

ACCESS TO HEALTH CARE IN RURAL AMERICA

HEARING
BEFORE THE
SUBCOMMITTEE ON RURAL
ENTERPRISES, AGRICULTURE, AND TECHNOLOGY
OF THE
COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTH CONGRESS
SECOND SESSION
WASHINGTON, DC

MARCH 19, 2002

Serial No. 107-48



Printed for the use of the Committee on Small Business

U.S. GOVERNMENT PRINTING OFFICE

79-326

WASHINGTON : 2002

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

COMMITTEE ON SMALL BUSINESS

DONALD MANZULLO, Illinois, *Chairman*

LARRY COMBEST, Texas	NYDIA M. VELAZQUEZ, New York
JOEL HEFLEY, Colorado	JUANITA MILLENDER-McDONALD,
ROSCOE G. BARTLETT, Maryland	California
FRANK A. LoBIONDO, New Jersey	DANNY K. DAVIS, Illinois
SUE W. KELLY, New York	BILL PASCRELL, JR., New Jersey
STEVE CHABOT, Ohio	DONNA M. CHRISTENSEN, Virgin Islands
PATRICK J. TOOMEY, Pennsylvania	ROBERT A. BRADY, Pennsylvania
JIM DEMINT, South Carolina	TOM UDALL, New Mexico
JOHN R. THUNE, South Dakota	STEPHANIE TUBBS JONES, Ohio
MICHAEL PENCE, Indiana	CHARLES A. GONZALEZ, Texas
MIKE FERGUSON, New Jersey	DAVID D. PHELPS, Illinois
DARRELL E. ISSA, California	GRACE F. NAPOLITANO, California
SAM GRAVES, Missouri	BRIAN BAIRD, Washington
EDWARD L. SCHROCK, Virginia	MARK UDALL, Colorado
FELIX J. GRUCCI, JR., New York	JAMES R. LANGEVIN, Rhode Island
TODD W. AKIN, Missouri	MIKE ROSS, Arkansas
SHELLEY MOORE CAPITO, West Virginia	BRAD CARSON, Oklahoma
BILL SHUSTER, Pennsylvania	ANIBAL ACEVEDO-VILA, Puerto Rico

DOUG THOMAS, *Staff Director*

PHIL ESKELAND, *Deputy Staff Director*

MICHAEL DAY, *Minority Staff Director*

SUBCOMMITTEE ON RURAL ENTERPRISES, AGRICULTURE, AND TECHNOLOGY

JOHN THUNE, South Dakota, *Chairman*

ROSCOE BARTLETT, Maryland	TOM UDALL, New Mexico
FELIX GRUCCI, New York	DONNA M. CHRISTENSEN, Virgin Islands
MIKE PENCE, Indiana	DAVID D. PHELPS, Illinois
BILL SHUSTER, Pennsylvania	BRAD CARSON, Oklahoma

BRAD CLOSE, *Professional Staff*

CONTENTS

Hearing held on March 19, 2002	Page 1
WITNESSES	
Hatch, Ron, Owner, Hatch Furniture	3
DeVany, Mary, Avera McKennan TeleHealth Network	5
Nelson, Wayne, President, Communicating for Agriculture	7
Hill, Edward, Chair-Elect, Board of Trustees, American Medical Association ..	9
APPENDIX	
Opening statements:	
Thune, Hon. John	19
Prepared statements:	
Hatch, Ron	19
DeVany, Mary	21
Nelson, Wayne	26
Hill, Edward	28

ACCESS TO HEALTH CARE IN RURAL AMERICA

TUESDAY, MARCH 19, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON RURAL ENTERPRISES,
AGRICULTURE, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:20 p.m., in room 2360, Rayburn House Office Building, Hon. John R. Thune [chairman of the Subcommittee] presiding.

Present: Representatives Thune and Udall.

Chairman THUNE. This hearing will come to order.

Good afternoon. I want to welcome you to the hearing of the Subcommittee on Rural Enterprises, Agriculture and Technology. I want to thank particularly all the witnesses who have traveled over long distances to be here with us today.

Today we are going to be examining the issue of health care in rural America. Obtaining access to adequate and affordable health care is a problem for small business owners throughout the country, but it can be particularly difficult in rural areas. As Congress continues to address the health care problems our country faces, we must not lose sight of the 43 million uninsured Americans. This is a real crisis. Many people don't realize that over 60 percent of our uninsured population consists of small business owners, workers and family members. By addressing the access problems faced by millions of workers, Congress can greatly reduce the number of uninsured.

One of the reasons small businesses cannot afford health coverage for their employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions. For example, on average, a worker in a firm with less than 150 employees pays 18 percent more for health insurance than a worker in a firm with 200 or more employees. In addition, self-employed individuals can only deduct 70 percent of their health insurance premiums from their taxes, while their corporate counterparts can deduct 100 percent of the cost of health insurance premiums for their employees. Small businesses suffer from unequal treatment. What they want most is a level playing field when it comes to health care.

Large corporations use the purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other hand, have to find their insurance on an individual basis; and in rural areas insurers have been leaving the small group insurance market, making it difficult to find affordable health coverage.

I was very heartened to see President Bush today issue his plan for helping small business prosper in our economy. The President is aware of the health care access and affordability problems facing small businesses, and his plan includes concrete steps to increase health security for employees of small businesses. His agenda calls for Association Health Plans to be available for associations that want to provide them for their members, and it calls for a permanent extension of Medical Savings Accounts, including a significant reduction in the required deductible for these health accounts.

Congress needs to ensure there are many different health insurance options for small business owners to utilize. We need to help our businesses attract and keep employees, and nothing helps more than the ability to provide health insurance. For rural States, the ability of small business owners to obtain and provide affordable health insurance for their employees is vital to our efforts to attract new jobs and prevent population loss.

I look forward to hearing testimony from our witnesses today, and I want to thank you all for participating in this hearing.

I would now yield to the gentleman from New Mexico, Mr. Udall, for an opening statement.

Mr. UDALL. Thank you, Chairman Thune. I appreciate all of you being here today on this hearing regarding access to health care in rural areas.

In the past 100 years, medicine has advanced dramatically. We have experienced the eradication of life-threatening diseases, treatment of once debilitating ailments and improvement of our quality of life. Today we are living longer, healthier and more productive lives.

Just one of our recent technological advancements is telemedicine. Through telemedicine physicians can diagnose and treat patients with hundreds of miles distance between the physician and the patient. It is encouraging, it is exciting and exhilarating to live in a time of such innovation. However, despite these advancements, the rural areas of America have managed to advance incrementally, slow, if at all.

Rural America faces two major barriers: access to health care and access to health insurance. Many of the constituents I represent in New Mexico and the Chairman I know represents in South Dakota live in rural areas. They experience firsthand the difficulties of living without health care due to limited rural health care centers or lack of health insurance. In most cases, the only time they receive medical attention is in emergency situations. The lack of and limited services provided in rural areas have resulted in an increased incident rate of preventable chronic illnesses.

The recruitment and retention of high-quality physicians is challenging. Medicare reimbursement rates in rural areas are not sufficient. What types of incentives are available for physicians who choose to practice in rural communities? Compared with their urban colleagues, rural physicians work longer hours and are paid less.

Rural health care clinics are pivotal. Clinics with a solid public health infrastructure provide high-quality, culturally sensitive and cost-effective services. Nearly 40,000 Americans are without health insurance, with 20 percent of them living in rural areas. Half of

those—that must be 40 million, excuse me—40 million are living without health insurance, with 20 percent of them living in rural areas. Half of those without health insurance are hard-working individuals with full-time jobs.

Large businesses and labor unions have the benefit of exercising their purchasing power to negotiate with health insurance companies for better rates and terms. The rising cost of health insurance premiums has made it difficult for small businesses to purchase health insurance for their employees, even though this is the best investment an employer can make in their employees. It is disheartening to know that, as premiums increase, employers are left with two choices—reduce the number of employees with health insurance or keep all employees and eliminate their health insurance benefits.

Making health insurance available to small business employees is a challenge, but it is feasible. Association Health Plans, managed care organizations, tax credits and deductions and Medical Savings Accounts propose to solve these problems.

Small businesses must pool resources and work collaboratively to provide their employees and their families with much-needed and much-deserved health insurance benefits. Furthermore, successful rural health centers should not be curtailed or punished for providing health services available to hard-working, vulnerable and isolated communities. Instead, they should be commended for their altruistic efforts.

Again, thank you, Mr. Chairman; and I look forward to hearing the testimony from today's panel.

Chairman THUNE. Thank you.

Before we begin receiving testimony from the witnesses, I want to remind each of the witnesses to keep their oral testimony to 5 minutes. In front of you on the table is a box, and that box will light up yellow when have you 1 minute remaining. When 5 minutes expires, the red light will appear.

There is no trap-door that drops or anything, but once the red light is on we would ask that you, if you could, begin wrapping up your testimony as soon as you are comfortable.

We want to begin the Subcommittee hearing with Mr. Ron Hatch, owner of Hatch Furniture Stores. Mr. Hatch has stores located in Yankton, South Dakota, and in Sioux City, Iowa. So please proceed, Ron.

**STATEMENT OF RON HATCH, OWNER, HATCH FURNITURE,
YANKTON, SOUTH DAKOTA**

Mr. HATCH. Thank you, Mr. Chairman.

On behalf of NFIB, which I am a proud member of, and our 600,000 other members I thank you for the opportunity to come and talk to your Committee.

I am Ron Hatch, fourth generation. My great-grandfather started our business in Wakonda, South Dakota, in 1903. My son is presently in the business, and he is fifth generation.

I entered the business in 1974. At that time, we had a health care program which my mother and father had started for our employees. As far as a group rate, the first several years it was not a very difficult thing to get a rate, get a portable health care insur-

ance, but in the last few years it has gotten really, really tough for us, particularly last year.

We were with a carrier that determined to completely pull out of their program in South Dakota. I don't know if that was because of mandates or because of lack of population, but it was something that caused them to completely—I have got a lot more than 5 minutes, okay—but they pulled out of the State, and we were forced to essentially get new bids for a new carrier, which gave us a relatively short time to rebid the program.

We received four bids, all of them approximately the same, all of them approximately 50 percent higher than the rates we had. For example, my rates personally went from \$390 a month to \$695 a month—almost \$400 to almost \$700—and that included only my wife and myself on the new policy, where before we had wife and dependents on the old policy. So it would have been—I don't remember how much more, but even considerably more if we would have left our son on the program. We were forced to get separate coverage for our 16-year-old son.

As far as Hatch Furniture's group, we have 28 employees that would be eligible. Presently, we have only nine of them covered under our particular program, mainly because our program is too expensive. We pay \$125 of the premium and the employees pay the bulk. Now that is fine for the younger employees. Most of them are on it. But the older employees such as myself you know are not staying on our group program; and I am afraid that, you know, if we get any more increases we are going to have even more and more people drop off of it. Some have been able to obtain outside coverage if they are healthy, but the ones that aren't healthy, it presents a real problem.

It also has an adverse effect on Hatch Furniture as far as a viable company. It isn't just being a good employee and trained to provide health care coverage for our employees. I wish we could do more, but our profitability doesn't allow us. It has been a really, unfortunately, tough couple of years bottom-line-wise; and so I wish I could do more. It hurts that I can't.

Another issue that comes up is we have lost our—have been unable to hire good employees because our health care program is not competitive with a lot of our bigger competitors or other industries.

South Dakota is not a problem for Yankton. We are fortunate we have good facilities in Yankton and Sioux City, but it is a problem for a lot of other people in our State.

One of the things that we are running into, though, is the PPO provider list that our different carriers have—for example, we have Avera in Yankton, Sacred Heart Hospital, Avera, and we just received notification that the carrier that we have our son in is probably not going to renew the PPO list with Avera. So, if that is the case, then we are going to be forced to go down the road 60 or 90 miles to—and I hope they get that worked out. It isn't a final thing. But it is an issue that—kind of an ongoing matter that is going to face us.

One of the things that hurts us is a modification problem that, without the HP, we have groups that—we have group insurance but we are still rated—if we have two or three unhealthy employ-

ees, like diabetic, for example, we are not able to get a good rate, where the HP would, I am sure, resolve that for us.

Thank you.

Chairman THUNE. Thank you, Ron.

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

Chairman THUNE. Our next witness is Ms. Mary DeVany from Sioux Falls, South Dakota. Ms. DeVany is the manager at TeleHealth Services at Avera McKennan TeleHealth Network. I have seen firsthand some of the remarkable things that are being done in my State of South Dakota with telehealth and its application in rural areas. It is very exciting. I think Mary is going to share some of that with us. So please proceed.

**STATEMENT OF MARY DeVANY, AVERA MCKENNAN
TELEHEALTH NETWORK, SIOUX FALLS, SOUTH DAKOTA**

Ms. DEVANY. Thank you for this opportunity today; and a special thank you to you, Mr. Thune, for your ongoing support of telehealth activities.

The Avera McKennan TeleHealth Network was established in 1994. Our network primarily uses two-way interactive videoconferencing throughout. We also have a video bridge that allows us to connect multiple sites simultaneously.

Our network averages about 400 clinical telemedicine consults annually in various specialty areas. However, telehealth is more than just telemedicine. The system is also used for distance education activities, whether it is for clinical education such as tumor conferences and various grand rounds topics, or staff and community education, as well as for various meetings.

As you are aware, obviously, South Dakota is very rural, with only 10 communities with a population over 10,000. From a health care standpoint, specialist physicians are concentrated on the eastern and western edges of our State, with about 350 miles between them. The number of miles for our own network sites runs anywhere from 45 to 170 miles one way.

