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AFFORDABLE HEALTHCARE: A BIG PROBLEM FOR SMALL BUSINESSES

FIELD HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JANUARY 10, 2008

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COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

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SECOND SESSION

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AFFORDABLE HEALTHCARE: A BIG PROBLEM FOR SMALL BUSINESSES

THURSDAY, JANUARY 10, 2008

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS AND
ENTREPRENEURSHIP,
Washington, DC.

The Committee met, pursuant to notice, at 2:12 p.m., in the Reading Room, James J. Hill Reference Library, 80 West 4th Street, St. Paul, Minnesota, the Honorable Norm Coleman presiding.

Present: Senator Coleman.

OPENING STATEMENT OF THE HONORABLE NORM COLEMAN, SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP AND A UNITED STATES SENATOR FROM MINNESOTA

Senator Coleman [presiding]. This hearing of the Small Business Committee is called to order. I want to first say what a great pleasure it is to be here, to be back in St. Paul, a very special place for me. There is a hockey team that has a new owner, by the way, that is just around the corner from here. So it is always a special place in my heart.

I want to thank the panelists for being here, for helping to educate me and my colleagues, this testimony will be transcribed and will become part of the official record.

I also want to thank Chairman Kerry and Ranking Member Snowe for scheduling this field hearing in Minnesota. I am sorry that they are not going to be able to be here firsthand to hear from our panelists.

Let me start by saying that James J. Hill, this library's namesake, the empire builder who changed the economic destiny of this whole region, did not start as a tycoon. He began as a small business person. So did William McKnight, who began 3M. So did Dick Schulze, who began Best Buy. So did Rose Totino, the frozen pizza queen. So did Earl Bakken, who started Medtronic. Not every small business becomes a Fortune 500 company, but almost every business starts out small. By encouraging and sustaining our small business base, we make possible the big businesses of the next generation.

In Minnesota, and across the country, small businesses form the backbone of our economy. They are our job creators, our innovators, our producers, from the farm to Main Street. Yet they face unique challenges in order to grow and remain competitive, challenges

borne not only by the owners but also by their employees. This is especially evident in regard to health insurance where small businesses are often at a disadvantage with their larger competitors and are increasingly struggling to offer affordable health coverage to their employees.

Health insurance costs in Minnesota have risen dramatically, growing at twice the rate of inflation over the past 10 years. I believe the data shows that premiums increased 7.6 percent in 2006 alone. This not only leads to higher health care costs for business owners, but also higher out-of-pocket expenses for employees. In fact, between 2000 and 2008, the number of Minnesotans who spent more than 10 percent of their pre-tax income on health care increased by 490,000. These figures reflect the real-life stories I have heard from small business owners and families across Minnesota. When I travel the State, the single issue that is most prevalent, that is raised most often, is health insurance, and among small business people, this is also the issue that is raised most often.

Today, we will have the opportunity to hear some more of these compelling stories. We will hear from Sanjay Kuba, CEO of GCI Systems in Shoreview. Despite years of success, president Kuba recognizes the challenges he will face while trying to expand his company over the next few years. As health care costs continue to increase at record rates, Mr. Kuba must decide if he can continue to add the employees needed to meet growing demand. We will also hear from Mark Carlson from Minnesota Mailing Solutions who recently sold his business to Pitney-Bowes. He will share that a major factor in his decision to sell his business was based on the unsustainable small business health care market. Both these stories show that without reform, health care costs can prevent small businesses throughout this country from truly meeting their economic potential.

As many of you know, this is a problem which dates back to the 1940s. Since World War II, health insurance has moved toward an employer-based system. Because a large majority of folks are insured through their job, there is a misconception that most of the uninsured in America do not have jobs. In reality, of the 47 million who will be uninsured at some point this year, almost half are employed by small business.

For example, one survey showed that only 9 percent of workers in large firms—and that is firms of a thousand or more employees—and their families were uninsured compared to small firms—less than 10 employees—where 34 percent were uninsured. The statistics make clear that increases in health care costs have forced many small business owners into a position where they are simply not able to afford to offer health insurance to their employees. Besides its obvious negative impact on the health of families across the country, the lack of a health plan can also make it difficult for small businesses to maintain and keep the talent that they need in order to be competitive.

In order for our small businesses to prosper and ensure that working families have access to affordable quality health care, we need to find effective and reasonable solutions. As a Member of the Senate Small Business Committee, I am dedicated to finding ways

to expand insurance coverage for employees of small businesses. As with most issues, the best ideas will undoubtedly come from folks who are personally dealing with this challenge in their communities far from Washington, DC, which is why I am pleased that we are holding this field hearing in my favorite city, St. Paul. No offense to Minneapolis or any other city, but as a former mayor of this great city, I know how important small businesses are to the overall economy of St. Paul, Minnesota, and to the entire States and the entire country.

In addition, our State is a natural location for a field hearing on this issue because of its strong leadership on health-related issues, as well as our State's large number of small businesses. Minnesota not only has the second highest health care quality ratings as measured by the Agency for Healthcare Research and Quality, AHRQ, but also the lowest rate of uninsured residents in the country. Yet with all our State's success, Minnesota's more than 500,000 small businesses still cite increasing health care costs as their number one concern impeding future economic growth—the number one concern impeding future economic growth.

As we explore the possible fixes, I continue to support association health plans, AHPs, which would allow small business associations to band together across State lines to offer affordable health insurance. AHPs would allow small employers to tap into the same health care system utilized by large employers. According to the Congressional Budget Office, AHPs could provide small businesses with premium reductions of 13 percent, on average, and as high as 25 percent. That is about $450 to $1,250 savings per covered employee—savings that would translate into millions of people getting health insurance.

While this certainly is not a silver bullet, it is a good option for one segment of the uninsured population. I also look forward to hearing today from our excellent panel some of the other potential solutions to this national problem. In the end, we must do what we can to help both small business thrive and working families receive the health coverage that they desperately need. After all, it is access to health care that is the key to keeping your family healthy, and no one should ever be left out simply because of the size of their employer.

I will close with a quote that many of you have heard me say time and again. Winston Churchill once said, "Some people see business as a predator to be shot. Some see it as a cow to be milked. Few see it for what it really is: A sturdy work horse pulling the wagon of human progress." We all want to see that strong, sturdy horse continue to pull the wagon of progress, and I think we will hear today that progress cannot continue without comprehensively reforming the small business health care system.

I want to thank everyone again for attending. I would now like to take a minute to introduce our witnesses.

Cal Ludeman is Commissioner of the Minnesota Department of Human Services. As the Commissioner of Minnesota's Department of Human Services and co-chair of the State's Smart Buy Alliance, I am looking forward to Mr. Ludeman's insight on how we need to reform the way we purchase health insurance. I certainly support

the idea of bringing more transparency and quality data into the health care system.

Mr. Mark Carlson is president and CEO of Minnesota Mailing Solutions. Mr. Carlson will share his 9 years of experience as CEO of a small business and provide insight on some of the challenges he faces in purchasing health insurance for his employees.

Mr. Sanjay Kuba is president of GCI Systems. As someone who employs parents of children who suffer from chronic diseases, Mr. Kuba will discuss the impact of health insurance mandates and other regulations on small businesses. Like Mr. Carlson, his personal experience will help us understand some of the disadvantages small businesses face and the need to level the playing field.

Jason Flohrs is director of Government Affairs, Twin Cities Chamber of Commerce. Mr. Flohrs will be testifying on behalf of TwinWest's 1,000 members and will provide some recommendations on how to achieve better health outcomes and slow the rate of cost increase. I had a chance to be at TwinWest yesterday, and it is good to see you again today, Mr. Flohrs.

And Bill Oemichen is president and CEO of Minnesota Association of Cooperatives and Wisconsin Federation of Cooperatives. Mr. Oemichen will share with us how the Minnesota and Wisconsin cooperative model works and make suggestions for reducing the health care costs of small business. I often say, Mr. Oemichen, that the family farmer is the ultimate small business in this State, and certainly in this country.

Mr. Patrick McLaughlin is director of Marketing and Membership, Employers Association, Incorporated. We had another witness, Sue Eskedahl, who could not be here. She had a family emergency and will not be able to make it. Patrick has been kind enough to take her place here today, and he will discuss Employers Association's success with health care purchasing pool and highlight the benefit of association plans. I worked with Mr. McLaughlin for many, many years, if not at this point actually decades, and so I appreciate his leadership and his being here today.

I want to make it clear to the witnesses that this testimony today will be entered into the formal record, and so the hearing will remain open for 2 weeks after we are done, for additional testimony, and if I send questions to you, there is time for you to submit additional answers.

Commissioner Ludeman, I know you have to leave at 3, so we are going to start with you. We will hear your testimony, and I may have some questions for you.

STATEMENT OF CAL LUDEMAN, COMMISSIONER, MINNESOTA DEPARTMENT OF HUMAN SERVICES, ST. PAUL, MINNESOTA

Mr. LUDEMAN. Thank you very much, Senator Coleman. I appreciate your indulgence for my——

Senator COLEMAN. If you could move the mike closer.

Mr. LUDEMAN. I will say it again. Thank you, Senator Coleman, for your invitation, the Committee's invitation for this testimony from me and the other panel members. While I am Commissioner of the Department of Human Services in Minnesota, the largest State agency and the largest purchaser of health care in Minnesota, I am also what you called an "ultimate small business

owner," and so I have been faced with this issue for a lifetime of career in small business as well. And I appreciate your indulgence for my need to leave in about an hour.

There is no question—you have said it extremely well—this is a very important issue facing our Nation and our State, the rising health care costs. It is no news to anyone that health care costs are consuming all our pocketbooks, not just small businesses but Government as well. And so every business, individual, and the State of Minnesota will be facing a major financial crisis, already are in many regards, if we do not change the current health care delivery system.

We must address, I think, a very important flaw in the system. We currently pay on a fee-for-service model based on volume. We pay for volume. Someone does a service and we pay for it. The more volume that they do, the more services they provide, the more that goes out of the checkbook.

But we do not pay on value, which leads to unnecessary, repetitive, and even unsafe care. Many people are familiar with the Rand study of 2006 which revealed that, on average, a person receives recommended care only 55 percent of the time, yet pay every time that they are seen. The small business owners here today know that they would be out of business if their customers were satisfied 55 percent of the time.

So what is acceptable in health care? I will tell you today what is happening today in the status quo is not acceptable. The problem is that when we buy health care or use the health care system, not only are costs unknown to us, they are unknown to everyone, including your doctor or even major purchasers. If the quality—and I think generally most just do not believe that that is an issue at all, quality—but the truth is that the system is largely a black hole in a black box, which is left grossly unaccountable for outcomes and costs alike. This black box of the health care system must be open and transparent, and that is my major message today. We must address quality of care and payment reform. As we head into the 2008 election year, you will hear a lot of debate about access to health care and the uninsured, which are very important issues. But we must look beyond access alone, especially in the State with the lowest uninsured rate. If we do not, health care will not be affordable to anyone, small business, large business, or Government alike.

The State of Minnesota is addressing this issue by building alliances with other purchasers of health care. The State of Minnesota has a majority of the market share, spending over $4 billion a year on health care, covering over 770,000 Minnesotans, which is not enough to even effect the change of the entire market. That is why in 2004 Governor Pawlenty announced the formation of the Smart Buy Alliance, a private-public purchasing alliance made up of large, small, and mid-sized businesses, including the State of Minnesota as a health care purchaser. The alliance members leverage their purchasing power to drive value into the health care delivery system. The goals are to improve quality and lower cost by reducing inappropriate and unnecessary care and also hope to achieve savings in the long run through coordinating their members' expectations on quality and value based on four key buying principles.

And I will tell you those principles, and then I will ask if you have any questions.

The first principle is to reward or require "best in class" certification. The marketplace that small business is used to knows that they are best positioned in the market if they are regarded as "best in class" in whatever it is that they do. Customers come to their door knocking when they know that they are going to get the best or the best value. We do not do that in health care. Employers need to buy health care from the best and send their employees to the facilities and physicians where they can receive the best care.

The second principle is to adopt and utilize uniform measures of quality and results. The alliance adopts uniform methods of measuring quality of care so that we are able to implement pay-for-performance programs and to reward health plans and providers of high quality. That is underway today. Having organizations like Minnesota Community Measurement and the Institute for Clinical Systems Improvement, called ICSI, helps steer employees and businesses to the high performers. Minnesota is the only State in this Nation that has a measuring organization like Minnesota Community Measurement and any organization based on subscription by physicians themselves which help establish what is called "best practice."

The third principle is to empower consumers with easy access to information. It will be impossible for consumers, whether empowered by a high-deductible HSA account, for example, to use their health care dollar wisely if they do not have cost and quality information. Therefore, the Smart Buy Alliance works to make this information available to consumers.

The fourth principle is to require the use of information technology. Virtually every other industry in this world has made major productive advances through the use of information technology. That is not as true in health care as in almost any other industry. The alliance requires the use of health information technology. I am sure that within your business, from the folks at this table, efficiencies and quality improvements come with the use of this technology, and the health care system has to catch up. Because of the Smart Buy Alliance's demand, Governor Tim Pawlenty joined with leaders from Minnesota's largest health organizations, including providers, to announce what is called an "electronic health information exchange." It is a business environment that we are engaged in even at DHS that now has an organization that will see that we will have electronic exchange of information as it relates to patient safety, as it relates to increasing the efficiency amongst health care providers, and as it relates to reducing administrative costs for all health care organizations.

I think an inevitable question that may come from you is: What can the Federal Government do? Although the Smart Buy Alliance represents a large portion of the State's health care market, it does not include Medicare. Minnesota has been very successful in using our purchasing power to leverage better results; however, Medicare is not in sync with these principles. Some examples where the Federal Government can help and Medicare can line up with the State's effort are to continue the hospital pay-for-performance model that HHS administered called the "Premier Hospital Quality

Incentive Demonstration." This option could result in substantial savings in the health care system, with a major share accruing to the Federal Government through reduced Medicare payments primarily from decreased hospital readmissions. But this savings would also accrue over time to everyone in this room.

We also need to look at what is called "episode-of-care payment" to transform the current Medicare fee-for-service payment system, which I spoke about earlier, to payments for episode of care, which is about changing the current distribution of cumulative fee-for-service costs per episode. So when you add up all the CPT codes, as they are called, for each service, there is no gathering of this information to say this is what it takes to have this episode of care and have it compete in the marketplace for cost or quality, and we should pay for those episodes, not for each procedure. This policy would change Medicare payment methods to reward and encourage more efficient and coordinated care, and the savings would also accrue to everyone else in this room.

