHPs). We believe this can be achieved by fostering a regulatory environment that enables private market innovation in product development and purchasing arrangements by removing barriers to the formation and operation of group purchasing alliances, minimizing benefit mandates, and eliminating restrictions to the development of multi-year insurance contracts. Our support for AHPs, however, is strictly contingent upon the safeguarding of state and federal patient protection laws, including but not limited to those state regulations regarding solvency requirements for insurers and prompt payment of insurance claims. In addition, AHPs should offer affordable premiums, reasonable cost sharing, and adequate coverage. The AMA believes that AHPs offer a promising vehicle for making health insurance more affordable for small businesses. We are confident that if properly crafted, AHP legislation could result in expanding affordable health insurance options for employees of small businesses without compromising important patient protections and the safe delivery of health care.

CONCLUSION

The AMA believes the time for action is past due. Physicians across the country are making practice decisions now that may affect access to affordable, quality health care. Congress has the opportunity to increase access to medical services and coverage, eliminate the need for medical treatment motivated primarily as a precaution against lawsuits, and curb the wasteful use of precious health care dollars. We appreciate this opportunity to discuss various health care proposals with the Subcommittee and look forward to working with Congress to find workable solutions.

Statement of Merrill Matthews, Ph.D.
Director, Council for Affordable Health Insurance

Testimony Before the
Subcommittee on
Workforce, Empowerment and Government Programs
Committee on Small Business
U.S. House of Representatives
Thursday, April 27, 2006

Good morning Madam Chairman and members of the Subcommittee. I am pleased to be here, and I want to thank the Chairman and the Subcommittee for calling this very important hearing today on "Health Care and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured." I commend your leadership for considering ways to increase access for millions of uninsured Americans and small businesses to affordable health insurance.

I am Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance (CAHI), which is located in Alexandria, Virginia. CAHI is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

We at the Council for Affordable Health Insurance believe that all Americans should have access to affordable health coverage. By taking just a few steps, this Congress can move us much closer to that goal.

Let me identify three issues:

- People need access to affordable health insurance policies.
- State laws sometimes impede that access.

- Congress can take steps to ensure there is a vibrant, competitive health insurance market.

If we can achieve those three elements, we will go a long way toward solving the problem of the uninsured.

I. Creating Affordable Health Insurance Policies

Everyone knows that health care costs have been rising. According to a study in the journal *Health Affairs*, health care spending rose 8.2 percent in 2004, down slightly from 8.4 percent in 2003 and 10.7 percent in 2002. So while we are trending in the right direction, several years of health care spending increases three-plus times the rate of inflation has made health insurance very expensive for American families. [1]

The rising cost of health care leads inevitably to the rising cost of health insurance premiums. And the cost of health insurance is one of the primary reasons why we have roughly 46 million uninsured Americans. Unless Americans have access to affordable coverage, the number of uninsured will only grow — to 56 million by 2013, according to an estimate published in *Health Affairs*.[2]

However, the rapid rise of consumer driven plans appears to be slowing the trend or reducing the cost of health insurance. The *Wall Street Journal* reported last year that data from 13,500 participants in Aetna consumer driven plans showed that companies that offered a consumer driven plan as an option saw their premium increases slow to 3.7 percent, while those companies that offered only a consumer driven plan saw their costs fall by 11 percent.[3] And a recent survey by Deloitte of 152 major U.S. employers found

[1] Bradley C. Strunk, Paul B. Ginsburg and John P. Cookson, "tracking Health Care Costs: Declining Growth Trend Pauses in 2004," *Health Affairs*, Web Exclusive, June 21, 2005. (http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.286)

[2] Todd Gilmer and Richard Kronick, "It's the Premiums Stupid: Projections of the Uninsured Through 2013," *Health Affairs*, Web Exclusive, April 5, 2005. (http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143)

[3] Venessa Fuhrmans, "Patients Give New Insurance Mixed Reviews," *Wall Street Journal*, June 14, 2005.

that preferred provider plans were going up an average of 7.2 percent and HMOs 8 percent, but consumer driven plans saw only an average increase of 2.8 percent.[4]

That is why we at CAHI believe that expanding access to consumer driven health plans, such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), is one of the best ways to keep health insurance affordable.

Health Savings Accounts became available in January 2004, though a much more limited and regulated version known as Medical Savings Accounts was created by Congress in 1996. HSA plans combine a high-deductible (e.g., $2,500 for a family) health insurance policy with money deposited in a personally owned, tax-free account. People use their HSA funds to pay for smaller and routine health care expenditures, while their insurance covers larger costs, such as hospital stays, once the deductible is reached.