The availability of telehealth helps to reduce the health care penalty for choosing life in a small town. Citizens should not be held at a disadvantage simply because they live in a rural area, especially if technology can help resolve that issue. Access to health care leads to improved quality of life for individuals in rural communities and allows them, and encourages them, to remain.

However, many communities are simply trying to keep their hospital open and to continue to provide those services that are currently available. The closing of a local hospital or health care facility signals a major crisis for a rural community, and every effort should be made to maintain its viability. A facility can be strengthened by making additional or enhanced services available. This technology makes specialty services more accessible to our rural residents.

I have included a specific example in my written testimony of how one facility was able to expand their service offerings via telehealth.

Physician isolation is an issue with which all rural communities are faced. However, physicians are not the only ones affected. All levels of health care providers experience this difficulty. The avail-

ability of telehealth technology and distance learning opportunities allow for greater peer-to-peer interactions. It also helps to improve the quality of services being provided at the rural facility by making current information available to staff.

As we all know, health care dollars are very tight. But staff still needs this training and educational opportunities. Video technology allows for a degree of cost savings over the year by allowing employees to attend an educational event from their home facility and reducing the need for travel.

Again, I have included an example of cost savings in my written testimony.

Probably the most far-reaching contribution made by telehealth technology is increased support for "main street." Allowing patients to receive specialty health care from their home facility helps keep additional dollars at home. The additional services like lab work, x-rays, or prescriptions are also done by local providers. Additionally, the peripheral stops that can go along with trips to Sioux Falls, like gas, groceries, a stop at Wal-Mart, are reduced and more of these dollars remain in the community as well, not to mention the additional hotel and restaurants expenses. Also, time away from one's job is greatly reduced, an hour or so, as opposed to a day or more.

Not only does this technology help to provide increased opportunities for health care services but also improves the perception of quality care available from a hometown provider and a health care facility. While it may not directly affect or be directly affected by the proposed Association Health Plans or the Medical Savings Accounts, telemedicine can help to keep the overall cost of Medicare down by providing care at a lower cost facility, helping with early diagnosis and care, and keeping more of those health care dollars at home.

There are a couple specific areas where your support is needed.

First is the area of reimbursement. Over the years, telemedicine has developed a successful track record and is a proven tool. In many respects it has been proven to be as good as a face-to-face consult. However, you wouldn't know that by looking at who and what is being paid. Your support is needed to expand the current level of reimbursement and to encourage Medicare and insurance companies to provide full coverage. The current Medicare reimbursement structure needs to expand the eligible facilities and providers as well as the allowable CPT codes.

Second, over the past months there appears to have been a somewhat arbitrary decision to move the Office for the Advancement of Telehealth, known as OAT, to be housed within the HIV/AIDS Bureau. The Nation's telehealth community is greatly concerned that this change signals a shift in the level of support for this program and that the awareness of telehealth will diminish from the lack of visibility. OAT has been a valuable resource for new and seasoned programs alike, and this shift is a great concern. We would rather that this—we would like to see the program reinstated into its former location within HRSA and rather than cutting funding for this program these activities should be expanded.

In closing, thank you for the opportunity again to share this information. In my written comments you will see several success

stories that can help bring the understanding of the benefits of telehealth to a level we can all appreciate. Thank you.

Chairman THUNE. Thank you, Mary.

I would also note, too, that all of your testimony will be submitted in its entirety for the record. I appreciate the additional information that you are furnishing regarding some of the success stories in that area.

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

Chairman THUNE. Next, the Subcommittee will hear from Wayne Nelson from Winner, South Dakota. Mr. Nelson is president of the group Communicating for Agriculture and is self-employed and I believe represents a number of folks who would have a very keen interest in making health care certainly more accessible and also more affordable in rural areas. So please proceed.

STATEMENT OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE, WINNER, SOUTH DAKOTA

Mr. NELSON. Thank you, Mr. Chairman, Congressman Udall. It is a pleasure to testify today before your Committee.

We feel that there are several areas that are key in trying to make sure that health care remains available in rural areas and also remains affordable.

One key point would be that Congress must maintain adequate funding for key infrastructure programs that help maintain the quality of rural health care services, particularly the National Health Services Corps and other programs that help bring and keep doctors and nurses and health care providers to rural areas to practice medicine and for telemedicine programs that support our rural providers and keep them linked to the latest and best knowledge available for quality care.

Another area that we are very concerned about is cuts and underfunding for reimbursement of Medicaid and Medicare for rural health care providers and their residual impact. We see a cost shifting that is happening from the underfunding of these government programs that—cost shifting by providers, and it results in higher costs for private insurance and higher premiums for consumers.

One of the most positive developments we have seen in recent months is passage by the House of Representatives of the President's proposal for refundable tax credits to help reduce the number of uninsured in this country. We feel that this is one of the most important issues that affects people in rural America, and that is the cost. A lot of the 40 million uninsured are uninsured because of the cost. We feel that tax credits are a good way to address that.

Getting more people adequately insured is the fundamental foundation that we have to pursue if we are to have adequate access to health care in rural America. The rising cost of health insurance is putting a strain on small businesses and particularly for individuals like our farmers and small business members.

Proposals for the refundable tax credit for health insurance premiums we feel tackles this issue head on. By making the tax credits refundable and advanceable, low-income people who don't normally pay much or any taxes would still benefit from the program.

By some estimates, as many as 6 million more people would become insured, reducing that 40 million uninsured if \$1,000 per individual or up to \$3,000 per family refundable tax credit would be offered. We clearly think this will make a big difference and help more people in rural America to become insured.

As you know, several bipartisan bills have been introduced in both the House and Senate that call for refundable tax credits. We do commend the House for passing health care tax credit bipartisan legislation in one of their stimulus packages. We were unable to get the Senate to approve the same proposal. So we think that could go a long way towards helping the 40 million uninsured.

Another problem the Chairman mentioned is tax equity for health insurance premiums. It seems patently unfair that large corporations can deduct 100 percent in the year of 2002 while self-employed can only deduct 70 percent.

Finally we will reach 100 percent in the year 2003, but the poor individual like the single mom that might be working two jobs, maybe part time in a McDonalds, part time at a store downtown, neither offers a program for health insurance, her deduction today is zero because she is not self-employed, but she is an individual that is paying for her own insurance. So we have expanded that to all individuals, not just to the self-employed.

Another part that we think would be very, very helpful would be to encourage more States to offer high-risk pools or health safety nets. CA has long believed in the right for everyone to have access to health insurance protection, regardless of their health, as long as they are willing to pay for it. The most effective way of providing this access guarantee is through high-risk health insurance pools. Twenty-nine States now have those pools, and we would like to see some Federal legislation that would help the other 21 States to develop pools and also to help with the assessment process to help pay for the pools for these other 21 States as well as the existing States.

We believe that the risk pool for the medical uninsurable is part of the health safety net that really supports the idea of having the availability of health insurance to everyone, no matter what their medical condition might be.

Another program that we have long supported and we are very happy to see it at least extended for 1 year are Medical Savings Accounts that were just signed into law this weekend by President Bush in the stimulus package. But that doesn't go far enough. They need to be permanent, and there need to be changes made in MSAs that would help to encourage more people to participate in the MSA programs.

Thank you very much for the opportunity to address you today, and I would be happy to try to answer any questions at the proper time.

Chairman THUNE. Thanks, Wayne.

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

Chairman THUNE. Our last witness this afternoon is Dr. Edward Hill from Tupelo, Mississippi. Dr. Hill is the Chair-Elect to the Board of Trustees for the American Medical Association. Dr. Hill, it is nice to have you today and I look forward to hearing from you.

STATEMENT OF J. EDWARD HILL, M.D., CHAIR-ELECT, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, TUPELO, MISSISSIPPI

Dr. HILL. Good afternoon, I am Edward Hill. I am Chair-Elect of the American Medical Association Board of Trustees and a family doctor in Mississippi.

After a Navy medical career I settled in a town of 3,000 people in central Mississippi, what is called the Mississippi Delta, in 1968, which was the early years of Medicare and Medicaid. This was a very high-need environment, with no physicians, no hospitals, no health care to speak of. In fact, the health care condition was—I could only describe as Third Worldish. I remained in that environment for 27 years before moving to my present position, which is director of the family medicine residency teaching program in the largest nonurban hospital in America in Tupelo, Mississippi.

So my knowledge of rural health access issues stems not from an interest in health policy but actually from long-time experience in underserved rural America.

Today I would like to touch on three components to improve access to health care in rural America: retention, recruitment and reform.

First, retention. On January 1, Medicare payments to physicians and nonphysician practitioners were cut by 5.4 percent; and CMS predicts that these cuts will continue to roughly 20 percent over the next 4 years and 30 percent if you count inflation. These cuts are the result of a flawed payment update formula, and we are extremely concerned about the impact of these cuts on patient access and the retention of physicians, especially in rural areas.

Two-thirds of all physicians offices are small businesses. If a business continues to lose revenue and operates at a loss, the business cannot be sustained. This means that physicians will be forced to make very difficult choices such as discontinuing seeing new Medicare patients, laying off staff, relocating to an area with a smaller Medicare patient population, or leaving the practice of medicine. These are not choices that doctors want to make.

In each case, the Nation's patients lose. For example, if one or more physicians in a rural area retires early because of the Medicare cuts, this could seriously hurt access to all patients.

The Medicare Payment Advisory Commission, or MedPAC, has recommended a new framework for Medicare physician updates. We support the MedPAC general framework, and we urge this Subcommittee to support legislation that would immediately halt the 5.4 percent Medicare payment cut, repeal the sustainable growth rate system, and replace the fraud Medicare payment update formula with a new system that appropriately reflects increases in practiced costs. So we ask this Subcommittee to support H.R. 3351 and H.R. 3882.

Second, I would like to address how we can recruit more physicians and encourage them to establish their practices in rural America. As you have heard, one program that has worked very well is the National Health Service Corps. In 1970, Congress created the Corps to encourage physicians and other health care providers to practice in underserved communities. Through scholarships and loan programs, the Corps provides incentives for physi-

cians to establish their practices in underserved areas, including rural areas.

Critical for the Corps to accomplish this goal is its adequate funding. The Corps' authorization, though, has expired. The AMA thinks that it is imperative that Congress reauthorize this program.

The third component of access in rural America is reforming our insurance system. Rural America suffers disproportionately from a lack of health insurance coverage. In fact, 21 percent of rural residents are uninsured. Nationwide, more than 39 million last year had no health insurance coverage.

The AMA has a proposal to reform the health care system in America to address this problem, which is summarized in this booklet which you all have a copy of. We propose that the country's health system be transposed from an employer-centered system to an employee-centered system. To accomplish that, a few changes in the current system would be needed.

First, we need refundable travel credits for the purchase of health insurance. The current tax exclusion system benefits only those taxpayers who obtain their health insurance through their employer. That leaves out those who are unemployed, those that are self-employed and those who do not receive coverage through their employer.

We propose a tax credit system. Under our proposal, employer contributions to health insurance would be reported as taxable income and individuals would take a tax credit on the portion which they spend on health insurance. These tax credits would have to be large enough to ensure that health insurance is affordable. They should also be advanceable, refundable, and inversely related to income.

The second part of our proposal would require creating new opportunities for alternative health insurance markets. This could be accomplished in the rural areas through the formation of purchasing cooperatives.

The AMA proposal would be fiscally responsible, promote greater fairness in the Tax Code, increase employee choice and expand health coverage throughout the country.

So, thank you, Mr. Chairman and the entire Committee, for asking us to testify this afternoon.

Chairman THUNE. Thank you, Dr. Hill.

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

Chairman THUNE. I appreciate all your testimony.

I would add, as a matter of experience in having been out traveling across my State of South Dakota, I have had some meetings in the last few days in small communities that currently have hospitals and as well as nursing homes and assisted-living centers; and the issues, in my opinion, that impact rural areas are particularly acute in the area of health care. We are seeing, I think, in terms of an ability to maintain a population base to attract new jobs through economic development, that health care is a critical component when it comes to quality of life.

In drawing on my own experience, I grew up in a little town of about 650 people. I think it was back in the 1960s that we got a Federal grant to build a brand new hospital. At the time, I think

it was \$300,000, which at that time built a pretty nice hospital. But it was open for 1 year. We had a doctor for 1 year, and the doctor left, and we couldn't get another doctor to that hospital. So for the next 35 years that place went unused, a beautiful facility which at the time had very modern equipment and technology and everything else. So it is sort of typical I think of the plight of America in rural areas.

As you look now—and my folks still live in that community. They are 82 and 80, and the closest hospital is Pierre, which is 60 miles away. So you find increasingly that distances and geography works against us in rural areas. I know the gentleman from New Mexico faces a set of similar circumstances. Trying to figure out how to make health care accessible and affordable to more people in country is the challenge.

What I would like to do is focus a little bit, too, on some of the suggestions that have been made. I would ask the question of Mr. Hatch, because you raised the question about the increase in insurance premiums. Did you get any explanation as to why those premiums increased by that amount?

Mr. HATCH. It was mostly our experience modifier. The quotes that we would get from the individual carriers were an estimate, and then we would spend a lot of time—

First of all, when we change policies it is always a very time-consuming process because we go through the underwriting—you know, all 28 of the employees have to fill out the application, might take an hour, hour-and-a-half, and—you know, if we are getting four bids. But then what happens is we had an employee that had migraines that was on a continuing prescription, an employee that has diabetes, an ex-employee that was still on COBRA that had a heart problem. So, basically, that was why we had and continue to have the problem, is because just a few people in our small group underwrite us basically out of business. And I can't just fire those people. I mean, it isn't ethical.