Also, Medicare needs to think about how to strengthen primary care and care coordination. One of the reasons Minnesota enjoys one of these positions of the lowest uninsured rate and high-quality care is that our percentage of primary care physicians to the population is one of the highest in the Nation. We need to change the reimbursement so that the primary care physician practices to coordinate and support enhanced services, such as care coordination, care management, and easy access to appropriate care. The physician practicing in Minnesota today has few of those responsibilities because they are simply not paid for or encouraged.

And then we need to correct the market signals, the price signals in the health care market. We have simply all glided along on a medical trend cost rise that we have accepted. The options need to address the tendency of current pricing mechanisms to send the wrong signal to participants in the market. So physicians are confused; governments are confused; small businesses are confused; and I am reminded of the champions in Minnesota's business history that you outlined in your opening comments that, with the exception of Earl Bakken, for example, those champions were not in the business of health care. The small business owners you see here today have had to become health care insurance experts, and that is not what their intention was. And so that is what we can do the most for small business in Minnesota.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Ludeman follows:]

Cal Ludeman

Commissioner of MN Department of Human Services

Chair, Governor Pawlenty's Health Cabinet

Testimony before the Committee on Small Business and Entrepreneurship

United States Senate

January 10, 2008

Senator Coleman, thank you for inviting me here today to discuss a very important issue facing our state and nation; rising health care costs. It is no news to anyone that health care costs are consuming all of our pocket books. Although small business has unique challenges, every business and individual, including the state of Minnesota will be facing a major financial crisis if we do not change the current health care delivery system.

First we must address an important flaw in the system. Currently we pay for volume of care rather than value, which leads to unnecessary, repetitive and even unsafe care. In fact, a Rand study revealed that on average a person receives the recommended care only 55% of the time, yet pay every time they are seen[1]. Small business owners know they could not survive with these results. So why is it acceptable in health care? I will tell you today that it is not. However the problem is that when we buy or use the health care system not only are the costs unknown to us so is the quality. The system is largely a black hole left grossly unaccountable for outcomes and cost alike.

The current debate tends to focus too much on access. Access is very important; however in a state with the lowest uninsured rate (60% of Minnesotans and 78% of children are eligible but not enrolled in state programs[2]) we must address quality of care and payment reform. If we do not address these issues health care will not be affordable for anyone, including government.

The State of Minnesota is addressing this issue by building alliances with other employers and purchasers of health care. The State of Minnesota has the majority of the market share, spending over $4 billion dollars a year on health care covering over 770,000 Minnesotans, however not enough to effect change over the entire market. That is why in 2004 Governor Pawlenty announced the formation of the Smart Buy Alliance, a public private purchasing alliance. This is an alliance of large, small and mid sized businesses including the State of Minnesota (as a health care purchaser only) that leverage their purchasing power to drive value in the health care delivery system. The goals are to improve quality and lower costs by reducing inappropriate and unnecessary care, encouraging evidence-based medicine and use of highest-performing providers, and reducing providers' administrative costs through common reporting requirements. That is,

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[1] RAND Corporation study published in the New England Journal of Medicine March 2006

[2] 2004 data from the Minnesota Department of Health

the alliance hopes to achieve savings in the long run through coordinating their members' expectations on quality and value based on four key buying principles:

1. Reward or require "best in class" certification. Alliance members build on existing "best in class" certification programs that identify health care providers achieving certain levels of expertise, experience, proficiency, and results. Just as with any business, you want to buy from the best. Employers need to buy health care from the best and send their employees to the facilities and physicians were they can receive the best care.

2. Adopt and utilize uniform measures of quality and results. The Alliance adopts uniform methods of measuring quality of care and results and uses them to implement pay for performance programs and to reward health plans and providers. We are able to do this in Minnesota because we have the Institute for Clinical Systems Improvement (ISCI) who sets standards and MN Community Measurement who reports the results on a public website. Purchasers can use this information to steer their employees and business to the high performers.

3. Empower consumers with easy access to information. It will be impossible for consumers to use their health care dollar wisely if they do not have cost and quality information. Therefore the Smart Buy Alliance works to make this information available to consumers through their purchasing power. The Alliance uses these market forces by speaking in one voice and coordinating the "ask". Some examples are:

- **MN Community Measurement**: This public website provides information on how well providers perform in specific areas. It currently provides comparative quality information for the treatment of asthma, children's health, depression, diabetes, high blood pressure, and women's health. Also provides information on how to work with your doctor to stay healthy (www.mnhealthcare.org). In late 2008 MN Community Measurement will also be reporting cost information. This will allow for consumers and purchasers to buy health care based on value, again rewarding better care vs. more care.
- **RxConnect:** In the fall of 2003, Governor Tim Pawlenty instructed the Department of Human Services and the Department of Employee Relations (the State of Minnesota employee group) as well as other state agencies, to develop new ways to help Minnesotans reduce their prescription medicine expenses. The order resulted in the development of RxConnect, a Website that provides information about affordable prescription medication options.
- **Compare Your Care:** Consumers take an online survey about care they receive. Surveys exist for adolescent, child, and adult general and preventive health; pediatric and adult asthma; diabetes; heart disease; and depression. Consumers are provided with information and advice for self-care. The accumulated responses enable comparisons among clinics, networks, and care systems (www.healthfront-info.org/).
- **Minnesota Health Information Web Site**—A clearinghouse that connects consumers with a wide range of information about the cost and quality of health care in Minnesota. The site includes links to numerous health-related sites that

compare provider performance and costs, help consumers manage their health conditions, give tips on purchasing care, and offer strategies for staying healthy. The site was created by the Governor's Health Cabinet and is administered by the Minnesota Department of Health (www.minnesotahealthinfo.org).

- **The Adverse Health Events Reporting Law:** This state law provides health care consumers with information on how successfully hospitals and outpatient surgical centers prevent adverse events. Twenty-seven types of incidents are tracked and publicly reported, including wrong-site surgery, retention of a foreign object in a patient after surgery, and death or serious disability associated with medication error. Under the legislation, hospitals must notify the Minnesota Department of Health (MDH) when any of these 27 errors occur. The MDH publishes an annual report of the events by facility along with an analysis of the events, corrections implemented by facilities, and recommendations for improvement. In September 2007 Governor Tim Pawlenty announced that Minnesota is the first state in the nation to establish a statewide billing policy for care made necessary by preventable medical errors, "adverse health events," under the agreement; hospitals in Minnesota will not bill insurance companies and others for any of the 27 types of reported adverse health events.
- **New State Law Requires Electronic Exchange of Administrative Health Care Transactions:** In health care, as in other industries, administrative costs are reduced and productivity increased when transactions are processed electronically using common formats and conventions. However the health care industry still lags behind other sectors in its use of information technology and common data standards. This leads to duplicative and unnecessary administrative costs and waste. To address this issue, a new law signed by Governor Pawlenty in May 2007 will require all group purchasers and health care providers to electronically exchange the following three health care transactions: eligibility; claims; payment and remittance advice by 2009. The new law will accelerate the use of standard, electronic transactions to help reduce health care administrative costs and related "hassle factor." This will free up more health care dollars that can be spent on maintaining and improving health.

4. Require use of information technology. The Alliance encourages efficiencies and quality improvements by supporting development and/or requiring adoption of interoperable health information exchange. Because of the Alliance's commitment, Governor Tim Pawlenty joined with leaders from Minnesota's largest health care organizations to announce an electronic health information exchange that will connect doctors, hospitals and clinics across health care systems so they can quickly access medical records needed for patient treatment during a medical emergency or for delivering routine care. The Minnesota Health Information Exchange will improve patient safety, increase efficiency among health care providers, and reduce administrative costs for all health care organizations. This public-private partnership plans to go live in early 2008. It will be one of the largest health information exchanges in the nation, serving more than three million Minnesotans, and additional Minnesotans will be served as more health care organizations join the exchange.

These four principals were highlighted because they will bring about the largest and most comprehensive reform to the health care system. When purchasers ban together small large, government and union, use buying power to demand better results, everyone benefits. Essentially what we are doing is bringing much needed information to consumers and small business so they can make choices based on value.

What can the federal government do?

As mentioned above, the Smart Buy Alliance represents a large portion of the state's health care market; however it does not include Medicare. Minnesota has been successful is using our purchasing power to leverage better results however Medicare is not in sync. Some examples where the federal government can help and Medicare can line up with states efforts are:

- **Hospital Pay-for-Performance:** Establish a Medicare pay-for-performance program for all hospitals similar to the current Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration. This option could result in substantial savings in the health care system with the major share accruing to the federal government through reduced Medicare payments, primarily from decreased hospital readmissions. This savings will benefit all addressing the affordability issue.
- **Episode-of-Care Payment:** Transform the current Medicare fee-for-service payment system to payments for episode of care (based on the current distribution of cumulative fee-for-service costs per episode). This policy would change Medicare payment methods to reward and encourage more efficient, coordinated care. Again the saving would be significant and would avoid cost shifting.
- **Strengthening Primary Care and Care Coordination:** Change reimbursement to primary care physician practices to support enhanced primary care services, such as care coordination, care management, and easy access to appropriate care.
- **Correcting Price Signals in the Health Care Market**: These options seek to address the tendencies of the current pricing mechanisms to send the wrong signals to participants in the market. These include signals for higher rather than lower costs and pricing mechanisms that support inefficient care and wide variation in costs without corresponding differences in quality and outcomes across geographic areas.
- **Medicaid waivers**: There are limitations to what states are able to do with the Medicaid program. There are times when federal waivers are needed to implement some of the reforms mentioned in this statement. For example, Minnesota has signed onto the US Department of Health and Human Services' Four Cornerstones. In order to comply with these principals federal support is necessary.
- **Allow for Flexibility**: Equally important is to allow states the flexibility to innovate and try new ways to reform health care.

- **Pre Tax Health Care Dollars**: Small businesses and individuals should be able to buy health care with pre tax dollars. Just like the large employers there needs to be a change in the tax code to allow small businesses this same benefit.

These are just a few examples of where the federal government can help states in their health care reform efforts. In Minnesota we have a very strong history of public private collaboration. This is also true in health care, however purchasers need to ban together, demand results and information on cost and quality. We need every Minnesota to use the information currently available which I discuss in this statement so that pressure is placed on the system to deliver greater transparency to consumers, business and government. We cannot fix what we don't know is broken and consumers have been in the dark for too long. I would ask every small business to join with us in this effort and I would ask the federal government to partner with states, use their buying power and restructure the payment system to ensure all Americans receive the best care at the right time for the best cost.

Senator Coleman, I commend you and this committee for taking on this tough issue and the time listen to the states and the people you represent. We can all agree this issue is not going to be solved over night with a band-aid. We need a complete system overhaul to bring about the much needed change within our health care system.

Senator COLEMAN. Thank you.

Mr. Earl Bakken was an engineer. He was a fix-it guy.

Mr. LUDEMAN. He turned into a health care guy.

Senator COLEMAN. He turned into health care in a big way. Thank you, Commissioner. Just a couple of observations, and I have a couple questions. But in my travels around the State, your next to the last point, talking about primary care physicians, one of the challenges we face is getting folks to be primary care physicians. And in part it is about—reimbursement. Part of that and pay is part of that, and we have got young folks or folks getting out of med school with huge debt, and you have got a choice to be going into a specialty or becoming a primary care physician. What I am hearing time and again is folks are deciding from economic necessity to go one path, and that is creating a real challenge for us. So it is something we are not addressing at this hearing. But I really believe that we have to be cognizant of it.

The other comment or question is I appreciate—and I have heard some discussion of this—episode-of-care payment versus procedure. The benefit is that you can look at things in a holistic way. So it is not isolated—and I would presume an offshoot of that would be coordinated care and quality of care that could be enhanced. So I think it is a concept certainly worth looking at.

I heard loud and clear your message about quality and your message about transparency, and I hear it again and again, and certainly it is something that we have to take to heart. And I appreciate your kind of preempting my question about what the Federal Government can do because that is important.

As we talk, though, about transparency—and we talk about, empowering consumers—one of my concerns has to do with consumers shopping around, making choices. But you really need an educated consumer to do that. Are we at that point today? And what is it going to take us to get to that point?

Mr. LUDEMAN. Senator Coleman, that is a great question. The answer to that question today is no, we are not at a very high plane or level of consumer education about the literacy of people. When you talk about CPT codes, I doubt that there is even maybe a lot of people in this room that know what some of these coding arrangements are or how it relates to a physician's office.

Talking about to be able to measure adequately enough so that we can get to an outcome is where the consumer wants to be, and that is what they need to find out. So when you can say that if you are a diabetic or have diabetes in your family and you want the best possible diabetes care, whatever that is—you may not know it yet, but you can at least find out what these measures are so that you can find the best possible performers in the marketplace to say—and we can do that in Minnesota today, one of the few States in the Nation that can do it. Let's say Norm Coleman's Physician Clinic is the best in this State in the diabetes care, whatever that is. But you have to have at least that much literacy to know I have diabetes, this is going to take—it is a life-changing event. I am going to have to have a lot of care coordination and self-care involved. I need to go to the best. So at least we have that information public today. Adding price information to say is this episode-of-care management, as you described it, getting that price in a

basket of care or episode of care, whether it be in the acute world or even over a lifetime, is the harder part, but we are going to announce soon a new pricing transparency project that will be launched this year as well. So you can tell both the price and the quality based on what your particular health care need is.

Senator COLEMAN. So there are really three parts to this. There is, one, the information itself, information about quality. There is then the ability to access—is it accessible information? And with computer technology, what I am hearing in Minnesota, we can access. But the third piece is do you have the ability, the literacy, the level of literacy to understand how to get there.

We have looked at this issue. I am co-author of the Health Literacy Act of 2007 to educate the individual to be able to access information. But what I am hearing in Minnesota, I understand we do a good job having the information available, and having a way to get there. It is that other element to connect people with that pool of information that I think is critical.

Also, you talked about requiring use of information technology. That is an expensive proposition for a lot of institutions. Who pays for that? Is there a role that the State or the Federal Government has in dealing with the cost of utilizing information technology in the delivery of health care?