HSA opponents typically claim that no one would want them, or if they did, it would only be the young or the healthy or the wealthy. Critics also say the poor and working families would never want HSAs, and that people would spend their funds foolishly — only to find their accounts empty when they really needed to pay for care.

It is remarkable how wrong HSA critics have been. And it shows how little they understand about how health insurance works and what consumers — especially the uninsured — want.

- First, we know that workers and employers like HSA plans. America's Health Insurance Plans (AHIP) reports that roughly 3.2 million Americans are now covered with HSA plans.[5]
- Second, we know that the uninsured like HSAs. AHIP points out that 31 percent of those in the individual market purchasing HSAs were previously uninsured; and in the small group market, a third of the HSA plans went to previously uninsured companies.

---

[4] Deloitte, "Survey: Consumer-Driven Health Plan Cost Growth Significantly slower than Other Plans," January, 24, 2006.
[5] America's Health Insurance Premiums, Center for Policy and Research, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans," January 2006.

- Third, we know that middle-age families like HSAs. About half of the HSA plans went to people age 40 or more.
- Finally, we know that HSA plans are more affordable, with the average family premium for those in the 20-to-29-age range being $2,507, and $5,690 for those ages 55 to 64. Compare that to about $10,000 for family purchasing traditional insurance.

However, even though HSA plans are more affordable than traditional coverage, Congress can make them even more affordable by expanding the tax treatment of HSAs. For example:

Non-self-employed individuals who purchase health insurance get no tax break, as most other workers do. Giving them a full tax break for their insurance and HSA contribution will help level the playing field and make health insurance more affordable for them.

In addition, Americans spend a lot of money out of pocket on health care, but much of that spending is with after tax dollars. Allowing them to use tax-free money in their HSA will lower the effective cost of health care for them.

Let me emphasize that these proposals are not radical. They, in essence, help the HSA market to work more like the traditional insurance market, and would go a long way in giving more people access to affordable health insurance and health care.

II. Not Everyone Has Access to Affordable Health Insurance Policies

So, if Congress makes the changes recommended above, everyone will have access to affordable health insurance, right?

Not necessarily. Frankly, when it comes to the high cost of health insurance, the states have only exacerbated the problem.

A. *Health insurance mandates* — For 40 years, states increasingly have tried to micromanage health insurance, and premiums have ballooned as a result.

A health insurance "mandate" is a requirement that an insurance company or health plan cover (or offer coverage for) health care providers, benefits and patient populations that health coverage might not normally provide. They include:

- Traditional providers such as chiropractors and podiatrists, but also social workers and massage therapists.
- Benefits such as mammograms, well-child care and even drug and alcohol abuse treatment, but also acupuncture and hair prostheses (wigs, usually for those undergoing radiation and chemotherapy for cancer).
- And populations such as adopted and non-custodial children.

While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. In some markets, mandated benefits increase the cost of health insurance by as much as 45 or 50 percent.

Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Cadillac loaded with options, you have to walk.

So why do so many elected representatives persist in passing mandates? They find it difficult to oppose any legislation that promises enhanced care to potentially motivated voters.

In 1965, only seven benefits were mandated by the states; today, the Council for Affordable Health Insurance has identified 1,843 mandated benefits and providers nationwide.[6] (Available at www.cahi.org.)

Mandates enjoy wide bipartisan support, and some states are much worse than others.

- Minnesota has 62 mandates, the most of any state, Maryland 60, and Virginia 54.
- However, Washington, DC, has only 17, Alabama 18 and Idaho 13.

[6] Victoria Craig Bunce, J.P. Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States, 2006" Council for Affordable Health Insurance, March 2006. (http://www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf)

Some mandates will have a much larger impact on health insurance costs than others. In order to remind legislators that mandates usually aren't free, the Council solicited input from a group of respected actuaries who estimated how much each mandate could affect the cost of a health insurance policy. Their conclusion is that, depending on the state where one lives, Americans could be paying between roughly 20 percent to 50 percent more for their policies because of state-imposed mandates.

B. Guaranteed issue and community rating — Even more costly than a multitude of mandates is guaranteed issue and community rating, especially when applied to the individual market. Guaranteed issue requires insurers to accept applicants regardless of their health status (although some guaranteed issue provisions may include certain restrictions). People may forgo insurance coverage when they are in good health and purchase it when they are sick. As a result, the pool gets smaller and the insurance more expensive because young and/or healthy people drop out of the pool, knowing they can return when they get sick.

