SMALL BUSINESSES AND PPACA: IF THEY LIKE THEIR COVERAGE, CAN THEY KEEP IT?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

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CONTENTS

OPENING STATEMENTS

	Page
Hon. Renee Ellmers	1
Hon. Cedric Richmond	2

WITNESSES

Mr. Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Washington, DC	4
Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, DC	10
Mr. Brian Vaughn, President, Nearly Famous, Inc., Douglas, GA	13
Mr. William Dennis, Jr., Senior Research Fellow, National Federation of Independent Business, Washington, DC	15
Mr. Timothy Stoltzfus Jost, Robert Willett Family Professor of Law, Washington and Lee, University College of Law, Lexington, VA	16

APPENDIX

Prepared Statements:	
Mr. Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Washington, DC	31
Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, DC	40
Mr. William Dennis, Jr., Senior Research Fellow, National Federation of Independent Business, Washington, DC	55
Mr. Brian Vaughn, President, Nearly Famous, Inc., Douglas, GA	57
Mr. Timothy Stoltzfus Jost, Robert Willett Family Professor of Law, Washington and Lee, University College of Law, Lexington, VA	67
Questions for the Record:	
Chairwoman Ellmers Questions for Larsen	78
Chairwoman Ellmers Questions for Jost	81
Answers for the Record:	
Larsen Answers for Ellmers	83
Jost Answers for Ellmers	95
Additional Materials for the Record:	
"Health Reform's Grandfathering Rules Likely to Raise Costs," by Judith Messina; Bloomberg News	102
"Small-Business Health Care Tax Credits Are Having a Miniscule Impact," by Salley Pipes; Forbes	104
"Healthcare Law Could Leave Families with High Insurance Costs," by Julian Pecquet; The Hill	106
Associated Builders and Contractors, Inc. Letter for the Record	108
American Bankers Association Letter for the Record	110

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THURSDAY, JULY 28, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:05 a.m., in room 2360, Rayburn House Office Building, Hon. Renee Ellmers (chairwoman of the Subcommittee) presiding.

Present: Representatives Ellmers, King, Richmond, and Altmire.

Also Present: Representative Kingston.

Chairwoman ELLMERS. All right. We are going to go ahead and get started. Good morning to everyone, and I call the hearing to order.

I want to thank the witnesses on both panels. We will have two panels today who are testifying, and we certainly appreciate their attendance and participation in this important Subcommittee hearing.

Although the health care law won't be fully implemented until 2014, businesses are already feeling the effects. A study released this week by the National Federation of Independent Business found that small firms are worried that the law could lead to higher taxes, more administrative burdens, and bigger budget deficits without lowering costs or making Americans healthier.

Under the law, many small business owners will be required to offer coverage to their employees or pay a penalty. And the small business tax credit that has been touted to offset the cost of health insurance is, in reality, a temporary and a narrow one, where the full credit applies only to the smallest of businesses.

If your firm has more than 25 employees, you are one of the 23 million self-employed, you qualify for no credit whatsoever.

We have heard small businesses are concerned that regulatory requirements on insurers, such as the medical loss ratio, may drive some carriers out of the market, resulting in fewer options and premium hikes. Small firms are uncertain about whether they will be able to continue offering coverage; if so, at what cost; and if not, what their penalties will be and what the coverage will cost taxpayers.

This is all while our economy is still very fragile, an economy that is adding fewer jobs than forecast, and still has a high unemployment rate. In this environment, it is not surprising that small business owners continue to be hesitant to create jobs, expand or invest. And there are more regulations ahead.

During the health care debate, one of the most repeated assurances was that if you like your current health care coverage, you would be able to keep it. However, for a number of reasons, a small business may be driven out of its current plan.

The Department of Health and Human Services predicts that over half of all employers and up to 80 percent of small firms may relinquish grandfather status by 2013. This means that small business owners and workers may be forced to switch to higher-priced plans or drop insurance altogether.

Although the goal of the health care law may have been to make health care insurance more accessible, its taxes, mandates, regulations, and administrative burdens are causing many small businesses, our best job creators, to postpone hiring and expanding.

Again, I thank the witnesses who are here with us today for participating. I look forward to hearing their input on how we can help to reduce the impact of some of the health care law's uncertainty, mandates, regulations and requirements for our small businesses.

I now yield to Ranking Member Richmond for his opening statement.

Mr. RICHMOND. Thank you, Madam Chairwoman. Thank you for yielding.

Today's hearing will focus on the health insurance landscape for small businesses since the passage of the health care bill.

Currently, employers are the principal source of health insurance in the United States, providing benefits for more than 158 million people. Given the role of business in providing insurance, two questions have been raised about the Affordable Care Act. First, will small firms be able to keep existing health plans and, equally important, how will the Affordable Care Act affect small firms' decision to offer coverage? These are the questions we will address today.

Small businesses face numerous challenges when choosing a health plan. This includes making tough choices about coverage, benefits, which physician should be part of the insurer's network and what co-pays should apply to services.

Yet with all these challenges, cost remains the greatest barrier to coverage. According to one report, over the last decade health insurance premiums have increased 113 percent.

The Affordable Care Act was enacted to lower costs and create more quality health care choices. Still, the legislation has not been without its critics. Some have argued that small firms will not only lose their ability to keep their plan, but most will drop coverage altogether. We will hear from the administration and witnesses on both of these issues.

One, on the matter of retaining current health plans, CMS has issued regulations outlining how firms can maintain so-called grandfather status. The regulation provides latitude for firms to provide changes because of rising prices. It also clarifies for firms what they need to do to keep their plan despite ACA changes.

While protecting small businesses' ability to retain plans is important, the reality is many firms will make changes. Historically, small firms change plans due to rising prices or different benefit needs. Now, small firms will be afforded better service and choice when choosing a new plan.

The Affordable Care Act not only creates new incentives but maintains laws that encourage employers to purchase insurance. Most notably, the employer-provided benefits remain tax free and employees can still pay premiums on a pretax basis. And since 2010, small firms have been eligible for a new health insurance tax credit.

One of my constituents, Ms. Verna Williams, owner of Nola Health Care LLC, provides a great example of how firms are using this successfully. She owns a private health clinic in New Orleans and was able to avail herself of the new tax credits. Now, all 12 of her employees have health care coverage, and she said she was very pleased with the new health care legislation and its benefits for her employees.

In addition to the incentives, insurance reforms are already on the books that benefit small firms. No longer can insurance companies discriminate based on preexisting conditions or raise premiums without adequate justification.

Again, starting in 2014, private health insurance exchanges will create a virtual market for buying insurance. Exchanges will provide another option and enhance competition, something lacking in the small-group market.

With all these changes, what will all of these changes mean for small businesses? One study predicted that employer-sponsored insurance could shrink by over 20 percent. However, others, such as those by the RAND Corporation and the Robert Wood Johnson Foundation, found that small firms would increase coverage.

This hearing will give members of the Committee the opportunity to discuss the Affordable Care Act and its implementation. Ensuring that small firms can keep their plan, while making coverage more affordable, is critical.

I want to thank Director Larsen and the witnesses that have taken time out of their busy schedules to be here today. I look forward to hearing from you all.

With that, I yield back, Madam Chair.

Chairwoman ELLMERS. Thank you, Mr. Richmond.

Chairwoman ELLMERS. As you can see, some of our other Committee members have not arrived yet, but I will state for the record that if they have any opening statements they can submit that for the record.

I would like to take a moment just to explain the timing the lights. You will have 5 minutes to deliver your testimony. The lights will start out as green. When you have 1 minute remaining, the light will turn yellow. Finally, it will turn red at the end of your 5, minutes and I ask you to try to adhere to your 5-minute time limit.

You have the button there to push to speak into the microphone.

Our first witness is Mr. Steve Larsen, who is director of the Center for Consumer Information and Insurance Oversight, or the CCIIO, with the Centers for Medicare and Medicaid Services. Prior to his current position, Mr. Larsen served as director of the Division of Insurance Oversight at CCIIO.

Welcome, Mr. Larsen. You will have 5 minutes to present your testimony. Thank you.

STATEMENT OF STEVEN B. LARSEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. LARSEN. Good morning, Chairwoman Ellmers and Ranking Member Richmond and members of the Subcommittee. Thank you for the opportunity to discuss how the Affordable Care Act is improving the affordability, the accessibility, and the quality of health insurance available to small businesses and their employees.

Providing and maintaining health insurance coverage for employees has been a challenge for small businesses for many years. States have struggled for decades, really, to improve their small-group health insurance market, and I know this from my many years of experience as insurance commissioner in the State of Maryland.

Small businesses pay significantly more than large firms for the same health insurance policies. Some estimates put that at about 18 percent more. There are a number of reasons for this. Small businesses lack the purchasing power that large employers have, administrative costs for insurers in handling small businesses are much higher than for large businesses. Small businesses often don't have the human resources staff to navigate through the difficult process of choosing between health plans.

Prices for insurance for small businesses can be more volatile, due to the smaller risk pool, compared to large businesses, and employees in small businesses are subject to medical underwriting in many States. So this means that the rates that small businesses are charged can spike if just a single employee becomes very ill. The Affordable Care Act addresses these challenges in the market and helps close the gap between small- and large businesses' ability to offer health insurance to their employees.

First, starting in 2014, small businesses will be able to reduce administrative costs and pool their buying power by purchasing insurance through the exchanges. The exchanges are State-based, competitive marketplaces for buying private health insurance. Small businesses will be able to buy health insurance through a part of the exchange called the SHOP.

SHOPs will give small businesses and their employees many of the advantages of large employers that large employers have today, such as more choice, more competition, and more clout in the marketplace. These SHOP exchanges are a one-stop shop where small businesses and their employees will be able to easily compare health plans, get answers to questions, and then enroll in high-quality health plans that meet their needs.

Health plans that participate in the State exchanges will compete for business on the basis of price and quality, and this type of market competition has the power to drive improvement in both plan quality and affordability.

We recently issued draft regulations which will provide States the flexibility to provide small employers with a range of options on how the employers offer coverage to their employees. For example, a small business participating in the SHOP exchange may choose a level of coverage and a level of contribution towards that coverage, and then employees will choose among the health plans

available on the exchange within that level of coverage offered by their employer. Or, employers may provide to their employees a broader range of options, such as shopping for any level of coverage among competing health plans.

Under the proposed regulations, the employer would write a single check to the SHOP, reducing administrative burdens. The SHOP, as a premium aggregator, would handle the administrative functions that can burden the small business owner. SHOPs will simplify the employee decisionmaking process by providing side-by-side comparisons of health plans' premiums, benefits, and cost sharing. Not only will the Affordable Care Act benefit small employers by enabling them to pool their buying power, it will also protect them from premium spikes caused by an employee's illness.

Beginning in 2014, the ACA prohibits new health plans from rating on the basis of health status or claims history. In addition, the law limits how much insurers can increase rates based on employees' ages. These new rating limitations will help make small businesses' health insurance rates fairer, more predictable, and easier to understand.

In addition, limits on health plans' medical loss ratios will also save small businesses money, as insurers that fail to meet the MLR standard will provide rebates.

Finally, the law established a small business tax credit that is making health coverage more affordable for small businesses. The tax credit is designed to encourage both small businesses and tax-exempt organizations to offer health insurance coverage to their employees for the first time or to maintain coverage that they already offer.

Small businesses are already benefiting from the Affordable Care Act and those benefits will expand dramatically as the ACA continues to take effect.

Thank you for the opportunity to appear before you today to discuss the Affordable Care Act's critical provisions to support small businesses' ability to offer health insurance to their employees.

Chairwoman ELLMERS. Thank you, Mr. Larsen.

Chairwoman ELLMERS. And I will begin the questioning.

Generally, grandfathering should allow you to keep the coverage you had when the health reform law was enacted, with some exceptions. The June 17, 2010, and November 17, 2010, rules on grandfathering list several changes that disqualify a plan from being grandfathered.

The rules seem to leave open whether other changes will be disqualified, and leave open the possibility of additional administrative guidance, to explain how plans must comply to continue to be grandfathered, I am wondering how can small businesses count on grandfathering if the guidance is vague and the rules may change as we go along?

Mr. LARSEN. Sure. Well, as you point out, we put out the initial interim final rule back last summer, which laid out kind of broad categories in which small businesses and health insurers have flexibility to alter some provisions of their health coverage, but not so much that it really changes the fundamental nature of the coverage.

We received and have reviewed various comments on many aspects of that regulation. We did, in fact, amend the interim final rule to provide actually more flexibility to businesses and small businesses to maintain their existing coverage by allowing them to, for example, switch carriers. If they wanted to switch carriers, if they thought they could get a better deal.

So, in fact, although we have amended the initial guidance that we put out last summer, we have done so in a way that really provides more flexibility to small businesses and to the health insurance issuers that provide that coverage.

Chairwoman ELLMERS. I have another question for you at this time. Small businesses are concerned about the possible mandates in the health care law's minimal essential benefits package. Because many new services, treatments, are likely to be required, the cost of premium is also likely to increase.

What can you tell us about the Institute of Medicine's forthcoming recommendations on the essential benefits package?

Mr. LARSEN. Well, I can't tell you much about what they are going to say. We haven't received their recommendation. But if I could just summarize the process that we will follow, and I would add that we are, I think like you, very aware and tuned into the need to make sure that the package of essential health benefits is an affordable package.

There is kind of a multistep process that we are following at HHS. The first step was that the Department of Labor performed a survey of employers to gauge what were the typical benefits that are offered in employer-sponsored coverage today, and we have got that survey. That has been published.

The Secretary also, as you point out, did ask the Institute of Medicine to recommend to us methodologies or ways to think about how we should define the package of essential health benefits. But I do want to be clear, because I know there has been some confusion on this. The IOM is not the body that will be charged with defining what that list is. That is left to the HHS, and we will do that. And I think we have announced previously that our objective is to have that guidance out sometime this fall. We know there is a lot of interest in that, both in the States and among businesses and among insurers, so we are hoping to get that guidance out this fall.

Chairwoman ELLMERS. So basically you do anticipate that there will be additional administrative guidance on the grandfathering?

Mr. LARSEN. Well, on the essential health benefits, yes. On the grandfathering, I can't speak to that at this point. I don't think we are anticipating anything, but we continue to review these, and as they need to be tweaked and improved, if that need arose, then we would look at that as an opportunity.

Chairwoman ELLMERS. Okay. I now yield to Congressman Altmire for his questions.

Mr. ALTMIRE. Thank you, Madam Chair.

Director Larsen, thank you for being here. Economists, like Dr. Holtz-Eakin, who we are going to hear from shortly, have predicted that the employer mandate will lead to dramatic declines in employer-sponsored coverage, as you well know.

In your view, will most small firms drop their coverage or simply pay the penalty? And what do you expect they will—do you expect that they will continue providing health care to their workers? What do you expect the outcome will be?

Mr. LARSEN. We do expect small employers to continue to offer employer-based coverage. It is really a cornerstone of our economic system, of our employer-based insurance system.

If you look at a number—and I know there are a number of different studies out there, but if you look at, for example, the RAND analysis or the Urban Institute—there are those two—for example, I think predicted significant increases in the offer rate, not decreases but increases.

For example, RAND predicted that you would see an increase for very small businesses. I think, for example, less than nine, nine or less employees, from about 50 percent today to about 70 percent in the future under the ACA, and its numbers were similar for The Urban Institute.

Mr. ALTMIRE. And regarding the medical loss ratio in particular, as you know, the ACA requires insurance companies to spend at least 80 percent of their premiums they collect on medical care. What will this mean for small firms and how will it affect the cost of coverage, in your view?

Mr. LARSEN. The medical loss ratio provision of the ACA is a very important provision and helpful provision to small businesses and individuals because it applies to individual purchasers as well. It helps to provide value to small businesses when they are paying their insurance premiums by ensuring that issuers are not spending inordinate amounts on administrative expenses. So it drives efficiency in the issuers for the insurance company, and that creates value for the premium dollars that small businesses are paying.

Mr. ALTMIRE. Now the companies would argue that it doesn't just drive efficiency, they might dispute that on its face, but they also would say that it is going to drive small insurers out of the health insurance market entirely.

Do you have a response for that?

Mr. LARSEN. We don't think that is the case and we haven't seen that. I guess I would also hasten to add that the Affordable Care Act specifically provides States and the Secretary with the flexibility to address, at least in the individual market, the medical loss ratio provisions.

In the small-group market, in fact, many States already had in place medical loss ratio targets. I think there were around 10 that were already at 80 percent. There were a handful that had less than that, so that was already present in the marketplace, and many insurers were already used to pricing to an 80 percent level.

Mr. ALTMIRE. Do you envision CMS playing a role in and ensuring competition in the market? Were you given that authority under the law and are you going to——

Mr. LARSEN. Well, I mean, when we get to the exchanges in 2014, competition is kind of the cornerstone of what we are trying to accomplish in the exchanges. And we will be working actively with the States as they set up their State exchanges. And to the extent that we are operating a federally facilitated exchange, we will do everything we can to make sure that there is competition

among insurers. The exchanges are all about competition among private carriers to the benefit of, you know, small businesses and individuals.

Mr. ALTMIRE. And last question, Madam Chair. Since 2010, eligible small firms have had the ability to obtain a health care tax credit. And according to the NFIB information provided to this Committee, 1.1 million small businesses are eligible for either a partial or full credit. And while I realize the IRS administers that credit, does CMS have any estimates on employers taking advantage of the credit and how it has lowered their costs?

Mr. LARSEN. Yes, I know that there are varying estimates about both the eligibility rate and the uptake rate, and some of it is survey-based. We are currently working with our colleagues over at Treasury and IRS to get an estimate on what that is. I apologize I don't have it for you here today, but we hope to get that soon.

Mr. ALTMIRE. Great. Thank you.

Chairwoman ELLMERS. Thank you. I have a couple more questions for you, Mr. Larsen.

Small business owners have told us the new law and its regulations are vague, and we mentioned that already, and they don't know what is required of them. For example, many aren't sure if the employer mandate applies if they have employees who are working 30 hours a week or less.

If they currently offer insurance to the individual employee, they aren't certain if the new law requires them to also cover the employee's family. How are the small business employers, who don't have the benefit of large administrative staffs or outside benefit counselors to advise them, to be expected to comply with the complicated law and its numerous regulations? Can you clarify just some of that for us?

