Testimony of

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"Rethinking Insurance"

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Good morning. Thank you for this opportunity to come before this Committee to share some of my experiences as a physician in private practice. After 15 years of watching my profession go through profound changes, I would like to share some insights.

In 1965, a friend of mine was volunteering in a New Jersey hospital. She remembers that, at that time, a day in the hospital was billed at $39. 1965 was the year that government entered into the payment of medical bills, for it was the year that the two huge government programs, Medicare and Medicaid, were begun. This was also the year that medical inflation began, caused by an enormous infusion of federal dollars, resulting in today's sad statistic that a day in the hospital in New Jersey is billed anywhere between $3000 and $5000. My name is Dr. Alieta Eck. I was a registered pharmacist before going to medical school. I graduated from St. Louis University School of Medicine and then did a residency in Internal Medicine at Robert Wood Johnson University Hospital in New Brunswick, NJ. I am Board Certified in Internal Medicine and am part of a four physician multi-specialty practice.

Special Challenges in New Jersey

I live and practice in New Jersey. I participate in a Health Benefits Reform message board, and experts from all over the country shake their heads in awe at how a state government could mess things up so thoroughly. In 1992, New Jersey created the Individual Health Coverage Program to ensure that people without access to employer or government sponsored health care programs could purchase health coverage from a variety of carriers. All plans were standardized, and any attempt to alter the plans to satisfy consumer demands became illegal. Insurance companies were told exactly what had to be covered, what the maximum deductibles could be, and who would be eligible to enroll.

The state was attempting to make it easier for NJ citizens to understand the plans and comparison shop for the best rates. But the net effect was a staggering increase in premiums, and an equally staggering increase in the number of uninsured citizens. 220,000 individual state-approved health insurance policies were obtained in NJ in 1996. This number has dropped to 90,000 and the number is falling quickly. Anyone can pull up ehealthinsurance.com, type in a New Jersey zip code and view rates that are laughable. For example, the March, 2004 quote for a single person, "Plan C," with a 30% co-pay and a $1000 deductible, is an astounding $4419 per MONTH as quoted for all to see, by the Celtic Insurance Company. The *least* expensive plan, which still allows the patient to choose his own physicians, is offered by Oxford, at a rate of $912.20 per month for a single person. These astronomical rates can be explained by six NJ laws and facts that cause insurance rates to rise.

1. **COMMUNITY RATING--** Charging the same whether one is male or female, 18 or 64. The healthy 18-year-olds are not willing to pay the rates needed by the sicker 64 year olds, so they drop out. This leads to more uninsured New Jerseyans and higher rates for those left in the system.

2. **GUARANTEED ISSUE**- People can avoid purchasing insurance until they feel they have a good reason. They can wait until they have symptoms, purchase health insurance, and, after the one year obligatory

waiting period for pre-existing conditions, be covered for everything. One can find he has contracted Hepatitis C, wait the one year period, and then be covered for some very expensive medicines. Less healthy people in the pool increases the cost of health insurance for all.

3. **$300 MANDATED ALLOWANCE FOR CHECK-UPS**- This actually costs $500 when you consider the bureaucratic paperwork to process the claims. Health insurance costs rise.

4. **GOVERNMENT MANDATES**- Every time we turn around, our legislature is satisfying another special interest group, mandating that all health insurance policies cover another service—in vitro fertilization was added last year. These mandates cause health insurance rates to rise and more people to drop out.

5. **LIMITING THE LEVEL OF THE DEDUCTIBLE**- In an effort to find lower cost insurance, people are asking for higher deductibles. This would lower the premiums and protect the assets of those who own a home. Individual policies with a deductible greater than $2500 are illegal in NJ.

6. **INTENSE POLITICAL PRESSURE TO AVOID CHANGE-** There are currently separate laws for Blue plans, commercial carriers, HMO's, small groups, large groups and individual plans. A "divide and conquer" mentality allows the legislature to write laws that satisfy special interests but do not apply to enough people to cause a massive protest. Regulation should focus on solvency and disclosure, applying to all plans across the board. The rest should be left to the marketplace.

