Testimony from

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On behalf of
THE NATIONAL SMALL BUSINESS ASSOCIATION

For the hearing

"47 Million & Counting: Why the Health Care Marketplace is Broken"

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Good morning. I would like to thank Chairman Baucus, Ranking Member Grassley and the committee for inviting me here today. I am honored to testify before a committee recognized for its hard work and for its bipartisan cooperation. Each of us testifying today will provide you with a different story, a diverse perspective and I expect one, common conclusion—small businesses are being crushed by the burden of the increasing cost of health care.

I am here today in two capacities, as a small business owner and as a past Chair of the National Small Business Association and so have two parts to my testimony. The first is an overview of the challenges I have faced in providing affordable, quality health insurance to my employees; the second to briefly describe NSBA's position and policy recommendations for reform. I am not an authority on health insurance but I have had a lot of experience as a consumer, and participated in developing NSBA's policy recommendations.

Before I get into my health insurance adventures, it is important that we understand how broad this issue is, and why dealing with the problems facing small business are important. According to data from the U.S. Census and Small Business Administration Office of Advocacy, there are approximately 70 million people in the U.S. who work for or run a small business – that is more than half of the private U.S. workforce. For the past 15 years, small business has created on average 93.5 percent of all net new jobs—resulting in an average of 4,000 new jobs EVERY day. The small-business community's role in creating jobs and stimulating economic growth cannot be underestimated or made merely into a talking point. Neither can the extreme time and financial drain the current health care system poses for small-business owners.

In nationwide surveys, small-business owners consistently rank health care among their top concerns. According to the recently-released NSBA Survey of Small and Mid-Sized Business, only 38 percent of respondents—nearly 90 percent of whom employ less than 19 workers—offer their employees health insurance. That is down 3 percent from one year ago, down 11 percent from 2000, and down 29 percent from 1995. Despite the low-rate of offering health insurance, 69 percent of respondents rated health insurance as the top benefit they WANT to offer.

The cost of health care disproportionately hurts the smallest businesses, with only 25 percent of companies with fewer than 5 employees offering health insurance to their employees. Furthermore, the Kaiser Family Foundation estimates that 60 percent of small businesses shop for a new health insurance plan every year, but of those, less than half actually make any changes. These statistics tell us one very important, and far too bleak fact: small businesses have very few viable options. Unfortunately, that is where I find myself today.

Experience of Phoenix Products, Inc.

From the day we started our company, providing affordable, comprehensive health insurance has been a primary priority. My partner was a cancer survivor who had a variety of chronic health problems that were the result of the severity of his illness and the extreme measures taken to battle it. For over 30 years I have had to confront the challenge of finding suitable health insurance plans during which period the health insurance landscape has changed dramatically.

During that time we moved through a progression of coverage options; going from 100 percent, company paid indemnity plans with low deductibles through Preferred Provider Organizations (PPOs), to an HMO plan with a Point of Service option to high deductible coverage. In our discussion this morning I will focus on changes over the last few years.

My company also has gone through substantial changes, growing from a youthful start-up into a fairly large, small business with nearly 100 employees. Today, due to fundamental changes in the size of our core market and fierce foreign competition we are a much smaller and mature organization.

Phoenix Products is now 31 years old, and our employee group has gotten older with the company. Today our "average" employee is over 52 years old and has been with the company nearly 16 years. As the group has aged,

our health expenses have grown significantly and we have had to dramatically change the benefit structure of our plans to offset rising costs.

As recently as 2003 we still could afford to provide a plan with a $250/$500 deductible which included a $15 co-pay for office visits and modest co-pays for prescription drugs. The monthly premium for this plan was $218 for a single employee and ranged up to $677 for full family coverage. But our group was shrinking, growing older and consuming more health care. At the same time, the cost of health care was increasingly rapidly, out of step with the rate of cost increases in other market segments. So my plan demographics and the dynamic increase in cost for health care were working against my group.