Mr. LARSEN. Yes, and that is a very important question. I think some of the surveys that have done—and although we don't necessarily agree with many of the points that came out in the NFIB report or the McKinsey report, I think one thing that comes through clearly in those is that there still remain a lot of questions among small business owners. Either they don't understand the law, or they don't feel they have enough information. And I think that is an important point that we have to take note of, that between now and 2014 we have to continue our efforts to reach out to small businesses and educate them.

There are some tools that will be available, for example, in the exchanges. There is a role of these entities called "navigators," which are going to help people understand the health care law, understand how to access the exchanges. But there is more work to be done there, and I think there has been confusion, some misinformation, and I think it is something that we definitely need to focus on between now and 2014.

Chairwoman ELLMERS. New regulations require insurers to spend 80 to 85 percent of premiums on direct care for patients rather than administrative costs. These requirements may be difficult for small insurers to meet, driving them out of the market, limiting consumer choice, and raising the cost of insurance and, as the market decreases, that is always that risk.

How can small insurers compete when they don't have the resources or economies of scale to do so?

Mr. LARSEN. Well, we are certainly sensitive to the need to maintain competition.

Ultimately, the Affordable Care Act provides some flexibility in the individual market, but less flexibility to modify the MLR standard in the small-group market. However, again, I think as I mentioned earlier, there were already existing in many States a medical loss ratio standard at or about the standards set out in the ACA, and I think that provided a benchmark from which carriers, you know, could launch from.

Chairwoman ELLMERS. Interestingly enough, very recently, in fact last Friday, The Hill newspaper had a front page article titled, "Health Care Law Could Leave Families with Higher Costs."

The article describes the debate over what the story terms a major provision of the health care reform law, which provides that if a worker has employer-based coverage that is affordable for the employee only, the family is expected to take the employer coverage even if it is unaffordable.

Is this the correct interpretation and can you clarify some of that for us?

Mr. LARSEN. We are actually looking at that very issue, which is the interpretation of the application of the tax credit to the individual, to the family, and who qualifies at what point? When an employer makes an offer, is that binding on the dependence of the family members of the employee?

We are anticipating in future guidance to clarify this and a number of issues relating to the application of the tax credit and how it works. You know, we put out a first—kind of a wave of guidance just a couple of weeks ago on the exchanges. And the next phase of that, which will deal with eligibility and enrollment and the application of the tax credit, hopefully will clarify some of those issues.

Chairwoman ELLMERS. And then I have one last question. This also addresses one of the issues that Mr. Altmire referred to.

The tax credit may apply temporarily and narrowly if the business has fewer than 25 full-time or equivalent employees making an average annual wage of $50,000 or less. But what about every other small business? What advantages do they have as far as a tax credit?

Mr. LARSEN. Well, you are correct in that the tax credit was targeted towards the smallest of the small businesses with, you know, under nine getting the maximum credit, and you can get up to 25, depending on what the wages are that you pay your small business.

You know, one of the reasons why it was targeted, because those were the small businesses that had the lowest offer rates. As you move up to, say, employers with 50 employees, you have offer rates, offer rates of insurance coverage that can be in the 80 to 90 percent rate.

So the tax credits were targeted towards that segment of the market that was most in need of help in terms of getting the offer.

There are still many benefits, as I mentioned, in the Affordable Care Act for businesses that are larger than 25, the rating restric-

tions are very important. Small businesses, and I know this from my own experience, in many States small businesses get rated up if they have sicker members. And so that practice is going to go away. It is going to create a lot of fairness and benefit.

And then the general benefits of the exchange, much lower administrative costs. The CBO found that as well for—and that applies to all small businesses, not only just those under 25 employees.

Chairwoman ELLMERS. So you do see some possible changes or flexibility in the whole——

Mr. LARSEN. Well, there are benefits to small businesses. But you are right, the tax credit is targeted to the smaller small businesses because, again, it was concluded those are the ones that have the lowest rates of insurance coverage for their employees.

Chairwoman ELLMERS. Thank you, Mr. Larsen. I just would like to ask if Mr. Altmire has any additional questions. Okay.

Well, Mr. Larsen, I thank you for joining us today to answer our questions and providing your insight on these issues. We will continue to closely follow them and want to work with you and help ensure that small businesses have flexibility and choices in their health care coverage decisions.

I want to suggest that Mr. Larsen ask a member of his staff to remain here during the testimony of the second panel. And would you please identify—and I believe we have already spoken, so, thank you, perfect, wonderful.

And, thank you again, Mr. Larsen, for your time.

Mr. LARSEN. Great, thank you.

Chairwoman ELLMERS. I truly appreciate it.

Chairwoman ELLMERS. And now I would like the second panel to come forward.

Wonderful. Let's go ahead and get started. Thank you so much for coming today to be with us for this Subcommittee hearing.

Our first witness is Dr. Douglas Holtz-Eakin. Dr. Holtz-Eakin is president of the American Action Forum. He served as a commissioner of the congressionally chartered Financial Crisis Inquiry Commission from 2009 to 2011, and director of the Congressional Budget Office from 2003 to 2005. Dr. Holtz-Eakin received his B.A. in mathematics and economics from Denison University and his Ph.D. in economics from Princeton. Welcome, Dr. Holtz-Eakin, and you have 5 minutes to present your testimony.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, DC; WILLIAM DENNIS, JR., SENIOR RESEARCH FELLOW, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC; BRIAN VAUGHN, PRESIDENT, NEARLY FAMOUS, INC., DOUGLAS, GA, TESTIFYING ON BEHALF OF THE UNITED STATES CHAMBER OF COMMERCE; AND TIMOTHY STOLTZFUS JOST, ROBERT WILLETT FAMILY PROFESSOR OF LAW, WASHINGTON AND LEE UNIVERSITY COLLEGE OF LAW, LEXINGTON, KY

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. HOLTZ-EAKIN. Well, thank you, Chairwoman Ellmers and Acting Ranking Member Altmire. I appreciate the chance to be

here to talk about the Affordable Care Act's small businesses and employer-sponsored insurance. And you have my written testimony which I submit for the record.

Let me just make a couple of points. The first point, and I think the overriding one, is that ultimately the ability of small businesses to offer insurance is contingent on the health of those businesses and their ability to grow. And the Affordable Care Act contains many provisions that I think are detrimental to the abilities of small businesses to prosper and grow.

There are taxes, the 3.8 percent investment tax that is going to be a direct hit on small businesses.

There are a large number of mandates and penalties, and the regulatory implementation I think is daunting to any small business. We are in an environment where in 2010 we had a record number of Federal Register pages. That was prior to the implementation of the Affordable Care Act and Dodd-Frank and a whole bunch of other things. So this adds to the regulatory burden.

And even some of the so-called help, the tax credit in particular, is structured in a way that penalizes growth. If you had workers, if you pay higher wages, even this temporary tax credit gets scaled back and it is ultimately a penalty against those who succeed. And so the structure of the ACA is not one that I would call good economic policy to promote growth, especially on small businesses.

The second is that the Affordable Care Act is actually going to raise insurance costs. There is now consensus that it fails to bend the health care cost curve, which is the fundamental driving force underneath the premiums, and small businesses will suffer from that.

It has $500 billion in new taxes. Many of them are taxes that are going to go directly to the premium bottom line. My testimony outlines the impact of the so-called premium tax on health insurers. There is medical device taxes. All of these are higher costs in the food chain that lead to higher premiums that is going to hurt the ability of a small business to continue to offer insurance and lead many of them to elect to drop their coverage and/or never offer it to begin with.

The third point, I guess, is this issue that Mr. Altmire mentioned with the previous witness, and that is the question of the incentives for employers to drop coverage and send their employees to the exchanges.

And there have now been a number of studies, as was mentioned, one that I did with Cameron Smith, my colleague, that looked at the pure financial incentives for employers and employees to mutually agree that it would be in their financial interest to provide the insurance through the exchanges. And we concluded that up to 35 million American workers would benefit from this arrangement, and that their employers would agree that they should go off the exchanges. The only loser in that is the taxpayer who has to pick up an enormous tab.

A recent paper by Cornell Professor Richard Burkhauser and colleagues comes to roughly the same conclusion. I am aware there are other studies that say that, no, that won't happen. Their leading argument appears to be that, well, it won't happen because we

have always offered insurance. But in the face of a dramatic policy change, I don't see why that is a compelling argument.

We are now seeing the leading edge of evidence. We have survey evidence from McKinsey, from PriceWaterhouseCoopers, and I will let Mr. Dennis speak for the National Federation of Independent Business, suggesting that in fact this financial impact is not only real, it will be pursued by businesses.

And so I think this is a serious concern because the subsidies are enormously generous. We are talking about $7,000 for someone making $59,000 in income in 2014. This is well over 10 percent of their income. It would be financially irrational for employees and employers to ignore that kind of money.

And if it is true that many pursue this, budgetary cost of the insurance subsidies through the exchange is going to explode. It could easily be double what was in the original bill. We are all well aware of the financial problems that face the United States Government. And to have this come in much more expensive than was budgeted, I think, is an extreme danger.

Which brings me back to my first point which is, in the end, it is going to be the environment for small businesses to grow and prosper that is crucial. There is nothing about sailing directly toward a debt crisis that is good economic policy or beneficial for the small business community at the heart of our debt problems, our explosive entitlements.

And my view is that the Affordable Care Act has a whole series of upward risks on the budgetary side that make the possibility of that crisis much higher, and, as a result, have to be viewed as a threat not just to the economy, but to small businesses in particular, and certainly to their ability to continue to offer insurance to their employees.

And I understand the sentiments behind the Affordable Care Act, but I think on balance its structure is one that hurts the small business community and doesn't aid it in the end. Thank you.

Chairwoman ELLMERS. Thank you for your comments. And we do have your testimony, as we do all of our panelists.

I now yield to Representative Kingston from Georgia for the purpose of introducing his constituent as a witness.

Mr. KINGSTON. Thank you, Madam Chair. It is a great honor to be with you on this dais, you and Mr. Altmire, a good friend of mine from Pennsylvania. And I appreciate all the hard work that you do on this Subcommittee to try to promote jobs in this tough economic environment. I appreciate the panel for being here.

I have a hard deadline at 11 o'clock with another Committee on which I serve, so I am going to be leaving shortly before then. But I wanted to say hello and introduce my constituent, Brian Vaughn. He is no stranger to the struggles of an entrepreneur. He has been with the Burger King franchise operation since 1980 and kind of came up through the corporate structure, working in Florida and in Georgia, and then in the 1990s took the plunge to become a franchisee himself; and, since that period of time, has bought out his partner and been on his own with his wife—I am not sure if Cindy is here—but knows the importance of keeping employees happy by offering a good compensation package, including a good benefit package, worker safety, a good environment to work in, and

has many employees who have been with him on the management side for over 10 years, which is remarkable.

He has four stores in three different cities and also knows what it is like to compete in this environment and to get the customers back in when it is very hard on their pocketbooks in today's economy, but knows all the challenges that small business people face, really: labor, environmental regulations, safety regulations, franchise regulations. I think he has been through it all, but has done it successfully.

So I am very proud to have him as a constituent and as an example of an entrepreneur. And I wanted to point out also, one of his jobs before he became an entrepreneur was to recruit entrepreneurs. So he looked at it, and did not have to take that plunge, yet he made it anyhow.

So I am proud to have Brian Vaughn here today and I look forward to his testimony.

Mr. VAUGHN. Thank you.

Chairwoman ELLMERS. Go ahead.

STATEMENT OF BRIAN VAUGHN

Mr. VAUGHN. Chairwoman Ellmers, Congressman Altmire, and distinguished members of the Subcommittee, thank you for inviting me to testify before you today on how the new health care law will impact my business and my employees.

As the Congressman stated, by name is Brian Vaughn and I own Nearly Famous, Incorporated, which consists of four Burger King restaurants in Georgia, and I am happy to be here today on behalf of the U.S. Chamber of Commerce. I am also a proud member of the National Franchisee Association and have served on their board of directors for 3 years.

Nothing I say here today reflects the position or opinions of my franchise or Burger King Corporation. You know, when people think of Burger King, they think of a big international corporation. Even though the sign on the door says Burger King, my four restaurants are small family-owned and -run businesses.

I began working as a Burger King assistant manager in 1980, as the Congressman said, earning $14,000 a year. After working my way up, I partnered in 1993 with Francis Lott to open our own four Burger King restaurants in Georgia. In 2001 I bought out my partner's interests and today I operate these four restaurants with my wife, Cindy.

At our four restaurants, we are proud to have created 182 jobs. We have 59 full-time employees and 123 part-time employees; 14 of our full-time employees are managers, for we currently pay 100 percent of their health care premiums at an annual cost of nearly $56,000. We also pay for term life, short-term disability, vision, and dental insurance. My wife and I participate in this very same plan.

For our other employees, we offer a value mini-med plan at a cost of between $106 and $165 per month. Currently only 19 of the more than 100 part-time employees have elected to participate. Many employees choose to keep the wages they earn to help pay for their day-to-day living expenses rather than use a portion of their wages to pay for the coverage.

As the president of my company, I also have to decide how much of the company's income can be used to pay for wages and benefits and how much has to be used to cover the expensive daily operations. There is only so much money, and, first and foremost, we all have to cover our daily expenses.

Washington, it seems, really doesn't understand this. A lot of noise was made last fall about the types of plans that I offer my employees. Under the health reform law, Washington has decreed that these so-called limited benefit plans are not acceptable. Despite repeated promises that if you like your plan you can keep it, the law has outlawed these plans, beginning in 2014.

I understand that for many, a more comprehensive plan seems critical; and, by comparison, these limited benefit plans are slim. However, it is important to acknowledge reality. These plans are less expensive and allow my team members to choose to take more of their wages home and use a smaller amount of their wages to pay for some coverage.

Prior to health care reform, I had the flexibility to hire more workers, pay them a wage and offer them access to this moderate coverage. Now I am being told by Washington that I have to offer all my full-time employees Washington-defined health coverage or pay a penalty. Because of the cost of offering this prescribed coverage and the size of the penalty, I will have no choice but to restructure my workforce in a way that protects me from losing everything I have worked for.

What does this mean? Well, given the law and the unfinished regulations, and I mean unfinished regulations, it is hard to say. I have no idea. Prior to the law's enactment, my goal had been to hire fewer people for more hours. It is easier to retain employees that work full time.

However, now that the law is passed, I have to consider options other than what makes practical business sense. Now, because of what Washington has mandated, it may make more sense for me to hire more people for fewer hours at a time when millions of Americans are out of work. Is this really the right incentive?

This is not what I want to do, and it is not what is best for my employees, but in order to survive and be able to pay the employees that I have to, it is what we will have to do.

While I have not read the entire law, and I am not able to follow the regulations—which are being issued at record speed, mind you—I am trying to figure out how to protect the company that I have spent my entire life building. It is ironic that the law touted as the Patient Protection and Affordable Care Act neither protects patients nor makes health care affordable. Instead it is a law of broken promises under which no one will be able to keep the health care they have. Even if they like it, it is a law which incents companies to scale back their workforces and reduce the benefits offered to their valued employees.

In conclusion, I understand that given the existing political realities, Washington, D.C., a total repeal of the health care law by Congress is an unlikely proposition, at least for now.

However, I am hopeful that Congress will repair or eliminate the more onerous burden, such as the employer mandate. These provisions saddle businesses with new requirements that actually en-

courage us not to expand our business and, astoundingly, discourage us from creating jobs.

The bottom line is that your decisions can help or hinder this. The laws you create can either give small businesses greater confidence and certainty to grow and generate new jobs or just do the opposite. Regrettably, this new health care law is already doing the latter, and Congress must take the action to rectify it.

Again, thank you again for this opportunity, and I look forward to your questions.

Chairwoman ELLMERS. Thank you, Mr. Vaughn. I will just tell you that my very first job at age 16 was with Burger King back in Madison Heights, Michigan, back in 1980.

Mr. VAUGHN. Thank you.

Chairwoman ELLMERS. Thank you again for your testimony.

Chairwoman ELLMERS. I would like to introduce Mr. William Dennis. Mr. Dennis is senior research fellow at the National Federation of Independent Business. He has directed the NFIB's research foundation since 1976.

Welcome. And you have 5 minutes to present your testimony. Thank you.

STATEMENT OF WILLIAM DENNIS

Mr. DENNIS. Thank you, Madam Chairman, Mr. Altmire, and Representative King.

Last week NFIB released a study called "Small Business and Health Insurance: One Year After Enactment of PPACA."

I would like to focus my remarks on the results of that study, since it is quite current and relevant to what we are talking about today.

First of all, we surveyed only people, small employers that had 50 or fewer employees. It was a nationally random sample, not just the NFIB members. There will be probably some randomly in there, but this was a national random sample. The survey was conducted in late April and in May of this year. So, while it wasn't done yesterday, it is current enough so that I think we can say it is the state of what we know today.

The findings are really quite simple. The first is that we are in this period of declining offer rates by this group of firms. There are 42 percent that now offer, which continues the down trend over the last 10 years at least. MEPS just produced a 39 percent estimate, which is lower, and so the NFIB survey really does capture the trend.

Something else that you should understand is that nothing has happened in the last year and nothing is projected to happen in the next year. People who had offered before tend to offer now and expect to offer in the future. And, those who do not or have not offered didn't pick it up this year, and they don't plan to in the future. So we expect this down trend to continue.

Twenty percent with insurance do expect major changes in that insurance. Virtually all those changes are not to the benefit of the employee. Since enactment of PPACA, one in 8, 12 percent, of small employers have either lost their specific plan or been told they will lose their specific plan.

Of those who claim to be familiar with the law or have some familiarity with its contents—by very large margins, overwhelming margins, particularly those who insure—think it will not reduce the cost of health insurance. It will not reduce administrative burdens, will increase taxes, and will add to the deficit. They do agree more people will be covered, although they are not quite sure whether that is going to yield better benefit or yield greater health outcomes.

Let's just look at the tax credit. We estimate using some new data that we recently collected that out of the 5,228,000 small employers with under 25 employees, an estimated 245,000 will be able to take advantage of the full credit, and 1.165 million will be able to take advantage of the partial credit. That is not how many will. Fewer will probably take advantage of that in part because of awareness. Those numbers are the maximum that will take part.

Now, beyond that, there is the whole incentive effect. How many will the credit incent? One of the ideas behind this is just not to provide a windfall, to have people do what they are already doing, but to provide an incentive for people to purchase it.

We calculate that only about 2 percent have an incentive based on the full credit, though more than that have an incentive based on the partial credit.