Guaranteed issue is even more destructive when combined with community rating, which requires an insurer to charge the same price to everyone in a "community," or pool, regardless of the differences in the risk the individuals present. Age, lifestyle, health and gender factors may not be used to determine rates. In other words, everyone can get a policy at roughly the same price. "Modified community rating" will allow some variation in premium, such as for geographic location.

Several states passed guaranteed issue and community rating legislation in the early 1990s, destroying those states' individual health insurance markets.

New Jersey is the poster child for how not to reform the health care system. When New Jersey's guaranteed issue legislation became effective in 1994, a family policy (known as "Plan D") with a $500 deductible and a 20 percent copayment (i.e., the insurer pays 80 percent) cost as little as $463 a month and as much as $1,076, depending on which of the 14 participating insurers the family chose, according to the New Jersey Department of Insurance. Today, *the lowest monthly premium* for a family Plan D policy is $4,262, offered by Oxford.

Monthly premiums for family coverage under an Aetna Plan D policy, the least costly after Oxford, rose from $769 in 1994 to $6,916 today, a stunning 800 percent increase. Remember, that's the *monthly* premium.

Supporters of guaranteed issue say it is necessary to make coverage accessible to those who need it most. But state-sponsored high-risk pools are the best way to make coverage accessible to the medically uninsurable. High-risk pools act as a safety net for people who are uninsurable, or whose premiums cost more than the standard. Established more than 25 years ago, high-risk pools operate in 33 states and covered more than 182,000 people as of December 2004, according to Communicating for Agriculture.[7]

The point is that just because there are affordable policies on the market doesn't ensure that All Americans have access to those policies. But Congress can fix that problem by allowing people to buy health insurance across state lines.

III. Ensuring a Competitive Health Insurance Market Nationwide

About half of all insured Americans under age 65 get coverage through the individual and small group markets. And states play a large role in determining the type and cost of coverage available to them.

As a result, someone living in Pennsylvania has pretty good access to a wide range of affordable health insurance options; someone living next door in New Jersey doesn't. One way to fix that problem and expand competition and choice is to give that person in New Jersey the ability to buy a policy currently being sold to the citizens of Pennsylvania.

That is what the Health Care Choice Act (H.R. 2355) does. I know of no reform currently on the table that would cost the federal government less and do more than the Health Care Choice Act for expanding access to affordable health insurance coverage.

---

[7] "Comprehensive Health Insurance for High-Risk Individuals — A State-by-State Analysis," Communicating for Agriculture, Inc., Nineteenth Edition, 2005/2006.

There are states where health insurance is very affordable and states where no one but the wealthiest can buy it. You, as members of Congress, have it within your power to change that.

The Act allows individuals to purchase health insurance coverage across state lines. It requires that the state law where the policy is filed (primary state) would apply both in that state as well as any other state (secondary state). Other consumer protections include requirements regarding disclosure, fraud and abuse, prohibition against "bait and switch" tactics, financial stability of the insurance company and ensuring an independent review mechanism for all who purchase coverage under the terms of this legislation.

Some fear the Health Care Choice Act will disrupt the current health insurance model, bypassing most state regulations and perhaps even agents. However, this ignores the fact that consumers are already searching for new and innovative ways to purchase health insurance.

The U.S. workforce is much more mobile and decentralized than it was 30 or 40 years ago. The Internet and other communications tools allow millions of workers to live in a different location than where their employer is based. For example, I live in Dallas, Texas, while the Council is headquartered in Alexandria, Virginia.

I don't get my health insurance through the Council, but if I did, it would be from a health insurance company licensed in Virginia, and adhering to Virginia's regulations and mandates: hence a Texan with a Virginia-based and regulated health insurance policy. Sounds a little like the Health Care Choice Act — and that is in practice today.

In addition, one of the fastest growing sectors of the health insurance market is what is known as "association group insurance," in which individuals who are members of an association (e.g., the Chamber of Commerce) are offered health insurance from a state-regulated and fully licensed insurance company. States impose some oversight on these policies, but most impose far fewer restrictions and regulations on association group insurance than they do on a traditional insurance policy sold to individuals. The reduced regulations and the ability to be more flexible and innovative in their policies allow those insurers to keep their premiums low.

So you have an insurance company that is domiciled in one state selling less-regulated, affordable health insurance through an association in almost every state in the country.