Chairman THUNE. Do you think if you had 2,800 employees as opposed to 28 that would you have the same trouble?

Mr. HATCH. I would sure think so, yes.

Chairman THUNE. Okay. Have you lost employees—I mean, have you had people, because there is the loss of health care, who have just said, I have got to find a different job?

Mr. HATCH. That was—a few years ago, we had an individual that left. And most of it now has been a few employees that we have made offers of employment, but—we felt they were qualified people, but when they looked—when someone interviews, they say, do you have a health plan? We say, yeah, we have a health plan. But then they look into it and find out what it really costs as far as their participation. It presents a problem for us as far as recruiting.

So it has been more of a problem of inability to hire someone, particularly if they already have a dependent, for example, that needs extensive health care.

Chairman THUNE. You mentioned, as a member of NFIB, if Association Health Plans were made available and an organization like NFIB chose to create one, do you see that as a solution that would be helpful?

Mr. HATCH. I certainly do. We presently have—like with the South Dakota Retailer Association, we have supposedly a group there, but it still goes through the individual underwriting. So it really isn't—even though we may have a lower base rate through an association, it still doesn't help you if you have a few people with health problems. So I think this would really rectify that problem.

Chairman THUNE. Does the—Mr. Nelson, you suggested that one of the things you talked about, and I think Mr. Hill as well, is tax credits. That is something that we kicked around here. In terms of a health care model, the one that we have today is a third-party-pay, employer-based system. If you went to some sort of a tax credit, that would be particularly helpful to those who don't currently have insurance and also might begin creating some competition in the existing health care market.

I guess I would throw this question out to whomever would like to answer it, but the increasing costs that we are seeing, particularly among small businesses, to whom do you attribute that? Is that a provider issue? Is that an insurer issue? Is it a customer issue?

I talked with doctors who say that the expectation levels are so high now that when someone comes in they are demanding the treatments, the modern technologies, the breakthroughs that we have seen in health that exist out there; and it tends to kind of build on itself. But it seems to me that there isn't a lot of incentive to control costs. Because those costs are always passed on. Ultimately, the consumer is the one who pays the cost.

But if the consumer, the individual, had more control and you moved away from the employer base, it would seem to me that that there would be someone in that equation somewhere who would have an incentive to control costs.

Mr. NELSON. No question, I think that would help. I think it is a combination of several things. It is not just one single thing that make health insurance costs go up so much or health care costs in general.

But certainly empowering consumers to become better educated to understand their own health care and understand what it costs—you know, simply going to an employer group and showing people that have their insurance—not so much in small business but in large businesses like the 2,800 you mentioned, their insurance is likely 100 percent paid for by their employer. They don't even know what it costs. They don't know what it costs, and they have a \$10 co-pay. They go to the pharmacist. They have a \$5 or \$10 co-pay at the pharmacy. They have no idea what this is costing them.

We feel, as I am sure others do, too, that to empower them personally to understand and take charge of their own health care would go a long way towards helping lower costs.

Dr. HILL. First dollar coverage demands no accountability of any kind. We have evidence in another program in the Medicare program if we reform Medicare the way we would like to then we wouldn't have Medigap coverage. So patients wouldn't have this first dollar coverage, and then they would have to think twice about spending for the routine health care. It would cut services

utilized by Medicare patients by 28 percent, which would amount to \$52 billion over 3 years.

I know the other side of the argument, that people might neglect themselves. I have heard both arguments. But we have to hold people responsible and accountable. If they were individually-owned purchasers and chose their health benefit plan, then they would be much more responsible.

Chairman THUNE. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman.

You know, Mr. Chairman, one of the things that I think is inter-related here, we had previous hearings on getting infrastructure into these rural areas. And your testimony about telemedicine, what I am wondering, these previous hearings we don't see the kind of broadband and Internet services in rural areas that we see in the urban areas. How much is that holding us back in terms of capitalizing on things like telemedicine and getting it into all of the rural areas across America?

It doesn't just have to be to Mary. Any of the other panelists can comment on that.

Ms. DEVANY. Sure. The issue of conductivity has been one that we have dealt with since the beginning of our program. A lot of our sites where we really need to get the technology out to we have not been able to simply because of exactly what you mentioned. They don't have the infrastructure available for the type of lines that we had need of to make those connections and the telemedicine connection. We need a larger bandwidth for the clinical side of things to make sure that the diagnosis is accurate.

What we have been seeing, though, is a shift in technology itself, being able to utilize some other types of networks out there. We have been able to utilize and piggyback off some of those networks already in place for the purposes of telemedicine, but we still have not been able to reach every facility within our network. We have several that flat-out can't afford to have a network connection with our facility, whether it be for data or for telemedicine.

Mr. UDALL. In order to do telemedicine, what types of lines are required?

Ms. DEVANY. Anywhere from—we utilize ISDN lines. We use T-1 lines. I think we also have a facility that has been fortunate enough to have an OC-3. These are the type of lines that our network has utilized.

Mr. UDALL. Any other of the panelists on this issue?

Mr. NELSON. Preventative medicine was brought up as one of the problems that is seen when you have individuals paying for their own health insurance and understanding what it is really costing. Certainly telemedicine and the telehealth program could go a long way toward helping consumers to have a more reasonable cost for preventative medicine.

Dr. HILL. The AMA is very supportive of piloting telemedicine. Telemedicine is in its infancy. It has got a tremendous amount of evolving and developing to do before we learn how to use it practically. I think we will. I think we will learn how to use it efficiently. I think eventually it may even reduce the cost of health care and certainly will keep people out of the hospital.

In order to fund that kind of technology, however, there are very few health systems that are capable of doing that around the country, particularly in the rural areas.

Mississippi happens to be a very wired State. I don't know whether you knew that or not, but we are close to topping a few things, and one of them is being wired for those fancy lines that I don't know anything about except I know what they do. We have demonstration projects now at our medical center. But we are taking care of congestive heart failure patients at home and keeping them out of the hospitals, which is saving hundreds of thousands of dollars a year.

I am running a program with schools right now, doing routine check of children who come to the school nurse using interactive telemedicine. We think that is going to be very practical because the parents don't have to get off work to come and get them and take them to the doctor's office. The teachers that can be treated by telemedicine don't have to get off work.

But we are a long way from this being developed into the stage that we can start talking about it becoming commonly used. I hope that it will. I think that it will. But it is going to require some funding and some support in order to see what works and what doesn't work over time. But I am very supportive of us persisting with that funding of telemedicine.

Mr. UDALL. I wish we were as wired as you are in Mississippi. We have real—we really lack it in New Mexico.

One of the other issues, you have touched on it, each of you have touched on it a little bit, is the whole issue of getting doctors to go out and live in rural communities. I guess one of the biggest success factors has been if a doctor—if an individual is raised in a rural area and is familiar with it and that is part of their background, generally if they become a physician and they come back to the rural area, they stay there. Other than that as a drawing card, I think we have a real problem.

I mean, I have been told by many executives and health clinic people just how many problems they have in terms of getting people out there. It has been said over and over again we have to think outside the box in terms of getting physicians into rural areas. Do any of you have any thoughts on what you think is working in terms of getting physicians into rural areas, and are there programs that are there that help that we are not funding or putting the resources behind?

Dr. HILL. There are two things that will change behavior. One thing is the incentive, and the other is money, and they are the same thing. I mean that sort of facetiously, but also there is some truth in that.

You are right. The two things that we know are directly related to getting physicians to practice in rural or underserved areas is, number one, being reared in that area and, number two, their career choice as a freshman medical year student being underserved care.

Now that is not true with other primary care specialties. For instance, in internal medicine, it is universally related, which I think is fascinating. Pediatrics, it is neutral. So family medicine seems to be the way to go.

Of course, I am extremely biased. I will admit that up front. But I think the salvation of our health care system in this country has got to be the opportunity for every citizen to have access to a well-trained primary care physician to manage their health care. We are not doing that. And that is where we need to emphasize, I think, showing my bias, where we need to be. The National Health Service Corps certainly has had some successes.

Some of us—and this is a personal opinion, not AMA's opinion—think that if we reengineered that program a little bit we could make it 100 percent better and make more people stay longer. We have statistics that shows if somebody stays in an area for 5 years they are much more likely to stay there the rest of their life. My wife says it is because they bought a house there or married a girl or have a loan at the bank. Whatever the reason, it appears to be true.

This program requires 2 to 4 years. Loan repayment, no question about it. The average medical student now is \$97,500 in debt when they graduate from medical school. Loan repayment programs absolutely have an impact, and we need to work much more innovatively on those types of programs.

Mr. NELSON. One thing we did in my social community in south central South Dakota—it could be done all over—but we went to—this is about 20 years ago, wanted a surgeon in our community to serve our hospital. We had a family physician, but we thought we needed a surgeon. We went around and collected money from the surrounding area business people and farmers and went to the University of South Dakota Medical School and said if someone would come and stay 5 years as a surgeon we would offer some funding for their medical education. We were able to do that, and that surgeon—that was 20 years ago, and the surgeon is still there.

So I agree with you that the 5 years is key. We feel we have a lot to offer all over rural areas, New Mexico and South Dakota and Mississippi. Five years would enable someone to see what there is to offer. There is kind of a bias against getting to go out there in the first place. But once they are there I think they find that it might be worthwhile to stay.

Ms. DEVANY. I think the technology can also help facilitate some of that that has been shared. Just the ability to continue your education is vitally important. Often a physician would have to pick up, leave for a week or whatever, for educational opportunities. Telehealth technology allows them to go down to a conference room for an hour get a credit unit and go back to their practice, allowing them to increase their ability to have that ongoing education opportunity.

Mr. UDALL. Thank you very much for your testimony.

Chairman THUNE. I will just explore a couple other issues.

Mary, you had mentioned, and I think that if you look at some of the smaller communities across South Dakota, bandwidth—obviously, in order to get the transmission quality and the resolution necessary—I mean, Dr. Hill noted, too, and I think it is true—in order to be able to do consultations, you have got to have a level of transmission quality that enables you to see with great clarity what is happening off site. Right now, it seems to me at least, that there are—in some of the areas in our State we are doing pretty

well with that, but is that primarily the barrier right now? Is it a connectivity issue? Or are there other things that we need to do that will encourage new communities to accept and utilize telehealth services?

Ms. DEVANY. The wiring issue is one—is just one issue. Culture is another. Often, a physician is not comfortable using the equipment, and that doesn't encourage them to pursue it very often. Insurance coverage is another reason for not using telemedicine. It is not covered as it would be the same as a face-to-face consult.

Now, there are obviously some situations where telemedicine cannot provide the same type of service. But there are many situations where telemedicine can, and those are the areas that really need to be looked at and opened up for insurance coverage. Whether it be Medicare or whether it be third-party payers, they need to be encouraged to expand their offerings of coverage.

Chairman THUNE. One of the things that—the whole reimbursement issue is something that I worked on a couple of years ago, but we have got a lot of room to improve there I think. But clearly that is one of the issues that, if we are going to really make this program work, we are going to have to, as the doc said, provide incentives/dollars, to put those incentives in place.

I mean, one of the things that I have been doing is I have traveled around and listened to health care providers in some of the smaller settings—smaller community, smaller hospitals. This week, I am cosponsoring legislation that would expand the critical access hospital program to hospitals with 50 or fewer beds and also expand it to include some post-acute areas like home health skilled nursing, ambulance service, those types of things, investment in infrastructure and technology. Those are all things that we feel are particularly needed.

There are a lot of hospitals who can't meet the eligibility criteria right now to get cost basis reimbursement under the critical access hospital program. But if we expand that model a little bit it would be able to draw more of those facilities in and hopefully prolong their livelihoods, make them—at least right now a lot of those small health care facilities, hospitals, clinics are losing money. It is the old axiom that we lose a little bit on each sale, but we make up for it in volume. You can only do that for so long. This is what we are seeing out there.

The one thing that I also noted in your testimony was the impact on the local economy. If you are not having to send somebody—if somebody can be treated there instead of having to send them to Sioux Falls, it does keep people in town. You know, when people go to a bigger community they obviously do their shopping and everything else there. I think it does have a very direct impact on the local economy. The jobs issue very much comes into play.

So you see I am very excited about the prospects of that. I am a big believer. I think there is a lot of potential. I understand what Dr. Hill is indicating in terms of this is in the very embryonic stages of its development, but I see some dramatic improvements all the time as I travel, just in the last year.

What we are doing I think down in Winner, Wayne, your hospital now down there has hooked up, and they have some pretty

remarkable things going on down there. So it is very encouraging to see that, but we have a lot of work ahead of us.

Tom sort of touched on this, but it is one thing I heard over and over, too, and that is not only are reimbursements an issue but also recruitment of health care professionals, that we are just having a really hard time getting people to go into rural areas.

Again, as I said, in the community that I grew up in, it has been a real challenge. You get out farther away from a population center and the distances become greater and there just isn't a whole lot of incentive for people to go live in those communities. I think it is a great place to live, but not everybody seems to share that opinion.

I think we have to be thinking of ways from an educational standpoint how we can put those types of incentives in place, too. Nurses, lab techs, all those type of things, we are really struggling to meet that need.

I guess I would just—Tom maybe has some more questions, too, but the whole question of the uninsured is, the higher level of uninsured—when you have got small employers—I think the number was with 18 or fewer or it is 18 percent higher premiums, if you have got a small business, as opposed to a business with 200 or more employees. That is something that I think that we need to be looking at very seriously. Because the number of uninsured goes up every year.

If you see these premiums increase, that is—you are all talking about it continuing to go up, more and more businesses continue to drop coverage, and you will see more and more in the ranks of uninsured.