Mr. LUDEMAN. Senator Coleman, about 60 percent of Minnesota consumers today, which is now a brand-new platform, have available to them electronic medical record or personal health records available to them electronically, which is good, and that is a high level across this Nation. A lot of that is because of our large integrated care systems in the metropolitan area. The State government sends out through the Department of Health anywhere from $15 to $20 million a year in what are called "electronic medical information grants," mostly to small clinics in certain parts of the State based on their need. They are connecting together more. There is actually a concentration on the market based on the need for electronic projects that have to happen, and physicians, clinics, and hospitals all know it, and they are searching for the money. But the basic intrinsic cost is borne by the provider, and some of the argument has been that they never are able to recover some of that cost. However, if it does lead to higher productivity on the part of that clinic or hospital, they should be able to regain those costs just like any other business environment that is represented here today.

Senator COLEMAN. Again, I understand the importance. The only concern—and this concern has been articulated to me—is that there are costs. And businesses, by the way, have to make those judgments. But if we require them to do it—it is one thing to say I am going to make this investment, even though it will take me X period of time to recover it, but you are going to make the decision because we require you to do it or because you have reached that point where you think it is to your benefit—I just think it is an issue that is worth further discussion. Particularly with small businesses, some of them simply may not be in the position to have the capital up front, particularly small operations, and there are rural health clinics and a range of others, many of the rural hospitals which operate on, very thin lines in terms of being able to

continue operating. Critical access hospital designation plays an important role in that. But I just think that this is an issue that should require further discussion between the folks at the State level, the Federal level, and then those folks at the local level.

Commissioner, I greatly appreciate your presence here today. I know you have to leave at a certain point in time. What I am going to do now is to proceed with the rest of the panelists, and each of them will provide their testimony. Then at the end, I will then have a series of questions, I presume, based on the testimony. But why don't we at least have the panelists present their testimony one at a time, and then I will have the complete record in front of me. Commissioner, thank you.

Mr. Carlson, you may proceed.

STATEMENT OF MARK A. CARLSON, PRESIDENT, MINNESOTA MAILING SOLUTIONS, GOLDEN VALLEY, MINNESOTA

Mr. CARLSON. Senator, it is an honor and a privilege to be able to present my testimony to you today. I am going to give you my statement in four parts. I am going to give you a little background of my company so it puts the healthcare issue in context for my size of business. I am going to give you our experience with cost and problems over the last 6 years in particular. I am going to give you a little bit of human impact from two of my employees' experiences. And then a couple of my thoughts about—as naive as I am—answers that I might be able to suggest to approach this problem.

For the past 9 years, Minnesota Mailing Solutions was a small, locally owned distributor of office automation equipment, particularly postage meters, folding inserting equipment, address printers and software, and letter openers. My testimony reflects these 9 years as a small business owner.

Minnesota Mailing Solutions has been in business for more than 20 years, and until last month, this business was always independently owned and operated. Last month, I did sell my business to Pitney–Bowes. Part of my decision, a big part of my decision, was making sure my employees could stay whole and be able to have affordable health care—something that I was no longer able to really provide for them.

We employ 17 people, and we have an annual payroll of around only $750,000 a year. The average age of our employee over the last 5 years ranges from 33 to 40 years old, so we are not an old population by any means. And all have been in good health. Dependent coverage is carried by 45 percent of my employee group, and the average cost to an employee to cover their dependent has been over $6,000 annually. Employees pay 100 percent of their dependent portion of the coverage, and they utilize the section 125 pre-tax premium option to help offset some of that cost.

As the employer, I have always paid 100 percent of my employees' coverage. On December 1, I sold my business to a major U.S. corporation, as I said, to keep the employees and offer them some relief. The average employee realized a savings of over $3,000 a year by going to a major employer and their coverage.

My experience over the last 6 years, we have had 18 to 24 percent premium increases annually. These premium totals are greater than 2½ times higher than they were 5 years ago and over

$50,000 a year annually. That is a full-time equivalent person for my company. I could have hired a marketing person at that rate. It is $50,000 less for me to reinvest in employee training, in capital equipment, in growing the business, or even in just profit. It really begs the question: Do I grow the business or do I remain status quo?

We have had no catastrophic events in our employee group to fuel increases, just normal life events: Three or four babies born over that period of time, one gall bladder surgery, maybe a broken limb here or there, prescription drugs. Nothing out of the ordinary of everyday life.

Every year we have increased deductibles; we have increased co-pays, we have increase out-of-pocket maximums, just to limit that increase of a 20-percent increase annually. Had we not done that, we would have had 30-, 40-, 50-percent increases in premium. Without these changes and reductions in services, we would have ended health care a long time ago. We had to do this just to remain stable and to keep our employees covered as best we could.

The average, fully insured plan for a small employer like mine utilizes about 95 percent of the premium dollars they pay in in health care coverage. Last year, our usage was only 79 percent of all the premiums we paid. I was expecting no increase this year. I got a 10-percent increase instead. I was not rewarded for having a healthy workforce. I was penalized for it. The reason I was given by my carrier for the increase in my premiums was that there were so many gastric bypass surgeries performed that it is now a mandated coverage in Minnesota; the cost had to come and be paid for somewhere. And so as a small business owner, I had to help cover that.

Additionally, a fully insured plan such as mine and a small employer, I am required to pay additional taxes to cover the uninsured—maybe this is just a Minnesota issue; I am not sure—to cover the uninsured in Minnesota, the underinsured, and the uninsurable. And those tax rates added another 10 percent of my premium, which only small business has to pay. Large employers are exempt from this if they are self-insured carriers. And so, again, the bulk of carrying the load falls on small business.

What happens with this kind of a situation is that small employers that go to associations and things as such—this is not in my testimony, but it is a thought that just occurred to me—is that we start to eliminate the pool of healthy employees and the pool of uninsured gets bigger and bigger.

Senator COLEMAN. Mr. Ludeman, before you go, there was one more question I was going to ask you.

Mr. CARLSON. Sure. No problem.

Senator COLEMAN. Mr. Ludeman has talked about data—cost and quality data. Do you think employers are going to utilize this data? As a small business person, do you even have the ability to tap into that?

Mr. CARLSON. Personally, I would. My employees are all connected. I have a server system within my network, and we are small enough that as a driver, because it is important to me, I would be able to do that. I cannot say that for other small businesses. I think that would be a challenge.

Senator COLEMAN. I would like Mr. Ludeman just to hear that. And, Mr. Kuba, I turn to you and probably would ask you the same thing with the Commissioner here. This data, would this be helpful to you? Give me a sense for the Commissioner because he is the guy that is putting the time and energy into this.

Mr. KUBA. You know, like Mr. Carlson, we can do it. You know, we are fully networked and everything. I would like to learn more about it. I cannot really say how helpful it would be based on what I know right now. But we could easily do it.

Senator COLEMAN. OK. I just wanted to take the opportunity with the Commissioner here to provide a little feedback. Commissioner, thank you very, very much.

Mr. Carlson, please finish at this point.

Mr. CARLSON. Sure. So small businesses, once again, like in property tax, seem to be the ones who have to carry the brunt of the load.

A couple of experiences I want to share with you regarding two of my employees. One employee has two family members who are diagnosed with a bipolar disorder. In addition to the $8,000 in premium he pays to cover his family on his $48,000-a-year salary, he is paying $300 to $400 additional per month—and this is what I know of; it may even be more than that—in prescription out-of-pocket expenses that are not covered or that require much higher co-pays.

I have another employee, he is married, he has three children on his plan. They are healthy, yet because of the dependent coverage, he pays $9,000 annually in premium on his $50,000 earnings. That is almost one-fifth of his pay.

Both of these employees are earning over $23 an hour, yet the strain on their family is tremendous. They are hard-working, stable, middle-class families. I cannot imagine the difficulty less fortunate workers might have.

While I wished I had the magic bullet or the right answer, from a small business perspective I fully support the idea of employee responsibility and for employee incentive to use their plan wisely, to share in the costs and to control expenses. I think that is a wise and prudent thing for all of us. However, I think employees are also responsible for making healthy lifestyle choices and practices and to minimize their risks. However, these costs must be realistic and affordable. Health care mandates for coverage are designated to protect individuals. I know they are necessary, but mandates should not have to be borne by only small business but, rather, by users of such services, all employees, and the entire public in general.

The system rewards practitioners for the number of services provided. I think that is backwards. Service providers that are cost-effective, efficient, and have higher results, they should be rewarded, and they should be rewarded by additional business. That is the same way it works in my business. The better I am, the more business I get. Until we change the model of performance and result, the spiraling costs will only continue. In my own business, we are not rewarded for how many calls we make to a customer but, rather, the fewer calls we made; and the higher satisfaction level

the customer has, the more reward we get. I think the same should be in our health care system.

I thank you for your time.

[The prepared statement of Mr. Carlson follows:]

MINNESOTA
Mailing Solutions

Mark A. Carlson
President

Thank you for letting me share my health care story as a small business owner. Here is some background on my business to help put the impacts of on going trends into context

Company Background:

- For the past nine years Minnesota Mailing Solutions was a small, locally owned distributor of office automation equipment, postage meters, folding inserting equipment, address printers and software as well as letter openers. My testimony reflects these past nine years as a small business owner
- Minnesota Mailing Solutions has been in business for more than 20 years. Until last month this business was always independently owned and operated.
- Minnesota Mailing Solutions employs and average of 17 people and has an annual payroll around $750,000 annually.
- The average age of our employee group over the last 5 years has ranged from 33 – 40 years old. We are not an old population by any means. All have been in good to excellent health.
- Dependent coverage is carried by 45% of the employee group. The average cost to an employee for the dependent coverage is over $6000 annually. Employees pay 100% of the dependent portion of their coverage and utilize a Section 125 pre-tax premium option.
- As the employer, I have always paid 100% of the employee's coverage
- On December 1st I sold my business to a major US corporation. Part of my reason for selling stems from the health care issue and an inability to keep up The large corporation brings some relief and longer term security for the employees

Experiences over the last six years:

- **18% - 24% premium increases annually.** Premiums totals are greater than 2.5 time higher than 5 years ago ... over $50,000 additional annually. That is a Full Time Equivalent (FTE) staff person. It's $50,000 less to reinvest in marketing, employee training, capital equipment, growing the business or profit. It begs the question . grow the business or maintain status quo, if you can.
- **No catastrophic events** have occurred to fuel this increase, just normal life events ...three or four babies (all normal deliveries), one gall bladder surgery, maybe a broken limb here or there, routine office visits and prescription drugs.
- Every year we have **increased deductibles, co-pays and out of pocket maximums** to limit the increases to the 20% averages. Without these changes and reductions in service the increases would have been significantly higher. While catastrophic coverage (out of pocket maximums, etc) remains pretty stable the cost to the employee and to the employer are becoming unmanageable and unsustainable.

- **The average fully insured plan utilizes about 95% of their premium dollars** annually, while our usage has been no different, this past year posed an interesting twist Our usage was less than 79% of premium dollars, yet our rates increased over 10% (our lowest in six years). One would have expected a decrease or a very minimal increase given our great year. The reason provided for the increase was that there are so many gastric by-pass surgeries performed/mandated now that they have to recover the cost somewhere. If the government mandates, why is it always at the expense of the small business owner?
- Additionally, **as a fully insured plan (as are most small businesses) we are required to pay 10% of their premium cost to cover uninsured and underinsured individuals** that fall under the care of the State. Large employers who self insure are not required to make this payment. So once again, small business is carrying the cost of this insurance for a welfare benefit available statewide. Why is this not everyone's responsibility to pay this. If the Federal government moves toward this universal care approach small business will be out of business. Like property tax this premium surcharge becomes taxation without representation for the small business. Many small businesses are not able to vote in the areas where their business is located and make them an easy target for politicians to dodge.

Examples of the Human impact for two employees:

- One employee has two family member diagnosed with bi-polar disorder. In addition to the $8000 premium he pays annually on his $48,000 a year earnings he is paying $300 - $400 a month in prescription out of pocket expenses that are not covered or require much higher co-pays.
- Another employee covers his wife and three children on the plan. They are healthy. yet he pays $9000 in annual premium for his coverage on his $50,000 earnings. One fifth his salary.
- Both of these employees are earning over $23/hr, yet the strain on their families is tremendous. These are hard working, stable middle class families. I can't imagine the difficulty for less fortunate workers.

No easy answers:

- I fully support the idea of employee responsibility and for employee incentive to use their plans wisely, to share in the costs and control expenses.
- Employees are responsible for making healthy life style choices and practices to minimize their risk and costs.
- However, these costs must be realistic and affordable. Health Care mandates for coverage are designed to protect the individual. Mandates should not have to be born by only small business (i.e. my example on gastric by-pass), but rather by those users of such services, all employers or the entire public in general
- The system of rewarding practitioners for the number of services provided is backwards. Service providers that are cost effective, efficient and have higher success rates should be rewarded. Until we change the model to performance and results, the spiraling cost will only continue. In my own business, we are not rewarded for how many calls they make to a customer, but rather the few calls made and the higher satisfaction level the customer has with our product or service. Health care should be no different.

Senator COLEMAN. Thank you very, very much, Mr. Carlson.
Mr. Kuba.

STATEMENT OF SANJAY KUBA, PRESIDENT, GCI SYSTEMS, SHOREVIEW, MINNESOTA

Mr. KUBA. Thank you. Well, I would like to say thank you to the Senate Small Business and Entrepreneurship Committee and Chairman Kerry for the work in tackling this very important issue. Also, thank you to Senator Norm Coleman and his staff for their work in putting this event together and for providing me the opportunity to testify.

GCI Systems is an information technology distributor and consulting and services company that started in 1988. We currently have 23 employees. We started as a one-person business and have grown nicely over the last 20 years. We began to offer health insurance to our employees in 1995. We have seen an increase in our health care expenses every year since 1995, with the exception of this year, 2008. Most of those years involved double-digit increases. Each year we spent a great deal of time going out to the market to price the three or four carriers that offer health insurance in the small business marketplace in Minnesota. That exercise has also included an analysis of co-pay amounts, hospitalization percentages, and maximum out-of- pocket amounts to get the most palatable blend of company premium increase versus benefit and related expense to the employee.