The point is that despite concerns that the Choice Act could disrupt the current system, deprive states of their ability to oversee insurance and protect consumers, and generally undermine the health insurance market, the market is already moving in that general direction.

IV. Conclusion

In summary, let me say that with a few small steps, Congress could dramatically improve Americans' access to affordable health insurance — especially for those living in states that have virtually destroyed their health insurance market.

Employers and health insurers are moving in the right direction. The Bush administration has proposed reforms that will accelerate that move. And several members of Congress have expressed strong support for that trend and are supporting it will meaningful legislation.

Madam Chairman, I want to thank you for giving me this opportunity to address the Subcommittee, and I applaud your leadership on this issue. I believe, with your support, that a viable, affordable health insurance market for all Americans is achievable.

Testimony of Paul Hense

Hense & Associates

On Behalf of
The National Small Business Association

House Small Business Subcommittee on Workforce, Empowerment, and Government Programs

Hearing:

"Healthcare and Small Business: Proposals That Will Help Lower Costs and Cover the Uninsured"

April 27, 2006

1156 15th Street, N.W., Suite 1100
Washington, DC 20005
202-293-8830

Chairwoman Musgrave, Ranking Member Lipinski and members of the committee, thank you for the opportunity to testify on an important piece of legislation that can immediately reduce the cost of health insurance for self-employed individuals. My name is Paul Hense and I am the President of Hense and Associates, a CPA firm located in Grand Rapids, Michigan. I also serve as the Chairman of the Board for the National Small Business Association.

As members of this committee are very aware, the tax treatment of health insurance is an important factor in plan participation. All workers at a large C corporation, from the mail room to the board room, can exclude employer provided health insurance from their gross income. This ability to treat health insurance as a form of tax free compensation is today taken for granted by many Americans.

Imagine then the shock of a small business owner upon their discovery that, in their new role as a self-employed tax payer, they are excluded from those tax savings granted the CEOs of Fortune 500 companies. This is the reality of our current tax code, which excludes self-employed individuals from deducting the cost of their health insurance for self-employment tax purposes. This inequity in the tax code means that the self-employed pay a 15.3% premium on their health insurance that no one else has to pay.

It used to be worse for the self-employed. Before 1997, the self-employed were prohibited from fully deducting the cost of heath insurance when calculating both income tax and payroll taxes. Thankfully, Congress recognized this glaring inequity and small business owners are now able to deduct the cost of personal health insurance against their income taxes. A genuine thank you to all who helped fix this glaring error.

Many of you are also aware that our job is not finished. As the law stands now, self-employed individuals still pay for their health insurance with money that has been subject to the self-employment tax. All employed individuals pay the FICA tax on their income, of which 6.2% is allotted for Social Security and 1.45% goes to Medicare. Employers are required to match employee contributions with a 7.65% contribution of their own.

Self-employed individuals are required to pay both sides of this tax resulting in a total 15.3% tax on income, commonly referred to as the "self-employment tax." Contrary to rules for C Corporations, a provision of the Internal Revenue Code requires self-employed individuals to pay the additional 15.3% self-employment tax on the cost of their health insurance premiums. No other worker is required to pay FICA taxes on any portion of their employer-sponsored health benefits. With health insurance costs already sky-high, our members find it unbelievable that the federal government would slap an extra tax on those who have the hardest time securing coverage in the first place.

The issue of full deductibility for the self-employed goes far beyond the simple inequity of the matter, there is a very real economic impact as well. A recent report released by the U.S. Small Business Administration's Office of Advocacy titled, *Health Insurance Deductibility and Entrepreneurial Survival,* shows that the allowance of health insurance deductions for income tax purposes has had a major impact on business survival rates.

When a family's principle earner makes the decision to leave the predictable and structured world of a large employer and strike out their own, availably of health insurance is a major issue. Adding to the cost of health insurance for that individual by not allowing their health insurance the same tax treatment they received at a former employer makes the final calculation for striking out on an entrepreneurial path much more difficult. It stands to reason that the positive results from income tax deductibility for health insurance discovered by the SBA Office of Advocacy report would grow if Congress allowed the self-employed full deductibility.

Fortunately, many members of Congress agree that it is unfair and unwise to penalize the self-employed. Just a few weeks ago, Representative Melissa Hart and House Small Business Committee Chairman Donald Manzullo stepped up to the plate and offered legislation to fix this inequity. H.R. 4961, *The Self-Employed Health Care Affordability Act of 2006,* would allow our nation's roughly 16 million self-employed business owners to fully deduct the cost of their health insurance. I wish to thank those members of the committee who have already added their names as cosponsors to the bill.