I think this whole idea of coming up with a model that is sort of different than what we have used in the past, the employer-based, third-party-based system where you have an individual having more control over their health care choices, gives them more choices and I think creates more competition and, hopefully, will help control costs.

Mr. HATCH. That is another problem we have. When we are forced to select a program I have got, you know, various employees, and a different program would suit each one of them different. We are forced to pick one program, whether it be a PPO or some—you know, a major medical would be more appropriate. As a purchaser of a small group, I don't know if—I would like to see some way that the HP plans would allow us some selectivity on an individual basis.

Chairman THUNE. Yes.

Other questions, Tom?

Mr. UDALL. Just one additional question here.

Over 23 percent of the Medicare population is located in rural areas, while rural areas account for only 20 percent of the total population. Yet Medicare spends less money on rural beneficiaries than on urban beneficiaries. Do any of you have any thoughts on that and why that is happening? Are there any corrections we need to make there?

Dr. HILL. Urban patients require more services or ask for more services is the reason the cost per capita is higher. That is the

issue, the same issue of the gypsies that I do not want to talk about today.

Mr. UDALL. Very well put, Dr. Hill.

Dr. HILL. But I will, if you want me to.

Mr. UDALL. Go ahead.

Dr. HILL. I am teasing. I do not want to talk about it.

Mr. UDALL. I think both of us appreciate very much your coming and your testimony today. Thank you very much.

Chairman THUNE. Thanks, Tom. If anybody has any concluding remarks, or if there is anything that we have prompted in our questions that did not get adequately addressed, feel free to comment. We are getting ready to wrap this up. But the testimony is very useful. This is an issue that is not going away. It is one that populations in rural areas tend to be more elderly, and so the Medicare/Medicaid caseload in most of the hospitals in rural areas is a very high percentage of total revenues, and total caseload, treatments, everything else. And I think that is something that, as we talk about how to make Medicare strengthened and improved and so forth, too, those are all issues. And the issue of prescription drugs seems to come up frequently in visiting some of those rural settings.

Does anybody have any closing remarks or comments with respect to this issue, things that we perhaps have not touched on?

Mr. NELSON. Just overall I would like to add that it is not—every rural area is different. It is not one size fits all. Certainly we want to think outside the box and come up with new things, but it has to be able to adjust to different areas of the country and different parts of rural hospitals and providers and whatever. So it is not just all try to fit in all into one size. I think that is important.

Dr. HILL. We did not talk about the soaring medical liability insurance premiums. They certainly have an impact, I think, on physicians' choices of careers for that matter. And I think that is a big issue that needs to be addressed, probably from a Federal level, because it is not being very well addressed at the State level.

Chairman THUNE. Okay. The one thing in addition to that too, yesterday I was in Kent, South Dakota, and the administrator there was a new administrator in the last year or so, and he showed me the amount of paperwork that it took to change the name of the administrator of the hospital from the previous administrator to this administrator, and it was like an inch thick. And that was another thing I heard a lot about was just the paperwork compliance and the regulations and so forth. That is something.

Mr. HATCH. The Patients' Bill of Rights is also an issue somewhat related as far as lawsuits. If I am a small businessman, and I have the fear of being sued by my employees, it is going to make me less conducive to even carrying a plan. And a lot of that may be just a fear factor as far as a lot of our NFIB members, but it is still an issue. The more people that drop their program, the bigger the problem becomes nationwide.

Ms. DEVANY. The only other issue that relates to the total situation is the cross-State licensure of physicians. That is an issue that we continue to work with. Fortunately, most of our physicians that use the system are licensed in our three-State area. We are kind of in that vicinity. So most of them that use the equipment are li-

censed, but to try to encourage additional specialists to look at this as an opportunity, that remains an issue for us.

Chairman THUNE. Great.

Well, again, I appreciate all of your testimony and your response to the questions. This has been very helpful. And if you have anything to add, the record will be open. We would be happy to get that included as part of the permanent hearing record.

With that, we are adjourned.

[Whereupon, at 3:20 p.m., the Subcommittee was adjourned.]

OPENING STATEMENT OF CHAIRMAN JOHN THUNE, SUBCOMMITTEE ON RURAL ENTERPRISES, AGRICULTURE AND TECHNOLOGY

Good afternoon and welcome to this hearing of the Subcommittee on Rural Enterprises, Agriculture and Technology. I want to thank all the witnesses who have traveled over long distances to be here with us.

Today we will be examining the issue of health care in rural America. Obtaining access to adequate and affordable health care is a problem for small business owners throughout the country, but it can be particularly difficult in rural areas. As Congress continues to address the health care problems our country faces, we must not lose sight of the 43 million uninsured Americans—this is a real crisis. Many people do not realize that over 60% of our uninsured population consists of small business owners, workers, and family members. By addressing the access problems faced by millions of workers, Congress can greatly reduce the number of uninsured.

One of the reasons small businesses cannot afford health coverage for their employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions. For example, on average, a worker in a firm with less than 10 employees pays 18% more for health insurance than a worker in a firm with 200 or more employees. In addition, self-employed individuals can only deduct 70% of their health insurance premiums from their taxes, while their corporate counterparts can deduct 100% of the cost of health insurance premiums for their employees. Small businesses suffer from unequal treatment—what they want most is a level playing field when it comes to health care.

Large corporations use the purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other hand, have to find their insurance on an individual basis, and in rural states, insurers have been leaving the small group insurance market, making it difficult to find affordable health coverage.

I was very heartened to see President Bush today issue his plan for helping small businesses prosper in our economy. The President is aware of the health care access and affordability problems facing small business, and his plan includes concrete steps to increase health security for employees of small businesses. His agenda calls for Association Health Plans to be available for associations that want to provide them for their members, and it calls for a permanent extension of Medical Savings Accounts, including a significant reduction in the required deductible for these health accounts.

Congress needs to ensure that there are many different health insurance options for small business owners to utilize. We need to help our businesses attract and keep employees, and nothing helps more than the ability to provide health insurance. For rural states, the ability of small business owners to obtain and provide affordable health insurance for their employees is vital to our efforts to attract new jobs and prevent population loss.

I look forward to hearing testimony from our witnesses, and I thank you all for participating in this hearing.

TESTIMONY OF RONALD HATCH, PRESIDENT, HATCH FURNITURE

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

My name is Ron Hatch, owner of Hatch Furniture, a fifth generation retail furniture store that was founded in 1903. We have two stores, one in Yankton, SD, a community of about 15,000, and one 60 miles away in Sioux City, Iowa, with

about 130,000 residents. In 1974, I entered the business after serving as a pilot in the United States Navy. My son, Jon Hatch became the 5th generation to enter the business. Most businesses survive an average of twenty years so we are fortunate but it is always a challenge.

At Hatch Furniture, we sell all types of home furnishings, floor coverings, and custom window treatments. I employ about twenty-eight full time workers and a few who work part time. Many of them have been with the company for ten or more years. My employees range in skill level, from high school to college graduates, in age, from twenties to mid-fifties, and earn salaries ranging from \$18,000 to the high \$50,000. My salary is \$24,000. Their roles include managerial, administrative, sales, and warehouse and delivery.

We value our employees, which is why Hatch Furniture has offered employee-sponsored health insurance since the early 70s. When I became president, I simply continued offering health benefits without much concern—until last year when the cost of our premiums skyrocketed approximately 50 percent. Since then, I've learned first-hand the struggle many small business owners face in trying to secure affordable health coverage.

Our trouble began last year when American Medical Security pulled out of the South Dakota market, leaving me to search for a new insurer. I was shocked to learn how difficult it was to find an affordable plan, and how burdensome it is to change carriers. My employees spent time away from their work completing lengthy health statement applications for four different insurers. After reviewing all four bids and seeing no great competition in costs, I decided to go with CBSA, a carrier that offers a Preferred Provider Organization (PPO). We are sometimes limited on choice because we need a PPO list that covers our employees in both Yankton and Sioux City.

This switch has been tough, as both the employer and employee shares for monthly premiums, co-payments, and deductibles have doubled. For example, I am fifty-five years old and I include only my wife on my plan. Our monthly premiums jumped from \$390 to \$695 for just the two of us. The prior \$390 rate included our sixteen-year-old son who is now under separate coverage.

It isn't just the monthly premiums that have shot up either. Last year my employees paid \$15 for a doctor visit and for prescription co-pays. This year, they pay \$30 for each visit or drug. In addition, our deductible went from \$250 to \$1,000 annually!

Because the cost increases have been extreme I've tried to help my employees in the best way that I can by absorbing more of the cost. For the past four years, I paid \$100 toward my employees' monthly premiums, but now, I pay \$125. Additionally, my company is paying \$500 of the \$1,000 annual deductible for each employee.

However, the ramifications go beyond cost. Because several employees could not afford the new coverage, only nine of my twenty-eight employees opt to have our group health care coverage at this time. Most employees who have chosen our coverage are in their twenties and thirties because the premiums are more affordable than for those who are in their forties and fifties, like myself. Our older employees have been forced to join the ranks of the working uninsured or obtain limited coverage outside our group.

Access to care is another issue. In an attempt to control cost, my wife and I purchased an individual policy with a separate provider for our sixteen-year-old son. This poses its own set of challenges, as his insurer is considering not renewing the contract at our local hospital. Therefore, if my son needs to go to the hospital and we want his insurance to cover it, we may have to travel 60 to 90 miles to the closest one, which is in Iowa.

To some in my state, a 60 to 90 mile trek might be considered a short trip. In Yankton, we are fortunate to have a good regional hospital but others in South Dakota aren't so lucky.

Unfortunately, rising health insurance costs go beyond insurance carriers. I feel federal and state mandates have a great deal to do with rising costs. As a board member of the Benedictine Foundation in Yankton, we approve expenditures for health care in the community. These expenditures include health related education, medical student tuition and equipment purchases. I am appalled at the cost of some medical equipment as we recently purchased a \$2,000 chair for people to use while they donate blood because it had to meet certain specifications. A \$300 chair from Hatch Furniture could have done the same job.

All of these factors—cost increases, lack of competition between plans, access to care, and mandates—make me very worried about Hatch Furniture's ability to offer health benefits in the future. In our July renewal brings another double-digit increase, I'm not sure how we will absorb it, or for that matter, how many employees will be able to keep their coverage. I fear that more might go without insurance.

If more employees decide to drop coverage, I may not even be able to qualify for group coverage, at which point everybody loses. The lack of competitive benefits also severely limits my ability to hire and retain employees.

It's for these reasons that I support legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from costly state insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business. In addition, AHPs will introduce into the market place much needed competition and diversity. Without the ability to shop for more affordable options, we are left with shifting cost or dropping coverage. Association health plans would be a health care purchasing dream come true and would ensure more choice for rural areas.

Eliminating the regulatory burden on medical savings accounts (MSAs) would also benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees by giving them control over their own health care dollars. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business. Tax credits for individuals would also be a welcomed option.

Now, I'm not a health policy expert, but to me, AHPs, MSAs, and tax credits seem like good, common sense solutions to controlling the cost of quality health care.

Mr. Chairman, thank you for allowing me to share my experience with you and the Members of the Subcommittee. I look forward to following the good work that Congress will hopefully do in relation to employer-based health care, and I am happy to answer any questions that the Committee may have.

STATEMENT OF MARY DeVANY, MANAGERS, AVERA MCKENNAN TELEHEALTH NETWORK

Good afternoon, my name is Mary DeVany. I am the manager of the Avera McKennan TeleHealth Network in Sioux Falls, South Dakota. Thank you to the committee for the opportunity to visit with you today, and a very sincere thank you to Mr. Thune for his ongoing support of telehealth activities.

History / Experience

The Avera McKennan TeleHealth Network was established in December 1994 and currently uses interactive videoconferencing at various hospitals within the region to provide telehealth services. The Avera McKennan TeleHealth Network primarily uses two-way interactive videoconferencing throughout its network. We also have a video bridge which allows us to connect multiple sites simultaneously for various events.

Over the years, our network has provided clinical telemedicine services in pulmonology, dermatology, neurology, orthopedics, surgical care follow-up, pediatrics, mental health, fetal ultrasound, internal medicine, and trauma. On average, we are providing about 400 clinical consults (physician to patient) annually. However, telehealth is more inclusive than just "telemedicine", or the clinical applications. The system is more inclusive than just "telemedicine", or the clinical applications. The system is also used for distance education activities whether it is for clinical purposes (tumor conferences and various grand rounds topics), or staff and community education, as well as for various meetings (administrative, association, community).

Issues

As you are aware, South Dakota is VERY rural. There are only ten (10) communities within the state with a population over 10,000. From a healthcare standpoint, specialist physicians are concentrated on the eastern (Sioux Falls) and western (Rapid City) edges of our state, with about 350 miles separating these two communities. The number of miles from our network's rural facilities to Avera McKennan runs from 45-170 miles (1-3 hour drive, one-way).

The availability of telehealth technology helps to reduce the "healthcare penalty" for choosing life in a small town. Citizens should not be held at a disadvantage simply because they live in a rural area, especially if technology can health resolve that issue. Access to healthcare leads to improve quality of life for individuals in rural communities and allows them (and encourages them) to remain in those rural communities.

Many communities are simply trying to keep their hospital open and to continue to provide those services that are currently available. Often facilities are having to choose, and limit, what services they are able to continue to provide. The closing

of a local hospital, or healthcare facility, signals a major crisis for a rural community and every effort should be made to maintain a facility's viability. A facility can be strengthened by making additional or enhanced services available. This technology helps make quality specialty healthcare services more easily available to our rural residents.