The survey also explored the reaction of these small business owners, if low-income people start to leave for the exchanges. About 21 percent said they would seriously explore looking at whether or not they are going to drop their health insurance for everybody. Another 26 percent said that they also would do that, but were less certain.

So there clearly are pressures that would lead folks in that direction. Once competition actually sets in, firms continue to churn, new firms enter without health insurance, we are going to see real market pressures, not to—not only not to add for those who don't have it, but to drop it for those who do.

Thank you.

Chairwoman ELLMERS. Thank you, Mr. Dennis.

Chairwoman ELLMERS. I now would like to yield to Mr. Altmire to introduce your witness.

Mr. ALTMIRE. Thank you, Madam Chair. And it is my pleasure to introduce Professor Timothy Jost. Professor Jost teaches at the Washington and Lee University College of Law. He is co-author of a casebook health law used widely throughout the United States in teaching health law.

Professor Jost is the author of numerous articles on health care regulations and comparative health care law and policy. He is also consumer representative to the National Association of Insurance Commissioners. Professor Jost earned his J.D. from the University of Chicago School of Law, cum laude. Welcome, Professor Jost.

STATEMENT OF TIMOTHY STOLTZFUS JOST

Mr. JOST. Thank you very much and thank you, Ranking Member Ellmers and Congressman Altmire and Congressman King.

The title of today's hearing is: "Small Business and PPACA: If They Like Their Coverage, Can They Keep It?"

This is a variation of one of the commitments made by the Affordable Care Act, realized in section 1251, that if you like your plan you can keep it. But, notice, the ACA's commitment is to individuals, not to employers.

It is not if you currently have insurance through your job, you are stuck with that insurance, no matter how it changes. It is if you the employee, or individual enrollee, like your coverage, you can keep it. In fact, most privately insured Americans do have insurance through their jobs and regulations adopted last summer by Labor, Treasury, and Health and Human Services, give employers considerable flexibility to change their plans without losing grandfather status.

Employers can change their formularies, providers, networks, and even insurers or plan administrators. They can increase deductibles, out-of-pocket limits, and copayments not only to keep up with medical inflation, but also up to 15 percent more. They can also reduce their own contributions to premiums by as much as 5 percent. They can add new employees and new dependents.

Of course, if the plan changes too much, it ceases to be the plan it was. It is probably no longer the plan the enrollee liked, and grandfather status is lost. The Department has projected that 15 to 33 percent of plans would lose grandfathered status in 2011.

Private surveys cited by Mercer and Hewlett in submitted testimony predict higher levels, although they also noted that many employers do not really view loss of grandfathered status as a major problem, and some said they wanted to comply with the new law as soon as possible.

The NFIB survey released last week surprisingly did not reflect widespread loss of grandfathered status. The NFIB reports that 90 percent of small businesses intending to make significant changes in their plan have not lost their plan.

It does report that 12 percent of employers have had their plan terminated or been told that it will be not available in the near future. This number is consistent with churn in insurance coverage observed in earlier years, and I believe I cited a 2008 NBER report which showed this kind of turnover in the early 2000s. Plans are always coming and going in the small-group market.

NFIB also reported that 20 percent of employers anticipated significant changes in their plans over the next 12 months, but last year and the year before changes in benefits, cost sharing, and premiums, as reported in the annual Kaiser HRET report, were at even greater levels. This is a bad time in the economy, as we all know, and things are changing.

Another and very important question is whether employers will continue to offer coverage after the ACA is fully implemented. A number of studies have addressed this question. Their predictions range at the extreme, from those of Dr. Holtz-Eakin, who predicted that ESI would shrink by 22 percent, and the McKinsey survey, which claims that 9 percent of employers will definitely drop coverage, to those of the RAND Corporation which estimated that coverage would, in fact, grow by 8.7 percent.

But most studies, including studies by Booz, Lewin, Urban, Mercer, Towers-Watson, and most importantly the CBO, predict that coverage will not change dramatically once the ACA is imple-

mented. In fact, all of the reasons employers offer insurance now will continue to exist after health care reform goes into effect.

Most importantly, employee benefits are exempt from Federal and State income taxes and payroll taxes. In Virginia, where I live, employees taxed at the alternative minimum tax marginal rate of 28 percent receive a subsidy of over $0.49 on every dollar for the coverage that they receive through their employer.

The average American covered by ESI has an income of 423 percent of the Federal poverty level and would not be eligible for any of the premium subsidies under the Affordable Care Act.

Employers who drop health insurance would have to dramatically increase after-tax cash compensation for their higher-income employees to cover this loss of tax subsidy, and the law prohibits them from dropping benefits from their lower-wage employees but keeping them for their higher-wage employees.

Health benefits also continue to be one of the most highly valued forms of compensation and also help insure a healthy and productive workforce. After 2014, employees are even more likely to demand health insurance at work because of the individual mandate; and large employers—not small employers—but large employers, will face a penalty if they don't offer insurance.

In Massachusetts, which adopted similar reforms in 2006, employer offer rates grew from 70 to 76 percent. There is every reason to believe the ACA will not dramatically change the scope of employer coverage in the United States.

Thank you.

Chairwoman ELLMERS. Thank you, Mr. Jost.

I will begin the questioning, and my questions are directed to each member of the panel.

Health care reform was supposed to make health care more accessible and affordable. Do you think the new law does anything to help reduce the cost of health care? And I will start with Mr. Jost.

Mr. JOST. Yes, and one example of that is the medical loss ratios, which has already been discussed. I follow the medical loss ratios very closely. I was very much involved in their drafting through the National Association of Insurance Commissioners.

One of the things that people are beginning to notice is that growth in health care costs has been dropping in the last couple of years. There is another report on that out this morning.

At the same time, in the very recent past, insurance profits have been growing very, very rapidly; and people who follow the insurance industry closely are saying that, if insurers have to spend 80 percent of their premiums on health care costs and costs are dropping, premiums can't continue to rise. They are going to come down.

And we already saw that in Connecticut, where one insurer dropped its rates by 10 percent. We are starting to see it in other States.

I think, in fact, that the MLR is going to have a dramatic affect in reducing the cost of health insurance for employers and individuals over the next couple of years.

And if I could just add quickly, one question that was asked earlier was, will it drive small insurers out of the market? I have read

all of the State adjustment requests that have gone final. In only one State have any insurers left since the law went into affect. As Mr. Larsen said, people are talking about it. It isn't happening.

Thank you.

Chairwoman ELLMERS. Mr. Vaughn.

Mr. VAUGHN. Well, I certainly would have no way of knowing, a nonacademic. I am a business person. But let me just give you a few numbers so you can understand my situation.

If you take 2010 and my small business—I am a Subchapter S Corporation. So, at the end of the year, the bottom line of my company was $319,000. The way this plan exists now, if I took this plan and I insured all of my employees the way it is designed, it would cost me $307,000, which leaves me $12,000.

Now, understand I am taxed personally on the net income of my company. But do I take that money? Absolutely not. What I do, I have to turn that money around and reinvest in the building, buy new equipment, and those sort of things. $12,000 does not even leave me enough to pay my taxes, let alone reinvest in my business.

The other piece of this is I am not likely to pay a penalty. Why would I do that? Because I am not really helping anyone. The penalty would cost as much as the insurance I am providing now. So if this thing continues on the path it is, I can tell you right now that I will do everything I can to avoid paying the penalty. I will probably more than likely drop coverage, and what it will do to the cost of insurance I have no idea.

Thank you.

Chairwoman ELLMERS. Mr. Dennis.

Mr. DENNIS. It is really important to remember is when we started this thing, small businesses were very much in the forefront of calling for reform of health care. The reason was cost. Cost increases drove us. This morning, I believe I opened the Journal—the Wall Street Journal—and saw a study from the Social Security Administration which projected that, under PPACA, costs would rise faster than they would otherwise. It wasn't a great deal, but it was indeed faster. That is the first point.

The second is we have had some lower rates recently than we have seen over the past several years. It has been attributed in some quarters to the new law. What we see, is that this recovery is very different from the last five recoveries. Relative demand for various services has been much slower than average; and health care has been one of them. Whether it is people not having money or being more parsimonious with the money they have, I don't know. But, still, the whole thing is that this is a very abnormal period.

And then we start to look at everything that is inherent in PPACA. You are going to have minimum benefits. While we don't know what is going to be in the minimum benefit package, clearly, as Mr. Vaughn's example shows, there is going to be a whole series of folks who are either going to have to add a lot more benefits or do something else.

Then we have all types of expensive things that we haven't even talked about which don't necessarily directly affect smaller firms. Things like the CLASS Act for example. Then we have, of course,

a whole lot of new folks coming on. So all this together is going to drive costs higher, I am afraid.

Chairwoman ELLMERS. Thank you, Mr. Dennis.

Dr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. I would largely concur. In analyzing the bill as it passed and became the law, the CMS actuary, the administration's own actuary, concluded that it would raise, not lower, national health expenditure. If the national health expenditure bill is larger, the insurance that covers that bill has to be larger. There is no way around that. When the CBO put out its new long-term budget projections, it found that, after passage of the law, things went up, not down.

The law contains two new entitlement spending programs. The CBO estimates they grow at 8 percent a year as far as the eye can see. There is no evidence of bending the cost curve anywhere to be found in those kinds of numbers.

And so if you dial the clock back to the beginning of the debate, there were two criteria by which any health care reform should be judged: the ability to cover more Americans with affordable and quality insurance, and the capacity to deliver those services with lower costs and higher quality. And the Affordable Care Act flunks the latter, which is ultimately the fundamental driver of the insurance costs in the United States. And so things like the MLR are mere fiddles at the edges of a tidal wave of health care spending. Unless we get the tidal wave under control, the premiums go up.

Chairwoman ELLMERS. Thank you.

I have one more question for you. Do you think the health care law's mandates and taxes, along with the numerous regulations that are being issued, make it less likely that small businesses will hire more workers and expand their companies?

And again I will start with Mr. Jost.

Mr. JOST. Well, the small businesses, there is some incentives and disincentives. There are benefits under the law that small businesses get and that large businesses don't get, and there are some benefits that large businesses get that are not available to small businesses.

For example, small businesses need to cover the essential benefits package. It is not clear to me that that is going to be a major expense. Because in fact what happens is that State mandates are going to go away. It is not at all clear the Federal essential package is going to cost more than State mandates, but that is something that small businesses need to cover that large businesses do not need to.

On the other hand, large businesses need to pay the penalty if they do not cover their employees; and small businesses don't.

I come from a family that started a small business about 20 years ago, that my brother-in-law started by borrowing money from the rest of us in the family, and it is today a $300 million publicly traded company, and its product is a household name. They didn't worry about am I going get this benefit or lose this benefit if I grow a little bigger. They tried to help out their employees, they tried to help out their customers and sell a good product.

I think that is the way American businesses work, and I think that under this law it is going to continue to work that way. It is

just that employees and individuals are going to have better health care coverage.

Chairwoman ELLMERS. Mr. Vaughn.

Mr. VAUGHN. Well, I can start out by saying that overregulation is killing small business.

Let's go back to minimum wage. I have already scaled down my staff, and I am running as, frankly, as lean as I can possibly run right now and make a living. The reality is there are going to be virtually no full-time jobs in this industry. I can tell you the way it will work in my company is only my management staff will be full time. Everyone else will work 29 hours a week or less. And it is just that simple. We cannot afford this thing.

Chairwoman ELLMERS. Thank you, Mr. Vaughn.

Mr. Dennis.

Mr. DENNIS. Well, right now, immediately, the overwhelming issue is uncertainty. We have absolutely no idea what is going on, and I think everybody would agree on that. I don't think that is a very controversial statement. Nonetheless, that has an enormous impact on what you are willing to do in terms of hire and invest; and we are seeing that very clearly within the small business population.

We do this monthly survey, as we have been doing since 1973, and it is constantly showing that small businesses are much more pessimistic and feel much less—how can I say—favorable towards the economy than do larger folks. That is borne out by—their sentiment is borne out by a whole series of measures, including some that are contained in a recent Federal Reserve of New York paper that is just out. But that is the immediate thing.

Longer term, you have the whole issue of cost and taxes; and they go together. And what does that have to do? All that means is, if the government has it, then you don't have it, and you have less available to do that. And so the question is you can't invest if you don't have it.

And then we have the interesting issue of growth and does the 50 divide mean anything. And for some firms it clearly will. It won't just mean do I go over 50 or not, whether I hold back a little bit from 50 for fear that I am going to be hung up on that whole thing. There will be a lot of firms who are growth firms that, as Mr. Jost used as an example of his brother-in-law, that will just go blowing right on by. They are going to be high-growth firms, and they are not going to pay attention to anything. But it is going to have an impact on a whole lot of small firms.

Chairwoman ELLMERS. Dr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. Well, I guess I would echo the firm level recognition of the regulatory costs that Mr. Vaughn mentioned. I think I would echo the uncertainty in the firm level growth incentives that Mr. Dennis highlighted.

But if you step back and take a look at the basic architecture of the Affordable Care Act, it says let us spend a trillion dollars over the next 10 years and finance that by raising $500 billion on new taxes and much of it on inputs into what will be paid for by insurance, and thus make insurance more expensive, and let's finance the rest by cutting $500 billion roughly out of Medicare, something the CMS actuary said is simply economically unrealistic and would

mean the closure of a large number of hospitals and failure to serve those beneficiaries.

So I would probably take that with a grain of salt.

What you have in the end then is higher taxes, much larger deficits, in a recovery that is utterly unsatisfying. And I cannot conclude that that will be beneficial for the hiring practices of small businesses.

Chairwoman ELLMERS. Thank you, Dr. Holtz-Eakin.

I yield to Mr. Altmire for questions.

Mr. ALTMIRE. Thank you, and I am glad that our panel brought up the subject of taxes and the burden that it places on small business.

I wanted to ask Mr. Dennis and Mr. Vaughn, as you are aware, currently health benefits for employees is non-taxable; and some proposals have recommended requiring employees for the first time ever to pay taxes on health care benefits. And I was wondering from Mr. Dennis, how would a fundamental change like that impact a small business' decision to offer health care to its workers?

Mr. DENNIS. Well, the question is really equity. Right now, we have a system where if I am an employer and I contribute $1,000 or $5,000 to help my employee buy their own insurance on the market, whether it is through the exchange or whatever, there is no tax exclusion for the employee. If an employer pays for it, there is an exclusion. That clearly is inequitable. In the long term that is going to hurt smaller firms, and their ability to contribute.

You are not asking about the inequity, though. You are asking about whether or not the exclusion itself is important. The exclusion does lower the amount that you have to pay up front. Long term, it encourages more people to use more services. And more services means higher costs, and long term we just can't have that. We have to start being more parsimonious on many of these things.

Mr. ALTMIRE. So you are in support of that policy change to tax——

Mr. DENNIS. We would be in support of making it equitable. I am not sure that our organization has taken a position on whether or not they would be in favor of eliminating or curbing the tax exclusion.

Mr. ALTMIRE. Thank you.

Mr. Vaughn, as a business owner, how would your employees react if they had to pay taxes on the health care benefits that you provide?

Mr. VAUGHN. Well, that is a hypothetical; and I apologize for really not having an answer to that. I can't predict how they would react.

But there is something really important here that I don't want to get lost. Let's define what is a small employer and what is a large employer? The method that is being used right now—and, frankly, I can't understand it—and what is a full-time employee and what is a part-time employee, I can't understand that either.

There was a study done recently by the University of Tennessee funded by the likes of Burger King, McDonald's, and different ones to determine what would be the best way to determine what a small business is and what can they afford.

Have you heard about profit per employee? As opposed to this very drawn out, sort of complicated formula for figuring these things out, it is a real simple formula. It is how much money do I make net, divided by number of employees. Guess what it is in my industry? $1,300. If I paid the penalty, the penalty is $2,000. Is that equitable? Does that make sense?

I have got to tell you, there are other industries, whether it is financial or insurance industries, they are $10,000 plus per employee, profit per employee.

So my position is this. This thing has to be repealed. I mean, it has to be repealed. If it is not repealed, at the very least the regulatory aspect of it should be changed to a system like profit per employee.

Again, I apologize for not answering directly. I really don't know how they would react.

Mr. ALTMIRE. Are you concerned to hear that that is a proposal? If your representative came and sat down before you and said, hey, here is something I am thinking about supporting, taxing your employees' health care benefits, you wouldn't——

Mr. VAUGHN. Of course, I would be concerned about that. I am for lower taxes for anyone. Yes, absolutely.

Mr. ALTMIRE. Mr. Jost, do you want to comment on what type of fundamental change like that, what the impact would be on the health market?

Mr. JOST. I think it would destroy our employment-based health insurance system in this country. We have a long tradition in the United States that actually has been very successful in providing health insurance to people through their jobs. We are now trying to get beyond that to reach those people who are not covered through that, and that is what the Affordable Care Act is going to do. But to pull the rug out from under employment-sponsored health insurance by removing the tax deductions and exclusions would destroy it and would throw our health care system into chaos.

Mr. ALTMIRE. Dr. Holtz-Eakin, do you want to comment on that? I am going to move on to a different question, but you look like you might have something to say.

Mr. HOLTZ-EAKIN. There are really two aspects that I think bear mentioning. One is, it figures prominently in this discussion about how many employers will drop coverage under the Affordable Care Act. Because the basic horse race is between the pile of cash being put out in the exchanges for low-wage workers, where there is a clear net advantage for the employer to drop coverage, pay the penalty, give the employee a raise, let them go use their after-tax wages, plus a subsidy, and get insurance.

And another Federal subsidy, which is nontaxation of employer-sponsored insurance which benefits high-wage workers. And those who conclude that there will not be a big employer drop are counting on the fact that that tax subsidy for high-wage workers will dominate. Employers will continue to use it to pay the high-wage workers, and nondiscrimination rules will keep everyone in.

I think that is an optimistic fantasy, quite frankly. Be quite aware that, in the end, all you are doing is a horse race between

two Federal bribes; and one of them is going to win. We will see how it plays out, but it is costing the Treasury either way.

The second thing is, most people who talk about changing the tax treatment of employer-sponsored insurance are looking at revenue-neutral tax reforms that broaden the base and thus bring in subsidized consumption like health insurance in exchange for lower tax rates. And I think that is a very different question than simply saying do you want to go tax health insurance. It is about having a tax system that is fair across low- and high-wage workers and provides greater growth incentives because marginal rates are lower.

Mr. ALTMIRE. Last question. I wanted to give you the chance to answer that because I thought I knew what you were going to say.