In the 108th Congress, Chairman Manzullo and Ranking Member Velazquez introduced identical legislation, H.R. 1873. That bill, supported by many members of this committee, ultimately gained 68 bi-partisan cosponsors and was joined by complimentary legislation in the Senate authored by Senator Craig Thomas and Senator Jeff Bingaman.

Our advocacy on this issue sprung from our landmark study of the tax code. NSBA's report, titled "The Internal Revenue Code: Unequal Treatment Between Large and Small Firms," details a broad array of tax policies that discriminate and act as a disincentive to entrepreneurship. Aside from the unfair self-employment tax on healthcare, the report has encouraged legislation that would allow business owners to participate in Section 125 "Cafeteria Plans" along with their employees and allow business owners and their employees to contribute to SIMPLE 401(k) plans at the same dollar amounts as traditional 401(k) plans. I encourage all members of the panel to read the report, a copy of which can be found on our website, www.nsba.biz.

In closing, I hope that all members of this committee will think of the inequity faced by self-employed individuals and H.R. 4961 when they wrestle with the crisis in rising health insurance costs faced by your constituents. Allowing self-employed business owners to fully deduct the cost of health insurance is an important part of the health care debate that will bring immediate relief and equity to your constituents.

THE HSA COALITION

2121 K Street, NW, Suite 800, Washington, DC 20037, Phone (202) 558 2303 Fax (202) 544.5552

Testimony before the U.S. House Small Business Committee

Subcommittee on Workforce, Empowerment
and Government Programs

Chairwoman Representative Musgrave

on Health Savings Accounts

April 27, 2006

Dan Perrin

President, HSA Coalition

Mrs. Chairwoman and members of the Committee, on behalf of the members of the HSA Coalition, I thank you for the opportunity to address you today and ask that my comments appear in the Committee record as if read.

People often ask, "What is an HSA? How do I explain them?" Here is what I told Congresswoman Julia Carson (D-IN), who wanted to know the same thing.

"Congresswoman, let's say you had a savings account with $2,500 in it for your health care costs each year. You keep what you do not spend, and if you spend the entire $2,500, then your health insurance kicks in. That's an HSA."

No slouch, Congresswoman Carson asked, "Where did the $2,500 come from?"

"It came from cutting the cost of your health insurance premium by at least $2,500. That savings goes into your account."

With a modest deductible like $2,500, you save that much on insurance premium.

The reason HSA qualified plans have a higher deductible is to free up funds that can be deposited into the HSA. Those funds previously went to the insurance company. Under an HSA, those funds go in your pocket instead. Think of HSAs as re-financing your health care.

Exhibit A contains an example of how an employer or an individual can freeze their annual health care costs at last year's levels, decrease the funds going to the health insurer, and provide better coverage to their employees or themselves.

The HSA Marketplace

Mrs. Chairwoman, after six years of the Medical Savings Account pilot, and two years of HSAs, we know the following:

HSAs are working to increase the number of insured and to contain health care costs – two long-term goals of both Republicans and Democrats.

In that regard, here are some key HSA facts (contained in Exhibit B, the HSA Coalition fact sheet):

- More than 95% of health insurers in the U.S. sell HSA-qualified health plans
- More than 400 banks offer Health Savings Accounts
- More than 200 credit unions offer Health Savings Accounts
- 9 out of the top 10 investment firms (like Vanguard and Fidelity) offer mutual funds in which HSA funds can be invested in
- More than 200 different individual mutual funds accept HSA dollars

From the end of the first quarter of 2005 to early 2006, America's Health Insurance Plans said the number of HSA-qualified health plans grew from 1 million sold to 3.2 million sold – tripling in a roughly 10-month period.

The U.S. Treasury estimates that there will be 14 million to 21 million HSAs in four years.

Mellon Financial estimates that 32% of employers either will offer HSAs in 2006, or already offer HSAs now to their employees.

Fidelity Investments surveyed its jumbo employer clients, those with more than 10,000 employees, and found that 28% were going to offer HSAs in 2006, or do so now.

Further, nearly a third of those Americans who enrolled in an HSA-qualified plan were previously uninsured. No other type of health insurance product has drawn such a high a percentage of the previously uninsured to becoming insured.

Mrs. Chairwoman, since the uninsured have expressed a preference for an HSA-based insurance – then it follows that helping the uninsured become insured with an HSA would simply reinforce an existing marketplace trend already in place.