Example.—The availability of the OB Ultrasound via telemedicine at the Flandreau Municipal Hospital has allowed them to offer a service they previously had to eliminate from their facility. This has encouraged families to consider this rural facility to handle their healthcare needs instead of looking to facilities in other regional communities. By providing a wider range of healthcare services, patients are encouraged to stay in their own community to access their healthcare and also keep more of their overall dollars within their hometown economy.

Physician isolation is an issue with which all rural communities are faced. However, physicians are not the only ones affected. All levels of healthcare providers experience this difficulty. The availability of telehealth technology and distance learning opportunities allows for greater peer-to-peer interactions. It also helps to improve the quality of healthcare services at the rural facility by providing current medical information to healthcare and administrative staff on a regular basis. Increased educational opportunities for healthcare providers can improve their ability to provide quality healthcare.

Rural hospitals and other healthcare facilities have learned to be very frugal with their budget. Dollars are always tight. Staff still need appropriate training and educational opportunities, and the availability of video technology allows for a degree of cost savings over the year by allowing employees to attend an educational event from their home facility and reducing the need to travel in order to obtain the necessary information.

Example of the dollars saved.—In both cases, the amount of money the participants would have spent to attend the event on site was calculated (driving/meals/hotel) as was the number of non-productive hours and added together to reach the total savings amount.

- One 2-hour event (HIPAA/EMTALA regulations) had a total savings of \$5,077. This relates directly to the rural facilities and their ability to address federal regulations.
- 6 month estimation of dollars saved for January–June, 2001 was \$33,311. This includes non-productive hours (drive-time for just one person) and mileage for 4 sites.

Probably the most far-reaching contribution made by telehealth technology is increased support for “main street.” Allowing patients to receive specialty healthcare from their home facility, helps to keep additional dollars “at home.” By receiving services “at home”, the additional lab work, x-rays, or pharmacy needs are also met by local providers. Additionally, the peripheral stops that can go along with a “trip to Sioux Falls”, like groceries, gas, a stop at Target or Walmart, are reduced and more of these dollars remain in the community as well, not to mention any additional hotel and restaurant expenses that might occur.

Not only does this technology help to provide increased opportunities for improved healthcare services, but it also improves the perception of the level of quality care available from their hometown provider and healthcare facility. Telehealth has become an important tool in the provision of quality healthcare, especially rural healthcare. While it may not directly affect, or be directly affected by the proposed Association Health Plans or the Medical Savings Accounts, telemedicine can help to keep the overall cost of medical care down by providing care at a lower cost facility, helping with early diagnosis and care, and keeping more healthcare dollars “at home.”

Next Steps

Awareness is key to the success of telehealth networks. Improving awareness, whether it is at the federal level or at rural community level, will only serve to strengthen the programs, the rural facilities and the communities in general.

There are a couple of specific areas where your assistance and support is needed. One is in the area of reimbursement. Over the past years telemedicine has developed a successful track record and is a proven tool. In many respects it has been proven to be as good as an actual face-to-face clinical consult. However, you wouldn't know that by looking at who and what is being paid. Your support is needed to expand the current level of reimbursement and to encourage Medicare and insurance companies to provide full coverage. There has been a good start, but more progress is needed. Specifically, your assistance is needed in expanding the current Medicare reimbursement structure. There needs to be expansion in the eligible facilities (long term care facilities, i.e. nursing homes and in-patient/out-patient mental health fa-

cilities) and the eligible providers (occupational therapists, speech therapists and physical therapists), as well as the allowable CPT codes.

Also, over the past few months there appears to have been a somewhat arbitrary decision to move the Office for the Advancement of Telehealth (OAT) to be housed within the HIV/AIDS Bureau. There is a great concern that this change signals a shift in the level of support for this program and a greater concern that the awareness of telehealth will diminish from a lack of visibility. The telehealth community around the nation has a great deal of appreciation for OAT and their support of our projects over the years. They have served as a valuable resource for new and seasoned programs alike. We would like to see this program reinstated in its former location within HRSA and rather than cut funding for this program, these activities should be expanded.

While there are other federal funding sources for technology, the OAT is really the only one that has developed an understanding of how telehealth really works within a rural setting and regularly encourages information sharing between projects. It is of great concern that HRSA appears to have a reduced interest in this program and the benefits brought to small communities through the availability of telehealth services.

Additional Information

Also included with this testimony, are several "success stories" from various facilities within the Avera McKennan TeleHealth Network. These help bring the understanding or the benefits of telehealth to a level we can all appreciate.

TELEHEALTH/TELEMEDICINE SUCCESS STORIES

Avera McKennan: Family relations Strengthened

When possible we try to link patients required to stay in the hospital for long period of time with their family at a distance. We were contacted by our Leukemia and Bone marrow Transplant program to see if we could connect a daughter and family in Fairbanks, Alaska with her father hospitalized at Avera McKennan. We were fortunate to coordinate with the University of Alaska who allowed the patient's family to use one of their rooms, free of charge.

The visit started with the patient, wife and transplant team present at our location and the daughter, husband and 2 children present in Alaska. A team conference was held first, updating the daughter on her father's progress. After the conference was completed, the team left and family was allowed to visit. During the conference the 5 year-old showed everyone her new school shoes and talked about her excitement of entering school. The nicest moment, when you know that telemedicine really brings families closer together, was when the 18 month-old reached out to the TV screen and wanted grandpa to pick him up (and cried when he couldn't . . .). Not quite the same as being there, but very close!

Avera McKennan: A Little Help From Friends

In an effort to fight a case of home-sickness/depression, a young patient suffering from head-trauma visited with her schoolmates via interactive-video. Even though this was not an official "consultation" involving a physician, it was beneficial to the overall care of the patient. Not only did it improve her overall mental health status, it also gave the speech therapist, who attended the event with the patient, a better understanding that this patient could be pushed harder during her therapy sessions and possibly could be progressing at a faster pace. The patient's parents and her hometown school principal requested this session. Her twin sister and her brother were also involved in the event from the school, strengthening their relationship during her absence. It also gave her classmates a sense of her progress.

Gregory Healthcare Center: CME Credits & Psychiatry

Prior to the availability of telemedicine, the physician group traveled at least 2.5 hours to get CME's. Now through Grand Rounds there are active participants every week and it is something that the doctors have utilized to its fullest. Geriatric psychiatric service is also something now provided because of telemedicine. This has been a very positive service as many of the people being treated are nursing home residents and it would be difficult for them to travel to Sioux Falls, or elsewhere, for evaluations.

Madison Community Hospital: OB Ultrasound

A patient presented to this facility for an OB ultrasound, with cramping in the second trimester of pregnancy. The ultrasound was obtained and the specialty physician recommended the patient come to Sioux Falls to have a cerclage procedure

done. This was done in Sioux Falls that same day, but this patient has since returned to MCH for her follow-up ultrasounds. Prior to telemedicine capabilities, this patient would have been sent to Sioux Falls and her care would have been followed up there. But because of telemedicine, this patient has been able to return to Madison for her care, and as far as I know plans on delivering here at Madison.

Avera Sacred Heart Hospital, Yankton: Burn

A young man received electrical burns last summer while working on power lines for the REA in a rural South Dakota community. He was transferred to Minneapolis for burn therapy. Following his discharge, the doctor treating him had asked to use the telemedicine system for monitoring his progress. This would allow the contact visually without this person having to travel to Minneapolis for the follow-up. We were able to arrange and the visits were held here at ASHH and the person now is discharged and no longer has need for the system. The savings to that individual were both in time and travel.

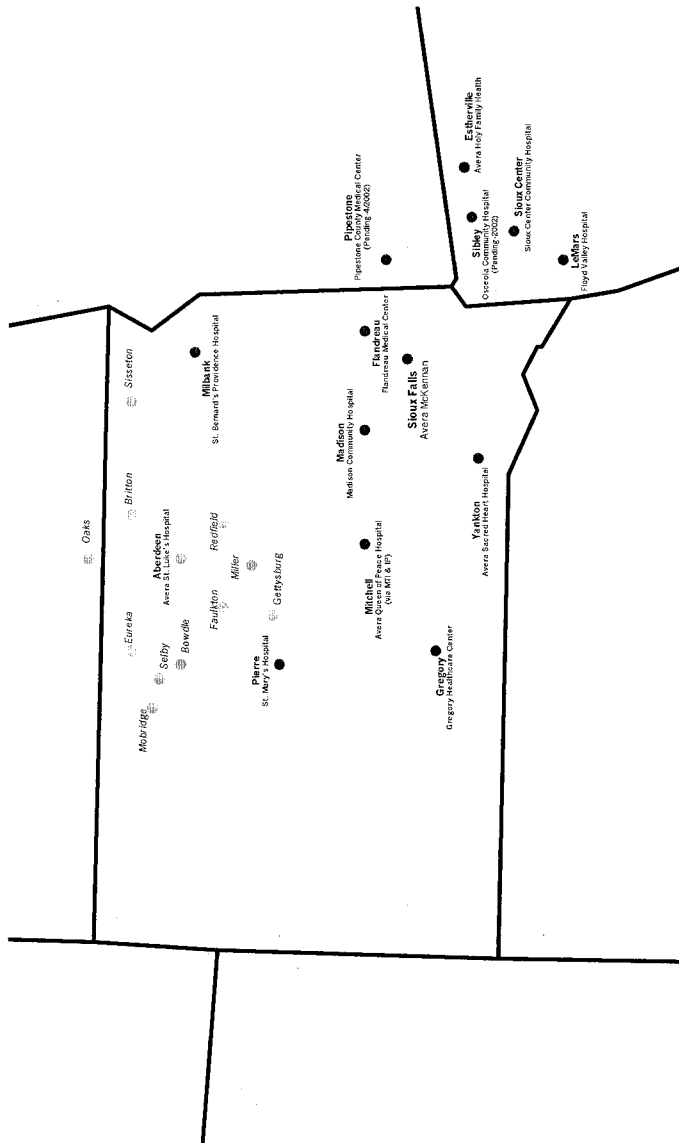
St. Bernard's Providence Hospital, Milbank: OB Ultrasound

One specific example, we had an emergency consult via telemedicine with the perinatologist on a patient. His recommendation was to do a C-Section immediately. The C-Section was done, and a healthy, normal baby was born. The outcome could have been detrimental to the baby, which could have resulted in high medical bills for the patient over the years. It could have resulted in a legal situation, costing the facility and the facility's insurance company money. However, it didn't happen because the consult changed the outcome. How do you attach a dollar value when you don't know what the outcome would have been? Is it worth the risk, when you have the capabilities? We feel that the patient's welfare should come first. If it is financially possible for the facility to handle the cost of telemedicine, whether it makes money or not, we would be willing to handle the cost.

Flandreau Community Hospital: Pulmonology

A gentleman presented himself to the Flandreau Medical practice with advanced COPD. His condition placed many limitations on him as any activity exhausted all oxygen reserves. Therefore, travel was not considered a positive option. This patient was scheduled with pulmonologist via telemedicine, who changed his treatment regimen, making medication adjustments and incorporating pulmonary rehab into his schedule. The improvement was impressive. Telemedicine allowed the patient to remain in his home community while accessing specialized health care. The outcome . . . the patient regained a substantial quality to his lifestyle.

**Avera McKennan TeleHealth Network
FY 2002**



TESTIMONY OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE &
THE SELF-EMPLOYED

Chairman Thune, members of the subcommittee, I want to thank you for the invitation to share our thoughts about critical issues facing access to health care communities of our country.

My name is Wayne Nelson. I serve as president of Communicating for Agriculture & the Self-Employed (CA), and I also am a grain farmer from Winner, South Dakota. CA works on a variety of priority issues on behalf of our farmers, ranchers and rural small business members. However, throughout CA's 30 year history, we have worked to maintain and improve the quality of health care services available in rural areas, and we've worked to try to keep health insurance affordable for rural people so that they can, in fact, have access to health care services. Health care access and affordability has been a priority for us from the beginning.

There are five key recommendations we would like to make to the committee today:

1. Congress must maintain adequate funding for key infrastructure programs that help maintain the quality of rural health care services; particularly the National Health Services Corp and other programs that help bring and keep doctors, nurses and health care providers to rural areas to practice medicine; and for telemedicine programs that support our rural providers and keep them linked to the latest, best knowledge available for quality care.

2. We're very concerned about cuts and under-funding for reimbursement of Medicaid and Medicare for rural health care providers and their residual impact. For years, reduce funding of the government programs has led to cost shifting by providers, resulting in higher costs for private insurance and higher premiums for consumers. There are significant problems in some rural states where Medicaid and Medicare makes up the majority of health care. There is a growing shortage of specialists and technology available in some rural areas because these providers fear they will lose money.

3. The most positive development we've seen is the recent passage by the House of Representatives of the President's proposal for refundable tax credits to help reduce the number of uninsured in the country. The most important issue for the rural health care system and for rural Americans when it comes to health care is the affordability of health insurance. For too many small businesses, and too many individuals, health care costs and health insurance premiums are rising above their ability to pay. The increasing lack of affordability of health insurance is causing more people to go uninsured, and that harms the economic viability of the rural health care infrastructure. Refundable tax credits for health insurance addresses the issue head on.

4. CA has long fought for tax equity when it comes to the deductibility of health insurance premiums. Rural America's economy is made up of more self-employed people, and more small businesses, which find it difficult to offer health insurance. Self-employed people now only receive a partial tax deduction for health insurance, and people who work for businesses that don't offer it received zero deduction. This is truly unfair discrimination in tax policy that makes the net cost of health insurance for these people far more expensive than for people given the employer tax deduction subsidy.