By moving away from what was a pre-paid health care plan that covered almost everything to an insurance plan that protects our employees from catastrophic events we have been able to control the premium increases which have grown by only about 10 percent from 2003 to 2007. Last year alone we avoided a 22 percent increase by moving to a very high deductible level. We were forced to pay a little more to cover much less.

Today we have a plan with a $3,000 deductible for a single employee and $5,900 for a family. The insurance company does not pay a thing until that deductible is met. Prescription drugs and office visits are treated like any other medical expense and are included in the same deductible limits. However, our company self-insures a part of the deductible so the actual exposure is limited to $1,750/$3,500 per employee.

Following our renewal last year I learned that we had a covered participant who had been diagnosed with Gaucher's disease, a very rare enzyme deficiency. While not immediately life threatening its long term effects can be devastating. Treatment consists of bi-weekly enzyme replacement therapy. Because the condition is so rare the cost of the drug is extremely high. As a result we have had extremely high utilization this last year and our renewal rates reflect that.

Our 2008 renewal rates are 35 percent above last year; the maximum allowed under Ohio insurance regulations. Quotes from other carriers were two to two-and-a-half times higher than our current rates. At this point we have exhausted all of the plan design options that could minimize our increase. Neither the company nor our employees are in a position to absorb an increase of almost $40,000 in premiums.

The company pays a variable percentage of the premium based on the employee coverage, but in total we bear over 80 percent of the total cost. The increase in the cost of our health insurance has affected our employees over the last few years. The employee contributions have grown with the premiums. Wage rates have been frozen since 2001, though we do make occasional lump sum distributions of profits as conditions permit. The market is brutal so let me emphasize the word "occasional. "

We have not yet figured out exactly what we are going to do about this renewal. We provide life insurance plus short-term and long-term disability coverage at the company's expense. Our average employee is now eligible for four weeks of paid vacation in addition to nine paid holidays. We are a family-run business and our employees are part of our family. As much as I do not want to resort to reducing some of these benefits, there are few other viable alternatives to offset the cost of health insurance.

Our situation has been aggravated because we have a single case that has such a dramatic effect on the total group. But last year, before this case emerged, we were confronted with a 22 percent increase that we averted by substantially increasing the deductible and self-insuring part of that risk. Despite countless hours working to redesign our plan to ensure its affordability, the rapid inflation in health care costs and our aging group are catching up with us.

As this committee rightly focuses on how to help small businesses afford health insurance, I urge you not to lose sight of the indirect costs our health care system imposes upon entrepreneurs. Often overlooked in the policy discussion is the time required to create and sustain a health insurance group plan. There are plan policies, procedures and documents that must be created and maintained, along with filing requirements for larger plans.

Annual shopping for new carriers or the evaluation of other plan design options also consume countless hours. In most small companies this means that the owner or other key employees are devoting their limited time to this effort. I can not begin to describe the exasperation and frustration that I experience trying to select the best plan option while lacking basic information about the actual utilization of the plan benefits; this information being "protected" under the HIPAA confidentiality shroud or otherwise unavailable. Each hour I spend struggling to find a way to continue offering health insurance to my employees is an hour NOT spent working to hire more employees.

Our group has experienced many challenges over the years and we have been fortunate to be able to find ways to continue providing our employees with a quality insurance plan that was affordable. But now we are squeezed between our group's demographics, the huge expense of a single case and the explosive increase in health care costs. After 31 years we may have finally found the limit of our ability to provide this benefit to our employees.

Broad Reform Proposal

My story is not unique. Small businesses are nearing a cliff, and we cannot continue down this path that creates such a significant competitive disadvantage globally and among larger businesses in our industry. When I was Chair of NSBA in 2004, the small-business community had been experiencing year-after-year double-digit increases in the cost of health insurance, and we decided it was time to come to the table with more than our horror-stories and criticisms. We spent a year working with myriad business owners, insurers and consumers, and crafted a proposal for reform that would fix not only our dilemma, but address the overall failures of the U.S. health care system.