Because of all the mandates, New Jersey is being left in the dust when it comes to the establishment of the newly enacted Health Savings Accounts. One insurance agent told me that there are 2300 open questions concerning the structure of these plans and the legalities of implementing them with the existing New Jersey laws.

At a recent conference I suggested to our own Senator Jon Corzine that there was one law that he, as a US Senator, could support, that would cut the number of uninsured in NJ in half. That would be *to allow us to purchase health insurance across state lines.* The internet provides a perfect vehicle, and Washington could help undo the extensive damage done by legislators in states like New Jersey. This would be entirely consistent with the Commerce clause in the US Constitution. His answer was completely unsatisfactory. He thought that this would result in insurance companies "cherry

picking" only healthy people. I countered, rather, that this would result in more people being insured, avoiding the risk of bankruptcy by owning affordable health insurance.

The Problem with HMOs and Government Run Health Insurance

Early on, in our practice, we avoided enrolling as physicians in the HMOs, unwilling to sign contracts that tied our hands while paying us some un-negotiated fee. We were being asked to swear our allegiance to the HMO, while pretending to care about our patients. I remember attending a hospital Grand Rounds where we were shown a graph with the horizontal axis being our patient's length of stay and the vertical axis being the amount spent on the patient's care. We were told that BAD doctors had patients in the upper right hand corner while GOOD doctors had patients who fell into the lower left hand corner. In other words, we were "good" or "bad" depending on how much money our patients cost the system. There was no mention about how sick the patient was, how much pain and suffering the patient endured, how kind we were, how complicated the diagnosis was to make, or how well we implemented treatment. The heart of our medical training was being undermined, and we were being taught to consider the bottom line above all else.

For several years we participated in one "non-capitated" HMO, but dropped out when the company representatives read some of our charts and determined that we had spent too much time with the patients. If we billed for a "level 3" visit, and they decided it should have been "level 2," they asked for a refund. We got out in a hurry. We wrote to our patients, explaining that we wanted to be their doctors, not the servants of their insurance company. In the letter, I included a quote from Atlas Shrugged, written in 1957, by Ayn Rand:

> "I quit when medicine was placed under State control, some years ago," said Dr. Hendricks. "Do you know what it takes to perform a brain operation? Do you know the kind of skill it demands, and the years of passionate, merciless, excruciating devotion that go to acquire that skill? THAT was what I would not place at the disposal of men whose sole qualification to rule me was their capacity to spout the fraudulent generalities that got them elected to the privilege of enforcing their wishes. I would not let them dictate the purpose for which my years of study had been spent, or the conditions of my work, or my choice of patients, or the amount of my reward. I observed that in all the discussion that preceded the enslavement of medicine, men discussed everything – except the desires of the doctors. I have often wondered at the smugness with which people answer

> their right to control my work, to force my will, to violate my conscience, to stifle my mind – yet what is it that they expect to depend on, when they lie on an operating table under my hands? Let them discover what kind of doctors that their system will now produce. Let them discover, in their operating rooms and hospital wards that it is not safe to place their lives in the hands of a doctor whose livelihood they have throttled. It is not safe, if he is the sort of doctor who resents it – and still less safe if he is the sort who does not."

Many patients left our practice, and went looking for a "$10 doctor" who would only charge them the co-pay, but many have returned, seeing a big difference in the care they receive. They now see us "out of network."

So now we do not participate in any insurance scheme, though we do continue to see patients in the Medicare program. We do not "participate" in Medicare and most of our patients pay the government determined "limiting fee," at the time of service. We dutifully send in the claims electronically, abiding by the Medicare laws. The patients get reimbursed. We do not know how much longer we will do this, as Medicare is becoming more and more intrusive, demanding and punitive—all while lowering its fee schedules. The only reason we remain in the program is the fact that senior citizens are not given any alternative. People over 65 cannot purchase health insurance outside of the Medicare system.