Since 1998, the company has had two employees who each has one child with a chronic medical condition. The annual medical expense of each of those children is substantial and sometimes approaches $100,000. This is completely beyond the company's and the employee's control. We do not have enough employees to adequately spread the risk to a carrier offering health insurance based on these two cases; therefore, everyone in the company must have either considerably higher out-of-pocket expenses or opt out of our program.

In 2005, we moved to an HSA. When we moved to an HSA, the increase in our health insurance premium and combined with the HSA contribution expense dropped to single digits. And in 2008, the company's total health care expense will drop based on our current employee count. However, we are in a sense passing an additional burden onto our employees as the out-of-pocket maximum has increased from $5,250 to $5,900 for family coverage.

Today, only 12 of our 23 employees participate in our plan. Ten of those 12 are covering only themselves as part of a single plan. The only two that are opting for the family plan are the two people mentioned earlier.

Based on the current employee count, the company will spend approximately $50,000 on premium and HSA contribution expenses. The 12 employees' combined out-of-pocket expenses will be between $28,000 and $52,000 this year. The two employees who have a child with a chronic condition will most likely have out-of-pocket costs of $12,000 and $15,500, respectively. And these are truly burdensome amounts.

We do offer a solid health plan as the company contributes $1,300 to $2,000 annually to each employee's health savings ac-

count, depending on which plan they participate in, single or family. However, I am hearing from other businesses, and many much larger than ours, that they make no contribution to their employees' HSAs.

How is this impacting our business? First, we spend a great deal of time analyzing the marketplace and our options in going out for bids each year. Second, the expense is burdensome for both the company and its employees, as described earlier. Third, it is a constant obstacle in attracting new, highly skilled, and qualified employees. In fact, we just lost another prospective employee last week because of extremely high family medical insurance costs. When you compare the amount of out-of-pocket expenses that our employees pay versus a company that is self-insured, we are paying sometimes twice as much or more for family coverage.

The marketplace is clearly broken. In particular, Minnesota has some extremely burdensome regulations. The requirement that carriers must be not-for-profit and must have minimum loss ratios makes this market very unattractive for competitors. I believe that only four companies participate in the small business market today.

The carriers that participate in the market are mandated to cover some 150-plus treatments and conditions. Only the companies participating in a small business marketplace contribute to Minnesota Comprehensive Health plan, or MCHA. That is unfair as it is a benefit to the entire market.

Insurance is supposed to be about spreading risk. How can there be any kind of competitive marketplace when 3M is treated as one group and 23-employee GCI Systems is treated as one group? There is no real risk spread in the small business marketplace. Association health plans are not allowed. Association health plans can be a great way to spread risk. And only health insurance premiums made as part of an employer-sponsored plan or flexible spending plan are tax deductible. Why is that?

What do I think should be done about this? Here are some of my recommendations:

Pass association health plan legislation, first.

Two, increase the small business health insurance eligibility size to 100 employees; 100 employees is really the minimum to self-insure. We were in that 50 to 100 size at one time and could only find one carrier that would write insurance for us at that time, and we could not self-insure.

Three, reduce the regulations tied to the market like minimum loss ratios and excessive mandates to allow more competition and provide more choice.

Find another funding source for MCHA.

Five, make personal health insurance premiums tax deductible like the premiums that employers pay. Get employers out of the health insurance business.

And, six, move quickly to drive electronic medical records to lower administrative costs, provide better service, and increase the transparency to the system.

Thank you again, Senator Coleman, for this opportunity to testify.

[The prepared statement of Mr. Kuba follows:]

GCI SYSTEMS
technology solutions

Written Testimony to the United States Senate Small Business Committee

January 10, 2008

From: Sanjay Kuba
Title: President
Company: GCI Systems
Location: 4575 Chatsworth Street North, Shoreview, MN 55126

Thank you to the Senate Small Business and Entrepreneurship Committee and Chairman Kerry for your work in tackling this very important issue. Also, thank you to Senator Norm Coleman and his staff for their work in putting this event together and for providing me the opportunity to testify.

GCI Systems is an information technology distributor and consulting and services company that started in 1988. We currently have 23 employees. We started as a one-person business and have grown nicely over the last 20 years. We began to offer health insurance to our employees in 1995. At that time, we employed approximately 17 people.

We have seen an increase in our health care expenses every year since 1995 with the exception of this year, 2008. Most of those years involved double-digit increases. Each year, we spend a great deal of time going out to the market to price the 3 or 4 carriers that offer health insurance to the small business marketplace in MN. That exercise has also included an analysis of co-pay amounts, hospitalization percentages, and maximum out-of-pocket amounts to get the most palatable blend of company premium increase vs. benefit and related expense to the employee.

In 2005, we moved to an HSA. When we moved to an HSA, the increase in our health insurance premium and HSA contribution expense dropped to single digits. And in 2008, the company's total healthcare expense will drop based on our current employee count. However, the employee contributions are continuing to increase.

Since 1998, the company has had two employees who each have one child with a chronic medical condition. The annual medical expense of each of those children is substantial and sometimes approaches $100,000. This is completely beyond the company's and the employee's control. We do not have enough employees to adequately spread the risk to a carrier offering health insurance based on these two cases. Therefore, everyone in the company must have either considerably higher out-of-pocket expenses or opt out of our program.

Today, only 12 of our 23 employees participate in our plan. Ten of those twelve are covering only themselves as part of the Single Plan. The only two that are opting for the Family Plan are the two mentioned above.

We moved to an HSA to try and stem our health insurance premium increases and allow our employees a greater deal of control for their medical coverage. That change did help as our increases dropped into the single digits. In fact, this year the company's premium and HSA contribution expense will drop by about 7.8% based on our current employee count. However, we are in a sense passing additional burden onto our employees as the out-of-pocket maximum increased from $5,250 to $5,900 for family coverage.

Based on the current employee count, the company will spend approximately $50,000 on premium and HSA contribution expenses. The 12 employees combined out-of-pocket expenses will be between $28,000 and $52,000. The two employees who have a child with a chronic condition will most likely have out-of-pocket costs of $12,000 and $15,500 respectively. Those are truly burdensome amounts.

I believe that our plan is a solid plan and the company contributes $1,300 to $2,000 annually to each employee's Heath Savings Account depending on which plan they participate in – single or family. I believe that the number of businesses offering health insurance is dropping and that in 2007 approximately 63% of businesses offered coverage compared to 67% the year before. I believe that HSA's are a step in the right direction, but I am hearing from other businesses and many much larger than our that they make no contribution to their employee's HSA.

How is this impacting our business? There are several impacts. First, we spend a great deal of time analyzing the marketplace and our options and going out for bids each year. Second, the expense is burdensome for both the company and its employees as described above. Third, it is a constant obstacle in attracting new, highly skilled and qualified employees. In fact, we just lost another prospective employee last week because of extremely high family medical insurance costs. When you compare the amount of out-of-pocket expense that our employees pay vs. a company that is self-insured, we are paying sometimes twice as much or more for family coverage.

In my opinion, the marketplace is clearly broken. In particular, Minnesota really has some burdensome regulation:

1. The rule that carriers must be not-for-profit and must have minimum loss ratios make this market very unattractive for competitors. I believe that only 4 companies participate in the small business market.
2. The carriers that participate in the small business marketplace are mandated to cover some 150+ treatments and conditions.
3. Only the companies participating in the small business marketplace contribute to Minnesota Comprehensive Health plan or MCHA. That is crazy as it is a benefit to the entire market.
4. Insurance is supposed to be about spreading risk. How can there be any kind of competitive marketplace when 3M is treated as one group and 23-employee GCI Systems is treated as one group. There is no risk spread in the small business marketplace.
5. The state does not allow association health plans so that small businesses can combine to form larger groups.

At the federal level only health care contributions made as part of an employer-sponsored plan are tax deductible. Why is that? In addition, what happens when a business grows to more than 50 full-time employees? Generally, companies below 100 employees cannot economically self-insure. What happens to those business with between 50 and 100 employees? Our company was in that group for a brief period and we could only find one carrier to offer us insurance based on our history.

What do I think should be done about this? Here are some of my recommendations:

1. Allow association health plans and force Minnesota to conform with federal law.
2. Increase the small business health insurance eligibility size to 100 employees.
3. Reduce the regulations tied to the market like minimum loss ratios and excessive mandates to allow more competition and provide more choice.
4. Find another funding source for MCHA.
5. Make personal health insurance premiums tax deductible like the premiums that employers pay. Either get employers out of the health insurance business or fix the current system.

Thank you again Mr. Chairman and Senator Coleman for this opportunity to testify. And thank you for your work in this very important area.

Senator COLEMAN. Thank you very much, Mr. Kuba.
Mr. Flohrs.

STATEMENT OF JASON FLOHRS, DIRECTOR OF GOVERNMENT AFFAIRS, TWINWEST CHAMBER OF COMMERCE, PLYMOUTH, MINNESOTA

Mr. FLOHRS. Good afternoon, Senator Coleman. Thank you for the opportunity to be here today. I am pleased to submit the following testimony for the record, and thank you for holding this hearing here in Minnesota.

My name is Jason Flohrs. I am director of Government Affairs for the TwinWest Chamber of Commerce. TwinWest Chamber is a regional business organization representing about 1,000 business members in the western suburbs of Minneapolis. Of those 1,000 members, 78 percent are small businesses with less than 50 employees; 95 percent have fewer than 100 employees.

Health care remains the number one issue facing the business community in Minnesota. In a scientifically valid sampling conducted last summer with businesses statewide, over half of the respondents cited "access to affordable health care" as the number one or two issue facing their business. This level of concern is rising rapidly. This year, 40 percent selected it as their top issue, up from only 33 percent a year before.

Affordability of health care dramatically outweighs other concerns related to business competitiveness, including workforce education, recruitment and retention of good employees, taxation, energy costs, and even foreign competition. In our own, non-scientific surveys, "Business Ballots," and questionnaires, health care is consistently at the top of the list among our member businesses' concerns. In addition, in company visits made through the Grow Minnesota program, which is a business retention and expansion program that we partner on with the Minnesota Chamber of Commerce and the Minnesota Department of Employment and Economic Development, we continually hear anecdotal evidence and horror stories, really, of the difficulties that small employers especially are having in providing health care to their employees.

Growth in health care costs per person that are paid for by private insurance is still 2 to 3 times higher than growth in per capita income or wages and over 5.5 times higher than inflation. Employers continue to be the major source of health insurance for Minnesotans, but these cost pressures are causing a decline. Double-digit premium increases are squeezing employers, and employer-sponsored insurance dropped from nearly 70 percent in 2001 to barely 60 percent in 2004, only 3 years.

TwinWest supports creating a functioning health care marketplace that will achieve better health outcomes and slow the rate of these cost increases. The business community hopes to achieve this through a combination of both legislative action and individual responsibility for purchasing decisions.

Our initiatives are guided by five principles intended to work toward a viable health care market:

First, create understandable and comparable standards for pricing and quality of services so consumers can make decisions based on value. As you have already heard, Minnesota is a leader in this

endeavor, but much more can and needs to be done. Business owners are committed to getting this information into the hands of their employees and helping them make value-based, cost-conscious decisions.

Second, we have to reward doctors and hospitals for value, not volume. Our health care system should pay based on results and outcomes, not just on the number of procedures performed. Again, efforts are underway in Minnesota that do attempt to address this, but without similar alignment of incentives within Medicare, no large-scale progress or nationwide progress will be made.

Third, reform health care insurance so purchasers have more stability and predictability. This is especially important for small businesses, as one or two major adverse health events within a small employee pool can radically impact premium costs. You have heard some of those stories already today.

Fourth, we need to increase the use of health information technology to improve quality of patient care.

And, fifth, reward health and promote wellness. In order to decrease the cost of health care, we must also prevent the need for those services.

Finally, I would like again to stress our belief that efforts need to be focused on actually lowering the cost of health care. Without first controlling these skyrocketing costs, there is no viable financing solution.

Thank you for the opportunity to be here today. As an advocate for small business owners, TwinWest looks to you to continue to protect our members' ability to be competitive and to create jobs by solving one of our biggest challenges. Fixing the Nation's health care system is no easy task, but I hope it is one you will carefully deliberate and constructively approach in this Congress.

Thank you.

[The prepared statement of Mr. Flohrs follows:]

Statement on
Affordable Healthcare: A Big Problem for Small Businesses
Hearing before the
THE SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP
on behalf of the
TWINWEST CHAMBER OF COMMERCE
by
Jason Flohrs
January 10, 2008

Good Afternoon. My name is Jason Flohrs, I am Director of Government Affairs for the TwinWest Chamber of Commerce. TwinWest is a regional business organization representing 1,000 member businesses in the Western suburbs of Minneapolis. Of those 1,000 members seventy-eight percent are small businesses with less than 50 employees; 95% have fewer than 100 employees. I am pleased to be able to submit the following testimony for the record and thank you for holding this hearing here in Minnesota.

Health care remains the #1 issue facing the business community in Minnesota. In a scientifically valid sampling conducted last summer with businesses statewide, over half of the respondents cited "access to affordable health care" as the #1 or 2 issue facing their business. The level of concern is rising rapidly. This year, 40% selected it as their top issue, up from 33% only a year before. Affordability of health care dramatically outweighs other concerns related to business competitiveness, including workforce education, energy costs, and foreign competition.

In our own, non-scientific surveys, "Business Ballots", and questionnaires, health care is consistently at the top of the list among business concerns. In addition, in company visits made through Grow Minnesota program, a business retention and expansion program on which we partner with the Minnesota Chamber of Commerce and the Minnesota Department of Employment and Economic Development, we continually hear horror stories of the difficulties that small employers especially are having in providing health care to their employees. One of our members, Mark Carlson, is also hear today to share his own story.

According to the Minnesota Department of Health, health insurance premiums rose by over 60% cumulatively from 1999 and 2005. Growth in health care costs per person that are paid for by private insurance is still two to three times higher than growth in per capita income and wages, and over 5.5 times higher than inflation. While employers continue to be the major source of health insurance for Minnesotans although these cost pressures are causing a decline. Double-digit premium increases are squeezing employers. Employer-sponsored insurance dropped from 68.4 percent in 2001 to 62.9 percent in 2004.

TwinWest supports creating a functioning health care marketplace that will achieve better health outcomes and slow the rate of cost increases. The business community hopes to achieve this through a combination of both legislative action and individual purchasing decisions.