5. To improve access to health care for rural Americans, one of the most important aspects will be to make sure there is access in the individual health insurance market, and the best way to do so is via a state high-risk health insurance pool. These programs now exist in 29 states and have been shown to provide an access guarantee in a way that helps keep the individual market more competitive and viable for carriers. Funding is a key issue for states with risk pools and the federal government could lend a helpful hand.

Funding of Rural Health Care Programs

We are disappointed to learn that the President's budget proposed cutting funding for federal share of the State Offices of Rural Health. While we were pleased to see that the administration proposed increased funding for the National Health Services Corp and Community Health Centers, there were cuts proposed for other programs that assist and develop health care professionals to serve in rural areas. We need to maintain these assistance programs and they do work.

In the south central South Dakota community of Winner, where I live, we wanted to get a surgeon for our local hospital. A committee went around the town and collected contributions from individuals and businesses to help pay for a medical school for a surgical student if they would remain in Winner for at least five years. A surgical student was found that agreed to the terms, and several thousand dollars were

paid toward his medical school expenses. He has now practiced in Winner for more than 15 years. Every small town in rural America is not able to do this, but this example shows how local communities and government assistance can work together to achieve a common goal. Programs like the National Health Services Corp provide for this kind of assistance to benefit rural communities.

Medicaid and Medicare Reimbursement

Under funding of Medicare and Medicaid rural reimbursement rates continues to be a serious problem for rural states, and the repercussions of it should give pause to considerations of proposals to address the uninsured problem simply by expanding Medicaid.

In New Mexico, for example, we've been told that, as a result of lower reimbursement rates for Medicare and Medicaid, there are fears of a crisis for the state's health care infrastructure. Medicare and Medicaid account for almost one-half of the health care delivery in the state. (source—chair of the New Mexico Comprehensive Health Insurance Pool).

Medicare is reimbursed at approximately 38 cents on the dollar compared to bill charges, while Medicaid is 95 percent of that. When a small portion of a state's health care comes from government programs, it is a little easier for the rest of the system to absorb the losses. However, when a higher portion of health care services is paid for by underfunded government programs, it can get impossible for the rest of the system to absorb. This is causing problems in a number of areas in New Mexico. All of the uninsured and the Medicaid population now must go to the University of New Mexico Hospital in Albuquerque, which itself is facing major budget problems. There is an exodus of physicians willing to practice in rural New Mexico, and supplies and facilities there are becoming more inadequate.

It's a similar story in many other rural states, including South Dakota, Montana, Oklahoma and elsewhere. The Seattle Times last week reported that many Washington state doctors and clinics, including those in eastern Washington, are ending their participation in Medicare and Medicaid programs because of low reimbursements.

And let's not forget that the way the rest of the system absorbs underfunding of government programs, is by cost shifting into bills charged for private insurance. In New Mexico, that overwhelmingly means a cost shift to small business and individuals, which make up the vast majority of the state's insured.

According to Time magazine this month, as a result of higher costs and the recession, states—which collectively face a deficit of \$40 billion—cannot afford the extra Medicaid benefits they started to offer in the late 1990's.

Tax Credits—A Good Way to Address the Rural Uninsured Problem

Getting more people adequately insured is the fundamental foundation we have to pursue if we are to have adequate access to health care in rural America. Rising costs of health insurance is putting a strain on small businesses and particularly for individuals, like our members, who mostly pay for their own insurance themselves. Private insurance premiums rose 8.4 percent in 2000, the highest since 1993, according to a just released study by the federal Centers for Medicare and Medicaid Services (CMS). The report projected premiums rose another 9.6 percent in 2001, will reach 10.4 percent this year.

Proposals for a refundable tax credit for health insurance premiums tackle the issue head on. By making the tax credits refundable and advanceable, low income people who don't normally pay much or any taxes would still benefit from the program. By some estimates, as many as 6 million more people would become insured. An extra \$500 or \$1,000 per individual, and up to \$3,000 per family will clearly make a big difference. And it clearly would help many more rural people to get coverage.

As you know, several bipartisan bills have been introduced in both the House and Senate that call for refundable tax credits. We commend the House for passing health care tax credit bipartisan legislation that was included in a previous economic stimulus proposal.

CA has long supported refundable tax credits to assist those nearly 40 million Americans who are now uninsured. A large portion of this 40 million, including a great many rural workers and self-employed people, do not have access to employer-based insurance and must look for coverage in the individual insurance marketplace. That is why CA firmly believes the tax credits must go to the individual. It is appropriate that the tax credits could be used by eligible individuals for employer-based coverage. However, the credits themselves should be provided to the individuals for them to use so that the self-employed and people who work for employers that don't provide coverage can make full use of the incentive.

CA will continue to work for eventual passage of legislation in both Houses and signing by the President that will provide these important tax incentives and assistance to expand coverage by making it more affordable.

Tax Equity for Health Insurance Premiums

The current, welcome interest in tax credits to reduce the number of uninsured should not deter anyone in Congress from the need to fix the unfair discrimination that has long existed regarding the tax deduction allowed for health insurance premiums that is allowed for employer-based plans, but not for individuals that pay their own insurance.

Tax equity has to be brought to the table, especially concerning individuals purchasing their own insurance. Do you realize that a single mother working two part time jobs to feed her family, who does not get health insurance from either job, gets ZERO tax deduction for the health premiums she pays. Yet corporate employees where insurance is provided through their job receive a 100 percent deduction. The difference in the net cost of insurance to the individual because of this unfair, unequal federal subsidy is a major contributor to the high rate of uninsured. CA and many other groups have worked for years to get 100 percent deduction for the self-employed paying their own health premiums. That goal will be achieved next year when the phase-in of the 100 percent deduction for the self-employed becomes law. But this policy should be law for everyone who pays for their own insurance.

Support State Risk Pools for Access for the "Uninsurable"

CA has long believed, and long worked for, the right for everyone to have access to health insurance protection, regardless of their health, as long as they were willing to pay for it. And the most effective way of providing this access guarantee when it comes to the individual market is through state high-risk health insurance pools. State risk pools serve as part of the health care safety net that have played an important role in offering insurance to the so-called medically "uninsurable" for as long as 25 years in some states. Today, they are operating in 29 states, all with caps on the level of premiums that can be charged people in the risk pool and each subsidized by the industry and/or with state funding. More studies are recognizing that risk pools provide a means of providing insurance access that causes far less disruption to the private individual insurance market compared to other alternatives, in particular guarantee issue regulations.

The enrollment in risk pools is now steadily growing, as an outgrowth of declining coverage in the small group employer market forcing more people into the individual market, which these risk pools serve.

Currently, federal regulations complicate the ability of states to fund their state risk pools equitably across the entire health insurance industry. Even though it would be a comparably small cost compared to other health care initiatives, federal financial support for risk pools to help them pay for increasing subsidies levels, and to help low income people in the state programs would be helpful.

CA believes every state should have a risk pool for the medically uninsurable in place as part of their health safety net, and supports federal help to establish and fund these state-operated pools. For the first time, the financial support for state risk pools was included in the earlier economic stimulus legislation that passed the House, but failed to gain movement in the Senate. This was an important step, and we encourage Congress, as it considers broader ways to address the uninsured problem to include support for state risk pools so that we can expand them to more states and assist the 29 states that now have them.

These recommendations aren't the answer to all of the problems of the uninsured. However, together they make up critical parts of the comprehensive approach that will be required to solve this problem.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the Committee, my name is J. Edward Hill, MD. I am the Chair-Elect of the American Medical Association's (AMA) Board of Trustees. I am also a board-certified family physician from Tupelo, Mississippi. I began my professional career in the rural Mississippi Delta, where I practiced for 27 years. On behalf of the medical student and physician members of the American Medical Association (AMA), we are honored to have been invited to discuss with this Committee the critical issue of access to health care in rural America.

Introduction

The Secretary of the Department of Health and Human Services, Tommy Thompson, recently stated that "[w]e want all Americans, regardless of where they live,

to have an equal chance for a healthy life.” The AMA strongly agrees with Secretary Thompson, and adds that improving health care access in underserved areas remains an ongoing concern and top priority for the entire AMA.

Approximately 61.7 million United States residents (24.8% of the population) live in rural settings, according to the 1990 Census. In 1999, 14.3% of rural Americans lived in poverty. The Centers for Disease Control and Prevention (CDC) recently reported that most rural counties have a statistically higher percentage of uninsured than nonrural counties, and their remains a “relative scarcity of health care resources in nonmetro areas” which is a “continuing problem that is likely to have an enduring negative impact on health outcomes.”

The CDC has also reported that nationally residents of the most rural counties have the highest death rates for children and young adults, the highest death rate for unintentional and motor vehicle traffic-related injuries, and among men, the highest mortality for ischemic heart disease and suicide. Moreover, rural county residents also experience the highest levels of adolescent smoking, are least likely to have adequate oral health care, have the fewest specialist physicians and dentists per capita, and adult rural county residents experience a higher incidence of activity limitations caused by chronic health conditions.

Numerous factors have contributed to these significant disparities in health conditions for rural residents. As mentioned above, among the top causes is the relative scarcity of health care resources, or access to health care resources, including physicians. Despite more than 20% of the American population living in rural area, fewer than 11 percent of the nation’s physicians are practicing in nonmetropolitan areas. Physician recruitment and retention in rural areas therefore remains a significant problem for rural residents. The high incidence of uninsurance also creates a major barrier for rural residents to access health care.

In this Statement, we would like to highlight a few significant factors contributing to the problem of inadequate access to health care in rural America, and offer some proposed solutions.

Medicare Physician Payment Cuts Seriously Threaten Patient Access

Effective January 1 of this year, Medicare payments for physicians’ services were cut by 5.4 percent, and we are extremely concerned about the impact of these cuts on patient access. Rural areas, in particular, will be especially “hard-hit” by these cuts since these areas tend to have a much higher population of Medicare beneficiaries than in non-rural areas. Two federal bills that would halt the cut (H.R. 3351 and S. 1707) have achieved super-majorities in the House and Senate.

The 5.4 percent cut is the largest payment cut since the Medicare physician fee schedule was developed more than a decade ago, and is the fourth cut over the last eleven years. As recently as Sunday, March 17, the New York Times reported that “significant numbers of doctors are refusing to take new Medicare patients, saying the government now pays them too little to cover the costs of caring for the elderly.” Since 1991, Medicare payments to physicians have averaged only a 1.1 percent annual increase, or 13 percent less than the annual increase in practice costs, as measured by the Medicare Economic Index (MEI). (See attached Chart 1, Medicare Payments vs. MEI, which compares Medicare physician payment updates to increases in inflation.)

This cut applies to all Medicare services provided by nearly one million physicians and other health professionals, including, but not limited to, physical therapists, speech pathologists, optometrists, advanced practice nurses and podiatrists. In addition, many private health insurance plans base their rates and updates on Medicare payment rates, which mean an additional loss of revenue from non-Medicare sources.

Most significantly, the payment cut jeopardizes access for elderly and disabled patients. Two-thirds of all physician offices are small businesses. If a business, especially a small business, continues to lose revenue and operates at a loss, the business cannot be sustained. Thus, when medical practices experience a Medicare cut of the magnitude being incurred in 2002, as small businesses, they may not survive. This means that physicians and non-physician practitioners and their staff are left with very few alternatives for maintaining a financially sound medical practice. These alternatives include:

- Discontinue seeing new Medicare patients;
- Opt out of the Medicare program;
- Move from being a participating to a non-participating Medicare provider;
- Balance bill patients (subject to Medicare charge limits);
- Lay off administrative staff;
- Relocate to an area with a smaller Medicare patient population;
- Discontinue certain low-payment/high-cost Medicare services;

- Shift services into the hospital outpatient setting, which increases costs to Medicare and to patients;
- Limit or discontinue charity care;
- Retire early;
- Reduce hours of practice
- Change career;
- Shift into a position which involves reduced or no patient care responsibilities; and

- Postpone or discontinue necessary investments in new technology.

These are not choices that physicians want to make. In each case our patients lose. As discussed above, these choices particularly impact patients in rural areas. For example, if a physician in a rural area discontinues seeing new Medicare patients, there may not be another physician in that area to see Medicare patients. In addition, if one or more physicians relocate from a rural area to another area with a smaller Medicare population, this could seriously diminish patient access. Finally, if physicians in rural areas leave the practice of medicine, patients in those areas, where physicians may already be in short supply, obviously would be greatly impacted.

There are many reports that access is indeed being impacted by the 5.4 percent cut. For example, the National Committee to Preserve Social Security and Medicare has stated that their members are having difficulty finding a physician who accepts Medicare because physicians cannot afford to keep their offices open. A cardiology group in Colorado is being forced to lay off employees and, in Texas, spine surgeons at Baylor University plan to stop taking Medicare patients.