Our practice is very efficient. Our four doctors function well with one full time employee, one bookkeeper and six part time nurses and receptionists. No one needs to spend valuable time asking permission of the insurance companies to do tests. We negotiate directly with each patient, discussing the costs as well as the benefits of any tests we recommend. We have many patients who are uninsured, so we are very careful to order medications that are the most cost-effective. We are free to spend as much time as is needed for each patient and have a loyal following.

Caring for the Poor and Uninsured

Early on in our practice, we learned the folly of getting involved in any government program for the poor. Something seemed disingenuous in government officials promising *they* would provide free health care for the poor, and then expecting *us* to foot the bill. The reimbursement is so ridiculously low, and that comes six months after the

visit. Taking on many Medicaid patients would jeopardize our survival, so we choose to screen them ourselves, and treat the poor for free.

We began to study the root causes of poverty, and were heavily influenced by Marvin Olasky's book, The Tragedy of American Compassion (c. 1992 by Marvin Olasky, published by Crossway Books). The government looks on poverty as a simple lack of funds, and has a hard time categorizing the poor. Indeed, the government is criticized heavily when it attempts to distinguish between the "worthy" poor, those who are poor through no fault of their own, and the poor who should not be given money-- those who have a lack of funds due to bad choices and bad behavior. Both may need help, but the kind of help needs to be very different. Olasky teaches the "ABC's of Compassion," and recommends that successful people personally reach out to those who are poor. A brief summary of his seven principles of compassion is as follows:

- **Assertive**- Actively seeking ways to meet needs, fight social ills, and care.
- **Basic**- Look for people closest to the individual to meet the needs—first the family, then the community, and finally the local and state governments. This describes "subsidiarity," where those nearest the problem are most responsible, and are *subsidized* by the next level of caring commitment. Subsidiarity represents the most efficient way to care and is the least subject to fraud and wastefulness.
- **Challenging**- Gently pressure people to make changes, instead of pampering them. Help develop character traits that lead to more self-sufficiency and growth.
- **Diverse**- Treat each person as an individual, without a one-size-fits-all approach. Each is an individual made in the image of God.
- **Effective**- Try to avoid being bureaucratic and unchallenging. Utilize volunteers with their unique gifts and capabilities. The bottom line is changing lives, not counting the numbers of people treated.
- **Faith-Based-** Well managed Christ-centered charities are more effective at fighting poverty and changing lives than their non-religious counterparts.

- **Gradual**- Continually re-evaluate and check the results of the program. Gradual sustained results, tested at each step of the way, will make helping the poor most successful and sustained.

We were fortunate to belong to a church that had a building that was not in use. It had been devastated by Hurricane Floyd in 1999 and was sitting dormant. A lot of fundraising and volunteer work led to the complete renovation of the building and the emergence of the new Zarephath Health Center. (www.zhcenter.org.) Employing the principles laid out above, we began operation in September of 2003, and have been seeing and caring for the poor and uninsured ever since. Here are a few of the people our physicians, nurses and support volunteers have helped:

- A 28-year-old woman came to us six months after her father had died from a long illness. She had been his primary caretaker while holding down a job in a drugstore. When she became depressed, she lost her job and her apartment. When she applied for financial aid from the state, she was told by the caseworker that, in order to qualify for funds, she needed to get pregnant. She needed medicine that cost $230 per month. We helped her access a program designed by the pharmaceutical companies, allowing her to receive a three month supply for free. The program refused to give her more unless she had a letter from the state agency explaining their denial of aid. They would not write it. So we priced around several stores and bought her medicine to carry her over. She is getting back on her feet, has enrolled in a course to become a phlebotomist, and will be on her own by the end of the summer. She will not need us any more.

- A 20-year-old just graduated from college and was removed from her parents' insurance. She stayed at home for several months, caring for her sickly grandmother who was bedridden with advanced Alzheimer's disease and eventually died. With no paycheck and no insurance, we were able to take care of this young woman's simple illness at no cost to her. She is now at work and does not need us any more.