Our initiatives are guided by five principles:

- Create understandable and comparable standards for pricing and quality of services so consumers can make decisions based on value.
- Reward doctors and hospitals for value, and not volume. Our health care system should pay based on results and outcomes, not just the number of procedures preformed.

- Reform health care insurance so purchasers have more stability and predictability. This is especially important for small businesses, as one or two major adverse health events within a small employee pool can radically impact premium costs.
- Increase use of health information technology to improve quality of patient care.
- Reward health and promote wellness. In order to decrease the cost of health care, we also must prevent the need for services.

Thank you for the opportunity to join you today. As an association of primarily small business owners, I look to you to continue to protect our members' ability to be competitive and to create jobs by solving one of our biggest challenges. Fixing our nation's health care system is no easy task, but I hope it is one you will carefully deliberate and constructively approach in this Congress.

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The TwinWest Chamber of Commerce is one of the largest chambers in the state of Minnesota. It is an active, 1,000-member chamber serving 10 communities in the western and northwestern suburbs of Minneapolis and the surrounding areas. The Chamber's members represent a variety of businesses and industries, ranging from nationally and internationally renowned corporations and industrially driven manufacturers, to home-based businesses and companies involved in the service and professional sectors.

Jason Flohrs is director of government affairs for the TwinWest Chamber of Commerce, located in the western and northwestern suburbs of Minneapolis. He also serves as the lobbyist for the Metropolitan Coalition of Chambers, which represents 25 metro area chambers of commerce with members in more than 60 metro area communities. His role at TwinWest includes lobbying city, county, state and federal government representatives on behalf of TwinWest's 1,000 member businesses, and managing a range of TwinWest programs such as the Legislative Breakfast series and *Inside Politics* program. He also provides staff support to the TwinWest Political Action Committee. Prior to this position, Flohrs was a legislative assistant and constituent services writer in the Minnesota House of Representatives. He has also served in the Peace Corps in Eastern Europe. Flohrs graduated from Gustavus Adolphus College in 2003 with a major in international economics.

Senator COLEMAN. Thank you, Mr. Flohrs.

Mr. Oemichen, am I pronouncing the name right?

Mr. OEMICHEN. Oemichen, Senator. But I found being in St. Paul, growing up here, it was an advantage to be Irish as opposed to German.

[Laughter.]

STATEMENT OF WILLIAM L. OEMICHEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MINNESOTA ASSOCIATION OF COOPERATIVES AND WISCONSIN FEDERATION OF COOPERATIVES, ST. PAUL, MINNESOTA

Mr. OEMICHEN. Thank you, Senator and Members of the Committee. We are very pleased to be here. I am Bill Oemichen, president and CEO of the Minnesota Association of Cooperatives and Wisconsin Federation of Cooperatives, and I am going to talk about what appears to be a pretty unique project of joining individuals together for purchasing health care as a group. But I want to just set the stage here for just a couple of seconds.

We are proud that Minnesota is the leading cooperative State in the Nation. We have over 1,000 cooperative businesses in the State. Our sister organization in Wisconsin is proud that Wisconsin is the second leading cooperative State in the Nation. Between the two States, 6.3 million residents have ownership interest in a cooperative, and it is more than half of the State's population in both States. And these numbers are all according to statistics developed by the U.S. Department of Agriculture, so Federal Government statistics. Here in the Twin Cities, three of the largest businesses operate as cooperatives, including Land O' Lakes, CHS or Cenex Harvest States, and HealthPartners HMO.

The health care challenge for agriculture is what I would really like to talk about today, and for us it is both a combination of price and access. There have been a number of surveys done of agriculture populations. One of the best that we have looked at was done by the University of Wisconsin-Madison, and they found that 41 percent of farm families in the Upper Midwest could not afford to insure every member of the farm. In addition, about 18 percent of farmers operate uninsured, and probably more importantly, for many of the farmers, even though they are considered to have insurance, what they have is a high-premium, high- deductible, what can really be only called a catastrophic health care plan. And, unfortunately, what we are finding in Wisconsin—and we think the same statistics are going to be verified in Minnesota—is that most farmers also do not have coverage as part of their health insurance plan for any farm-related injuries. So if they are injured milking the cow in the barn, that would not be covered.

The net result is health care is agriculture's number one problem. We know this from surveying farmers. One survey from 4 years ago of dairy farmers in the Upper Midwest showed that even though dairy prices were at record lows, the number one reason dairy farmers were exiting was the fact that they could not get affordable quality health care.

So this led to a challenge, or this leads to a challenge for agriculture in our State of Minnesota because to the extent farmers

cannot get health care, they are making decisions to leave, and much of the State's economy depends on agriculture.

So how did the cooperative community and agriculture community respond? We moved forward legislation in Minnesota and Wisconsin back in 2001, 2002, and 2003, to create purchasing alliances. In Wisconsin, they were specifically made cooperative purchasing alliances, and I am pleased to recognize State Senator Sheila Harsdorf, who is here today sitting in the audience. She was the principal author of the Wisconsin legislation. And Liz Quam, who is also here, was the originator of the idea here in the State of Minnesota, and she is a former Assistant Commissioner of Health. Forming cooperative purchasing alliances is a cooperative way. You can remember—not personally—but remember back to the years of rural electrification and rural telephone service. When there has been a need, people have banded together to try to deal with the problem.

So the whole idea was to leverage buying power amongst all these individuals because farmers typically buy their health insurance as self-employed individuals, and a statistic you might be interested in is farmers pay 3 times as much as salaried individuals for their health insurance. They pay twice as much, on average, as other self-employed individuals. And one of the principal reasons for that is farmers are typically seen as being in dangerous occupations. And if Commissioner Ludeman were still here, he probably could talk about that from a very personal perspective.

So we decided to work on forming a health care cooperative. We approached Congress and we are very appreciative to you, Senator, and your colleague Senator Herb Kohl from Wisconsin, and Representative David Obey for providing $4.4 million in Federal appropriations for an initial stop-loss fund for the Farmers' Health Cooperative. This has been used primarily as a risk fund to get insurers interested in providing insurance for the Farmers' Health Cooperative. And prior to getting that money, we had approached every insurer in the State of Minnesota, every insurer in the State of Wisconsin, and they said they were not interested. Once they saw there was actually some stop-loss fund dollars there, they understood that this is a serious project.

So we launched the Health Care Cooperative in Wisconsin on April 1, 2007, working on a very similar project here in the State of Minnesota, and as part of the co-op care legislation sponsored by Senator Harsdorf, there have actually been, in Wisconsin, a number of small employer health care cooperatives—one in Brown County, Wisconsin, for example, and forgive me for saying "home of the Green Bay Packers." But there are 120 small businesses in that cooperative and buying their health insurance together for over a year now, and they report that it is operating quite successfully.

As part of the health cooperative, we are providing much better benefits than what farmers typically receive. We are providing that 24-hour coverage, so if they are injured in their barn, they are covered for that. We are providing prescription drug coverage, which most farmers do not currently get. We are also providing—very importantly, we think—preventative health care for farmers, up to $500 per family member per year. It is probably well known in ag-

riculture that farmers are proud about the fact they have not seen their physician in 10 to 20 years. But as you can imagine, we need to encourage them to get in, and this has certainly helped to do that.

So we commend Congress for looking at health care reform, and especially you, Senator, and your interest in association health plans. We think that that certainly represents a viable model that can work very successfully across the country. We tend to be a little biased and express a little bit of preference for the cooperative model for obvious reasons, as the Federation and the Association of Cooperatives. But we like that model because it is a health care entity that is actually owned by the members who are buying their health care insurance from that entity, and so they really have a strong input on what their health care looks like.

When we developed the Farmers' Health Care of Wisconsin Cooperative, we surveyed over 4,000 farmers by telephone, brought several hundred farmers into focus groups, and said, "What would you like in your health care plan?" And the health care plan that was designed was based on what they wanted to see, and the board of the cooperative is totally made up of farmers. And we think that is something that gave a lot of confidence to the farmers who are members there.

Another thing, one of the issues that I think you will find in association health plans—this is not an argument against association health plans and perhaps we can suggest a way to deal with this—is if you have a small business member from New York and a small business member from Minnesota, typically health care costs are going to be higher in New York. We have found that in Minnesota you see similar things. Where I grew up out in western Minnesota, in the Benson area, health care costs are typically lower than in the Twin Cities. And what we did is we were able to price that health care in part based on the geographic location of where that member is, and we were allowed to do that under law. And so may I suggest that to you as part of the association health plan.

We also very much like the idea of multi-State plans. One of the desires, obviously, here in Minnesota is to have a health care cooperative like the one operating in Wisconsin and that has been very successful to date. And we have to go through—get separate State legislation in every State we go to, and we have to deal with the complex State insurance regulations in each State. And in saying that, I used to work for the State office of the Commissioner of Insurance, and I also served in Wisconsin as the chief consumer protection official for the State when Tommy Thompson was Governor. And so perhaps in some cases, I put those regulations into place, but they are very, very difficult for consumers and providers to understand. So allowing cross-border operations I think would help in efficiency.

A couple other requests we would make to Congress: ERISA currently preempts cooperatives from State insurance regulation for electric co-ops and telephone cooperatives. We would suggest the possibility of looking into expanding that preemption for other types of cooperatives as well, and this is not—and I tell you as a former consumer protection official this is not an effort to get around mandates. We actually fully comply voluntarily with all of

the mandates, but basically the idea is to give us the ability to build these efficient—more efficient, at least—health care entities across State borders.

Health savings accounts. One of the issues we have run into there in operating Health Care Cooperative is Federal law for HSAs does not allow for a family deductible, and for farm families this has been a problem. They are each looked at individually, and so they have to satisfy their individual deductibles. And for farmers, they would like to do that as a family, if possible.

Prescription drugs. We are glad we are able to finally provide that type of coverage to farm families, but they are certainly concerned about the cost of those prescription drugs. And I know Congress has been looking at ways to address that.

And just very quickly, I would like to echo or put an exclamation point on everything that Commissioner Ludeman said on transparency of claims. In our contract with Aetna, who is our health insurance company, we have negotiated transparency with them. So all of that health care data flows through to the cooperative, so the cooperative can make real pricing decisions and have a greater ability to negotiate with Aetna in future rate increases, or hopefully someday maybe even rate decreases. And that we thought was really, really important.

Senator COLEMAN. He is an optimist.

[Laughter.]

Mr. OEMICHEN. Yes, absolutely. So we appreciate the effort to be here, and I will point out that the Congressional Research Service is publishing a report on State health care innovations, and they have informed us that they are citing this as one of the principal State health care innovations for 2007.

Thank you again for the opportunity to testify.

[The prepared statement of Mr. Oemichen follows:]

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Written Statement of William L. Oemichen, President and CEO
Minnesota Association of Cooperatives/Wisconsin Federation of Cooperatives
Before the U.S. Senate Small Business and Entrepreneurship Committee
On Health Care Solutions for Small Businesses
January 10, 2008
St. Paul, Minnesota

Thank you for the opportunity to provide testimony in support of federal reforms that would help small employers, including farmers, gain access to affordable, quality health insurance coverage.

Together, the Minnesota Association of Cooperatives (MAC) and the Wisconsin Federation of Cooperatives (WFC) make up a two-state trade association representing farm supply, grain, electric, telecommunications, credit unions, health care, dairy, grocery, farm credit, and housing cooperatives in Minnesota and Wisconsin. I am proud to say that Minnesota is the number one cooperative state in the nation, and Wisconsin is number two. MAC and WFC represent more than 800 cooperative businesses in both states owned by an estimated 3.4 million Minnesotans and 2.9 million Wisconsinites. Several of the largest businesses in the Twin Cities operate as cooperatives, including Land O' Lakes, CHS, Inc. and HealthPartners HMO.

Not coincidentally, agriculture and related manufacturing jobs are the backbone of both the Minnesota and Wisconsin economies. Rural communities in Minnesota, where the majority of our cooperative businesses are located, depend on viability of agriculture to keep their economies strong. Sadly, the Upper Midwest is losing, at an alarming rate, the family farms that are so critical to our economies and such a huge part of our rich heritage. One of the biggest reasons families get out of farming today is the high cost of health insurance. We know this from a number of surveys conducted on farmers since the late 1990's by MAC, WFC, the Farm Credit System and the University of Wisconsin.

Those surveys revealed some startling facts. For one, farmers pay three times more than the average wage earner for health insurance coverage. This is because they are often considered high-risk by insurers and are forced to purchase insurance on the individual rather than group market where they can be denied coverage. Because of the costs and inaccessibility of health insurance coverage, 18 percent of Wisconsin's dairy producers, for example, choose to go without health insurance altogether, while 41 percent do not have health insurance for every member of their family. The vast majority of plans sold to farmers in both states are high deductible plans with no coverage for preventative care and no coverage for accidents that might occur as a result of working on the farm. This exclusion for injuries "otherwise covered by workers compensation" which most farmers do not carry is common in both *group* and *individual* health insurance policies.

In light of these facts, Minnesota and Wisconsin cooperative leaders knew they had to do something to improve the cost and quality of health insurance available to farmers. Both Minnesota and Wisconsin have long traditions of applying cooperative principles to problems facing their communities: In the 1930's, rural electric cooperatives brought electricity to areas of the country investor-owned utilities deemed unprofitable. Later, citizens were forming telephone cooperatives for the same reason. These businesses have not only survived, but thrive in today's marketplace because consumers recognize the value of the member-owned and governed business model.

We believe the member-owned cooperative model that puts consumers in charge of their own health decisions is the perfect fit for health care. With the support of our member cooperatives, MAC and WFC created a project we call *"Co-op Care"* to allow small employers, including farmers, to join together to purchase health insurance as a large group. We successfully sought passage of enabling legislation in both Wisconsin and Minnesota to provide a *Co-op Care* model, and have since worked to establish health care purchasing cooperatives in both states aimed at farmers and small businesses.

The Cooperative Approach

The MAC and WFC *Co-op Care* projects offer a private sector solution to the health insurance problems facing small employers. When compared to the large group market, small employers and especially farmers buying health insurance face greater challenges: stricter underwriting, fewer choices, lower quality benefits and little or no data upon which to base informed decisions. Bringing small employers together under the cooperative umbrella allows the cooperative, governed by a board of directors made up of members buying insurance, to negotiate directly with insurers or providers similar to a large employer. This in turn allows the cooperative to negotiate higher quality coverage, improve benefit choices, relax underwriting criteria if it so chooses and utilize cost and quality data to educate members about cost drivers and ensure that rate increases are in line with claims experience.