Mr. HOLTZ-EAKIN. It was a shocking question.

Mr. ALTMIRE. The question I wanted to ask you—and you are not here to pontificate about politics or to speculate about what the Congress is going to do or should do certainly, but you bring great credibility to the debate based upon your background and your involvement in the past. So I ask just out of interest, given where we are. This is the law. The bill has passed. It is the law. The Supreme Court may or may not rule, absent knowing what is going to happen there. Repeal has failed in the current political environment. We don't know what the future holds there.

To the degree you are comfortable assessing it, what would you suggest the Congress do as far as tweaking the current law, assuming this is a fact, this is going to continue, or continue to push repeal even though it doesn't look like it is a viable option?

Mr. HOLTZ-EAKIN. Wow, can I have 5 hours instead of 5 minutes?

Briefly, I think you can point to a couple of things. There are some provisions of the law that I think have universally garnered some suspicion—I will use that word. And I think the CLASS Act is the first among those and probably should go away as something that is ill-designed and dangerous to the American taxpayer.

The second would be, in the array of coverage expansions, the heavy reliance on an unreformed Medicaid program I think many people find problematic. We know Medicaid beneficiaries have much more difficulty finding primary care physicians and seeing specialists. To simply put more Americans into a substandard health care system is problematic, and I have a concern that there is just too much money on the table in exchanges. I won't relitigate that. So in terms of the coverage expansion pieces, I think you have to look at all that.

I won't say a lot about the regulatory initiatives. I think making them cleaner and getting the rulemaking done in a fashion that doesn't leave the business community so perplexed can be entirely beneficial.

On the delivery system reforms I think there are two very big concerns. One would be the role of the Independent Payment Advisory Board, which, as structured, appears inevitably to be led to near-term provider reductions as opposed to quality improvements or other things that everyone thinks would be desirable. Just can't get there. It is given 1-year targets. It is going to go slash reimbursements probably on the most innovative and, thus, the most

expensive new therapies. That is detrimental for health care. I would worry a lot about that, quite frankly.

And the ACOs appear to be a recipe for industry concentration, not better care.

So, you know, across all of these things I think there is work to be done in improving the delivery system, improving the financing of the coverage expansions, and making sure that this thing hangs together budgetarily, about which I have deep concerns.

Mr. ALTMIRE. This is really the last question. Are there things in the bill that you think are worthwhile in isolation that should be kept?

Mr. HOLTZ-EAKIN. I have always been a proponent of exchange-like entities—forget the label attached to them. Better ability to shop, compare, and pursue health insurance has always been—I think every economist would like that, and I certainly do. So the design of those and exchange rulemaking I think is a critical moment in the life of this law.

Mr. ALTMIRE. Thank you all for being here.

Chairwoman ELLMERS. I now would like to recognize Mr. King for his questions.

Mr. KING. Thank you, Madam Chair.

I thank all the witnesses for being here to testify and regret my schedule did not allow me to hear it all in depth. So I hope I don't duplicate anything that has been raised here before this panel.

First, I think I need to make a statement as to anybody who wonders where I stand on this issue. I look at it from a whole number of different perspectives.

I just don't think it is arguable whether this is sustainable economically or whether it will improve our health care or whether it will avoid eventually rationing or whether it will reduce research and development. I think those things all we understand—at least I think I do—thoroughly, that we are not going to see better health care at a cheaper price that is more accessible or more available. You will see different people who have access perhaps, but it is perhaps a shift within the population. I don't think it changes anything beyond that.

So I have spent my life—my working life as a small businessman. I started a construction business out in 1975, and we provided—not on the first day, because I didn't have any employees the first day—but over a period of time as we began to accumulate employees, I took on a responsibility to voluntarily provide them health insurance.

And I have watched this debate be shifted here in this country so that the word health care and health insurance, those two words, have been conflated into the same meaning in the minds of many people that are advocates of this policy that is before us today. I think it was dishonest, I think it was disingenuous, and I think it was willful, a strategic effort to try to blur the definitions.

I remember our then-Governor of Iowa, Governor Culver, coming to this Capitol and our delegation meeting and saying 40,000 kids in Iowa don't have health care. I don't know how many times I had to ask him what that meant before I could get through to him that health care and health insurance were two different things.

I will make the point that I don't believe an employer has—if they choose to accept a responsibility to provide health insurance for their employees, that is a competitive position in the marketplace, but it is not a moral obligation for the employer. To hire good people and keep good people is the motive.

When the Federal Government decides to impose an employer mandate, then that sets another standard; and in the minds of people now they think it is an entitlement that goes with a job. I think that is a mistake. I think it saps some of our vitality.

I wanted to take this down to the constitutional aspect of it, just noticing we had a law professor here, Mr. Jost. That is the part that grates on me the worst. We can talk about policy all day long. I have drawn my conclusions on that. And I have also drawn them on the constitutional side of this.

But I just take it down to the individual mandate rather than the employer mandate side of this and ask this question, if the Federal Government can constitutionally commandeer a portion of a person's paycheck or a portion of the revenue of an employer, for that matter, if they can commandeer that and assign it to a government-produced or a government-approved product, which is premiums for health insurance that is approved by the Federal Government, then what limitation would there be on the commandeering of that revenue stream beyond health care? Is there a constitutional line here I don't understand? Or could it also be for a car, an appliance, buying certain types of health food, or a membership in a health clinic—excuse me, perhaps a gymnasium? Is there a constitutional line beyond that?

If the Supreme Court rules in favor and upholds this bill, this Act, this law of the land, as Mr. Altmire referred I believe, if they do that, what then can the rest of the workers and the employers in America look forward to being commandeered? Where is the line?

Mr. JOST. Again, I only have 5 minutes, rather than 5 hours, probably less than that. I would refer you to the excellent opinion on this topic written by Judge Sutton of the Sixth District, a very well-known, conservative judge, who has in fact been prominently mentioned as a Supreme Court potential nominee. And what Judge Sutton said and what the other Federal judges, several Federal judges, the majority of the Federal judges who have considered this question have said in favor of the constitutionality of the statute, and where I believe the Supreme Court will come down, is under that Article 1 of the Constitution, Congress has the authority to regulate commerce.

Under earlier decisions, Congress must regulate economic decisions. It cannot regulate noneconomic conduct. But what Judge Sutton and what the other judges have found is that the health care marketplace and the health insurance marketplace are interstate commerce. In fact, it is the largest sector of our economy.

Mr. KING. Excuse me, Mr. Jost. If an individual doesn't engage in purchasing health insurance, then they are not engaging in interstate commerce with the purchase of health insurance. And if you expand the argument to utilizing health care services, if an individual is born and dies in a State and doesn't cross a State line and doesn't use medical of any kind—and that happens; it has al-

ways happened, every generation—how is it that they are engaging de facto in interstate commerce?

Mr. JOST. Well, what Judge Sutton said is, on its face, the statute is constitutional. As applied, there may be some situation where somebody may come forward and said, I never used health care in my life. I will never use health care in my life. I can prove it. The law should not apply to me. He said, that might be a different case. We will cross that bridge when we come to it.

Mr. KING. We have come to it, actually. Because the Constitution has got to apply to everybody.

Mr. JOST. Right, but a statute—the first question is, has Congress written a statute that is facially constitutional? Could it be constitutional as applied to some people? And as applied to 99.99999 percent of the population, people use health care.

Mr. KING. The statute presumes that everyone does use health care, and it presumes that health insurance is an obligation that is a component of health care. And if it presumes that everyone is utilizing, then the constitutional rights of those who do not are directly then incorporated into that. So they don't have their constitutional rights unless they assert them. We have to pass legislation that constitutionally protects everyone. That is the point I would make.

I went way past my time. I am sorry, but I appreciate the indulgence, and I yield back the balance of my time.

Chairwoman ELLMERS. Thank you. That was a very interesting exchange, so I appreciate the line of questioning. Those are definitely some of those issues as we move forward that really does need to be discussed. So even though we went over, that was—I can say it is all right.

Do you have any other questions at this time?

And, Mr. Altmire, do you have any?

I have a couple of more questions I would like to ask, starting with Dr. Holtz-Eakin.

You have said in the health care law it is a threat to the health care of—excuse me, the health of small businesses, and the mandates and penalties are a financial burden. Do you think small firms disproportionately affected by the various mandates, penalties, and taxes in the law, will this affect their ability to increase employee wages, purchase new equipment, and hire new workers?

Mr. HOLTZ-EAKIN. Absolutely. If you think of the smallest of the small businesses, the proponents of the law like to say, well, look they get the credit, and they are exempt from the mandate, and so it is all going to be good.

But the reality is they will face the upward premium pressures that inevitably come from the benefit mandates that have already begun to be implemented and which are driving premiums up. The taxes that will be imposed on insurers, medical device companies, and others will which inevitably drive—in my written testimony, I walk through the arithmetic of this. This is $5,000 for a family over the next 10 years, real big impacts on the cost of health insurance.

Every time those premiums go up, they come up at the expense of wages. There is no way around that. So even for those who are ostensibly spared the greatest regulatory burden, the greatest compliance cost burden, and even where temporarily helped, although

I am not a fan of the structure of that credit, it is available. I think it is, on balance, a bad deal.

Chairwoman ELLMERS. Thank you.

Mr. Vaughn, I have a question for you. You currently have 30 full-time employees; is that correct? And a number of part-time employees. So 30 full time and a number of part time. With the employer mandate in the health care law, is it likely that you will create any additional full-time positions?

Mr. VAUGHN. As I mentioned earlier, it is not likely. It is likely that I will cut to fewer full-time positions.

It is interesting about what Mr. Larsen said earlier, the tax credit—look, I am not going to participate in this certainly without tax-preferred dollars. He talked about—what was it—nine employees or less or some ridiculous number, and those are the only people who are going to get a tax credit. So this thing is extreme.

Mr. Jost said earlier that the large firms, they are not worried about it. It is probably not even on their radar screen. That is just the cost of doing business for them. But, again, it is clearly in my case going to create more part-time jobs and, frankly, people more dependent on the government, and I will be cutting even more jobs.

Chairwoman ELLMERS. Do you feel you may have to cut wages also, especially now, of course, with—you know, we have minimum wage. But as far as potential increases in wages, do you think you may have to draw back on that as well?

Mr. VAUGHN. I think so.

Someone mentioned earlier wages should be—absolutely should be a function of competition in the market. And I think that those of us that are in this business, we are all pretty much in the same situation. We are in a pennies business, and our margins—literally, we said this thing about Burger King, and people look at us as very wealthy and very rich. Out of a dollar, we keep less than a dime at the end of the day. And so there is just no way we can afford this. Absolutely not.

Chairwoman ELLMERS. Thank you, Mr. Vaughn.

And my last question—I have two questions, actually, for Professor Jost. If the forthcoming mandated minimum essential benefit package requires employers to offer a base amount of coverage, the package will undoubtedly exceed the coverage that small the businesses currently offer. Aren't the premiums likely to increase for the employer or the individual or both?

Mr. JOST. I would like to refer to a study that was published last month by the Urban Institute in which they projected that the firms for small employers, average employer contribution per person covered would in fact decrease by 7.4 percent after the Affordable Care Act was fully implemented.

The reason for that is the exchanges. Right now, small employers have to deal with individual insurance companies, and they don't have the economies of scale large employers do. They often have risk pools that are less favorable than large employers, and they are on their own. Even if they get a good rate this year, they could be cancelled next year or they could get a higher rate next year.

In the exchanges, their business is going to be pooled with the business of all of the other small employers, and there is going to be lots of competition in the exchanges. There are going to be na-

tional insurers as well as the domestic insurers, maybe some of these new cooperatives that they are going to be talking about today. And so the projection is that, in fact, costs will go down.

Now with respect to the essential benefits package in particular, I had always assumed that small businesses provide less rich benefits than large businesses. I tried to check on that the other day and found out if you look at the national compensation survey the benefits are pretty much comparable and cover the same things. The reason again is because of the State mandates that require in many States employers to cover a lot of the same benefits of shared employers.

Also the essential benefits package only covers benefits. It doesn't prescribe cost sharing. Right now, a lot of the gain is in trying to increase cost sharing in various ways. That is probably one of the reasons why health care costs are going down, because employees have more skin in the game. And I think that under the essential benefits package, number one, it isn't going to change that much what benefits employers are going to have to offer; and, number two, they will still have the ability to do considerable adjustment in the cost sharing to try to save costs.

Chairwoman ELLMERS. Can you just describe to me the difference—you mentioned national insurers and domestic insurers. Can you identify for us what you mean by that?

Mr. JOST. Yes. Under the Affordable Care Act, the Office of Personnel Management is supposed to come up with two national—at least two, maybe more—national multi-State insurance plans that will be available in every State. It will be like the insurance you have, Congresswoman, through the Federal employees health benefit package where you have a choice of national insurers as well as local HMOs or other small carriers at the State level. And that is going to introduce more competition into the insurance market.

Again, I have been looking at all of these adjustment requests as they come through, and what you see is that in many States you have what you see in my market, where you have one insurer with 85 percent of the market. Well, they set the price. Nobody else really can compete with them. But we are doing to see a number of insurers competing, and competition brings down prices.

Chairwoman ELLMERS. And so can you describe to me then the domestic insurer?

Mr. JOST. Well, by that, I meant insurers that are already there, that are licensed in the State.

Chairwoman ELLMERS. And when you describe the national, are those private insurance companies or would that be the government plan?

Mr. JOST. No, they have to be private insurance companies. They have to be a company licensed in the State.

Chairwoman ELLMERS. Okay. Well, thank you all so much for your participation.

I had asked—if you did have another question, I am more than willing—we will definitely approach that.

This Subcommittee will continue to closely follow the issues related to this implementation of the health care laws. It is very, very important that we stay on top of this as it moves forward, especially since things seem to be evolving as we go along.

I ask unanimous consent that three articles be submitted for the hearing record: an article from Crain's New York business dated June 23rd, 2011, entitled Health Reforms: Grandfathering Rules Likely to Raise Costs; an article from Forbes dated July 4th, 2011, entitled Health Care Tax Credits are Having a Minuscule Impact; and an article from The Hill, which I had mentioned earlier, dated July 21st, 2011, entitled Health Care Law Could Leave Families with High Health Care Costs.

Without objection, so ordered.

All those in favor, signify by saying aye. All those opposing, signify by saying nay. The ayes have it. The request is agreed to.

Chairwoman ELLMERS. And I ask unanimous consent that members have 5 legislative days to submit statements and supporting materials for the record.

Without objection, so ordered.

This hearing is now adjourned. Thank you so much.

[Whereupon, at 11:40 a.m., the Subcommittee was adjourned.]

STATEMENT OF

STEVE LARSEN

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DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE IMPACT OF THE AFFORDABLE CARE ACT ON SMALL BUSINESSES

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON SMALL BUSINESS,

SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY

JULY 28, 2011

House Committee on Small Business, Subcommittee on Healthcare and Technology
Hearing on the Impact of the Affordable Care Act on Small Businesses
July 28, 2011

Chairwoman Ellmers, Ranking Member Richmond, and Members of the Subcommittee, thank you for the opportunity to discuss how the Affordable Care Act is improving the affordability, accessibility, and quality of health insurance available to small businesses and their employees. The provision of health insurance to employees can present a very real challenge to small businesses. On average, small businesses pay about 18 percent more than large firms for the same health insurance policy.[1] Small businesses lack the purchasing power that larger employers have and are often the targets of insurance industry coverage restrictions and significant annual rate increases. Given the difficulties small businesses face in finding and keeping affordable, high-quality health insurance, it is not surprising that they are less likely to offer insurance to their employees. According to the 2010 Kaiser/HRET Employer Health Benefits Survey, 59 percent of businesses with 3 to 9 employees offered health insurance, compared with 99 percent of businesses with more than 200 employees. The Kaiser/HRET Survey also found that the most important reason that small businesses cited for not offering health benefits is that the cost of insurance is too high.[2] Small businesses in today's market are disadvantaged not only by their lack of purchasing power compared to large businesses, but also by the challenges they face in comparing various insurance products and selecting the best option.

The Affordable Care Act contains a number of provisions that will help close the gap between small and large businesses' ability to offer health insurance to their employees. For example, the law establishes tax credits for small businesses that provide health insurance to employees beginning with the 2010 tax year. Additionally, starting in 2014, it prohibits most insurers from charging small businesses higher rates based on the health status or gender of employees. Finally, it creates, as part of the Affordable Insurance Exchanges, the Small Business Health Options Program (SHOP), which will help small business owners compare insurance options in their State and purchase coverage for themselves and their employees. SHOP, which will

[1]Gabel J, McDevitt R, Gandolfo L, et al. Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down. Health Affairs, 2006, 25(3): 832-843.
[2] http://ehbs.kff.org/pdf/2010/8085.pdf, pages 37 and 43

become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.

Tax Credits for Small Businesses that Insure their Employees

The Affordable Care Act establishes a Small Business Tax Credit that is making health coverage more affordable for small businesses. The tax credit is designed to encourage both small businesses and small tax-exempt organizations to offer health insurance coverage to their employees for the first time, or to maintain the coverage they already offer. It is targeted at small businesses and tax-exempt organizations that primarily employ moderate- and lower-income workers. Small businesses can claim the credit for 2010 through 2013 and for two years after that. For each year from 2010 through 2013, the maximum credit is 35 percent of the employer contribution to premiums paid by an eligible small business, and 25 percent of the contribution paid by an eligible tax-exempt organization. After 2013, the maximum matching rate increases to 50 percent for small businesses and 35 percent for tax-exempt organizations, and the credit will be available only to small businesses that offer coverage to their employees through the SHOP.[3] The tax credits provide a vitally needed bridge to 2014, when small firms will be able to shop for coverage in the state-run Affordable Insurance Exchanges.