The American College of Nurse Practitioners warns that the pay cut is also forcing physicians and nurse practitioners to restrict their Medicare patient loads and cut back on the services they provide. Finally, recent press reports in many states also have documented the access problems resulting from the Medicare payment cut. Excerpts from these reports are as follows:

"As a result (of the 5.4% cut), doctors around the country are finding themselves pinched. 'If you continue to lose and lose, there may be a time when we will have to limit services or close one of our sites,' says Susan Turney, medical director of reimbursement at Marshfield Clinic, of Marshfield, Wis., which operates about 40 sites with 600 physicians. 'In some areas of Wisconsin, we're the only provider,' she adds." *The Wall Street Journal*, Jan. 20, 2002 (Some Doctors Say They Stop Seeing Medicare Patients After Cuts);

"Washington's health-care system is in serious decline, and the prognosis is guarded. 'Tests show the severity of the problem,' said Tom Curry, executive director of the Washington State Medical Association, which released a gloomy report in Olympia. Responding to an informal poll of members in November, 57 percent of physicians said they are limiting the number or dropping all Medicare patients from their practices. . . . The report says that for many years the state's health-care delivery system has been in decline, characterized by a slow erosion of funding for public health, growing administrative expenses for practitioners and mounting frustrations of physicians trying to cope with myriad regulations. A growing number of patients, even those with private insurance, are having trouble finding a physician because increasing numbers of doctors have been leaving the state or retiring early since the late 1990s, the report says." *Seattle Times*, Jan. 30, 2002;

"Medicare reimbursement to doctors was cut 5.4 percent the first of the month, worsening an already tight financial situation for rural hospitals. . . . One result likely will be a harder time recruiting doctors to rural areas. . . . Medical equipment purchases can suffer, staff cuts are more likely and doctors sometimes will leave for better conditions elsewhere, Bruning said (Dr. Gary Bruning of the Flandreau, South Dakota Medical Clinic)," *Associated Press*, Jan. 22, 2002 (Medicare Cuts Strain Rural Health);

"Other West Virginia doctors fear their peers will stop treating patients who have Medicare. . . . And some wonder how they will recruit doctors to a medical environment marred by the recent struggles over malpractice insurance. . . . At Madison Medical PLLC in Boone County, three doctors treat at least 80 patients a day. About 65 percent of them have Medicare, said office management Phyllis Huffman. The cut in Medicare reimbursement does not come at a good time, she said. In the last two years, for example, the physician group's malpractice insurance doubled. Huffman said she fears that in the long run, the practice will not be able to afford to replace a departing employee. Or they may have to stop offering services for which they get little or no reimbursement from Medicare." *The Charleston Gazette*, Jan. 23, 2002.

Immediate action is needed to remedy these growing access problems, and we urge the Committee to support enactment of legislation that would—

- Immediately halt the 5.4 percent Medicare payment cut;
- Repeal the sustainable growth rate (SGR) system; and
- Replace the flawed Medicare payment update formula with a new system that appropriately reflects increases in practice costs, including changes in patient need for medical services, changes in technology, and other relevant information and factors. (H.R. 3882, introduced by Rep. Nancy Johnson (R-CT), would accomplish this goal.)

Medicare Payment Advisory Commission Recommendations

The Chair of the Medicare Payment Advisory Commission (MedPAC) told the House Ways and Means Committee of February 28th that “maintaining access for Medicare beneficiaries and keeping physicians participating in the program and accepting new patients, will require that action be taken.” Further, MedPAC warned in June 2001 that if the 2002 update was lower than the CMS estimate, which at that time was -0.1 percent, it “could raise concerns about the adequacy of payments and beneficiary access to care.”

Clearly, this year’s 5.4 percent cut is significant, and it comes on top of sharp increases in professional liability premiums, as well as a host of costly regulatory burdens. And, the situation could become even more dire. CMS predicts that under the current system, the updates over the next three years will be, respectively, -5.7% , -5.7% and -2.8% . This is roughly a 20 percent cut in Medicare payments over 4 years (2002 through 2005), and this number increases to almost 30 percent when you account for medical inflation. Moreover, the 2005 conversion factor predicted by CMS would be lower than the conversion factor in 1993. Physicians will be paid less in 2005 than they were in 1993. A 20 percent pay cut over four years would add to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients.

MedPAC has adopted a recommendation that Congress replace the current Medicare payment formula with one that more fully accounts for increases in practice costs. Specifically MedPAC advised Congress to repeal the SGR system because an expenditure target system, like the SGR, does not appropriately reflect increases in practice costs. MedPAC further recommended that future updates be based on inflation in physician’s practice costs, less an adjustment for multi-factor productivity. H.R. 3882, the “Preserving Patient Access to Physicians Act of 2002” introduced by Rep. Nancy Johnson (R-CT), would implement the MedPAC recommendations.

We strongly agree with MedPAC’s assessment and support the general framework of MedPAC’s recommendations.

Medicare Physician Payment Update Formula

Medicare payments to physicians are annually adjusted through the use of a legislated “payment update formula” this is based on the SGR and the MEI, which measures increases in practice costs. These costs include, among others, such factors as payroll, physician time, office equipment, supplies and expenses.

This update formula originally was intended to cap increases in practice costs. It has several flaws that create inequitable and inappropriate payment updates that do not reflect the actual costs of providing medical services to Medicare patients.

The Sustainable Growth Rate System

Under the SGR system, CMS annually establishes an expenditure target for physicians’ services based on a number of factors set forth in law. CMS then compares actual expenditures to the target. If actual expenditures exceed the target, the Medicare payment update may be as much as 7 percent below the MEI. Conversely, if allowed expenditures are less than actual expenditures, the update may be up to 3 percent above the MEI.

The target is based on changes in expenditures for physicians’ services due to changes in (i) inflation, (ii) fee-for-service enrollment, (iii) gross domestic product (GDP), and (iv) laws and regulations. It is a highly unpredictable and unstable system that has as number of critical flaws:

GDP Does Not Measure Health Care Needs: The SGR system permits beneficiary Medicare spending for physicians’ services to increase by only as much as real per capita GDP growth—a measure of the economy that bears little relationship to the health needs of Medicare beneficiaries. Incidence of disease did not lessen with recent downturns in the economy.

Specifically, GDP does not take into account health status, the aging of the Medicare population or the costs of technological innovations. Thus, the artificial link between medical care spending and GDP growth under the SGR system creates a system that is seriously deficient. Unlike any other segment of the health care indus-

try, physicians are being penalized with a steep Medicare cut this year largely because the economy has slowed. Yet the health needs of patients continue, the number of beneficiaries continues to grow and the use of new medical services approved by Medicare increases.

SGR Requires Unreliable Economic Forecasts: To calculate the SGR, CMS must make projections of GDP, enrollment and other factors. It is nearly impossible to make accurate predictions about these factors and thus it is equally impossible to accurately predict future payment updates. When the resource-based physician payment system was first enacted in 1989, it was intended to provide predictability over time. Yet, the current update formula has created payment updates that are unpredictable and subject to sharp swings as economic circumstances, beyond physicians' control, change.

Further, because the update system is unpredictable, severe payment cuts may be imposed without any warning or opportunity for action by Congress. In March 2001, for example, CMS predicted that the Medicare payment update for 2002 would be a 1.8 percent increase. Ten days later, CMS reversed itself and stated that the 2002 update would likely be a 0.1 percent decrease. Finally, not until November, only eight weeks before the effective date of the 2002 update and with only a few weeks left in the Congressional session, CMS announced that the 2002 physician payment update would be a 5.4 percent cut. Like any small businesses, medical practices need to plan their expenses in order to remain financially sound. Small business are the engine of the U.S. economy.

For these reasons, as MedPAC has recognized, the current physician payment update system should be replaced.

Problems with SGR Projections: In annually calculating the SGR, CMS estimates of GDP growth and enrollment changes in 1998 and 1999 have shortchanged funding for physicians' services by \$20 billion to date. (See attached Chart 2, CMS Errors in SGR: Impact on Funding for Physician Services). CMS projected that Medicare+Choice enrollment would rise by 29 percent in 1999, even though many HMOs were abandoning Medicare. In fact, as accurate data later showed, managed care enrollment increased only 11 percent in 1999, a difference of about 1 million beneficiaries. This means that when CMS determined the fee-for-service spending target for 1999, it did not include in the costs of treating about 1 million beneficiaries. Nevertheless, these patients were and will continue to be treated, and since the SGR is a cumulative system, each year since 1999, the costs of treating these 1 million patients have been and will continue to be included in actual Medicare program expenditures, but not in the SGR target. Clearly, this disparity should be remedied.

CMS acknowledged its mistakes in calculating the 1998 and 1999 SGR estimates at that time, but concluded it did not have the authority under the law to correct its mistakes. We disagreed then, and were further shocked by CMS' announcement in the 2002 final physician fee schedule rule that not only do they have the legal authority, but the legal imperative, to change 1998 and 1999 SGR projections relating to spending for certain CPT codes overlooked by the agency. CMS' interpretation of the law is perplexing and seems to allow the agency to make SGR changes only when they result in Medicare payment cuts, but not when the same changes would increase payments.

The full magnitude of this problem has only recently become apparent. Information supplied by CMS suggests that the total amount of this latest "missing code" error was nearly \$5 billion. Recent predictions by CMS of continued payment cuts for several more years show that its decision to continue using bad data in the target while correcting the errors in actual spending will ultimately have a devastating impact on payments for physician services.

Flawed Productivity Adjustment Under the Medicare Economic Index.

In the early 1970s, pursuant to congressional directive, CMS developed the MEI to measure increases in physician practice costs. A key component of the MEI has been a "productivity adjustment," which offsets practice cost increases. Over the last eleven years, CMS estimates of productivity gains have reduced annual increases in the MEI by 27 percent. Such estimates contrast with MedPAC estimates of the degree to which productivity gains offset hospitals' cost increases. In fact, in 2001, MedPAC's estimate for hospitals was—0.5 percent, while CMS' estimate for physicians was—1.4 percent. It is highly improbable that physician practices could achieve such substantial productivity gains in comparison to hospitals, which arguably have a much greater opportunity to utilize economies of scale.

In recommending a framework for future payment updates, MedPAC is advising that the MEI should simply measure inflation in practice costs and that productivity should be separately reported. MedPAC further recommends that the productivity

adjustment be based on multi-factor productivity instead of labor productivity, and estimates that this would significantly reduce the productivity adjustment that CMS currently uses in updating the Medicare fee schedule.

Cost of New Technology Not Taken Into Account

Unlike most other Medicare payment methodologies, the Medicare physician update system does not make appropriate adjustments to accommodate new technology, and thus physicians essentially are required to absorb much of the cost of technological innovations. Technological change in medicine shows no sign of abating, and the physician payment update system should take technology into account to assure Medicare beneficiaries continued access to mainstream, quality medical care.

All of the foregoing factors contribute to a payment update system that does not adequately reflect increases in the costs of caring for Medicare patients and is already undermining Medicare patients' access to necessary medical services provided by physicians and other health professionals.

In addition to remedying problems associated with the payment update system, to improve physician retention and recruitment in rural areas the AMA has, among other proposals, supported changes in the scholarship and educational loan repayment provisions of the National Health Service Corps (NHSC).

NATIONAL HEALTH SERVICE CORPS

Practicing in medically underserved communities is an altruistic goal of many medical school students. However, the typical medical student departs from medical school with an average of \$97,750 in student loan debt. This is a tremendous hardship for any recent graduate, but it is an especially difficult predicament for those wishing to provide quality, primary medical care to the 61.7 million individuals living in rural American where reimbursement levels are below the national norms.

The AMA has been a long time supporter of the NHSC, program that recruits and retains primary care physicians and other healthcare providers into underserved rural areas within our great nation. The AMA is committed to the continuation of the NHSC and its objectives. Intrinsic within the NHSC's ability to provide access to primary health care to our Nation's underserved population is permanent and increased funding by the federal government.

An Opportunity for Physicians and Health Care Providers to Pursue a Calling to Provide Medical Care to the Rural Underserved Population

In 1970, Congress created the NHSC to encourage physicians and other health care professionals to serve communities that are designated as too poor, sparsely populated, or remote to attract such professionals. Currently there are over 3,000 federally designated health professional shortage areas (HPSA). Initially, the NHSC was comprised of Public Health Service Commissioned corps officers or federal employees. To increase the number of physicians and health care providers, the corps established incentive programs. Such programs include the NHSC Scholarship program and the repayment of school loans. In exchange for these benefits, the student or health care provider agrees to practice in isolated areas for a period of two to four years.

The NHSC recruits, prepares, and supports dedicated students and clinicians through a variety of programs and services. The goal is not only to recruit physicians and health care professionals to remote areas, but to retain them in these areas. To date, more than 50% of physicians and health care providers remain in underserved areas.

Committed to Providing Health Care to the Rural Underserved

A HPSA is a geographic area, population group, or medical facility that has been designated by the secretary of the Department of Health and Human Services (HHS) as having a shortage of health professionals. There are HPSAs for primary health care, dental health and mental health. HPSAs are assigned a numerical score based on the level of need.

Individuals living in HPSAs are spread across our Nation and its territories and have little or no access to primary health care services. The NHSC works with communities and health care facilities with the greatest need and serves these individuals regardless of their ability to pay for services.

Funding Must Continue

The results of NHSC have been proven. More than 2,300 NHSC clinicians provide primary and preventive health care to some 3.6 million people in rural and urban American communities.

However, the need for health care providers in rural America remains great in order to reach the myriad individuals that are not yet served by NHSC physicians and health care professionals.

The NHSC's authorization has expired. It is vital that this program be reauthorized so that it can continue to offer access to essential health care services to the nation's most underserved people.

HHS Secretary, Tommy G. Thompson recently announced that in 2002 the NHSC will offer \$89.4 million in scholarship and loan repayments to physicians and other health care providers who serve in areas that lack adequate access to care. This increase of almost \$19 million over last year's finding will support 900 new and continuing loan repayment awards and 400 new and continuing scholarship awards.

Additionally, President Bush has proposed a 32% increase in the NHSC's budget for 2003. This would increase 2002's total funding of \$145.5 million to \$192 million in 2003. The President's proposed funding is extremely important to the millions of individuals who will be well served through the NHSC's preservation and growth.