Year-Over-Year Cost Increases

In the largest employer study done ever, United Benefit Advisors surveyed more than 8,700 employers and reviewed actual plan data from more than 12,000 health plans last year. The results will likely surprise you: the year-to-year cost increase for an HSA-qualified health plan was 3.4%, compared to a 9.6% price increase for traditional health plans.

Deloitte's Center for Health Solutions, found that HSA-qualified health plans had a year-to-year cost increase of only 2.8%, compared to 8.0% for traditional health plans.

Finally, ehealthinsurance.com, who offers individual health plans via the internet, found that the premiums for insurers on its site selling HSAs to individuals (those without employer provided health insurance) dropped 15% between 2004 and 2005.

When is the last time you heard of health insurance premiums dropping in price, and in double digit figures?

Is it magic? Is the HSA Coalition coming before this Committee and "spinning?"

Mrs. Chairwoman, let me relay a story that you may find illuminating with regard to the low year-to-year increases in HSA premiums, experienced thus far.

I had the pleasure of taking my five children to one of those amusement parks where you pay a large up-front ticket price, and then the rides and Water Park is free, but food, games and souvenirs and other amusements cost more.

So my four older children wanted to go off on their own, while I took my four year old son to the kiddy-rides. So I gave my children $40 each – to buy food, play games and what ever else – and told them that this money was to last until we drove home in the early evening.

About three hours later, my two middle children came to find me. "Dad, do you have any more money?" (They arrived without a souvenir hat or T-shirt or large stuffed animal won playing a game, and did not have any other obvious thing that they had spent their money on.)

"What did you spend the money I gave you on?" I asked. Well, there was this coin operated telescope that took a lot of the money, and we spent a lot of time in the arcade, plus we bought our lunch. "No, I don't have any more money," I said and took them to the Water Park.

About three weeks later my wife told me that our cousins were coming to visit (three teenager girls) and I was elected to take all the children to the amusement park.

So, when we arrived, I handed out their $40 each, and told them that what they did not spend, they got to keep.

Well, first of all they thought they had hit the jackpot and some of them actually started to jump up and down.

Second, I noticed strange new behavior. At one point my son told me that the arcades and games were out because they were too expensive.

Really? I wonder why they weren't too expensive the first time we were here?

My daughter skipped lunch and had an ice cream cone to save some of her money. I actually saw one of my children argue with a cashier over the amount of the change. The teenage girls thought that the 20 SPF sun screen was too weak and wanted to buy 40 SPF, but took more than 15 minutes of discussion to decide how to break up the cost to pay for it.

Finally, when we were going to leave, the children wanted to buy some candy for the ride, and they all bought Tootsie Rolls, the least expensive thing in the store.

When an employer funds their employees' HSA with the premium savings over a traditional health plan, they are really setting up an ownership incentive for the employee not to spend all the money in their account. And if the employee does not spend all the money in their account, the employee will not breech their deductible and get into their insurance coverage.

The net result is that fewer employees get into 100% insurance coverage because employees now have a financial incentive not to waste health care dollars.

A five hundred dollar deductible, for example, does not provide the same incentive.

In my amusement park example, my children had no problem wasting "my" money. But when the money they were spending was their own, they were far more judicious with it. In fact, discreet inquiries during the ride home found that most of the children had saved 40% of the money I had given them.

My daughter allowed as how that it was "pretty amazing" because, as she put it, she is "genetically incapable of saving money."

Most people think my children were acting in an economically rational manner during both visits.

In fact, Mrs. Chairwoman, if members of the committee turn to Exhibit C, the graph done by the Joint Committee on Taxation shows exactly what the amusement park vignette illustrates.

As the out-of-pocket payments by Americans decreased, the health costs increased. Very simply put, when people are spending someone else's money – like an employer's or an insurer's – they spend it ways they would never spend their own.

The Less Healthy

Some people believe, however, that what this story really proves is that less healthy people will not spend their own money to seek treatment or care.

In order for this story to illustrate that fact, one or more of my children would have to be in pain or discomfort throughout the course of the day, and further, they would have had to not spend any money they had to make themselves feel better.

Further, study after study of those with an HSA qualified plan, and who are less healthy, shows quite clearly that the less healthy are more compliant with their treatment regime and are more involved in their own care, than those less healthy who do not have an HSA.

Why? The reason is really quite straight-forward. These folks have a financial incentive (as well as a personal incentive) to be as healthy as possible. Those with an HSA know they will be paying the first dollars for their care from their own pocket.