We are already seeing the benefits of these provisions of the Act. In a survey released by Small Business Majority in January 2011, one-third of small business owners surveyed who do not offer insurance said they would be more likely to do so because of the tax credit and the Exchanges. Nearly a third of respondents who were offering insurance said they would be more likely to continue offering it because of the tax credit and the Exchanges.[4] There are signs that insurance sales to small businesses are increasing. Blue Cross/Blue Shield of Kansas City, which reached out to local employers to make sure they were aware of the credit, is reporting a 58 percent increase in the number of small businesses buying insurance since April 2010. This

[3] http://www.irs.gov/pub/newsroom/taxcreditflyer.pdf

[4] http://www.smallbusinessmajority.org/reports/SBM-Healthcare_Survey_010411.pdf

translates into 400 new small businesses buying coverage for 9,000 employees in the area.[5] UnitedHealth Group enrolled 75,000 new customers in firms with fewer than 50 employees.[6]

Ending Price Discrimination Based On Illness and Other Factors

Small businesses are heavily disadvantaged in today's insurance markets. Without a large group of enrollees to pool risk, a single sick employee can cause a drastic premium spike for small employers. The premium spike can be particularly large if the employee or dependent has a costly condition such as cancer or heart disease or a complicated birth. While most States limit the extent to which premiums can vary due to employee health status and other factors, many do not. In the current market, health status and experience rating have a disproportionate impact on small businesses, and even with limits on variation, premiums can be significantly higher for small businesses.

The Affordable Care Act takes significant steps to eliminate this disparity. Beginning in 2014, the law prohibits new health plans from rating on the basis of health status or claims history. By eliminating these discriminatory rating practices, small businesses will no longer see their premiums skyrocket because one or two employees fall ill. In addition, the law prevents insurers from varying rates based on the gender of a small business's employees and limits how much issuers can increase rates based on employees' ages. These new rating rules will help make small businesses' health insurance rates fairer, more predictable, and easier to understand. CBO estimates that premiums in the small group market could be up to 1 to 4 percent lower than they would have been without the Affordable Care Act in 2016. Savings will come primarily from insurance reforms, the competitive nature of the Exchanges, and lower administrative costs. The small business tax credits that will help reduce costs for eligible small employers in SHOP will save those businesses even more.

Starting this year, limits on health plans' medical loss ratio (MLR) will also save small businesses money as insurers that fail to meet the standard (80 percent in the small group market) must provide refunds to the businesses to which they sold coverage. Finally, the Affordable Care

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[5] Cauthin P., "Tax Credits Spur Health Coverage," Kansas Health Institute News Service, January 10, 2011.
[6] Levey NN, "More Small Businesses are Offering Health Benefits to Workers," The Los Angeles Times, December 27, 2010.

Act provides $250 million to States to help improve the oversight of proposed health insurance premium increases, take action against insurers seeking unreasonable rate hikes, and ensure consumers receive value for their premium dollars.

Affordable Insurance Exchanges: Choices, Competition, and Clout for Small Businesses
The Affordable Care Act created the Affordable Insurance Exchanges (Exchanges), which are new State-based competitive marketplaces for buying private health insurance. Both individuals and small businesses will be able to buy health insurance through Exchanges beginning in 2014.

On July 11, 2011, the Centers for Medicare & Medicaid Services (CMS) released a Notice of Proposed Rulemaking (NPRM) outlining a framework that will enable States to build Exchanges. On the same date, CMS released a second NPRM that provides a framework for ensuring premium stability for plans and enrollees in the Exchanges. These NPRMs reflect more than a year's worth of work with States, small businesses, consumers and health insurance plans, and offer substantial flexibility to States in designing their Exchanges. We are engaged in a continuous dialog with States, small businesses, consumer advocates, and others on the best way to shape the Exchanges to meet their needs. In addition, on July 18, 2011, CMS released an NPRM that proposes standards for Consumer Operated and Oriented Plans (CO-OPs), new private non-profit, consumer-governed health insurance plans that will help increase competition in the Exchanges and give small businesses additional affordable health insurance choices.

These proposed rules are the latest in an ongoing series of steps that CMS has taken to help States develop Exchanges. Already, 49 States, the District of Columbia, and 4 Territories have received Exchange Planning grants authorized under the Act, and to date, over half of the States have taken additional action to establish Exchanges. CMS is accepting public comment on the proposed rules for 75 days to learn from States, consumers, and other stakeholders how the rules can be improved. CMS will modify these proposals based on feedback that we receive.

Small Business Health Options Program (SHOP)

Small businesses will be able to buy health insurance through a part of the Exchange called the SHOP. States can choose to operate separate Exchanges for individuals and small businesses, or

have a single Exchange offering individual and small group insurance. Additionally, States can choose to keep participants in the individual Exchange and those in the SHOP in separate risk pools, or they may merge the two risk pools, giving individuals in the Exchange and workers in small businesses the same plan options.

SHOPs are designed to make buying health coverage easier and more affordable. SHOPs will give small businesses and their employees many of the advantages large employers have today – such as more choice, more competition, and more clout in the marketplace. Small businesses and their employees will be able to easily compare health plans, get answers to questions, and enroll in a high-quality health plan that meets their needs.

Under the Affordable Care Act, businesses with up to 100 employees will be eligible to purchase health insurance through the SHOP. States can choose to limit participation to businesses with up to 50 employees until 2016. Starting in 2017, States may let businesses with more than 100 employees buy large group coverage through the SHOP.

Increasing choice and competition: SHOPs will enable small businesses to offer their employees a much greater choice of health plans from insurers, options that large employers enjoy in the current marketplace. In general, small businesses participating in the SHOPs will choose a level of coverage and a level of employer contribution to determine which qualified health plans they will make available to their employees. In this context, levels of coverage include four benefit categories that will be available through the Exchanges (bronze, silver, gold, and platinum) which indicate the cost-sharing level for consumers. Employees will choose among the available qualified health plans within the level offered by their employer, applying the applicable employer contribution to a plan within that level. This employee choice model provides side-by-side comparisons of health plans, benefits, premiums, cost-sharing, and quality. Exchanges may also choose to provide additional options to employers through SHOP.

Plans that participate in the Exchanges will need to compete for business by proving to employers and consumers that they can offer the best product at the best price. This type of market competition has the power to drive improvement in plan quality and affordability.

Exchanges will use a streamlined, simple enrollment system geared toward consumers. Exchanges will enable consumers to learn about coverage options provided in the market so they can make informed choices about the coverage available through the Exchange. State Exchanges have flexibility regarding how they design their website and whether they use the application that will be made available by CMS or design one on their own that is comparable. State Exchanges will design a process for ensuring that participants' information is safe and secure.

Exchanges will also build partnerships with and award grants to entities known as "Navigators," who will reach out to employers and employees, consumers, and self-employed individuals to:

- Conduct public education activities to raise awareness about qualified health plans;
- Distribute fair and impartial information about enrollment in qualified health plans, premium tax credits, and cost-sharing reductions;
- Assist consumers in selecting qualified health plans;
- Provide referrals to an applicable consumer assistance program or ombudsman in the case of grievances, complaints, or questions regarding health plans or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate.

States are given substantial flexibility in determining what role brokers and agents, who are a vital part of the small group market, will play in the SHOP. For example, States may allow agents and brokers to serve as Navigators in the SHOP.

Preserving employer control and State flexibility: While there are many new options available for small businesses as a result of the Affordable Care Act, small business owners will decide whether to participate in the SHOP. While the SHOP and Exchanges will dramatically expand coverage options for many, small businesses will still have the choice of purchasing private health insurance outside of the SHOP and the Exchanges.

If small businesses do participate in the SHOP, the NPRM proposes that they will be able to choose their own level of contribution toward their employees' coverage, and, if they choose, make a single monthly payment via SHOP rather than making individual payments to multiple

plans on behalf of their employees. Employers will write one check to the SHOP, and the SHOP will take care of paying each insurance company the correct amount. This single payment is designed to increase the convenience of participating in the SHOP for small employers and reduce their administrative burden, making it easier for them to offer a choice of plans to their employees.

Under the NPRM, States will have flexibility in deciding how the SHOP functions. During the current public comment period, we hope to hear from all stakeholders, including small businesses, on the best way to structure the SHOP to maximize choice, competition, and value for the employer's premium dollar. For example, in addition to employee choice among plans in a particular benefit level, the NPRM provides Exchanges the option to allow an employer to select one or more plans for its employees. This is how many small employers offer coverage in the current small group market. This additional flexibility could allow employers to choose an option where employees choose plans at multiple levels, with the employee paying the cost difference for more generous plans.

Increased clout: In the current market, small businesses pay disproportionately higher administrative costs compared to large businesses. SHOPs can save small businesses money by creating a competitive marketplace of qualified health plans and a simplified enrollment system. CBO estimates that lower administrative costs in the small group market, through economies of scale and standardization of benefits, will reduce average premiums by 1 to 4 percent.[7] In addition, insurance companies within the SHOPs will compete for business on a level and transparent playing field, driving down costs. As previously mentioned, small business may also be eligible for the small business tax credit when they offer health coverage to their employees through a SHOP after 2013.

Conclusion

Small businesses are already benefiting from the Affordable Care Act and those benefits will expand dramatically as the Act continues to take effect. The small business tax credit is lowering costs and providing a bridge to 2014, when small businesses will enjoy many of the

[7] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf (2009)

advantages from which large businesses already benefit: larger risk pools, greater purchasing power, and a choice of plans. In addition, limits on discriminatory rating practices, risk adjustment, reinsurance, risk corridors, and greater pooled purchasing of coverage will go into effect in 2014 – ensuring that small businesses do not face a premium shock when their employees get sick and need health coverage most, thus keeping coverage affordable into the future.

Small businesses will continue to benefit from the Affordable Care Act. The Rand Corporation estimates that without passage of the Affordable Care Act, only 53 percent of small businesses with fewer than 10 employees and 71 percent of small businesses with 11 to 25 employees would have offered coverage in 2016.[8] However, because of the Affordable Care Act, an estimated 77 percent of small businesses with fewer than 10 employees will offer coverage in 2016 – resulting in over 1 million additional employers and 6 million additional workers with health insurance coverage – and almost 90 percent of small businesses with 11 to 25 employees will offer coverage in 2016 – that's 3 million additional workers with coverage.[9]

Thank you for the opportunity to appear before you to discuss the Affordable Care Act's critical provisions to support small businesses' ability offer health insurance to their employees.

[8] http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf (2010)
[9] ibid.

Small Business and PPACA

Testimony before the United States House of Representatives
Committee on Small Business
Subcommittee on Healthcare and Technology

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July 28, 2011

*The views expressed herein are my own and do not represent the position of the American Action Forum.

Chairwoman Ellmers, Ranking Member Richmond, and Members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

1. The Patient Protection and Affordable Care Act (PPACA) raises the overall cost of operating a small business and undermines job growth in the United States;

2. The PPACA's new taxes will dramatically increase the cost of insurance premiums and force small insurers out of business; removing insurance options for small business owners and hastening the decline in employer sponsored insurance;

3. The small business tax credits and the grandfathering health insurance provisions included in the PPACA provide offer false promises to small business owners and create disincentives for future job growth; and

4. Ultimately, the PPACA will lead to a dramatic decline in employer sponsored insurance; meaning as many as 35 million Americans will not be able to keep their insurance if they like it and the federal government will need to substantially increase spending projections for the state exchange subsidies.

Let me discuss each in turn.

1. *The Patient Protection and Affordable Care Act (PPACA) raises the overall cost of operating a small business and undermines job growth in the United States.*

The PPACA is a threat to the health of small businesses. Its heavy dosage of mandates and penalties will be a financial burden, and the law is riddled with hidden barriers to stronger job growth.

The small business implications of the legislation are important because data from the ADP National Employment Report shows that since January 2001 companies with one to 49 employees were responsible for 36 percent of job growth, while those with 50 to 499 workers accounted for 44 percent of new jobs.

Small business vitality is crucial to the economic fortunes of U.S. workers, and substantial new costs that curtail their hiring should be of concern to companies, workers and policymakers alike.

Sadly, the new health-care law is an assault on small business, beginning with the 3.8 percent Medicare tax on net investment income – a direct tax on many business owners. Of even greater concern is the law's most celebrated feature – the mandate to cover full-time employees with health insurance. For businesses with more than 50 workers, this means paying a penalty if any full-time workers receive subsidized coverage.

The mandate creates a tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment t o 51 will trigger a penalty of $2,000 per worker multiplied by the entire workforce, after subtracting the first 30 workers. In this case the fine would be $42,000 to hire an additional worker. How many firms will chose not to expand?

The authors of the health-care law reflect liberal indifference to the climate for business, perhaps believing that businesses have a hidden well of resources or an infinite ability to evade the burdens placed on them. Businesses will try to shift costs. But their ability to push the burden on customers with higher prices is quite circumscribed.

Instead, we would expect that the effective burden will be borne by workers in the form of lower wage growth, fewer hours and reduced job growth. The only other avenue is for business owners to pay the costs out of scarce capital, raising the prospect of increased failure rates.

2. *The PPACA's new taxes and onerous regulations will dramatically increase the cost of insurance premiums and force small insurers out of business; removing insurance options for small business owners and hastening the decline in employer-sponsored insurance*

As businesses juggle new direct operating costs, they will face higher insurance premiums. The law levies roughly $500 billion in new taxes that will enter the supply chain for medical services, revealing themselves as higher medical costs.

Specific to health insurers, the PPACA imposes a fee that amounts to a *de facto* "health insurance premium tax" that will raise the cost of health insurance by an additional 3 percent for American families and small employers. Under the law, an annual fee will apply to any U.S. health insurance provider, with the intent of raising nearly $90 billion over the budget window. As shown in Table 1, the aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and rises thereafter.

Table 1: Aggregate Insurance Fees[1]

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [2]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder).[3] The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 2: Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0 percent
$25 million to $50 million	50 percent
$50 million or more	100 percent

Taken at face value, insurers have to pay this new "health insurance premium tax." Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. And as with any excise tax, firms don't really pay taxes; they are shifted to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax - the legal responsibility to remit the tax to the Treasury - and the *economic incidence* - the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" - that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue to serve policyholders effectively.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes on to either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive are markets for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the PPACA has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the budget window, the upward pressure will be $134.6 billion.

The line of reasoning outlined above is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability raise their scale of operations. In short, for insurers that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[4] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent.[5] Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

In short, the health insurance fee will likely quickly and nearly completely be incorporated into higher insurance premiums. To get a feel for the implications, I adopt the projected changes in insurance coverage by Medicaid and SCHIP; employers, and non-group and others contained in the Congressional Budget Office

letter to Nancy Pelosi on March 20 2010.[6] Using the rough assumptions that 55 percent of employer coverage is self-funded and that 66 percent of Medicaid and SCHIP is private coverage yields an estimate of the insured coverage in each year.

To compute the baseline premium income, I assume that premiums per person will grow at an average rate of 3 percent. When combined with the coverage growth implicit in the CBO projections, the result is projected growth in overall premium income. In 2009, overall premium income was $1.005 trillion, providing a starting point for a projection of premium income in each year.[7]

Table 3 shows the impact of the ACA on premiums. As shown at the bottom of the table, the premium tax in isolation will raise premiums from between 2.4 percent (in 2014) to over 3 percent (in 2015). If one factors in a second assessment on insurers that covers the transitional reinsurance program, the effect will be as large as 3.5 percent.

Table 3: Impact of PPACA on Insurance Premiums

Year	2014	2015	2016	2017	2018	2019
Fees: Fully Insured Plans Only ($B)						
Premium Tax (PPACA Section 9010)	$8.0	$11.3	$11.3	$13.9	$14.3	$14.3
Reinsurance (PPACA Section 1341)	$2.0	$2.0	$1.0			
Fees: Fully Insured & Self-Funded ($B)						
Reinsurance Transition (Section 1341)	$10.0	$6.0	$4.0			
Total Fees and Assessments ($B)	$20.0	$19.3	$16.3	$13.9	$14.3	$14.3
Impact: Fully Insured Premiums (pct.)						
Premium Tax	2.40%	3.03%	2.69%	3.02%	2.98%	2.89%
Premium Tax and Reinsurance	3.16%	3.45%	2.96%	3.02%	2.98%	2.89%

Data from the Kaiser Family Foundation show that the average overall family premium in 2010 is $13,770.[8] Using this as a rough guide, the ACA premium tax will add as much as $475 to the costs, or nearly $5,000 per family over a decade.

The ACA contains insurance reforms, medical device taxes, pharmaceutical fees, and insurance company fees that will raise the cost of insurance for millions of individuals, small businesses and households. This analysis suggests that the insurance tax in isolation will raise premiums by roughly 3 percent. An important topic for future research is to perform similar analyses for the other cost-raising aspects of the ACA in order to assess the overall pressure on premiums.

3. *The small business tax credits and the grandfathering health insurance provisions included in the PPACA provide offer false promises to small business owners and create disincentives for future job growth.*

Proponents of the PPACA point toward the fact that small businesses will receive aid in the form of a small business tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average earnings are under $50,000. Thus the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitation on employees, limitations on earnings, and phase-outs has surprised the small business community. IN particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the tax credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit. Unfortunately, the net impact of the credit in offsetting the cost of the PPACA will depend not upon eligibility but rather on receipt of the tax credit. This distinction was noted early in the debate by the Congressional Budget Office (CBO). In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from the credit in 2016."

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. An analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under PPACA, is more likely near 35 percent of all firms with less than 25 employees.

In the same way that the individual mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 thereby reducing the tax credit per worker from $2,100 to $1,596. In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesion is clear in that the structure of the tax credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.

Ultimately, the small business tax credits will prove to be little more than a talking point for PPACA advocates. Relatively few small businesses will qualify for the credit and even fewer will be able to offset the cost of PPACA on small business health insurance premiums. For those that do qualify, receiving the tax credits will impose a new regime of hidden effective marginal tax increases on a small business owner's ability to increase employment and hire more qualified employees.

Whether they qualify for the tax credit or not, small business owners can expect to be re-working their benefits packages. Even though President Obama promised that, "If you like what you have you can keep it," most small business owners will need to find new health insurance plans to for their employees.

In June 2010, the Administration released interim final regulations defining grandfathered status for health insurance plans (75 Fed. Reg. 24538). To be eligible for grandfathered status, employers cannot raise deductibles or out-of-pocket limits by more than 15 percentage points beyond the increase in the medical inflation, nor can they raise co-pays by more than that amount, or $5 if that is more. They also cannot increase employee coinsurance percentages at all. In addition, a health plan or benefit package will lose grandfathered status if the sponsor cuts their contribution rate toward total coverage costs by more than 5 percentage points.

These regulations essentially undercut the stated intent of the law (Sec. 1251) that "nothing in this Act requires an individual to terminate coverage under a group health plan or health insurance coverage in which they were enrolled on the date of the healthcare reform law's enactment."

The Obama Administration's interim regulations for grandfathered plans estimate that 18 percent of large employer plans and 30 percent of small employers plans would lose grandfather status in 2011, increasing over time to 45 percent and 66 percent respectively by 2013. This is at best an overly optimistic estimate, especially in light of recent employer surveys that indicate between 63 percent and 88 percent of employers anticipate losing grandfathered status by 2013.