While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying illness plaguing the entire system.

The Realities of the Insurance Market

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within it. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. But such is not the case in the health arena, where the costs of treating uninsured are split and shifted onto those with insurance in the form of increased costs. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Small businesses must function within the insurance markets created by their states. States have developed rules on rating and underwriting that attempt to establish the subsidies between the healthy and the sick. Most states require insurers operating in the small group market to take all comers and limit their ability to set rates based on health status and other factors. However, there is extensive variability among the states on these rules. Some states allow great latitude on rates, thereby limiting the cross-subsidies, but this makes insurance much more affordable for the relatively young and healthy. Other states severely limit rate variation, which often helps keep costs in check for many older, sicker workers, but drives up average premiums and puts insurance out of financial reach for many. These tight rating rules (known as "community rating" or "modified community rating") also can cause some insurers to leave certain markets they deem to be unprofitable. Problems in those states are then compounded by a lack of competitive pressures.

It is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the

individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have community rating in the small group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the "moribidity" of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

So long as we have in place a voluntary system of insurance, where individuals and businesses—at any given point in time—can choose whether or not to purchase insurance, this quest for the insurance rating "golden mean" will continue. While there has been endless debate about what the right set of rating rules should be, it is imperative that there be only one set of rules. Insurance markets where different players operate under different sets of rules are doomed to failure. Even in the interplay between the group and individual markets—which are different markets—we see the consequences of different rules. When two sets of rules operate within the same market, the self-interested gamesmanship that occurs among both insurers and consumers ultimately leads to dysfunction and paralysis.

Solution Principles

Any solution to the problem should abide by the following, most important principle - primum non nocere: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. Lawmakers must use a keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

The second principle when discussing a health care fix for small business is to understand the real problems small businesses face. The biggest problem small businesses face is cost and competitiveness. Health insurance in the United States has transformed from a "fringe benefit" to a central component of compensation. The realities of the small group market make it much more difficult for a small firm to secure quality, affordable insurance than it is for a large business. The ebb and flow of workforce in a large company can be compensated for in their insurance pool simply due to the large number of workers. Whereas in a small business, that natural shift in workers can lead to extraordinary fluctuations in health premiums. Given these costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

There exists another competitiveness issue, and that is a global one. The U.S. boasts a unique entrepreneurial spirit and has been a leader in technological advances. A great deal of that innovation and creation comes from small businesses. According to the U.S. Small Business Administration's Office of Advocacy, small firms represented 40 percent of the highly-innovative firms in 2002, a 21 percent increase in just two years. Unfortunately, health insurance costs can serve as the deciding factor whether or not an individual will opt to continue with his or her business. A report released earlier this week by that same Office of Advocacy states that the presence of the health insurance deduction decreases the rate of exit from entrepreneurship for self-employed individuals by 10.8 percent for single filers, and 64.9 percent for married filers. What this tells us is that we are losing potential new advances and innovations due to the cost of health insurance, which holds serious implications to our overall global competitiveness.

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals. Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

There is no hope of correcting these inequities until the U.S. has something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance.

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these relatively-healthy individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Of course, the decision to require individuals to carry insurance coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package should include only necessary benefits and should recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program all would be acceptable means of demonstrating coverage. More and more health care policy leaders are realizing the need for universal coverage through individual responsibility and a requirement on each person to have health insurance.

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of

the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates competitiveness concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small-business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they too often lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, and even death.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Improved Consumerism:

Pay-for-Performance must be a policy goal for all providers. Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, the Centers for Medicare and Medicaid Systems (CMS) already have begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—also could provide a level of provider defense against malpractice claims.

Enhancing the use of electronic medical records and procedures should be a priority. From digital prescription writing to individual electronic medical records to universal physician identifications, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also

can form the basis for publicly available health information about each health care provider so patients can make informed choices.