One insurer, Assurant, showed that those with an HSA spent more than 30% more on preventative care than those without an HSA. In general, the financial incentive of taking-care-of-yourself-because-if-you-don't-you-pay is stronger than the

minimal incentive to participate in preventive care if you are using a traditional health care.

It is also useful to note that many HSA plans cover preventative care expenditures below the deductible.

Finally, Mrs. Chairwoman, it is clear that the current manner of health care financing and design is simply not working.

Traditional health insurance design causes massive year-to-year cost increases that is steadily eroding the number of employers who are able to offer health insurance and is, quite simply, unsustainable.

Unsustainable means that the health insurance will become unaffordable to the middle class, and most employers will not be able offer their employees health insurance.

HSAs not only offer a way out of the current health insurance debacle, but they also give people the opportunity to build up funds during their working years so that when they show up at the gates of Medicare, they have cash in their pockets. This becomes increasingly important, since it is becoming evident that Medicare simply cannot offer the baby boomers the same level of benefits that Medicare now offers their parents.

It is likely that Medicare will (like many employers and individuals are doing today) have to move to a higher deductible to be able to sustain the cost of seniors' health care coverage. HSAs help prepare people, and give them the opportunity to build up funds for this possibility.

Mrs. Chairwoman, Exhibit D gives examples of what amount of savings could build up, over time, in an HSA for both individuals and families.

Defined Contribution Plans

Containing costs is clearly a major factor in employers and individuals (especially the uninsured) switching to an HSA. However, one interesting finding of the previously cited UBA Employer study was that a majority of employers predicted that health benefits would become a defined contribution benefit over the next five years.

Under an HSA, the employee gets the cash over the course of the year in their account, which they own and control. Under a traditional health plan, the employee benefit occurs if and when they become ill, or have health costs that move them into 100% coverage.

An HSA works particularly well in a defined contribution world, since the employee gets cash deposited into their HSA, instead of the employers' contribution being sent to the insurer. Employees, when faced with a choice of how to allocate their

employers' set dollar amount for their health benefit every year, will likely choose to take that benefit in cash, in their HSA.

It is likely that defined contribution health plans will be predominately Health Savings Accounts as employers move to this type of plan over the course of the next five years.

There are many different reasons that the growth of HSAs will continue to be rapid, but the move to a defined contribution design among employers, will likely be one of the most significant driver of HSA expansion.

Mrs. Chairwoman, HSAs have moved from being a novelty to becoming part of the mainstream of health benefits in the United States. They have grown faster than 401 (k)s or IRAs did in their first two years of existence, and I expect that the growth rates of HSAs will continue to surprise most observers and continue to have a positive effect on the affordability of health care for individuals and employers alike.

Thank you, Mrs. Chairwoman, and members of the Committee for the opportunity to address you today on this important issue; I am ready to answer any questions you may have.

Exhibit A

Comparing Current Health Insurance Costs to Current Health Savings Accounts

$927:	Average monthly premium for average 2005 family health insurance[1]
$11,124:	Annual 2005 cost of family health insurance in the U.S.