Hewitt Associates, a leading global health benefits consulting, conducted a survey of 450 employers representing 6.9 million employees that specifically focused on the grandfathered health plan rules. The survey found that 88 percent of self-insured medical plans and 81 percent of fully-insured medical plans expect to lose grandfathered status by 2014.

These results are corroborated by a similar study done by Mercer, another leading global health benefits consulting firm, 62 percent of small businesses have at least one red flag in their plan design that violates the new law's mandates, and 14 percent have two red flags.

Simply put the rules designed to determine grandfathered status undermine existing health insurance plans and contradict the stated intent of the bill as well as the promises made to the American people by President Obama. The grandfathered health plan rule erodes existing employer-based insurance plans, especially for small businesses.

4. *The PPACA will lead to a dramatic decline in employer sponsored insurance; meaning as many as 35 million Americans will not be able to keep their insurance if they like it and the federal government will need to increase spending projections for the federal government by $1.4 trillion.*

The PPACA will have profound implications for U.S. labor markets. Today about 163 million workers and their families receive health insurance coverage from their employers. While proponents of the PPACA insisted that a key tenet was to build on this system of employer-sponsored coverage, the healthcare law creates strong incentives for employers to drop employer-sponsored health insurance.

Roughly one-half of the $900 billion of spending in the PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative - subsidized source of insurance for their workers - which can be accessed if they drop coverage for their employees. The most simple calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the PPACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Caterpillar for instance noted that it could save 70 percent on health care costs by dropping coverage and paying the penalties; AT&T's $2.4 billion cost of coverage would drop to just $600 million for the penalties. And the list could go on.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package employees receive as a result of competitive pressures. And the evidence suggests that if one portion of that package is reduced or eliminated – health insurance – another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – and save money.

Table 4: Health Care Reform and Employer-Sponsored Insurance in 2014
(Employer Health Plan =$11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health Plan[3]	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	-$128	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

Notes:
1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

As Table 4 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of untaxed employer-provided health insurance. Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Do the economics of PPACA ever suggest that employer's could drop? Yes. The employee would receive $14,176 in federal subsidies – more than the value of the lost health insurance. On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is

room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminate employer-sponsored insurance.

The remaining rows of Table 4 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package. Appendix Table 1 repeats this analysis and checks the robustness of this conclusion if one assumes that health care costs are significantly higher and the employer's contribution to the insurance plan rises to $15,000. In this instance the decision holds for up to 200 percent of FPL.

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work (the employment-population ratio is 58.8 percent) and about 60 percent of those receive employer- sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance if the health plan costs the employer $11,941.

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 million plus an additional 38 million in 2014) – the gross price tag would be roughly $1.4 trillion[3].

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

This analysis has been recently corroborated by employer surveys conducted by McKinsey & Company and PricewaterhouseCoopers (PwC). The McKinsey survey of more than 1,300 employers across industries, geographies, and employer sizes found:

- Overall , 30 percent of employers will definitely or probably stop offering employer-sponsored insurance in the years after 2014
- Among employers with a higher awareness of reform, this proposition increases to more than 50 percent, and upward of 60 percent will pursue some alternative to traditional employer-sponsored insurance

As part of its annual report, PwC surveyed employers about changes they are making in their benefits plans. The survey found:

- Overall, 86 percent of employers are likely to re-evaluate their overall benefits strategy
- One-half (50percent) of employers are considering significantly changing or eliminating company subsidies for dependent medical coverage.

With each passing day the impact of the PPACA grows clearer. The healthcare law harms small businesses and will have profound implications for U.S. labor markets. It must be repealed and replaced with real healthcare reforms that encourage providers to offer higher-quality care at lower costs; reduce the cost pressures that underlie the bankrupt Medicare and Medicaid entitlements; and give every American access to more options for quality insurance.

Thank you and I look forward to answering your questions.

[1] The non-deductibility of the Insurance fees raises their economic impact. See text for discussion.

[2] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

[3] There is some ambiguity as to whether the reduced percentages to the first $50 million apply to all firms. If it applies only to those with revenue below the threshold, the overall analysis is little changed, but the premium pressures will differ across market segments and products.

[4] See http://biz.yahoo.com/p/522qpmd.html.

[5] See also, "Health Care-Managed Care," Barclays Capital, November 19, 2009 which indicates an overall profit margin of 4.42 percent.

[6] See http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[7] See also, "Health Care-Managed Care," Barclays Capital, November 19, 2009 which indicates an overall profit margin of 4.42 percent.

[8] http://ehbs.kff.org/pdf/2010/8085.pdf .

Testimony of William J. Dennis, Jr., Senior Research Fellow, NFIB Research Foundation before the House Subcommittee on Healthcare and Technology

July 28th, 2011

Thank you Chairwoman Ellmers, Ranking Member Richmond, and all Members of the Healthcare and Technology Subcommittee for the invitation to testify today. My name is William Dennis and I am the Senior Research Fellow at the National Federation of Independent Business. As such, I manage NFIB's research program and direct long-term policy planning and annual surveys.

Earlier this week, NFIB released a survey titled, "Small Business and Health Insurance: One Year After the Enactment of PPACA." The data for this report were drawn from a nationally representative telephone survey of small employers during the latter part of April and the first half of May, 2011. The survey was conducted for the NFIB Research Foundation by the polling firm Mason-Dixon, Inc. of Columbia, Md. The sample was drawn from the files of Dun & Bradstreet with small employer defined as those employing 50 or fewer people other than the owner(s) – the number that triggers the employer mandate within the law.

Our results found that one year after passage of the Patient Protection and Affordable Care Act (PPACA), 42 percent of small employers – defined as businesses employing 50 or fewer people other than the owner(s) – offer employee health insurance. In the last 12 months, 1 percent of offering small employers added health insurance as an employee benefit while 4 percent of non-offering employers dropped it.

The number of small employers offering employee health insurance is likely to change little over the next 12 months. Virtually no small employer now offering expects to drop health insurance in the next year and virtually no non-offering employer expects to add it in that time frame.

Twenty (20) percent of small employers currently offering expect to significantly change their benefit package and or their employees' premium cost-share the next time they renew their health insurance plans. Almost all significant changes expected involve a decrease in benefits, an increase in employee cost-share, or both.

Since enactment, one in eight (12%) small employers have either had their health insurance plans terminated or been told that their plan would not be available in the future. Plan elimination is the first major consequence of PPACA that small-business owners likely feel.

Eighteen (18) percent of small employers think they are "very familiar" with PPACA and another 40 percent think they are "somewhat familiar" with the new law.

By overwhelming margins, small employers who have some knowledge of the new law think that PPACA will not reduce the rate of health care (insurance) cost increases, will not reduce the administrative

burden, will increase taxes, and will add to the federal deficit. They agree that PPACA will result in more people having health insurance coverage, but do not think it will yield a healthier American public.

The principal factor explaining the PPACA outcomes that small-business owners expect is their current offer/non-offer status. Those offering employee health insurance are notably more pessimistic about the new law's projected outcomes. Neither the degree of familiarity with PPACA nor employee size-of-business is associated with their expected outcomes.

Low-wage employees, particularly those experiencing a large premium cost-share, have a powerful incentive to bolt an employer's health plan for the newly established and heavily subsidized exchanges. Should employees begin to leave for an exchange, 26 percent of currently offering small employers are very likely to explore dropping their health insurance plans and another 31 percent are somewhat likely to do so.

A key factor in a small employer's decision to drop a current health insurance plan will be the proportion of employees who leave their health plan for an exchange. Forty-three (43) percent report that a majority of employees would have to leave before they would drop their plan and 35 claim it would require all of them.

An estimated 245,000 (out of 5,228,000 employers with fewer than 25 employees) are eligible for a full PPACA tax credit. Another estimated 1.165 million are eligible for the partial credit.

The PPACA tax credit acts almost exclusively as a windfall for small employers who currently offer health insurance rather than as an incentive to encourage its purchase. Considering eligibility and awareness issues, the full credit incents, but does not necessarily change behavior, of only about 2 percent of small employers having fewer than 25 employees.

Fifty-seven (57) percent of small employers express interest in contributing to defined contribution-type health plans. Their interest assumes employees benefiting from their contributions receive equitable tax treatment compared to that in employer-sponsored plans.

Thank you for this opportunity to report the findings of our survey. I look forward to answering any questions you may have.

William J. Dennis, Jr.
NFIB Research Foundation

Statement
of the
U.S. Chamber
of Commerce

ON: **"Small Businesses and PPACA: If They Like Their Coverage, Can They Keep it?"**

TO: **THE HOUSE COMMITTEE ON SMALL BUSINESS SUBCOMMITTEE ON HEALTHCARE & TECHNOLOGY**

DATE: **July 28, 2011**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. In addition to the U.S. Chamber of Commerce's 115 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

Statement on
"Small Businesses and PPACA: If They Like Their Coverage, Can They Keep It?"
Submitted to
THE HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON HEALTHCARE & TECHNOLOGY
on behalf of the
U.S. CHAMBER OF COMMERCE
By

Brian Vaughn
Owner & President
Nearly Famous, Inc.
Douglas, Georgia
July 28, 2011

Chairwoman Ellmers, Ranking Member Richmond and distinguished members of the Subcommittee, thank you for inviting me to testify before you today on the impacts the new health care law will have on my business and my employees. I commend your efforts in holding this valuable hearing to further understand the damage the new health care law will have on the ability of businesses, including small ones like mine, to compete, grow, and create jobs, as well as our ability to offer our employees health care benefits.

My name is Brian Vaughn, and I am the Owner and President of Nearly Famous, Inc. which consists of four Burger King franchises in Georgia. I am here to speak with you today on behalf of the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, the Chamber is

particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

I am also a proud member of the National Franchisee Association (NFA) and have served on their board of directors for three years. The National Franchisee Association, founded in 1988, serves the BURGER KING® franchisee community through advocacy, education and training, networking and member-focused programs, services and benefits. The NFA works with member franchisees, system suppliers, business partners and Burger King Corporation to promote franchisee growth and success and further its mission statement "to improve, preserve and ensure the economic well being of all members." The NFA represents independent Burger King restaurant entrepreneurs in the United States and Canada who operate nearly 5,000 franchised restaurants and employ almost 200,000 individuals across the nation. The NFA represents more than 75 percent of the BURGER KING® franchised restaurants in the United States and Canada. These comments are my own and nothing I say here today reflects the position or opinions of my franchisor, Burger King Corporation.

Company Background

When people generally think of Burger King, they think of a big corporation. However, although the sign on the door says Burger King, the company that my wife and I own is a small operation—consisting of four Burger King restaurants serving three small communities in Georgia. And the beginning of our story is even more humble, but it is the kind of 'pull yourself up by your own bootstraps' story that has happened for thousands upon thousands of other small business owners across our great nation—it's the type of story that goes to the very heart of what it means to

live the American dream and if we're not careful, stories like mine and that wonderful dream that has driven so many to succeed will cease to exist.

In 1980, I began my career with Burger King as an Assistant Manager, earning $14,000/year. It wasn't much, but it was a start and that is all I wanted. By working hard and smart, I was able to eventually work my way up through the company to an officer position where I was responsible for servicing franchisees. In 1993, I partnered with Francis Lott – a real estate developer/architect and together we opened four Burger King locations in Georgia. It was a great opportunity; I was able to stay with the Burger King brand while essentially venturing out on my own. Then in 2001, I bought out my partner Francis' interests and today continue to operate those four stores with my wife, Cindy. Our size allows us to be a professional operation while still maintaining an all important family environment that extends to our managers and employees, many of whom have been with us for over a decade.

Our sense of family actually stretches into the Georgia communities of Douglas, Hazelhurst and Baxley where we operate. We strongly believe that it is important to give back to the communities which have been so great to us. Through our financial donations to the academic and athletic boosters, we are able to contribute toward our area's school systems and the children enrolled there which is very important to us. I have also served as President of our local Lion's Club, which typically raises and spends $50,000 a year to purchase eyeglasses for the needy, and as Treasurer of our local chamber of commerce.

Like many other successful small business owners, I did not have anything handed to me—there was no proverbial goose with a golden egg, or silver spoon. I have worked hard and tirelessly for what I have now. My primary, current goals are twofold: first, to create financial security for my

family—my wife and our two children, one of who is just starting college; and second, to create more jobs and economic opportunities for others. To do this, our plan has been to expand and open a new store by reinvesting some of our profits back into our business. Sadly though, given the harm the new health care law is going to reek on our business as well as the uncertainty and the pain caused by other regulations, I fear that neither of these dreams nor my plans to achieve them will be possible. In fact, my worry is that everything I have worked for will be for not and may be wiped out by this new health care law. At the very least, I will be forced to adjust my number of full time staff and the economic opportunity that accompanies full time employment, in order to avoid the draconian provisions in the law.

Ten years ago, when we purchased our partner's interest in the franchise restaurants we knew that we were assuming a large financial obligation that had great risks. Up until the passage of health reform, our plan had been that after October 2011 (this October), my wife and I would have entirely paid off the debt on our business for that purchase. We have long anticipated and planned for the day when we could spend the money we were using to pay off this debt to expand our business and branch out further. For my entire career, I have been working to become financially independent but now I face a very uncertain future. I fear that everything I've worked for will be for naught.

The new health care law has wrecked our plans to grow our business and create jobs. We are already taking steps to downsize our team in anticipation of the full weight of the law's burden which will affect me most heavily in 2014. My new focus, unfortunately, is on how to have the leanest workforce possible and, even more dismaying, my worries about the very survival of our business are emblematic of the reactions of millions of small businesses throughout our nation. I

cannot imagine that this is what the President and Congress intended, particularly as they continue to try to pull our country out of a recession and reduce the unemployment rate. But intentions aside, it is the reality that they have created for us; it is the reality facing the very entrepreneurs that our nation needs to create the jobs to get our economy back on track.

It is ironic that the law touted as the Patient *Protection* and *Affordable Care* Act – neither protects our country's people, nor makes health care more affordable. It is a law of broken promises – under which no one will be able to keep the health care they have, even if they like it and one which will incent more companies to scale back their workforces and reduce the benefits offered that were previously valued by their employees. Having shared a little about my business, our history and our future, I would next like to discuss how the new health care law will pummel my business and my employees and how you might prevent that trauma from occurring.

Health Care

Up until now, my wife and I have been pretty fortunate; and while our business has been on sound financial footing, we are not flush with cash. Like most in the fast food franchisee world, we operate on low margins and are very susceptible to quickly loosing this footing and our solvency. Our fundamental fear is that the new health care law, when fully implemented, will devour our minimal profits and put us in a negative cash position. Simply put, the shock the law will have on our business and employees will be devastating and it is already forcing us to make incredibly difficult decisions. Will we completely close our doors, shutter one or two of our stores, cut employees' jobs, cut employees' hours or a combination of these? Honestly, it is very hard to say. Certainly, none of these options are appealing, particularly given that we had been hoping to

actually expand the business and add employees. Unfortunately, these are the types of choices we are left with as a result of the new health care law.

At our four locations, we are proud to have created 182 jobs. Fifty-nine of the jobs are full-time jobs and the rest are part-time positions with under thirty hours of work per week. Fourteen of the full-time jobs are management jobs for which we currently cover 100% of the cost of the health care for the employee at an annual cost to us of nearly $56,000 per year. For the fourteen management jobs, we also cover 100% of the cost of term life, short-term disability, vision and dental. Our current carrier for our management is a Blue Cross-Blue Shield Major Medical plan. My wife and I also participate in this same plan. I also offer a value mini-med plan to the rest of the employees at a cost of between $106 and $165 per month. Currently, only 19 of the more than 100 part time employees eligible for the mini med plan I offer have elected to take it. They simply would rather have more in their paycheck or they get coverage on a spouse's plan.

During a time when the economy is struggling to regain its footing and when unemployment rates continue to hover at 9%, my employees – like my wife and I – are grateful to have jobs. Many choose to keep the wages they earn to help pay for their day to day living expenses, rather than use a portion of them to pay for coverage that I offer. Just as my employees have a limited amount of income, so does our company. And just as my employees have to decide how much of their wages they need to use to cover their daily living expenses, as the president of my company, I have to decide how much of the company's income can be used to pay wages and benefits, and how much has to be used to cover the expenses of daily operations. There is only so much money and at the end of the day, my employees and I each have to first and foremost cover our daily expenses.

There was much ado last fall about the types of plans that I offer my employees – Washington, under the health reform law, decreed that so called "limited benefit plans" – are not acceptable. Despite repeatedly promising that "if you like your plan, you can keep it" the law has outlawed these plans. Now while I understand that for many, a more comprehensive plan seems critical and, by comparison, these limited benefit plans are slim, it is important to acknowledge reality. There is only so much money – both for my employees and for me. These plans offer less expensive coverage options that allow my team members to choose to take more of their wages home to pay for other expenses and use a small amount to pay for some coverage. Just like my employees, my income is limited. Prior to health reform, I had the ability to hire more workers, pay them a wage and offer them access to this moderate coverage. Now, I am being told by Washington that I have to offer all of my full time employees' Washington defined health coverage or pay a penalty. First, because of the cost of offering this prescribed coverage and the size of the penalty, I have no choice but to restructure my workforce in a way that permits me to avoid losing everything. What does this mean? Well – given the law and the regulations that are still being promulgated – it is hard to say.

What I do understand is that while it may be difficult for me to reduce my workforce to the extent that I am no longer an applicable "large employer" under the health care law, I may be able to restructure my workforce in a way to avoid the penalty. Although part-time workers are included in determining whether I am a large employer, they are not included in calculating the penalty. Prior to the law's enactment – my goal had always been to hire ***fewer*** people for ***more*** hours. It is easier to retain employees that work full time. However, now that the law has passed, I have to consider options other than what makes practical business sense. Now, because of what Washington has mandated, it seems to make more practical business sense for me to hire ***more***

people for *fewer* hours. At a time when millions of Americans are out of work, is this really the right incentive? This is not what I want and it is not what is best for my employees, but in order to survive and be able to pay the employees that I have, it is what I will have to do.

While I have not read the entire law, and I am not able to follow the regulations which are being issued at record speed by the Administration, I am trying to figure out how to protect the company that I have spent my entire life building. With 30 years in the business, I don't want to have to read "Interim Final Rules" and notices issued by administrative departments in Washington to figure out what my legal obligation is under the law. I want to keep my company financially afloat, to give back to my community and to keep my promise to my employees. Unfortunately, to do this, the law is forcing me to take a position that is 180 degrees from where I want to be.