Our cooperative model is currently providing health insurance coverage to farmers and agribusinesses via the Farmers' Health Cooperative of Wisconsin which contracted with Aetna to begin providing coverage in April of 2007. The cooperative has successfully used the power of group purchasing to negotiate a low renewal rate increase (7.9 percent), provide first dollar coverage of preventative care up to the first $500 and ensure that farm-related accidents are covered by health insurance. We were able to accomplish all this without denying insurance to any farmers or agribusiness that meets our membership criteria.

The *Co-op Care* model is not just for farmers. It is also working for small employers in Brown County Wisconsin, where the local Chamber of Commerce took the initiative to start a co-op (Healthy Lifestyles Cooperative) for businesses in that area of Wisconsin. Several other Chambers of Commerce, and even the Wisconsin Medical Society (Physician's Health Cooperative), is following suit to develop health care purchasing cooperatives for their members. These are only two of a number of examples.

In Minnesota, we are taking a similar approach to help farmers leverage their large group purchasing power, but the law .n this state would allow a cooperative to self-fund through a Multiple Employer Welfare Arrangement (MEWA). If we are given state Commerce Department approval, we intend to create a *Co-op Care* demonstration project that would give farm families access to a guaranteed issue product with no exclusions for pre-existing health conditions. The proposed concept may serve as a model for other rural and urban cooperatives to provide access to group coverage for patron-members.

In October 2006, we filed the preliminary Minnesota *Co-op Care* application with the Minnesota Commerce Department. The Department has not identified a formal application form or process for creating a MEWA. Therefore, the review process has taken considerable time at a considerable expense. More expense will be required to complete the application process. However, because of the great importance of this issue, we are continuing to work hard to move this pilot project forward.

The *Co-op Care* project in both states has received $4.45 million in federal appropriations in fiscal years 2005 and 2006 through USDA Rural Development to support these projects. The money is to be used for start-up and to support a stop-loss fund that would help buy down unexpected high-cost claims should we suffer them during the first critical years of the co-op's existence. We would like to take this opportunity to once again thank members of the Minnesota and Wisconsin Congressional Delegations for their support of these projects. In particular, we recognize Senator Coleman, Senator Kohl and Representative Obey for their work on behalf of our two-state organization.

Our federal appropriation is important to the national health care debate because with our grant, we are creating a pool of actuarial data for agricultural producers that purportedly exists nowhere in the U.S. We also are filling a public policy need by creating a health insurance model well-suited for small businesses and self-employed individuals in virtually any industry, around the country.

Overall, the stop loss fund provided for with the federal appropriation will make the cooperatives more attractive to potential insurers and health care providers and offsets the perceived risk brought to the cooperative by farmers and other individuals who have not had health insurance during the past year, and are therefore considered to be high risk by insurers.

In both Minnesota and Wisconsin, insurance and reinsurance carriers have stated that a stop loss fund will be necessary before they will consider working with the agriculture-based membership in the health care co-op.

As part of a larger group, cooperative members would have the leverage to negotiate better quality coverage, improve health care delivery, stabilize insurance rates and provide access to care for those who are currently not covered by an insurance policy.

Association Health Plans

The MAC/WFC *Co-op Care* projects differ from Association Health Plans (AHP's). Our health purchasing cooperatives are not operated by either WFC or MAC, but are free standing co-ops owned and governed by their members. As cooperatives, we understandably have a preference for the cooperative model for two reasons: (1) there are no potential financial risks and legal liability to the organization involved in forming the co-op, and (2) very importantly, it gives the purchasers of health care a financial stake in the success of their cooperative.

There are other important differences that distinguish cooperatives from AHPs. Cooperatives are able to underwrite to ensure a balanced risk pool, but because they are owned and governed by their members, they have built in protections against discrimination. Cooperatives are also able to stabilize their purchasing pool through a "capitalization fund" (utilized in Wisconsin) which allows the cooperative to encourage members to stay in the pool for a period of time or risk losing the amount charged to members to join the cooperative. This is critically important to insurers who are looking for ways to encourage a stable pool. Finally, because cooperatives are motivated by service and are nonprofit entities, they are able to provide quality options and customized benefits to their members.

In our view, multi-state AHP's may have difficulty working well for healthcare consumers in Minnesota, because Minnesota members would likely subsidize members in other, more costly states. In general, the Midwest has lower health care charges and utilization rates by enrollees so costs associated with more expensive states like New York would be shifted to Minnesota consumers. Unfortunately, for this reason, we are concerned that AHPs would not necessarily bring more effective competition to the Minnesota healthcare marketplace.

Changes needed at federal level

1. ERISA Pre-emption for Cooperatives

Our first recommendation for changes needed in federal law to help small employers meet their workers' healthcare needs is an ERISA preemption for all cooperatives. A precedent for this proposed change already exists; electric and telephone co-ops have an ERISA preemption which allows them to provide a multi-state benefit plan to electric and telephone cooperative employees. All cooperatives should be allowed this same preemption under federal law.

This would solve two major problems that currently prevent health purchasing cooperatives from living up to their true potential. The first is that most states do not have within their statutes a model for a health care purchasing cooperative. In fact, Wisconsin is the only state that has approved enabling legislation specifically for health care purchasing cooperatives, while Minnesota's state laws differ significantly. In fact, Health Partners, one of the largest insurance companies in Minnesota, operates as a member-owned cooperative but is not officially registered as a cooperative because Minnesota law does not recognize cooperatives as a business model for insurance companies. Wisconsin counts among its licensed insurers two extremely successful, cooperatively-owned insurance companies, Group Health Cooperative of South Central Wisconsin and Group Health Cooperative of Eau Claire that effectively compete with for-profit companies to provide coverage to families.

The second problem an ERISA preemption would solve is our inability to create a multi-state health insurance purchasing cooperative for Wisconsin, Minnesota and possibly other states. The major differences in insurance regulations from state to state would make it almost impossible to administer a multi-state cooperative without a preemption.

We want to be very clear. We are not trying to avoid state insurance mandates with an ERISA preemption. As member-owned cooperatives, our members have the ultimate say in the types of coverages they want provided and would most likely choose a plan with comprehensive coverage over a plan stripped of all mandates. Indeed, the Farmers Health

Cooperative of Wisconsin is complying with all state mandates even though we believe we are not required to do so under Wisconsin law. An ERISA preemption would be sought only to allow us to form one co-op across state lines rather than having to form separate co-ops.

2. Health Savings Accounts

The Minnesota and Wisconsin Co-op Care projects both utilize insurance products eligible for Health Savings Account tax deductibility. Unfortunately, there are certain federal requirements for HSA-eligible plans that make it difficult for members to choose these options. For example, HSA-eligible plans do not allow for a family deductible under federal law similar to other insurance plans. Instead, if a husband and wife are insured, each has to satisfy their deductibles separately in order to qualify for additional coverage. This is difficult for our members to understand.

Also, federal rules require HSA deductibles to run from January 1 to December 31. Flexibility on these dates would make it easier for someone initially joining the cooperative later in the year to take advantage of HSAs.

3. Prescription Drugs

Group purchasing can only go so far in controlling health costs. We must address the underlying cost drivers for health care, and the cost of prescription medication is one large cost driver that the federal government, and only the federal government, has the ability to oversee. While cooperatives generally favor less government regulation, we do see a role for the federal government when it comes to regulating direct-to-consumer advertising, health provider-incentives handed out for writing certain prescriptions and the drug patent process. For example, drug manufacturers have now taken to combining medications such as high-blood pressure medicines with heart medications and in the process, getting a new patent for these drugs. This kind of manipulation of the patent system is taxing our health care system.

4. Cost and Quality Transparency

Federal initiatives to encourage transparency of cost and quality information in a usable format would greatly enhance cooperatives efforts to educate consumers about health care cost drivers. The Farmers' Health Cooperative of Wisconsin, by contract, has negotiated for claims information from AETNA that goes beyond what is typically disclosed. We did this to ensure the cooperative's members could negotiate future pricing with a better understanding of what are the major cost drivers.

I would be happy to take questions from the committee at this time. Thank you for the opportunity to discuss federal healthcare reform with you and I will submit my testimony for the record.

Senator COLEMAN. Thank you, Mr. Oemichen.

I do want to note the presence of Senator Harsdorf and thank her for her leadership on this issue. I think you are doing extraordinary things, and it is nice to be able to do it, to have a framework that allows you to operate. So to both Ms. Quam, who apparently had the idea, had the thoughts behind this originally, and then for the leadership of Senator Harsdorf, I certainly express my appreciation. Thank you.

Mr. McLaughlin.

STATEMENT OF PATRICK McLAUGHLIN, DIRECTOR OF MARKETING, EMPLOYERS ASSOCIATION, INC.

Mr. MCLAUGHLIN. I am Pat McLaughlin, director of marketing for the Employers Association, and I appreciate the opportunity to share some thoughts, Senator, with you and the Committee today.

We were established over 70 years ago to provide assistance to employers in the areas of employer/employee relations and management and leadership training and project assistance in basically the HR area. We serve over 1,500 members, of which over 70 percent have 300 or fewer employees. But that represents nearly a million employees that are members through their employer of Employers Association. And a key issue for our membership is affordable and competitive health care options. That is no secret to anybody. Too many of our members, though, are questioning the decision to continue to offer health care as an option. Over 80 percent of the people employed in Minnesota are employed by organizations having fewer than 200 employees.

Among the efforts in health care that we have spearheaded and begun, we successfully ran a health care purchasing pool from 1991 to 1996, which at its peak covered well over 20,000 lives. We spent 3 years, from 2001 to 2003, in due diligence to find a fiscally prudent option after the plan that we did have was forced away from the market based upon, among the limited options out there, none of the health insurers wanting to book the business.

We were looking for something that would allow small and midsized employers to come together under a self-funded plan to minimize health care cost fluctuations and bring more competition to the marketplace. A couple of our panel members today have already talked about one in particular. Mark, I think you said that by selling to Pitney-Bowes, your employees saved 3,000 bucks apiece for family coverage. It is not a level playing field, and the ability to pool some risk is about one of the main ways that we are going to get there.

The average size of employers that showed interest in our plans was about 150 employees, and about two-thirds of those were manufacturing entities. In 2004, we formulated a separate trust comprised of our members who would spearhead the development of a competitive health care option for fellow association members. At the same time, bills were co-authored in the Minnesota House of Representatives and Senate to change four components of the Multiple Employee Welfare Arrangement, MEWA, in State statute. Technical changes were approved which allowed us to move forward with an application to the Minnesota State Department of Commerce, and in December of 2004, conditional approval was

granted—only to be recinded in April of 2005. This application also had strong bipartisan support from State House and Senate lawmakers who realized the benefits of the association's approach for businesses in their areas.

In July of that year, our president, Tom Ebert, stated in part the following:

> The health care crisis to which we responded in the early 1990s persists today with little substantive change. The fundamental issues causing spiraling health care rates are still the same: the lack of full disclosure of health care costs and the absence of a true marketplace where consumers can shop for health care based on price and on quality.
>
> To solve the health care crisis, enlightened governmental leadership, rather than political rhetoric, is required. A way must be found to truly pool the risk of small employers and to level the playing field for all employers and employees in the health care market.

In 2004, the Minnesota Legislature recognized the need for health care marketplace reform to benefit small employers when it amended the MEWA regulations. EA spent considerable time and money in its MEWA application effort over the past 3 years.

Disappointingly, the Department of Commerce rescinded its initial conditional approval. The DOC's contention that MEWAs would fail in the future because they have failed in the past is frustrating. In light of new health care product choices and plan design and more sophisticated leadership, we believe that MEWAs could be successful in Minnesota, as they have been in other States.

We believe passage in the U.S. Congress of a law permitting national associations to form health care co-ops would be a health care marketplace reform that would benefit small employers.

But there is another hope, another way. If Governor Pawlenty sees the need for exploring the MEWA option and encourages the Minnesota Commissioner of Commerce to waive MEWA restrictions—powers which he has been given by the legislature—the Governor would help Minnesota's small and medium-sized employers in providing cost-efficient health care coverage to their employees.

Over the past 2 years, we have tried to form strategic relationships to offer our members an opportunity to get bids on an individual-employer, self-insured health plan design, and developed and delivered training around designing and implementing various wellness and employee engagement initiatives. The first employer self-insurance plan design for the small employer has been met with anticipated hesitancy based on fear of fluctuating health care costs and few competitive marketplace options from which to choose. We ourselves as an employer went self- insured 2 years ago for health and dental care for our employees. Thus far, we have had one bad experience year, but a more positive second year, keeping in mind that we only had one viable option from which to choose.

Secondly, we implemented a population health management program for our employees, incenting healthy behaviors and action plans. Many of our members have also either come to training at EA to learn about a variety of health program designs or, more importantly, have moved into action and created programs that are working for them. Some examples range from offering only healthy vending machine foods to free dental checkups to full-blown com-

prehensive wellness programs. Our small and mid-sized employers are doing things differently. They are encouraging and in some cases mandating participation but, most importantly, realizing savings on health care premiums and potentially preventing more serious health problems in their employee populations.

Despite our efforts, small employers to compete effectively for talent, they must offer high- quality—and we heard that earlier—affordable health care to their employees. One way to accomplish this at the Federal level is to pave the way for small employers to collectively pool their risk, whether it is in association health plans or some other competitive market option, such as Taft–Hartley trust plans or successful MEWAs in existence today.

So provide pooling cost and quality information accessibility, and people will do that. We have learned that people will go after the information if it is out there. They have done it for years. The unfortunate part is that still today people are much more adept at finding out information on what toaster they ought to buy than where they ought to go for important health care.

We should also encourage embracing new ideas, and I think the Government can have a role in actually trying them in sort of control group fashion, to keep them under control, not have them run out of sight in terms of large numbers of people becoming involved, but rather use control groups of smaller numbers of people and approach new ideas and give them a chance to work in a marketplace economy.

Thank you.

[Mr. McLaughlin testified on behalf of Susan Eskedahl, vice president, Employers Association, Inc. Ms. Eskedahl's statement appears in Appendix Material Submitted, page 50.]

Senator COLEMAN. Thank you, Mr. McLaughlin.