NSBA's policy is broad, but doable. Five years ago the concept of requiring individuals to carry insurance was a non-starter, but that is no longer the case. With the Massachusetts legislature passing broad reform legislation that incorporates some of NSBA's key proposals, it is becoming clear that broad reform is really the only way to fix the problem. On the federal level, Sens. Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) have introduced legislation, the Healthy Americans Act (S. 334) that also has some key pieces of the NSBA framework. Though NSBA may disagree with certain aspects of each of these proposals, they are to be applauded for moving the ball down the field and in doing so, changing the dialogue on this very important issue.

Targeted Solutions

While we argue that a comprehensive policy is truly the way to fix the health care market, we also realize that our plan is aggressive. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

Expansion of Health Savings Accounts

Health Savings Accounts (HSAs) are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike their predecessors, Medical Savings Accounts (MSAs), however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, and there are no longer restrictive limits on the program.

While HSAs have been available for nearly three years, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability.

Pool Small Businesses Locally

There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total

of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

NSBA encourages the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs

In 2002, President Bush and the Treasury Department highlighted Health Reimbursement Accounts (HRAs), which are similar to MSAs, but only can accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform also would help those individuals seeking a low-deductible plan but also would like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small-business owners to participate. Like so-called "cafeteria plans", HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of "cafeteria plans" (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small-business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small-business owners generally cannot participate in "cafeteria plans". Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small-business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity

After 16 years of struggle and unfairness, small-business owners finally were able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Currently, workers are allowed to treat their contributions to health insurance premiums as "pre-tax," whereas business-owners are not. This distinction means that those premium payments for workers are subject neither to income taxes, nor to FICA taxes. While the self-employed owner of a non-C Corporation now can deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes as employer and employee on their own income for a total self-employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. An employee who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else is treated in this country, we can give entrepreneurs an immediate 15-percent discount on health insurance premiums. Legislation has been introduced in the Senate by Sens. Jeff Bingaman (D-N.M) and Orrin Hatch (R-Utah) and in the House by Reps. Ron Kind (D-Wisc.) and Wally Herger (R-Calif.) that would bring this much-needed equity and tax relief to the nation's self-employed. I urge your support and co-sponsorship of the Equity for Our Nation's Self Employed Act of 2007 (S. 2239 and H.R. 3660).

Reform the Medical Liability System

The enormous costs of medical liability and the attending malpractice insurance premiums are significant factors pushing health care costs higher and restricting choice and competition for consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers-making quality health care in rural areas and smaller towns increasingly difficult to access. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Pay-for-Performance

NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the CMS's new pay-for-performance policy change. CMS has taken the lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS now will require hospitals to comply with certain quality standards. Those that do comply not will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring is necessary in providing patients with the highest quality care possible.

Improvements in Technology

Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as frequently. Individuals all should have a privately-owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA urges the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes. The medical industry needs to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report their compliance with these protocols. Such information should be made widely available to health care consumers.

Protect the Small Employer Health Market from Gamesmanship

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals almost are always lower in the individual market than in the small group market. The opposite is generally true for older and less-healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be under a different set of circumstances. Premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the

business re-enters the small group market (much like the penalty for early withdrawal of Individual Retirement Accounts (IRAs)). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs

Much of the question of adequate health insurance coverage boils down to affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits-scaled to income, and targeted at individuals, such as those proposals that the president has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long-term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

Substantial cost containment is embodied in the NSBA Health Policy. Limits on the tax exclusion will drive individuals to become less-dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined-in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

I would like to applaud the members of this committee for their leadership and work toward broad reform. There have been several pieces of legislation introduced that aim to reform the small-group market, and even reform the entire U.S. health care system. While NSBA may not agree with every piece of every bill introduced, your efforts to truly address the problem are both admirable and appreciated.

I thank the committee for your time and welcome any questions you may have.