Conclusion

I understand that given the existing political realities in Washington, DC, a total repeal of the health care law by Congress is an unlikely proposition for now. However, I am hopeful that this Subcommittee and your colleagues in the House and Senate will focus on repairing or eliminating the more onerous mandates such as the employer mandate. These provisions saddle businesses with burdens that actually encourage us not to expand our business and astoundingly discourage job creation. The bottom line is that your decisions can help or hinder us. The laws you create can either foster an environment that gives small businesses greater confidence and certainty to grow and generate new jobs, or do just the opposite. Regrettably, this new health care law is already doing the latter and Congress must take the necessary action to rectify it.

Thank you again for this opportunity and I look forward to your questions.

IF YOU LIKE YOUR HEALTH PLAN, CAN YOU KEEP IT?

Statement of Timothy Stoltzfus Jost, J.D
Professor of Law, Washington and Lee University School of Law
To the House Committee on Small Business, Subcommittee on Health and Technology

Thank you Chair Elmers and Ranking Member Richmond for the opportunity to address the Subcommittee today on this important topic.

One of the premises of health care reform was "If you like your insurance plan, your doctor, or both, you will be able to keep them." My testimony today will address two important questions raised by this premise. First, how do the Affordable Care Act and implementing regulations fulfill this commitment by grandfathering in coverage provided through existing health plans? Second, what do we know about how the ACA will affect the willingness of employers to offer coverage after 2014? Obviously, if employers drop coverage, employees will not be able to keep the plans they like.

Grandfathering under the ACA.

"If you like your plan you can keep it" was written into the Affordable Care Act as section 1251, entitled "Preservation of Right to Maintain Existing Coverage." Section 1251 provides that many of the new reform provisions of the ACA do not apply to individual or group health plans that were in place on March 23, 2010.[1] These "grandfathered" plans can, therefore remain largely unchanged.

To understand the grandfathering provisions, it is important to understand the nature of the commitment it makes. The commitment is not, "if you don't like the coverage you have now, you are stuck with it forever." It is also not, "if the coverage you have now is completely inadequate, you cannot hope for better coverage." It is not even, "if you are currently insured, your employer or insurer can change your coverage in any way they

want and avoid offering you the consumer protections of health reform." It is simply, "if you you're your insurance plan, you can keep it."

This commitment poses two important questions: who is the "you" who gets to keep the plan, and what is the "plan" that can be kept? The most common form of health insurance coverage in the United States is employer-sponsored insurance (ESI).[2] Under ESI, the plan is sponsored and paid for in part by the employer, who normally selects the plan or plan options, even though the enrollee is the employee. The title of this hearing, "Small Businesses and PPACA: If They like Their Coverage, Can They Keep It?" assumes that the commitment was made to employers. The commitment, however, is to individual enrollees, and section 1251 quite clearly offers the right to maintain existing coverage to individuals. Section 1251 applies to group as well as individual coverage, however, and employers can also expect to continue to offer the coverage they are currently offering their employees, as long as the plan they offer remains the same.

Second, what is the "your plan," and when does it cease to be "your plan"? How much can an insurer or employer change a plan without losing grandfathered status? Obviously, a formulary change from Nexium to Prevacid isn't enough to lose grandfathered status, but surely if a deductible is increased from $500 to $5000, or a $20 copayment is changed to a 50 percent coinsurance obligation, the plan is no longer the plan that the enrollee had and is almost certainly not the plan the enrollee liked.

Exercising their delegated authority under the ACA, the Departments of Labor, Treasury, and Health and Human Services issued an interim final regulation on June 17, 2010 to implement section 1251, defining when a plan loses grandfathered status.[3] The regulation adopts bright line rules identifying the changes that will end grandfathered status so that insurers, employers, and enrollees will not have to guess when a plan ceases to be grandfathered.

The major changes that will result in the loss of grandfathered status under the regulation include:

- Elimination of all or substantially all of any benefit necessary to diagnose or treat a particular condition;
- An increase in coinsurance percentages;
- An increase in a deductible, out-of-pocket limit, or other fixed dollar cost-sharing requirement or limit other than a copayment by more than the increase in the medical component of the CPI since March 2010 plus a total of 15 percentage points;
- An increase in a copayment in excess of the greater of 1) medical inflation plus $5.00 or 2) medical inflation plus a total of 15 percentage points;
- A decrease of the employer contribution, whether based on the cost of coverage or on a formula, by more than 5 percentage points below the contribution rate in place on March 23, 2010; and
- The reduction in the dollar value of existing annual limits, the imposition of an annual limit on coverage by plans that did not impose any limits before, or the adoption of annual limits less than any lifetime limits a plan imposed before if it only imposed lifetime limits before Mach 2010.

Self-insured plans can change plan administrators and remain grandfathered, and under an amendment to the grandfathered plan rule adopted last November, employers can also change insurers and not lose grandfathered status.[4] New employees and dependents can be added to a grandfathered plan without losing grandfathered status. Finally, employers and insurers are not prohibited by the regulation from making changes in plan structure, provider network, or formulary.

In sum, the grandfathered plan rule takes a common sense approach, allowing employers and insurers to maintain the plans they had in March of 2010 and increase enrollee or employee cost-sharing and employee premium contributions to respond to increases in health care costs, while at the same time not forcing onto enrollee or employees continued enrollment in a plan that has become dramatically more expensive or less valuable than the plan that they had when the ACA was adopted.

Will Employers Continue to Offer Coverage?

Another very important question is whether employers will continue to offer coverage after the health care reform law is fully implemented. Obviously, if employers cease to offer coverage, employees cannot keep it.

A number of studies have addressed the question of how the ACA will affect employer-sponsored insurance (ESI). These predictions range at the extremes from those of Dr. Holz-Eakin, who predicted that ESI would shrink by 22.3 percent, to those of the Rand Corporation, which predicted that ESI would grow by 8.7 percent.[5] Most studies, however, including studies by Booz, Lewin, Urban, Mercer, and Towers-Watson, predict that coverage will remain largely unchanged.[6] This was also the conclusion of the Congressional Budget Office, which Congress entrusts with analyzing the effects of legislation. The CBO projected that the number of Americans covered by employment-related insurance would grow from 150 million in 2010 to 159 million in 2019, 3 million fewer than would have been covered had the ACA not been adopted.[7]

Another outlier study done by McKinsey and Company received a great deal of coverage when it was published earlier this summer. This survey reported that nine percent of employers stated they would definitely and 21 percent would probably drop coverage. McKinsey noted, however, that their survey was not intended as a "predictive economic analysis of the impact of the Affordable Care Act."[8] The McKinsey surveyors only asked about continued offering of coverage after selectively providing information about the ACA. The survey has been criticized as being effectively a push poll.[9]

On Monday of this week, the National Federation of Independent Businesses released a report on the effect of the ACA on small businesses.[10] One of the key findings of this report is that the ACA has not yet resulted in small businesses abandoning health coverage. Health insurance offers decreased only about 2 percent last year, which is consistent with declines in recent years. The Report also projects that there will be no net loss of coverage offers over the next year.

The NFIB study does project that 26 percent of small employers are very likely and 31 percent very likely to drop coverage after the ACA is fully implemented. This projection, however, is based on a fundamental misunderstanding of the ACA that formed the basis for the questions asked survey participants. The questions NFIB asked presumed that employees will be able to freely choose between offered employer coverage and receiving premium tax credits in the exchange. That is simply not what the ACA provides.[11] Employees who have a coverage offer from their employer are not eligible for premium tax credits unless the coverage offered is seriously deficient. Since the answers to these questions are based on a false premise, they have no predictive value.

Today, 69 percent of employers offer health insurance.[12] The percentage of employers that offer insurance has been steadily dropping in recent years, and is likely to continue to drop regardless of health reform.[13] Indeed, in a survey conducted in 2009, before the ACA was adopted, only 57 percent of employers were "very confident" that they would still be offering ESI in ten years.[14]

But all of the reasons that employers offer ESI now, and have done so since the 1940s, will continue to exist after health reform goes into effect. Most importantly, unless Congress decides to change existing law to reduce the deficit, the cost of employee benefits will continue to be exempt from federal and state income and payroll taxes. In Virginia, a low-tax state, an employee taxed at the Alternative Minimum Tax marginal rate of 28% receives a subsidy of 49 percent for every dollar spent on ESI. This is the federal government's largest tax subsidy and will amount to $249 billion in 2015,[15] almost 8 times the cost CBO estimates for the ACA premium tax credits and cost sharing subsidies in that year. The average American covered by ESI has an income of 423 percent of the federal poverty level and thus would not be eligible for ACA premium tax credits, which are only available to 400 percent of poverty.[16] Seventy-nine percent of employees insured currently insured through ESI have incomes above 250 percent of poverty.[17] Employers who drop health insurance would have to dramatically increase after-tax cash compensation for their employees to cover this loss of tax subsidy. This is particularly true for older employees who tend to be higher income employees and most of whom would not qualify for subsidies. (The McKinsey survey failed to mention the

continued availability of this tax subsidy in the information they provided the employers as they conducted their survey).

Second, health benefits will continue to be one of the most highly valued forms of compensation to employees.[18] Employers competing to attract and retain talented employees will have no choice but to continue to offer health benefits after reform is in place unless all their competitors also drop coverage. Third, employers will continue to offer health benefits to ensure a healthy and productive workforce. An increase in absenteeism and decrease in employee morale will likely result if employers drop ESI. The wellness program incentives available under the ACA will increase the ability of employers to use their health benefits to encourage worker health and productivity.[19] Fourth, Group insurance will also in all likelihood continue to be available at a lower cost than individual coverage with comparable benefits and cost-sharing, even after the exchanges are in place.

While all of these current incentives for ESI will remain after the ACA becomes fully effective in 2014, the ACA also offers employers new reasons to expand coverage. First, and most important, the minimum coverage requirement (individual mandate) will require uninsured Americans who can afford health insurance to buy coverage. Since employment-related insurance qualifies as minimum coverage, Americans will demand health insurance of their employers so that they can fulfill this requirement. The Rand Corporation projects that a dramatic increase in the percentage of employers offering coverage after the ACA goes into effect will be driven primarily by employee demand for insurance in response to the minimum coverage requirement.[20]

Employers with more than 50 employees who fail to provide coverage for their employees will also face penalties of $2000 per full-time employee if one or more of their employees receive premium tax credits.[21] This penalty will not be tax deductible, adding to its cost.

Some small employers that provide insurance for their employees through the exchanges, on the other hand, can receive a tax credit covering up to 50 percent of their share of the

premium for up to two years.[22] This provision seems already to be increasing coverage among very small businesses. As the NFIB survey pointed out, one of the biggest reasons it has not been more effective is lack of knowledge on the part of small businesses. You can play a useful role here by making sure that every small business in your district is aware of this opportunity.

Other provisions of the ACA may also, of course, incentivize employers to drop coverage. Most notably, employees with household incomes below 138 percent of poverty will qualify for Medicaid and those with household incomes below 400 percent of poverty will qualify for premium tax credits. Some employers who employ predominantly lower income employees will see this new tax subsidy as an opportunity to shift the cost of insuring their employees to the federal government. The ACA, however, prohibits employers from discriminating in favor of highly-compensated employees, so an employer that drops coverage for its janitors it will also have to drop coverage for its managers (and pay them enough in taxable income to allow them to purchase coverage in the nongroup market).[23]

Employers may also drop coverage if the cost of coverage increases dramatically under the ACA. Some provisions of the ACA, such as the elimination of annual dollar limits on coverage or the requirements that plans cover adult children up to the age of 26 or preexisting conditions are likely to increase the cost of coverage for group plans. The "Cadillac tax" provision will also impose a tax on high cost plans after 2018.[24]

Other ACA provisions, however, are likely to reduce insurance costs. The exchanges will afford small employers more bargaining clout and a more competitive market and may reduce the cost of insurance dramatically for small businesses.[25] Employers who can get a better deal outside of the exchange, of course, will continue to have access to that market. The medical loss ratio requirements of the ACA are already forcing insurers to become more efficient and are likely to drive down insurance premiums as medical cost increases moderate.[26] Overall, the CBO estimated that changes in premiums in the small group market would range from an increase in one percent to a decrease in two

percent while in the large group market the change would range from no change to a decrease in three percent.[27]

However, the ACA is likely to affect different employers differently. Employers with 100 or fewer employees will have to cover the "essential benefits package" provided by the ACA, which may be more generous than coverage offered currently by some employers in some states.[28] On the other hand, state benefit mandates will largely be eliminated, as the states will have to pay for any additional costs imposed by their mandates, thus coverage may become less costly in some states.[29] Employers with young, healthy workforces will face higher premiums once health status underwriting is eliminated, although employers with older and less healthy workforces will face lower premiums.

While in the end it is not possible to predict exactly how employers will react to all of these cross-cutting incentives, the best real world experiment we have is Massachusetts, on whose reforms the ACA was modeled. Since the Massachusetts reforms were adopted, employer offer rates have grown from 70 to 76 percents.[30] There is no reason to believe that employers would react radically differently to the ACA reforms.

Final Observations and Conclusion

It is important to remember that the effect of the ACA on ESI is only one of many considerations that must be weighed in evaluating health care reform. Obviously, many Americans with preexisting conditions who do not work for employers who offer health insurance and who cannot purchase it in the nongroup market now will benefit from being finally able to get access to affordable comprehensive insurance. It is also likely, moreover, that reform will lead to a burst of entrepreneurial innovation as many Americans who are stuck in dead-end jobs because they fear losing their health insurance can finally strike out on their own and start their own businesses, secure in the knowledge that they can get affordable health insurance regardless of their health status.

In conclusion, the grandfathering provisions of the ACA, and the regulations that implement it, do allow employees, and employers, to keep an insurance plan they like as

long as the plan does not change into essentially another plan. Moreover, there is every reason to believe that the ACA will not dramatically change the scope of employer coverage in the United States, although the elimination of current tax subsidies for deficit reduction could have that effect. The promise that "if you like your health coverage, you can keep it," is being fulfilled.

References

[1] Under the final legislation, grandfathered health plans are subject to the following provisions of the Public Health Services Act as established by the ACA:

- The coverage transparency provisions of section 2715.
- The requirement of section 2718 that plans spend at least 80 or 85 percent of their premiums on health care claims and quality improvement activities.
- The prohibition against waiting periods in excess of 90 days found in section 2708.
- Section 2711's prohibition against lifetime limits.
- The ban against rescissions except for fraud found in section 2712, and
- The requirement that plans cover adult children up to age 26 found in section 2714.

Additionally, the prohibitions of section 2711 against annual limits and of section 2704 against preexisting condition exclusions (initially only for children) apply to grandfathered group plans. The adult children requirement only applies to grandfathered group plans only if non-grandfathered group coverage is not available.

Grandfathered plans are exempt, however, from many of the 2010 and 2014 reforms, including the requirement that plans cover the essential benefits package and limit deductibles, the right to internal and external appeals, and requirements that plans cover preventive care without cost-sharing or provide access to emergency care without extra cost-sharing for out-of-network providers.

[2] Fifty-six percent of Americans had employment-related insurance in 2009. U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009, p. 24 (2010)

[3] 75 Fed. Reg. 34538.

[4] 75 Fed. Reg. 70114

[5] Avalere Health, The Affordable Care Act's Impact on Employer Sponsored Insurance (2011), available at http://www.avalerehealth.net/pdfs/2011-06-17_ESI_memo.pdf. Dr. Holz-Eakin's estimate is based on serious misunderstandings that make its projections unreliable. For example, the paper ignores the payroll tax and state income tax subsidies for ESI and seems to assume that employers can easily separate their employees by income for the purpose of extending health benefits, which is not only illegal but unrealistic.

[6] Id.

[7] CBO, Analysis of ACA, March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

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[9] Brian Beutler, Top Expert, Disputed McKinsey Health Care Study Akin to Push Poll, TPM, June 23, 2011, http://tpmdc.talkingpointsmemo.com/2011/06/top-expert-disputed-mckinsey-health-care-study-akin-to-push-poll.php

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[11] IRC ' 36B(c)(2)(B) & (C), added by ACA ' 1401.

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[13] Bowen Garrett & Mathew Buettgens, Employer-Sponsored Insurance Under Health Reform (2011), http://www.rwjf.org/files/research/71749.pdf at 6.

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[16] Kaiser Family Foundation, A Profile of Health Insurance Exchange Enrollees (2011) http://www.kff.org/healthreform/upload/8147.pdf

[17] Garrett & Buettgens, supra not 11 at 6.

[18] Top Employee Benefits, http://www.money-zine.com/Career-Development/Finding-a-Job/Top-Employee-Benefits/

[19] Public Health Services Act ' 2705(j) added by ACA ' 1201.

[20] Christine Eibner, et al., Establishing State Health Insurance Exchanges (2010), http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf at xi - xii.

[21] IRC 4980H(a), added by ACA ' 1513
[22] ACA ' 1521.
[23] PHSA ' 2716, added by ACA ' 1001.
[24] ACA ' 9001.
[25] Garrett & Buettgens, supra note 11, at 3-4.
[26] PHSA ' 2718, added by ACA ' 1001. See Carl McDonald, CitiBank, https://ir.citi.com/26MByRrEaOyRCT1ZcYVa6IJpglc%2F7pmh7WJrHPzv6hs%3D, analyzing the effects of the medical loss ratio requirement.
[27] CBO, Analyzing Premiums under the Affordable Care Act (2010) http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf
[28] PHSA ' 2707(a), added by ACA ' 1001; ACA ' 1302.
[29] ACA ' 1311(d)(3)(B).
[30] Health Reform in Massachusetts, (2011) http://bluecrossfoundation.org/Health-Reform/~/media/D0DDA3D667BE49D58539821F74C723C7.pdf

Questions Submitted for the Record
To Steve Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Hearing: "Small Businesses and PPACA: If They Like Their Insurance, Can They Keep It?"
Subcommittee on Healthcare and Technology
House Committee on Small Business
July 28, 2011

1. In response to a question from Chairwoman Ellmers on Medical Loss Ratio at the hearing, you said that you were only aware of one state that had experienced insurers leaving the state since PPACA went into effect. Are you aware that Aetna alone has left 9 states? PPACA's child coverage mandate has resulted in 17 states not having access to child-only insurance policies, and in 39 states, at least one insurance company has exited the child-only insurance marketplace.