I have a series of questions, some may be for individuals, some may be for the panel. One of them, Mr. Carlson, is up front. I was struck by your comment about selling the business to Pitney-Bowes, to a large employer. I think you said there was about $3,000 in savings for employees. Help me understand why. What are the competitive disadvantages that you have as a small business versus what the larger business could offer?

Mr. CARLSON. Although I do not know the intricacies of their plan, as a large employer, they are able to contribute more toward that dependent coverage that I could not pay, but they also have a greater risk pool so their premium rates are lower, so they are able to contribute more, so their overall cost is less. Thus, it is less expensive for the employee.

Senator COLEMAN. One of the common denominators in all of this testimony is—by the way, there are a number of common denominators that I have heard, and I will kind of walk through a couple of them, just to make sure I clearly understand them, but increasing the pools—and I want to make sure I understand this. Mr. McLaughlin, you talked about the MEWAs, the Multiple Employee Welfare Arrangements. And then at the same time, you also talked about the possibility of AHPs, kind of the national pooling, where as I understand these Multiple Employee Welfare Arrangements that typically it is kind of State focused. And perhaps the question is to you, Mr. Oemichen, or to Mr. McLaughlin. Are these in con-

flict? You mentioned that there are some things that if you are going to do AHPs to look at multi-State, to look at the reality that there may be more efficient and lower-cost operations in one area than the other. Do you see them—can you envision where they can co-exist in the same health care marketplace, or are they entirely separate entities?

Mr. MCLAUGHLIN. My view may be slightly myopic because the majority of our membership lies within the State of Minnesota. I would rather see, and from a personal standpoint, think it would work better if there were a national multi-State arrangement which would provide this kind of access for people.

Could they exist at the same time and in the same place? Perhaps so. But you do get into situations all the time within the MEWA of employees for a company that are located all over the country, and there are some considerations within that.

So that is not a perfect answer, but it is as close as we have found to date, and the association health plan from our standpoint would probably be a better solution.

Senator COLEMAN. Mr. Oemichen, could you see them existing in the same place? One of the other concerns that comes up again and again is added choices drive down cost. Would it be possible that, in fact, existing in the same place would actually provide greater choice and drive down cost?

Mr. OEMICHEN. I believe so. I do not think there is any inconsistency. One of the things that we found out when we created the Farmers' Health Cooperative in Wisconsin is that we started to see resulting decreases in premiums and additions to plan offerings by competitors in the State. So competition from our perspective is something that is very good for the health care marketplace. And so we think whether it is an association health plan, whether it is a cooperative, whether it is a Multiple Employer Welfare Arrangement, MEWA, the more options that are out there, I think the better it is for the consumer.

The one issue is to make sure that they are dealing with the law of numbers. The greater number of people they have in them, the greater ability they are going to be able to negotiate for a better price. The large companies, as has already been said, have figured out how to do that, and because of that the health care providers—not to give too much of my resume, but I sit on a hospital board, and I see this happening. With the large employers—they can negotiate a much better rate with the hospital. Where does that cost get pushed? It gets pushed down to the small employers who have not been able to band together to negotiate for a better price.

So I think all these things can work together, and competition would be very good for the marketplace.

Senator COLEMAN. Speaking about competition, one of the concerns that is reflected—I think, Mr. Kuba, you talked about a very systematic kind of searching for the best plan, the best option among the carriers. But the reality is that there are—what? I think the first largest carriers in the State have 98 percent of the market. There are a limited number of carriers.

Would any of you gentlemen suggest anything we could do on the Federal level to inject more competition into the State small group markets? Is there anything—or do you feel that the level of com-

petition we have today is sufficient? And I think almost everyone here has dealt with that.

Mr. KUBA. I will take a crack at it. I do not think the level of competition is adequate, and if the four or five—we usually,I think, we get bids from usually four. They are very similar in price. There is not a whole lot of difference. I think the marketplace overall seems to be set up so that you do not get a lot of price variation between the major carriers.

I think it is a statewide issue, so from a Federal Government perspective, I do not know exactly what can be done. But, you know, the idea that these carriers have to be not-for-profit so they set up not-for-profit subsidiaries or things like that and then have to carry minimum loss ratios. I believe the percentage is 78 or 80 percent or something like that. They cannot make more than 20 percent a year, so if they do lose money, it takes a long time to make that up.

Now, any carrier entering this marketplace to compete with Blue Cross and the others is probably going to incur losses just entering the market like you would entering—any business entering any new market. But they do not have—with loss ratios and things like that, they just do not have the ability to make that up. In my opinion, it really prevents other carriers to get involved in the market.

And, you know, the way the market is set up, if we are paying to insure companies, they are paying to providers, what is their incentive to get more efficient, the insurance company? You asked about IT for the providers, and the small providers. I mean, there could be an incentive from an administrative standpoint because the amount of time, the amount of manual time that small providers spend in just getting the records created correctly and compliance and submitting to the payers and those kinds of things, they could really benefit from IT to lower those administrative costs. I think their problem is that the market is so uncertain and the cost pressure is so high that there is too much uncertainty.

But what is the incentive from a large insurance provider right now to lower their costs? I mean, we basically are—and if their costs go up, they just charge us more money.

Senator COLEMAN. Anybody else want to address that issue of what we could do at the Federal level, things that we could do at the Federal level to increase competition in the State small markets?

Mr. OEMICHEN. Senator, I would say association health plans is one of the steps in the right direction because you are going to allow an association on broader than a State boundary level to put together a health care plan and get an insurer, and they will have to meet perhaps some State regulations depending on how you write the Federal legislation. But we would love it right now, for example, if the Wisconsin Farmers' Health Cooperative could start offering health insurance to cooperative members in the State of Minnesota. In many cases, they belong to the same dairy co-op, the same farm supply co-op that already operates across State boundaries. But the health care co-ops cannot because of State regulations.

So it is taking us fairly considerable time to get State approval here in Minnesota to get a health care cooperative or health care

trust put in place. It would be a lot easier matter if we could have some type of reciprocity, or the ability to operate across State lines, and by doing so, going back to that word again, "competition." It would create competition, and we think just like in Wisconsin, it might help provide better benefits at a lower cost to Minnesota residents.

Senator COLEMAN. Mr. Oemichen, you made a point in talking about expansion of ERISA to explain that we are not looking to get around mandates. Let me talk about mandates. In fact, Mr. Flohrs' testimony really mirrored what Mr. Carlson said, talking about gastric bypasses, for instance. You had a great record, you were saving costs, and all of a sudden, you find yourself, Mr. Carlson, with an increase. In part, you indicated, I believe, it was a certain mandated coverage that is now impacting that.

I have been working with the Mayo Clinic. This is politically a difficult issue. In Minnesota, we have lots of mandates. I think there are over 60 mandates. And any time you talk about eliminating a mandate, a group will come forth and say, hey, that is not fair to us. On the other hand, you know, if you are 21 years old and carrying health insurance, you need to carry 61 mandates; what is that going to do to costs? And for employers, even if we would have AHPs, if you have to carry 61 mandates, affordability is still going to be an issue.

The question is how you deal with that in a non-political way. The Mayo Clinic has talked about setting up some sort of independent commission. I wonder if I could get a reaction as to, one, your reflection on the issue of mandates, and whether that is an idea that makes sense. Or do you have another idea of how we could deal with it? Anybody want to raise that? I know at least two panelists raised the issue.

Mr. CARLSON. I will address it just from my own naive perspective. I really feel for families who have these major issues that need attention, and they can be very expensive. And so it becomes an entire issue for the entire population to deal with. And again, the problem is that a majority of it is falling on small business.

But I think we need to—as Mr. Ludeman has said—let us get back to the practitioners who are providing these services. The health care industry is the only industry I know that gets rewarded for how many times you go see the doctor. They can fail miserably in their diagnosis, and I still have to pay them. If I fail in my delivery to my customer, they do not pay me. And so if we can get control on that, we can get control under the mandates, and it can become more affordable for everyone. The mandates may not be that big an issue. Who is the best provider? Who is the best healer in that area of mandates? Who is most effective at it? Let us reward them and encourage others to get better at it, and then I think we all win.

Senator COLEMAN. Mr. Flohrs, I would like your perspective.

Mr. FLOHRS. The Mayo idea that you brought up is actually a point that is included in our health care policy agenda for the coming year. I think it is an idea that does make sense as you are dealing, as you mentioned, in a political environment, and oftentimes with very charged emotional cases where individual families and individual people are suffering great losses and great challenges.

There needs to be a response to that, certainly. But looking at it from a statewide perspective or a nationwide perspective, the overall health of the system also has to be considered. That is why we have called for an independent third-party kind of review of that based on scientific evidence, based on economic evidence, what it will do to a health care marketplace, to insurance premiums in general, and bring that back to the legislature to allow them to use that in making those decisions.

Senator COLEMAN. I want to take advantage of the panel here. I know we are just starting to get back some of the data on health savings accounts that I have heard anecdotally, high-deductible health plans. Could I get some reaction from folks as to what your own experience has been and how worthwhile these offerings are? Mr. Carlson?

Mr. CARLSON. I have never offered that in my company. I seriously looked at it this year, and we do have that option now under our new employer. I am not aware of any of my employees taking advantage of that yet. It takes a lot of education and a lot of understanding of why that would work. I think they are a good idea. I am just new to this, so I really cannot add much. Sorry.

Senator COLEMAN. I appreciate that.

Mr. Kuba.

Mr. KUBA. We adopted it in 2005. It slowed the growth of our health care expenses. We went to a high-deductible plan. We have about 50 percent of our people participating. The reason why we went that way was to add some—for two reasons. One is to add some predictability. So if you know you are going to be in a situation where you are going to incur high medical expenses, at least you have got some predictability as to what that is. Number two is that with HSAs, employees can contribute to their own HSA; it is tax deductible; and it is a way to pay the out-of-pocket expenses in a tax deductible manner, as opposed to going with a cafeteria plan like a section 125, or—I mean, excuse me, a flexible spending plan like a section 125, and a section 125 plan is much more onerous and much more risky for an employer than an HSA, is what we have found.

Senator COLEMAN. One of the complaints about HSAs, one of the criticisms has been that they are not helpful to employers at certain socioeconomic levels. Can you respond to that at all? Is there an income level where somehow it is less effective or people are less interested? And then let me—I hate to do two questions at one time, but I want to kind of follow up on this HSA question. Mr. Carlson's comment about the level of sophistication or knowledge that one would need to make those choices, could you comment on that? And, Mr. Flohrs, I would love to hear the TwinWest Chamber's perspective on that also.

Mr. Kuba.

Mr. KUBA. The 12 people who are participating in our plan right now are at all income levels. They are across the board. There is not any income level. However, only two people are participating in the family option. Everybody else is just covering themselves, whether they are married, with children or not. And those two are the ones that have the children that have chronic medical conditions.

Senator COLEMAN. Mr. Flohrs, could you give your perspective on this issue?

Mr. FLOHRS. Yes. I do not know if I can speak to the different income disparities and who would select them or not. The HSA model or the health reimbursement account model is something that the chamber has supported, really because of a desire to bring the marketplace back into health care. And the current system as we have it, without that, it does not provide a direct incentive for an individual to shop around, to compare that cost and value, to be careful about how they utilize their health care dollars or how they spend their health care dollars. It really puts that control directly back in their hands and reconnects them to those purchasing decisions, which does lead to real savings. It is not just a different way to finance it.

Senator COLEMAN. Mr. Oemichen.

Mr. OEMICHEN. Senator, with our Farmers' Health Cooperative, about 40 percent of the members are utilizing a HSA. Of our six plans, two of them are HSA eligible. And you might be interested to know that, regardless of income, the typical farmer, if he is in a family plan, has a $5,000 deductible, and so that is much higher than the $1,000 threshold. So if they can put that money in a tax-advantaged way, they absolutely would want to do it, and they very much appreciate the existence of HSAs.

Can I make one comment on mandates, Senator?

Senator COLEMAN. Please.

Mr. OEMICHEN. I want to go back to your previous question, because I said we have been complying with mandates. I understand from the consumer protection perspective the idea of having mandates because of the philosophical feeling that when a consumer is negotiating with a large insurance company, there is unequal bargaining power. I just want to point out that in a cooperative that is a little bit different because the consumer is the owner of the cooperative and making that health insurance choice. So I am not sure that same paternalistic thought really applies in that situation. And so I think that that could be a compelling case to say that perhaps the State should back off somewhat on requiring mandates when it is the consumer who owns the health care entity.

Senator COLEMAN. Mr. McLaughlin.

Mr. MCLAUGHLIN. We have an HRA in our plan, and the reason is that—and I think this speaks to the income disparity a little bit, the HSA was—one of the requirements of the HSA had to do with prescription co-pays, that they had to be covered under the HSA at one particular point in time. And the lower-income people would use up an HSA very quickly because they were not able to put as much into the HSA, and so the tax advantage of saving for the future was not there for those people.

In our plan, we as an employer—when there is a balance at the end of the year—put half of it into next year's HRA so that over time, hopefully you can offset the out-of-pocket increases that we have incurred as individuals.

I think over time it will work, but in my experience, those people that are of somewhat lower income are always going to be struggling almost regardless of what the plan is.

Senator COLEMAN. Let me ask, just if I can, one or two other questions. I do want to end this in a few minutes just to stay within the time that we allowed. You talk about allowing small businesses—and I will ask you, Mr. McLaughlin, or others—to pull together, self-fund. Are there protections or requirements to assure sustainability? Mr. Oemichen, I would ask you in terms of other—in Minnesota, we kind of pride ourselves on, you know, "co-ops are us," and we have got a long history. But that in and of itself does not guarantee sustainability, and I wonder are there kind of basic protection requirements that need to be in place to ensure the sustainability of some of these small business pooling and self-funding proposals.

Mr. MCLAUGHLIN. Absolutely. That is absolutely necessary. There is a long history of that, of certain trust plans getting into financial trouble. So the funding requirement needs to be policed. It needs to be regulated. But that can still be done and in the long haul save the consumer some dollars.

Senator COLEMAN. Mr. Oemichen, do you want to add to that?

Mr. OEMICHEN. I was just going to add there is a long history of cooperatives operating successfully. HealthPartners HMO, as I mentioned, operates on a cooperative basis, and they have a million members and have operated for several decades. And there are a number of examples across both States. The one issue I get concerned about is that because there is a potential threat we should not do any of them. And we need to have more experimentation out there, and there are going to be some risks that some are going to fail, but there is also the chance that many of them, like HealthPartners, like other cooperatives that have been successful, are going to go forward and have a very long life and provide that competition that is necessary.