- A 52-year-old woman stays home with her 54 year old sister, who is dying of metastatic breast cancer. Her husband's paycheck can keep the household going, but no one in the house has health insurance. She herself is at high risk of getting breast cancer, but had not had a mammogram in 5 years. She went to the local, state-subsidized hospital, hoping to get low-cost medical care. The physicians there did a physical exam and blood work, charging her $495. Then they handed her a prescription for a mammogram. When she came to us, we checked around

for the best price, and the Zarephath Health Center gave her a check to pay for her mammogram. She recently told me that her dying sister was told that she will qualify for Medicaid on July 1, two and a half months from now. This very sick sister will likely not live that long.

- A 49-year-old is disabled with complicated diabetes. His disability income is $1000 and his rent is $725. While he is on Medicare and the state-run prescription plan for the poor, he cannot even afford the $5 co-pay. We set up an account in his name, at the local pharmacy, to draw down each time he fills a prescription. The local food stamp office told him that he qualified for only $10 per month in food stamps, so his church supplies him with gift certificates to the local grocery store. Many hands are helping this man maintain his dignity and get the health care and other support he needs.

- A 28-year-old man was terrified that he was dying. He could not hold down a job. He made several visits to the emergency room, and tests all came back normal. He had $30,000 credit card debt and was paralyzed with fear. We spent a lot of time with him, mostly in phone calls, three times a week for several months. Each time we saw him we reassured him of his good health and placed him on medicine that seemed to help. We never charged him, but, each time, we encouraged him to find work. He finally enrolled in a truck driving school and called on the Saturday morning he passed the driving test. He now has a good job, is convinced that he is healthy, and no longer needs us. His mother is eternally grateful.

People ask why we started the Zarephath Health Center for the poor and uninsured, and we reply by telling the story of the Good Samaritan. It is a story that Jesus told, about a man who was lying by the side of the road, injured and bleeding. A minister walked by quickly, thinking that he had to hurry to preach his sermon. Then a Bible teacher came by, and also felt that he did not have the time to stop and help. Finally, a Samaritan, a religious outcast, saw the man, stopped to help, and gave of his own time and resources to see that the man got cared for.

We have determined to live out our faith by following the example of the Good Samaritan. When we see people in need, we are not going to demand another government program, but rather we will use our own time and resources, and find others willing to help us do the same. We are looking for physicians and support people to donate four hours per month. We believe that there is a God in heaven, and that He would have us show compassion by meeting the physical, emotional, spiritual and

relational needs of people with whom we come in contact. We do not shove religion down anyone's throat, but we are ready to give an answer if anyone asks why we have an enthusiastic optimism about the future. We are free to tell them how a relationship with God provided the missing link in our lives and how it can be the same for them.

There is another non-profit health center, the Parker Health Center, in Red Bank, NJ. In its four years of existence, this Center has reached a point where the physicians cared for 6,000 people, with 20,000 visits last year. All the doctors and most of the staff are volunteers. They have a budget of $500,000, which computes to $83 per person per year. I would like to challenge the government to demonstrate any program that delivers care with more efficiency, patient and physician satisfaction, and quality.

One additional concern of ours, as champions of the uninsured, is the tremendous cost differential between what Medicare pays and what the uninsured are billed for a hospital visit. In New Jersey, the uninsured are billed 300% of the cost of their stay. If their stay costs the hospital $10,000, they are billed $30,000. The uninsured have no clout, and if they happen to own a house, a lien is placed on their property. We have done some investigating and discovered that a patient can have his gallbladder removed in a nice little clean hospital on a Caribbean island, for less than $1000. Compare that with the $30,000 bill we saw from one of our patients at a hospital in New Jersey. After travel, lodging, and paying the surgeons and anesthesiologist, plus a week recovering in paradise, the total bill for a cholecystectomy would not be greater than $5000 in that island hospital. The Zarephath Health Center is looking into facilitating such medical tourism for those who are interested.