Family Health Savings Account Offered By an HSA Insurer

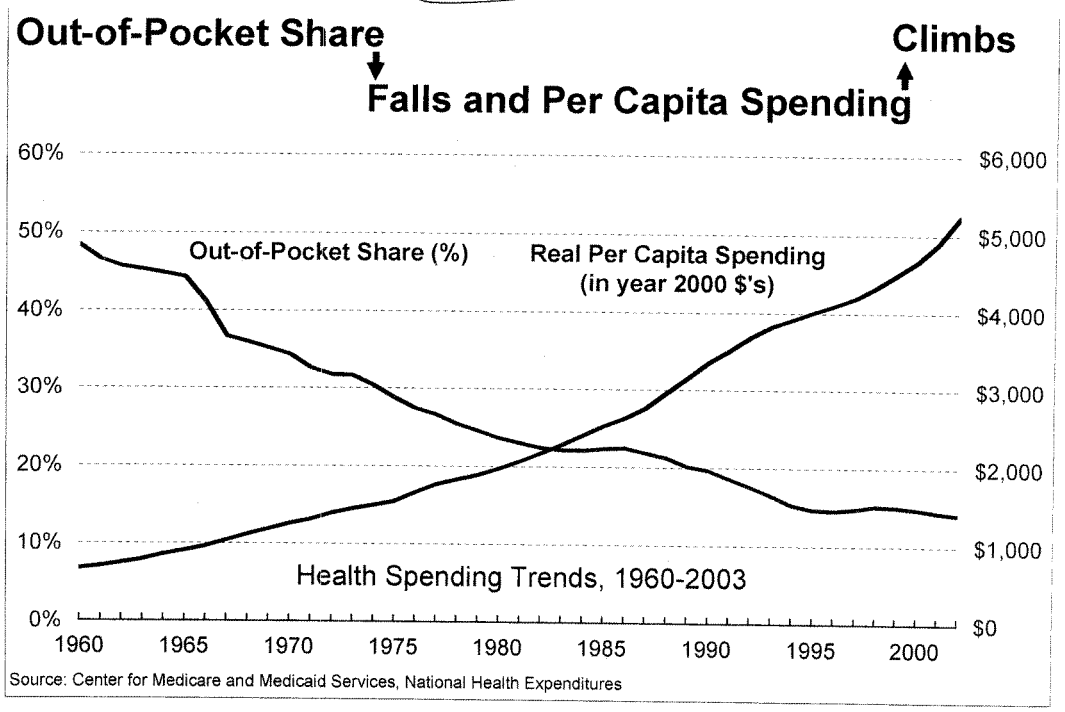
$418:	Average monthly premium for a $3,500 deductible family health insurance policy, head of household age 49[2]
$5,016:	Annual premium for a $3,500 deductible family health insurance policy[3]
$3,500:	100% of the family deductible is deposited in the HSA[4]
$8,516:	Total cost of premium and 100% funded HSA

Compare Costs:

$11,124:	Annual 2005 cost of family health insurance in the U.S.
$8,516:	Total cost of HSA qualified health plan premium and 100% funded HSA
$2,608	**Savings a Year with a Fully Funded HSA**

[1] "2005 UBA/Ingenix Employer Opinion Survey," which is the largest private survey done of employer provided plans, surveying 8,700 employers and reviewing data from more than 12,000 health plans.
[2] HSA Coalition estimate, 2005
[3] 100% coverage above the deductible is recommended because it is easier for employees to understand and until funds build up in the HSA, it has a lower out-of-pocket cost. In other words, the out-of-pocket cost should equal the maximum out-of-pocket cost during the first years of moving to an HSA.
[4] AHIP reports that the average family deductible for the individual (non-employer provided insurance) market in 2005 was $4,760.

Exhibit C



Prepared by the Joint Economic Committee
Chairman Robert F. Bennett
February 25, 2004

Exhibit D

Possible Savings For Individuals With An HSA Under Different Time and Medical Expense Scenarios				
Account Balance After X Years	**Age of Individual Starting at 25**	**After Individual Medical Expenses of $1,000 Each Yr**	**After Individual Medical Expenses of $500 Each Yr**	**Zero Individual Medical Expenses**
5 Years	30	$5,802	$8,703	$11,604
10 Years	35	$13,207	$19,810	$26,414
15 Years	40	$22,657	$33,986	$45,315
20 Years	45	$34,719	$52,079	$69,439
25 Years	50	$50,113	$75,170	$100,227
30 Years	55	$69,761	$104,641	$139,522
35 Years	60	$94,836	$142,254	$189,673
40 Years	65	$126,840	$190,260	$253,680

Assumes 5% interest per year, and 100% of a $2,000 deductible is deposited each year. One HSA insurer has paid 5% interest on balances in their HSAs and MSAs (during the MSA pilot) since 1/97. Source: The HSA Coalition

Possible Build-Up of Savings For Families With An HSA Under Different Time and Medical Expense Scenarios				
Account Balance After X Years	**Age of Head of Household Starting at 30**	**After Family Medical Expenses of $1,000 Each Yr**	**After Family Medical Expenses of $500 Each Yr**	**Zero Family Medical Expenses**
5 Years	35	$17,406	$20,307	$23,208
10 Years	40	$39,620	$46,224	$52,827
15 Years	45	$67,972	$79,301	$90,630
20 Years	50	$104,158	$121,517	$138,877
25 Years	55	$150,340	$175,397	$200,454
30 Years	60	$209,282	$244,163	$279,043
35 Years	65	$284,509	$331,927	$379,345

Assumes 5% interest per year, and 100% of a $4,000 deductible is deposited each year. One HSA insurer has paid 5% interest on balances in their HSAs and MSAs (during the MSA pilot) since 1/97. Source: The HSA Coalition

○