So this is maybe more of a philosophical response to your question, but I think that the proof is in the pudding. There are many examples where they have already been very successful.

Senator COLEMAN. Mr. Kuba, do you want to respond? I see a nodding of the head to indicate agreement with the previous comments.

Mr. KUBA. Yes. I do not have anything to add. I agree with all that.

Senator COLEMAN. Let me ask the last question, then. We have talked about the Tax Code allowing tax deductions for health care costs and some of the advantages. You know, Big Business has it. Just one open question to all the panelists. Tax policy can impact behavior and can make it easier to move into a certain arena, can provide greater opportunity. What additional tax policies can Congress enact to provide the most meaningful assistance to small businesses in the area of health care? Is there anything we did not discuss today? Are there other things we should actually go back to the Finance Committee and say it is strongly recommended that if you really want to do something meaningful, beyond what we have talked about, to help small business, this is it? Are there other things that should be put on the table, something that we have not discussed here today?

Mr. Flohrs.

Mr. FLOHRS. Senator Coleman, while I do not have any specific recommendations on Federal tax policy, I think that many of the things that can be done using that tax policy should be done in the way that puts decisions and puts the market back into the health care system, because we have talked a lot about different financing models this morning, different ways of grouping together, spreading risk. If something is not done about actually controlling just rising costs in the delivery of health care itself, all of those financing solutions are in the end unsustainable. The State has a large pool as it sponsors its uninsured, and yet those costs are still continuing to go up. So until we address the costs, many of the financing solutions need that cost piece to go along with it.

Senator COLEMAN. I have indicated before that I am going to keep the record open for 2 weeks. I lay that question out to the panelists, and within 2 weeks, if individually or any of the associations with which you work have some advice or counsel that you would so offer, I would love to hear from you on that very specific question.

Mr. Flohrs, your comment, that is perhaps a good comment to draw this to a close, but realize that we have got to deal with the cost of health care, and as that continues to rise, it makes it more and more difficult for small businesses, for the average individual to have the coverage that they need, regardless of what the pooling arrangements are and regardless of what the cooperative arrangements cost, is an issue that clearly has to be dealt with.

What I heard today, if there are themes, reward value not volume, again and again and again, quality, transparency, competition. So as I go back, those concepts will certainly be ringing in my ears and I will look for specific ways in which to do that.

I want to thank all the panelists for your participation. This has been very, very helpful. As I said, I will keep the record open for 2 weeks, and with that, this hearing is now adjourned.

[Whereupon, at 3:48 p.m., the Committee was adjourned.]

APPENDIX MATERIAL SUBMITTED

Health Care Issues for Small Employers

Susan Eskedahl
Vice President
Employers Association Inc.

- Employers Association Inc.
  Established over 70 years ago to provide assistance to employers in the areas of Employee/ Employer relations, Management/Leadership training and project assistance in human resources. Employers Association serves over 1500 member employers of which 73.5% have fewer than 300 employees.
- Key issue: affordable and competitive health care options for small to mid-sized employers. We handle over 6000 research calls per year as a part of the benefits of membership. One of the most recurring issues presented to our research specialists regards health care. Too many of our members are asking tough questions regarding the decision to give a raise or pass along more of the costs of offering their employees health care. Some are questioning the decision to continue to offer health care as an option. Over 80% of the people employed in Minnesota are employed by organizations having less than 200 employees. Their ability to compete with the large employers for employee talent in the state on the basis of wages and health care is being challenged. The Kaiser Family Foundation, Employer Health Benefits survey 2005 cited: "the cumulative result is a statistically significant decline in the percentage of firms offering health benefits, from 69% in 2000 to 60% in 2005. The drop is driven largely by a significant decline in the percentage of small firms (3-199 workers) offering coverage."
- Employers Association's efforts in Health Care:
  - We successfully ran a Health Care purchasing pool, 1991 to 1996, which at its peak covered 20,000 lives
  - Spent three years, 2001 to 2003, in due diligence to find a fiscally prudent option, which would:
    1. Allow small and mid sized employers to come together under a self-funded plan design to minimize health care cost fluctuations and bring more competition to the marketplace

2. Provide a comprehensive plan design using the high deductible concept and making use of Health Reimbursement Accounts (HRA's)
3. Continue working to eventually make information on cost and quality readily accessible to consumers so that they can make informed decisions
4. Engage the services of a reputable third party administrator and reinsurer who have longstanding business relationships in the community

- In our reintroduction to finding a solution, we held an informational meeting where close to 400 of our members came to hear about our new plan design, and close to 200 members wrote letters of support to the Governor of Minnesota for this initiative and gave a small but important monetary contribution to help with the legal costs of filing the plan.
    - Average size of those employers who showed interest was 153 employees representing a collective 27,000 total employee lives and 67% represented manufacturing organizations

- In January 2004 Employers Association formulated a separate Trust comprised of members who would spearhead the development of a competitive health care option for fellow association members. At the same time, bills were co-authored in the Minnesota House of Representatives and Senate to change four components of the Multiple Employer Welfare Arrangement (hereafter MEWA) in state statute. Technical changes were approved which allowed us to move forward with an application to the Minnesota State Department of Commerce. In December of 2004, a conditional approval was granted only to be denied in April of that year. This application also had strong bipartisan support from State House and Senate lawmakers who realized the benefits of the Associations approach for business in their areas. In July of that year Thomas A. Ebert, President and CEO of Employers Association Inc. when interviewed gave the following statement:

Reflections on Health Care Crisis: Thomas Ebert

"It all began with a question I posed to our EA management team fourteen years ago," said EA president Tom Ebert. "Could the Employers Association play a role in helping our small- and medium-sized members provide health care coverage to their employees?"

Ebert explained that at that time the spiraling cost of health care was the number one business issue confronting employers in Minnesota and everywhere else in the country. But the burden of

health care fell more heavily on the small employer who paid additional state taxes, was individually rated, and couldn't self-insure to spread risk among a larger number of employees, as large employers could. About eighty percent of workers in Minnesota and throughout the nation were then and are now employed by small and mid-sized companies.

In 1991 EA formed a health care purchasing pool (the EA Buyers' Coalition), one of the first such groups in the nation that eventually was made up of approximately 275 EA member-companies. "It was a success," Ebert said. "The EA Buyers' Coalition stabilized health rates for these employers and gave them a voice in the health care marketplace. "

In 1997 the Faulkner & Gray publishing firm identified Ebert as one of the Most Influential Managed Care Leaders in the United States. "As head of Employers Association, Inc., Ebert led an effort by Minnesota's small businesses to combine their purchasing power to obtain more affordable and higher quality health care."

"The health care crisis to which we responded in the early 1990s persists today with little substantive change," Ebert said. "The fundamental issues causing spiraling health rates are still the same: the lack of full disclosure of health care costs and the absence of a true marketplace where consumers can shop for health care based on price and quality."

The forces which Ebert points to as preventing needed health care marketplace reforms are: 1.) large bureaucratic HMOs; 2.) proponents of big government who favor a single-payer health care system run by the federal government; and 3.) the passive stance of many of the huge self-insured companies that are protected from the cost problems confronting smaller employers.

"To solve the health care crisis, enlightened governmental leadership, rather than political rhetoric", is required, Ebert contends. "A way must be found to truly pool the risk of small employers and to level the playing field for all employers and employees in the health care market," he emphasized.

In 2004 the Minnesota Legislature recognized the need for health care marketplace reform to benefit small employers when it amended MEWA (Multiple Employer Welfare Arrangement) regulations. EA spent considerable time and money in its MEWA application effort over the past three years.

Disappointingly, the Minnesota Department of Commerce (DOC) rescinded its initial conditional approval of the EA's MEWA application. Ebert indicated that the DOC's contention that MEWAs would fail in the future because they've failed in the past is frustrating. In light of new health care product choices and plan design and more sophisticated leadership, Ebert believes MEWAs could be successful in Minnesota, as they have been in other states.

Ebert believes passage in the U.S. Congress of a law permitting national associations to form health care coops would be a health care marketplace reform that would benefit small employers. While such a bill has been approved in the House of Representatives, it has long been tied up in the Senate.

"But there is another hope, another way," Ebert noted. "If Governor Pawlenty sees the need for exploring the MEWA option and encourages the Minnesota Commissioner of Commerce to

waive MEWA restrictions – powers which he has been given by the State Legislature – the Governor would help Minnesota's small- and medium-sized employers in providing cost-efficient health care coverage to their employees."

Ebert stressed that the EA's fourteen-year effort to bring some equity to the health care marketplace for smaller employers will continue. "For the last several years, many of our member-companies have generously supported the work necessary to secure regulatory changes allowing for the formation of a purchasing pool," he said. "We are deeply grateful to these members and to Representatives Fran Bradley and Thomas Huntley in the Minnesota House of Representatives, Senator Sheila Kiscaden in the Minnesota Senate, and other legislators for their considerable assistance in resolving the health care crisis."

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Currently, Employers Association focuses its health care energies in several areas including: participation on the Smart Buy Alliance of Health Care purchasers which is a group of large and small employer based groups including the State of Minnesota. The major reasons for coming together some 5 years ago are echoed in the current Four Cornerstones of Value-driven Health Care: 1. Increase transparency in Pricing, 2. Increase Transparency in Quality, 3. Encourage Adoption of Health Information Technology Standards and 4. Provide options that promote quality and efficiency in health care. This forum allows large and small employers to collectively work on initiatives to aid employers (purchasers) and their employees (consumers) driving positive changes in systems and having tools to navigate the health care system more effectively.

Specific Employers Association efforts for our members have revolved around moving dialogue into action and recognizing efforts of employers who are creating new programs and doing things differently. Over the last two years we have worked to form strategic relationships to offer our members an opportunity to get bids on an Individual Employer self-insured health plan design and developed and delivered training around designing and implementing various wellness and employee engagement health initiatives. The first Individual Employer self-insured plan design for the small employer has been met with anticipated hesitancy, based on fear of fluctuating health care costs and few competitive market options from which to choose. Employers Association went self-insured two years ago for health and dental care for our employees. Thus far, we have had one bad experience year, but a more positive second year; keeping in mind that we only had one viable option from which to choose. Secondly, we implemented a population health management program for our employees, incenting healthy behaviors and action plans. Many of our members have also either come to training at EA to

learn about a variety of health program designs or more importantly have moved into action and created programs that are working for them. Some examples, range from offering only healthy vending machine foods to free dental check ups to full blown comprehensive wellness programs – our small and mid-sized employers are doing things differently. They are encouraging and in some cases mandating participation but most importantly realizing savings on health premiums and potentially preventing more serious health problems in their employee populations.

One final initiative that I would like to comment on personally is that as a manager, an advocate, a consumer and a patient, there is the need be a role model and to say what you do and follow it up by doing what you say. I complete and share my wellness program each year with employees and I have been talking about and demonstrating consumer engagement. Five years ago I had a preventative colonoscopy due to family history. My purchasing decision was based on convenience and free parking, however in comparing my EOB (Explanation of Benefits) with a coworker who went to an inpatient facility, we saw that her bill was $500 more at that facility. Last Friday I had my second colonoscopy, as I am now at the recommended age 50. However, this year I took the time to investigate and compare. I chose a provider whose specialty center does 30,000 procedures a year, are involved in quality studies, were $75 dollars cheaper than the provider down the street that I used 5 years ago, and electronic results sent to my primary provider – my value equation has changed to quality, cost, access and convenience. In speaking with the doctor who performed the service, John Allen, MD, MBA, AGAF, FACG, Chief Medical Director, Minnesota Gasteroenterology, P.A. he indicated that by his free standing centers performing 30,000 procedures a year - an average savings of $776 per procedure or up to $23 million dollars could be saved by purchasers/employers and their employees/consumers than if they had been done in more expensive inpatient facilities. We - purchasers/employers and consumers/employees need the Four Cornerstones of Value-driven Health Care to become reality. Also, for small employers to compete effectively for talent, they need to be able to offer high quality affordable health care to their employees without worrying about forgoing initiatives and purchases to build their business and therefore the economy. One way to accomplish this is to federally pave the wave for small employers to collectively pool their risk whether it is in Association Health Plans or some other competitive market option, such as the Taft Hartley Trust Plans or successful MEWA's in existence today.

COMMENTS FOR THE RECORD

Testimony on health care cost challenges for small businesses

Darlene M. Miller President / CEO Permac Industries

Affordability remains the number one challenge with health care for Permac Industries. With a smaller group, a high claim in a plan year can lead to a significant increase in premiums upon renewal. Small businesses many times need to bring their group to the marketplace to shop for competitive rates each year, which is a very time consuming, labor intensive and expensive process. In order to hold premium costs to an affordable level, the trend in plan designs from insurance companies is increasing deductibles, and eliminating flat co-payments, pushing the consumer, our employees, into making a more informed market driven decision about their health care treatments. The challenge occurs in the transparency of pricing to make sure an employee can make an informed decision before electing treatment from a facility or doctor. Many facilities and doctor offices are unable to give a close estimate to what the actual cost will be. Many times the estimate will be a range too broad, providing no substance to base the decision on. A healthcare market place with simple menus of published set pricing for routine procedures, visits, and tests and treatments would improve the consumer's ability to make that informed decision when treatments are not emergency related.

PERMAC HISTORY

Permac Industries was founded in 1965 as a Brown & Sharp screw machine job shop located in Bloomington, MN housed in a leased space of 5,000 square feet. Ownership changed hands in 1979 and 4,500 more square feet were leased to accommodate CNC turning equipment. The late '80's brought in CNC milling and secondary equipment. In 1994 ownership changed to the current owner, Darlene Miller, to become a 100% woman owned small business. Growth continued in 1995 with the addition of an Acme Gridley 6 spindle screw machine. In October of 1998, Permac Industries relocated to its current headquarters in Burnsville, MN with 17,000 square feet of air conditioned space and enough land to double in size. New equipment such as CNC lathes with live tooling and sub-spindles, 8 axis twin spindle/twin turret turning centers and additional acmes have been added. Permac Industries continues in it's growth today and strives to stay on the cutting edge of technology with its equipment and processes. In 2007, Permac constructed an addition bringing total facility square feet to approximately 34,000 square feet. Permac continues to grow adding new equipment, capacity, employees and customers.

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