ADDRESSING THE PROBLEM OF THE UNINSURED IN RURAL AMERICA

As your Subcommittee has indicated, "small business owners, employees, and their dependents account for over 60% of the uninsured population, and this problem greatly impacts rural small businesses. Of added importance for rural states, the ability of small business owners to obtain and provide affordable health insurance for their employees is a crucial component to rural states' efforts to attract new jobs and prevent population loss." The AMA completely agrees with your Subcommittee's assessment of the impact of the "uninsured" on rural communities. We believe that the AMA proposal for addressing the problem of the uninsured would greatly benefit rural America.

According to the most recent Census Bureau figures released in September 2001, a staggering 39 million Americans lacked health insurance in 2000. New data show that 2 million Americans became uninsured in 2001, due primarily to job loss. Twenty-one percent of rural residents are uninsured. As these numbers remain high, health care costs continue to rise. The Center for Studying Health System Change just reported that health care costs rose 7.2 percent in 2000, representing the largest increase in a decade. In 2001, premiums for employer-sponsored coverage rose 11 percent.

Studies have also demonstrated that individuals who lack health insurance forego needed medical care and are sicker when they do seek care. They visit emergency rooms and are admitted to hospitals in disproportionate amounts, raising the medical care costs which are then passed on to an already overburdened system. As a result, the already overburdened health care system is forced to bear even higher costs to care for these Americans.

Lacking health insurance, moreover, has a direct effect on the health of those uninsured. Consider, for instance, that uninsured women with breast cancer are twice as likely to die of cancer as women who have health insurance. Uninsured men are nearly twice as likely to be diagnosed at a later—and potentially more deadly—stage for colon cancer as men with health insurance.

Most of the uninsured are employed—61% are full time workers and 84% are in families headed by a worker. With only two-thirds of non-elderly Americans (those aged 64 and younger) covered for medical expenses by an employer benefit plan, it is time to rethink health insurance.

A Proposed Solution

President Bush recently submitted to Congress his fiscal year 2003 budget which included a proposal for refundable, advanceable tax credits for the purpose of health insurance. The proposal would provide a \$1,000 tax credit for individuals, and up to a \$3,000 tax credit for families. These tax credits would be offered to low- and middle-income American families who do not have employer-subsidized insurance. The AMA applauds President Bush for his innovative proposal and believes it is an excellent step toward expanding coverage as well as encouraging individual choice and ownership of health coverage.

The AMA has long advocated for a health care system in which every American has health insurance. We propose health care finance reform which would dramatically increase the number of Americans with health insurance coverage while putting patients first in choosing an insurance package that best meets their needs. We suggest the offering of refundable health care tax credits for individuals, the promotion of individual selection and ownership of coverage, the use of health insurance marts, and the development of defined contributions from employers.

The ultimate solution is to encourage individual ownership and selection of health insurance as well as expand coverage to low-income workers who currently cannot afford coverage.

Summary of the AMA Proposal—Benefiting the Employee

Currently, the Federal government subsidizes the purchase of private health insurance by excluding from taxable income the portion of an employee's total compensation that the employer gives in the form of health benefits. The tax exclusion is sometimes loosely referred to as a tax exemption or deduction. In contrast with the tax exclusion for employment-based health insurance, health insurance tax credits—available only to those who obtain health insurance—would be subtracted from the individual's tax bill.

The cornerstone of our proposed plan is a system of individual tax credits for the purchase of health insurance that are refundable and income-related. The AMA would replace the current tax exclusion for health insurance with a tax credit for the purchase of health insurance. Among the core elements to the AMA plan are the following:

Converting to a Refundable Tax Credit System

The current tax exclusion must first be converted to a tax credit for those who purchase health coverage, whether or not they receive health benefits from their employer. The tax credits should be inversely related to income; that is, larger credits should be available to families and individuals in the lower tax brackets. The size of the tax credits should also be large enough to ensure that health insurance is affordable for most people. The credits must at least be sufficient to cover a substantial portion to the premium costs for individuals in the low-income categories. In addition, the tax credits should be "refundable" so those who do not earn enough to owe taxes can still claim a credit.

The current tax exclusion is inequitable because it provides a higher subsidy for those with higher incomes. Moreover, a large portion of the 39 million uninsured Americans are low-income wage earners who are not eligible for Medicaid. Under the AMA plan, the tax subsidy would be redirected toward those who need it most. Furthermore, compared to a tax credit that does not vary with income, a sliding scale tax credit reduces the federal spending necessary to expand coverage.

Reforming the Individual Health Insurance Market

The individual health insurance market must be reformed to create new opportunities for individuals to pool risks, obtain "group" insurance at lower rates and choose among a variety of plans to suit their individual insurance needs. To achieve this goal, the AMA supports federal legislation enabling the formation of "Health Insurance Marts" by various groups that could include coalitions of small employers, unions, trade associations, voluntary health insurance cooperatives, chambers of commerce and other community organizations.

Protecting Vulnerable Populations

Vulnerable populations must also be protected. One way to protect some of those populations would be by intensifying outreach efforts to ensure that the five million children and adults who are currently eligible are enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The AMA Proposal Would Also Benefit Rural Employers

The AMA's proposal for reforming the American system of health care financing would provide many significant benefits to employers, as well as employees. Under the current system, most employers provide a significant part of their workers' compensation in the form of health care benefits which are tax subsidized. Payments for such benefits are made through periodic withholding of money from paychecks rather than in a lump sum, and the costs of those benefits to employers are deductible as a legitimate business expense—a cost of doing business.

Under our proposal, all of these features would remain, except that the employee—not the employer—would choose the health plan, and the tax benefit for the employee, as explained above, would be in the form of an (inversely) income-related, refundable tax credit rather than a tax exclusion. The tax status for the employer costs of those benefits would not change; those costs would remain a deductible business expense. The employer's business operations also would not change—withholding for taxes and the employee shares of benefits would continue.

Rural employers who currently offer health benefits do so voluntarily in order to attract and retain workers, and this would continue to be the case. Some employers would likely decide to change their health benefits to defined contributions. In those cases, instead of continuing to arrange and offer specific health plans, the employer

would contribute a certain dollar amount (defined contribution) toward the employee's choice of plan. Under a defined contribution program, employers' health benefits costs would become more predictable. Employees would be able to combine defined contributions from their employer with tax credits to obtain group coverage through health insurance marts.

Because employees would have both choice and ownership of their own health expense coverage for no increase in cost, employers could offer their employees better health benefit products. Employees could choose the health plan that would best suit their needs, and they would not have to switch every year or so (as they do under the present system) simply because their employer may switch to a different carrier. As a result, for the same deductible business cost, firms could improve worker retention.

Under this proposal, employers would not need to pay for human resources staff to solicit and examine health insurance offerings and negotiate contracts, because employees would make their health plan choices through a health insurance mart. Those resources could be retooled into providing additional counseling for employees on their health plan choices or they could be turned into additional profits. Either way, the employer would benefit.

Employers and employees would also benefit if employees had a wider range of choices when selecting plans and physicians and could remain with the plans and physicians they selected as they moved from one job to another. Employees would receive continuous, and more consistent medical treatment, at a lower expense than they would receive by repeatedly switching plans and physicians. As a result, employees would likely remain healthier, and would overall be more productive workers.

Further, because employees would become more price sensitive, those employees would switch away from plans with high cost increases. In turn, health plans would be more cautious about demanding increases in premiums—potentially saving more money for employers and employees. Health care inflation may well continue, but at a lower level.

To ensure that these proposed changes in the health care finance system would in fact benefit the uninsured, the AMA has created several tax simulation models incorporating these changes. These models have consistently demonstrated that the AMA's proposal would significantly expand health insurance coverage.

We have previously shared with the Congress an AMA publication further detailing our proposal to increase the number of Americans with health insurance entitled, "Expanding Health Insurance: The AMA Proposal for Reform." We would like to make that publication again available to the members of this Subcommittee, with the hope it will prove helpful to you as you consider this subject.

TITLE VII—TRAINING FAMILY PHYSICIANS

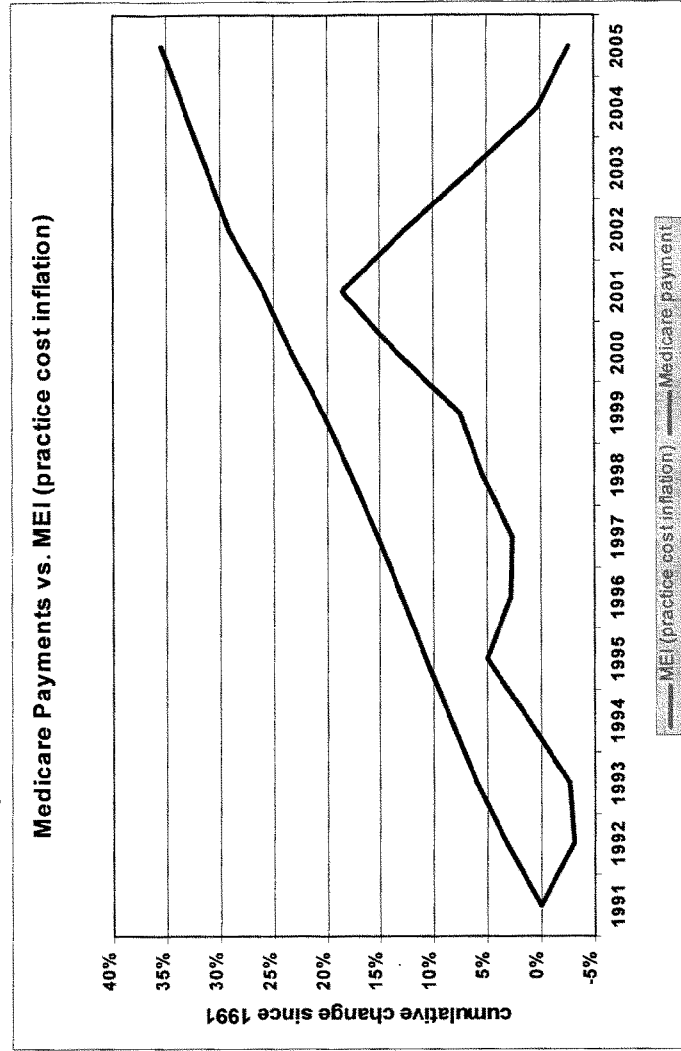
As a last point, we would like to bring to this Subcommittee's attention a concern of ours which if left unheeded will likely further reduce health care access for rural residents. Title VII of the Public Health Service Act, Section 747, authorizes appropriations for family medicine, general internal medicine and general pediatrics, physician assistants and general and pediatric dentistry. The Section 747 program is the only federal program that supports family medicine training programs at the undergraduate and graduate levels. The program's goal is to increase the number of primary care physicians and increase the number of health care providers—including physicians—to provide health care to the underserved.

We raise this issue at this time because the President's FY 2003 budget would zero out funding for the Primary Care Medicine and Dentistry cluster. In addition, the budget proposal would cut the current funding level for all of the Health Professions programs by 75 percent to only \$94 million. Despite language in the proposal claiming that "most of the health professions grants have not proven effective because they do not accurately address current health professions problems," we can attest that Title VII funds are effective in addressing major health profession problems and improving access to health care in underserved, including rural, areas. We urge Congress to reauthorize full funding for Section 747 of Title VII.

CONCLUSION

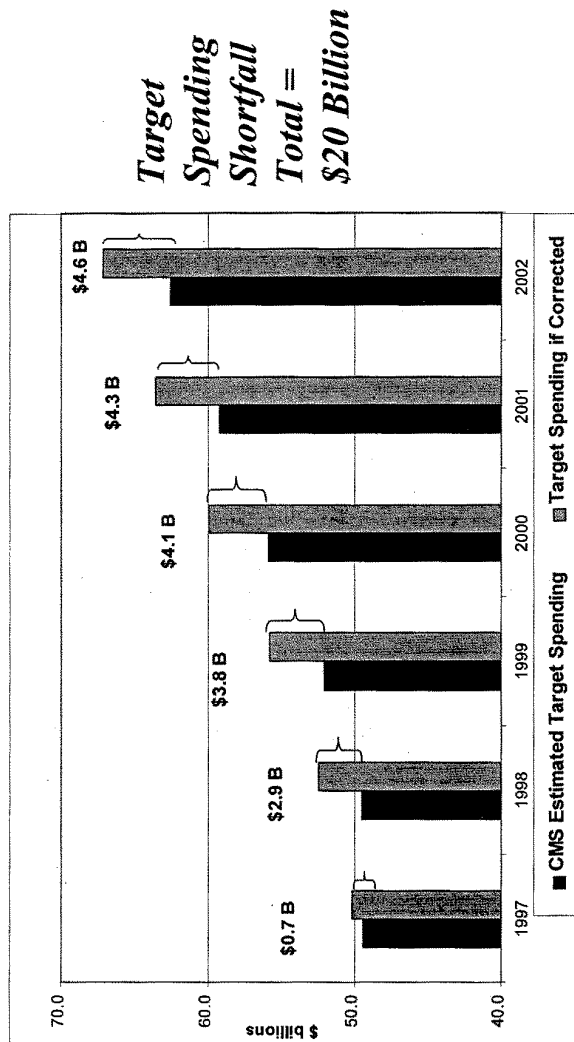
Thank you again for the opportunity to submit our thoughts and suggestions regarding access to health care in rural America. The AMA offers this Committee and the Administration our assistance and resources in finding solutions to this critical issue.

Medicare Payments vs. Practice Cost Inflation (MEI)



Source: 1992-97 pay change data, PPRC; 1998-2002, AMA; 2003-05, CMS projections

CMS Errors in SGR: Impact on Funding for Physician Services



Brackets } indicate CMS errors in GDP and enrollment factors in SGR. Data on GDP growth is from U.S. Department of Commerce; enrollment data is from CMS.