We have many options—but we simply ask the government to step aside and allow the free market to lower medical expenses for all. Food, clothing, and shelter are greater necessities than health care, yet we have a largely free market in these needs, and inflation in these necessities is kept lower than in health care. As Peter Drucker said in the Wall Street Journal in December, 1991:

"The government has proved incompetent at solving social problems. Virtually every success we have scored has been achieved by nonprofits." He adds, "Increasingly, these volunteers (in non-profits) do not look upon their work as charity; they see it as a parallel career to their paid jobs and insist on being trained, on being held accountable for results and performance, and on career opportunities for advancement to professional and managerial—though still unpaid—positions in the non-profit. Above all, they see in volunteer work access to achievement, to effectiveness, to self-fulfillment, indeed to meaningful citizenship."

Our Zarephath Health Center could do much more, at no cost to the taxpayer, if there were tort reform that would allow retired physicians to volunteer without fear of being sued. New Jersey has 15,000 retired physicians many of whom would love to provide meaningful aid to those in need. The physicians working for the medical schools have caps on malpractice claims, as well as state-covered malpractice premiums. Why not have a similar arrangement for those physicians who would donate their time to clinics for the poor? This would alleviate the tremendous burden on hospital emergency rooms, lessen the burden of the welfare system, and provide more comprehensive help to those without insurance. It is time that we roll up our sleeves and tackle these problems in a more reasonable way.

The Only True Insurance

- If you get insurance through your employer, *you are really not insured*. If you get too sick to work, you will lose your job. You will not be able to afford COBRA.

- If you are self-employed and buy your own insurance, *you are really not insured.* When you get too sick to work, you might not be able to afford your premiums.

- If you work for a big company and get insurance through it, *you are really not insured*. The company can get downsized, lay you off, or go bankrupt.

- If you work for the government, *you are only insured while you are employed*. If you get too sick to work, you lose your job and your insurance.

- If you count on Medicare, be careful. It will go bankrupt in 15 or so years. The next generation might have little patience with you when you are old and infirm. You certainly will not be in a position to demand more health care.

- If you count on Medicaid, you will find that access to care is severely compromised, as the bureaucrats are paid before the caregivers.

- The only real insurance is the kindness of our families, our churches, and our communities. This is true charity, a synonym for love. We had better be setting up institutions that are very inexpensive to run. We had better be figuring out ways to lower the costs and reduce government mandates. The market works best when it is un-coerced, unregulated, and rewarded. Likewise, charity works best when it is given and accepted freely.

In 1997, my husband, our five children, and I dropped our own health insurance. We were unwilling to pay those inflated New Jersey insurance rates, and we chose to join a faith-based medical cost sharing program. It is not "insurance," but a commitment to "bear one another's burdens and thus fulfill the law of Christ," as stated in the Bible. We pay $215 per month to help others in the program, and they in turn are committed to helping us if any medical event exceeds $911. They hold us accountable for healthy behavior. We cannot smoke, cannot drink alcohol to excess, must attend church, and must avoid sex outside of marriage. This is how the monthly contributions can be kept so low.

I love being a physician. It is the most rewarding of professions. I want my son to become a doctor. But unless we give our physicians the respect and freedom they need to practice the compassionate medicine for which they were trained, we will watch the deterioration of the greatest health care delivered anywhere in the world. Give individuals the freedom to purchase the health coverage they want, opening up insurance opportunities across state lines. Allow people to choose the best physicians, not just those on the list provided by their insurance company. Enact true tort reform, where patients are compensated, but are not awarded jack-pot judgments for "pain and suffering" for bad outcomes. We need tort reform, with relief from skyrocketing medical malpractice premiums, or the best and the brightest will no longer be attracted to the healing professions. And we must hurry—before more Americans are harmed by the diminishing numbers of neurosurgeons and obstetricians who are willing to take risks and use their superb skills to save them. Thank you.