2. During the hearing, you stated that Medical Loss Ratio would help small businesses by providing value. Would you explain what you mean by that?

3. In response to a question from Chairwoman Ellmers on the effect of Medical Loss Ratio on small insurers, you stated that you are sensitive to the need to maintain competition, but you acknowledged that there is less flexibility in PPACA to modify the MLR in the small group market than in the individual market. What do you think is the best way to ensure that small insurers remain competitive and are not driven out of the market, which could limit consumer choice, and raise premiums?

4. Many states will experience rate shock at the same time that the exchanges are established. How are states that have wider rate bands going to adjust for rate shock in 2014 when the exchanges open? Is there a plan to help ease this transition?

5. How are employers expected to track penalties for employees who go to the exchange for coverage? If an employee has coverage with one employer, then moves to another employer, does the employer get the penalty back?

6. What government entity will determine the amount of the employee's subsidy? Is it IRS? HHS? Another agency?

7. During the hearing, you stated that the exchanges will have lower administrative costs. On what data are you basing your statement? Massachusetts, for example, added a 4% administrative load onto the cost of premiums.

8. Small business owners are confused about the health care law generally and, in particular, about the application of the employer mandate. During the hearing, you said that various surveys have confirmed this, and CMS should reach out to small businesses to help them understand the law. What type of outreach and education do you anticipate, and when do you expect it to begin?

9. In response to a question from Chairwoman Ellmers about an article in *The Hill* titled, "Health Care Law Could Leave Families with Higher Costs," you stated that CMS is looking into the issues of: 1) application of the health care tax credit to the individual and to the family; and 2) when employer makes an offer of health insurance, whether it is also binding on the family. You mentioned that CMS anticipates future guidance to clarify these issues. Would you elaborate on when you expect that guidance and the specific issues that will be covered?

10. In response to a question from Congressman Altmire, you stated that CMS is currently working with the Department of the Treasury and the Internal Revenue Service to estimate how many small employers have claimed the small business health care tax credit, and you expect to have that information soon. Would you please provide that estimate in response to these questions?

11. You said the health care tax credit was targeted to the smallest businesses (those with fewer than 50 employees) because they had lower rates of health insurance coverage. However, many small businesses with more than 50 employees that offer health insurance may not be able to afford it if the premiums continue to increase. Do you think the tax credit should apply to more small businesses?

12. In response to a question from Congressman Altmire, you said that under the employer mandate, you expect employers to continue to offer coverage, and that some studies have predicted even more employers will offer coverage. What if the employer mandate results in higher costs and fewer employers offering coverage?

13. If a small employer currently offers a very basic or mini-med plan, and the Minimum Essential Benefit package requires the employer to offer a far more comprehensive package of benefits, won't the employer have the incentive to drop insurance and put his employees into the exchange?

14. Do you support allowing employers to continue offering a basic, limited benefit plan under PPACA that would allow employees to take home more of their wages as salary and a smaller amount for their health insurance coverage?

15. Do you believe the Minimum Essential Benefit package will cost small businesses, most of which currently offer employees catastrophic or very basic coverage, more than they currently pay because of the expense of additional required benefits?

16. Brian Vaughn, who testified at the hearing, is just one small business owner who has stated that he will restructure his workforce to avoid PPACA's many mandates. In fact, he stated that there will be very few full time jobs in the restaurant industry after PPACA goes into effect, because only his management staff will be full time, and the remaining employees will work 29 hours per week or less to avoid triggering the employer mandate. Do you think PPACA's employer mandate is encouraging job creation and economic growth?

17. As of July 1, there were ten states where the federal government will be taking over rate review under authority granted by PPACA to determine if rate increases are reasonable. How long will this takeover last? Do you think the federal government will be better able to determine whether rate increases are "reasonable"?

18. Will the subsidies for insurance on the exchanges apply to the employer or the employee?

19. Is there an incentive for employers to keep their employees together to purchase coverage in the SHOP market, rather than letting the employees seek individual coverage through the exchanges?

20. Will cost sharing for Minimum Essential Benefits be permitted?

21. In response to a question from Chairwoman Ellmers, you mentioned that you are "very aware and tuned into the need to make sure that the package of essential benefits is an affordable package." How will the determination be made as to what is "affordable"?

22. You said that you believe employers will continue to offer insurance for the reasons they have offered it since the 1940s, but particularly to stay competitive. What would the incentive be to continue insurance if their competitor(s) drop(s) insurance?

23. When do you expect the 105(h) non-discrimination rules to be issued? Are Medicare, Tricare or other programs excluded from this calculation?

24. The Chairwoman mentioned that small businesses are confused by PPACA and its vague regulations, and are having difficulty complying with them. You responded that there will be tools called "navigators" available in the exchanges to help people understand how to access the exchanges. However, small businesses are trying to understand the law now, comply with provisions and regulations that are currently in effect, and plan for implementation of the law before 2014. What tools are available now to help them?

25. A recent article in *U.S. News and World Report* said that an HHS rule mandates that states collect "raw claims data sets" from insurers on all individuals with private coverage purchased either individually or though small employers. Exactly what information does HHS propose be collected from insurers on individuals with private coverage, and what is the projected use of this information?

Questions Submitted for the Record
To Timothy Stoltzfus Jost, Professor of Law, Washington and Lee University School of Law
Hearing: "Small Businesses and PPACA: If They Like Their Insurance, Can They Keep It?"
Subcommittee on Healthcare and Technology
House Committee on Small Business
July 28, 2011

1. During the hearing, you mentioned that the move to exchanges – and the associated competition and pooling – would solve cost problems, and cited the Urban Institute study. However, these are one time improvements. Pooling happens once. Competitive pressure starts. After that, it is the pace of health care costs – which are constant – that matter. Won't these continuing costs eventually overwhelm the one-time gains from the exchange and pooling?

2. You cited a study that projected the average employee contribution would decrease under PPACA's exchanges. You then said the Minimum Essential Benefits will not markedly change what employers offer. If a small employer currently offers a very basic or "mini-med" plan, after the Minimum Essential Benefits regulations are issued, assuming they require more benefits than a mini-med plan, won't the employer's cost escalate?

3. In your testimony, you stated that all of the reasons that employers have offered employer-sponsored insurance since the 1940s will continue after PPACA goes into effect. Most large employers will probably continue to offer coverage. But don't you think many small business owners will, as Mr. Vaughn testified, find it difficult to offer health insurance or pay the penalty, and also keep their current employees and create new jobs?

4. What percentage of small business owners do you believe qualify for and receive the small business health care tax credit?

5. Like Mr. Vaughn, who testified at the hearing, many small business owners face the choice between offering health insurance or paying the electric bill. As he said, he is president of his company and "must decide how much of the company's income can be used to pay for wages and benefits and how much has to be used for daily operations. There is only so much money and, first and foremost, we all have to cover our daily expenses." Do you think most small businesses are in a cash position that easily allows them to offer health insurance or pay the penalty?

6. In your testimony, you stated that after 2014, "...large employers, not small employers will face a penalty if they don't offer insurance." What is your definition of a small business?

7. Small business owners have been telling us that they cannot afford to create full time jobs under PPACA. As Mr. Vaughn testified at the hearing, "Prior to health care reform, I had the flexibility to hire more workers, pay them a wage and offer them access to this moderate [health] coverage. Now I am being told by Washington that I have to offer all my full time employees Washington-defined health coverage or pay a penalty. Because of the cost of offering this prescribed coverage and the size of the penalty, I will have no choice than to restructure my workforce in a way that protects me from losing everything I worked for." Do you think small businesses should be permitted under PPACA to offer a mini-med plan indefinitely, and not just under the current temporary waivers?

8. Mr. Vaughn said that the employer mandate saddles businesses with new requirements that actually encourage businesses not to expand their businesses and not to create jobs. The Committee has heard this from many small businesses. Do you think the employer mandate employee threshold should be

increased to apply to businesses of 100 or more, or 200 or more, so that small firms with 50 employees can add workers without being subject to the mandate or a penalty?

9. In Medical Loss Ratios, do you think that insurance broker commissions should be included as part of the 80% calculation for health care, or the 20% for administrative expenses? If you said the 80% for health care, do you think insurance brokers will be forced out of business as a result?

10. In your testimony, you stated that "small businesses need to cover the essential benefits package. It is not clear to me that that is going to be a major expense." What do you expect to be included in the Minimum Essential Benefits package?

11. The budget analysis of CMS's own actuary, Richard Foster, found that the health care law would raise, not lower, national health expenditures. Doesn't it follow that if the national health expenditure is larger, the health insurance that covers those expenditures must also be larger?

12. The Institute of Medicine (IOM) is expected to release its recommendations for the Minimum Essential Benefits package by this fall. Jonathan Gruber, an economist who helped create the state plan in Massachusetts, told the IOM panel that a 10% rise in the cost of the essential benefits package would increase the cost of government subsidies by 14.5%, or $67 billion, while reducing the share of the insured by 4.5%, or 1.9 million, through 2019. Do you think increasing the cost of government subsidies while only reducing the share of the insured by 4.5% is a good tradeoff?

13. Dr. Holtz-Eakin testified that the numerous regulations promulgated pursuant to the law should be made cleaner and in a way that doesn't leave the business community so perplexed. What reforms to the PPACA regulatory process would you recommend?

14. Do you think that small businesses are disproportionately affected by the various mandates, penalties and taxes in the health care law? And if so, will this affect their ability to increase employee wages, purchase new equipment and hire new workers?

Steve Larsen Questions for the Record
Deputy Administrator and Director, Center for Consumer Information & Insurance Oversight
Centers for Medicare and Medicaid Services

House Committee on Small Business
Subcommittee on Healthcare and Technology
July 28, 2011

1. In response to a question from Chairwoman Ellmers on Medical Loss Ratio at the hearing, you said that you were only aware of one state that had experienced insurers leaving the state since PPACA went into effect. Are you aware that Aetna alone has left 9 states? PPACA's child coverage mandate has resulted in 17 states not having access to child-only insurance policies, and in 39 states, at least one insurance company has exited the child-only insurance marketplace.

Answer: The Affordable Care Act protects coverage for children by prohibiting most health plans from limiting or denying coverage for a child under age 19 simply because the child has a pre-existing condition such as asthma. On June 28, 2010, the Administration published regulations implementing this provision in both the group and individual markets for the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. For non-grandfathered individual health insurance policies, children under age 19 can no longer be denied coverage because of a pre-existing condition.

In March of 2010, the insurance industry said they wanted to make discriminating against children with pre-existing conditions a thing of the past. Several months later, they reneged on their commitment and unfortunately, some insurance companies simply stopped selling new child-only insurance policies. We stand ready to work with private insurers to facilitate their ability to offer child-only health care policies. Already we have offered to work with the private plans to have special open seasons and have advised them of other options available to limit adverse selection, such as adjusting rates for health status or permitting child-only rates to be different from rates for dependent children, consistent with state law. We hope that insurers in the affected States will examine all of the flexibility available to them to continue to offer child-only policies and reconsider their decision not to offer child-only policies.

Additionally, CCIIO will continue its work to ensure that Pre-Existing Condition Insurance Plans (PCIPs) in all States offer coverage for children at a premium based on the standard rate for children. The PCIP program includes coverage of pediatric benefits, prescription drugs, and inpatient, outpatient, and mental health services.

In addition to ensuring that children with pre-existing conditions cannot be denied coverage, the Affordable Care Act provides additional options for children, for example, allowing parents to keep dependent children on their health policies until the age of 26 and the Pre-Existing Condition Insurance Plan.

2. During the hearing, you stated that Medical Loss Ratio would help small businesses by providing value. Would you explain what you mean by that?

Answer: Today, many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs, profits, overhead, and marketing. Thanks to the Affordable Care Act, small businesses and their employees will receive more value for their premium dollar because insurance companies in the small group market will be required to spend at least 80 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs, starting in 2011. If they don't, the insurance companies will be required to provide a rebate to their small group customers starting in 2012 for the 2011 MLR reporting year.

3. In response to a question from Chairwoman Ellmers on the effect of Medical Loss Ratio on small insurers, you stated that you are sensitive to the need to maintain competition, but you acknowledged that there is less flexibility in PPACA to modify the MLR in the small group market than in the individual market. What do you think is the best way to ensure that small insurers remain competitive and are not driven out of the market, which could limit consumer choice, and raise premiums?

Answer: Section 2718 of the Public Health Service Act permits an adjustment to the 80 percent Medical Loss Ratio (MLR) standard for a State's individual health insurance market if the Secretary determines that applying this standard "may destabilize the individual market in such State." The statute does not grant the Secretary the authority to adjust the standard in the small or large group market.

In order to help small insurers remain competitive, the Affordable Care Act establishes Affordable Insurance Exchanges (Exchanges), where these insurers will be able to compete for new business in 2014, when the Exchanges start providing coverage. Exchanges will be State-based competitive marketplaces, where individuals and small businesses will be able to purchase affordable private health insurance and have the same insurance choices as Members of Congress. Each State has the opportunity to tailor its Exchange to meet its needs, but all Exchanges will serve as a one-stop shop where individuals and small businesses will get information about their options and enroll in the plan of their choice.

4. Many states will experience rate shock at the same time that the exchanges are established. How are states that have wider rate bands going to adjust for rate shock in 2014 when the exchanges open? Is there a plan to help ease this transition?

Answer: To help protect insurers against risk selection and market uncertainty, the Affordable Care Act establishes three programs that begin in 2014: 1) temporary reinsurance; 2) a temporary risk corridor program; and 3) permanent risk adjustment. Reinsurance and risk corridors will give insurers payment stability as insurance market reforms begin, while an ongoing risk adjustment program will make payments to health insurance issuers that cover higher-risk populations (e.g., those with chronic conditions) to more evenly spread the financial risk borne by issuers. These programs will ensure that health plans and issuers compete for coverage on the basis of price, quality, and service.

On July 15, 2011, the Department of Health and Human Services (HHS) published a proposed rule related to these provisions and solicited public comment. The proposed regulations provide standards to make the programs work and significant State flexibility for their implementation, while minimizing the burden on States and issuers. Well-designed reinsurance, risk corridors, and risk adjustment programs can help encourage innovative care delivery that will slow the growth in our nation's health care expenditures.

Further, Exchanges will make coverage more affordable through tax credits as well as creating larger risk pools and increasing competition, choice, and clout for qualifying individuals and small businesses.

5. How are employers expected to track penalties for employees who go to the exchange for coverage? If an employee has coverage with one employer, then moves to another employer, does the employer get the penalty back?

Answer: The Department of the Treasury has responsibility for the implementation of section 4980H of the Internal Revenue Code, which relates to employer responsibility payments. While regulations related to this provision have not yet been issued, the Department of the Treasury issued Notice 2011-36 on May 3, 2011 and Notice 2011-73 on September 13, 2011, soliciting comment on a variety of issues related to the implementation of section 4980H. Notice 2011-36 can be found at http://www.irs.gov/pub/irs-drop/n-11-36.pdf, and Notice 2011-73 can be found at http://www.irs.gov/pub/irs-drop/n-11-73.pdf.

6. What government entity will determine the amount of the employee's subsidy? Is it IRS? HHS? Another agency?

Answer: Proposed regulations issued by the Department of the Treasury on August 12, 2011 detail how premium tax credits and the affordability of employer-sponsored coverage will be determined. That regulation can be found here: http://www.ofr.gov/OFRUpload/OFRData/2011-20728_PI.pdf.

7. During the hearing, you stated that the exchanges will have lower administrative costs. On what data are you basing your statement? Massachusetts, for example, added a 4% administrative load onto the cost of premiums.

Answer: The non-partisan Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce premiums for the same plan in the non-group market between 7 and 10 percent through competition and administrative simplifications such as the elimination of medical underwriting. Premiums for the same plan would be reduced an additional 7 to 10 percent because of better risk pooling. Effects in the small group market range from a 1 percent increase to a 2 percent decrease. The CBO analysis can be found here: http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

8. Small business owners are confused about the health care law generally and, in particular, about the application of the employer mandate. During the hearing, you said that various surveys have confirmed this, and CMS should reach out to small businesses to help them understand the law. What type of outreach and education do you anticipate, and when do you expect it to begin?

Answer: Agencies across the Administration have participated in efforts to inform small businesses about the provisions of the Affordable Care Act. Within the Center for Consumer Information & Insurance Oversight (CCIIO), we have met with a wide range of stakeholders including chambers of commerce, agents and broker organizations, and other small business organizations, both to identify questions that should be addressed and to explore additional ways to communicate with small businesses. We have worked with the Small Business Administration to inform small businesses about the benefits of the Affordable Care Act, including the creation of Exchanges and the Small Business Health Options Program (SHOP). As States develop the Exchanges with Federal support, they are identifying communications strategies to reach eligible individuals, employers, and employees. We also understand the importance of brokers in this market and, in conjunction with the Department of the Treasury, we released a new round of outreach that targeted small businesses and brokers on September 7, 2011. The message is simple - the new Small Business Health Care Tax Credit is worth up to 35 percent of the health insurance premium costs a small business incurred in 2010 for insuring its employees. As part of this outreach effort, the attached letter was sent to thousands of agents and brokers, highlighting the availability of the credit, applicable filing deadlines, and encouraging them to talk to their clients who may be small businesses. We are excited to continue to work with States, other Federal agencies, employer organizations, employers, and insurance industry groups to help establish both a more transparent and competitive market and an innovative way to give employers the option of offering employees a broad choice of health plans.

We have also worked with the Department of Labor's Employee Benefits Security Administration (EBSA), which, along with the IRS, conducted a two part compliance assistance webcast reaching almost 2000 attendees. EBSA also held, in coordination with state insurance commissioners, 13 Health Benefits Education Compliance Seminars reaching almost 1600 small employers, HR staff and other plan service providers, with two more scheduled in the next couple of months. Both EBSA and the IRS provide FAQs on their respective websites to assist employers in understanding the law and their responsibilities. Additional seminars and webcasts are planned. For assistance, private sector employer sponsored plans and plan participants with questions about the law and their rights and responsibilities can contact Customer Service Representatives in CCIIO, Consumer Assistance Program grantees in the states, and EBSA Benefits Advisors located throughout the country. EBSA's Benefit Advisors may be reached electronically through www.askebsa.dol.gov or by calling toll-free 1-866-444-ebsa (3272).

9. In response to a question from Chairwoman Ellmers about an article in *The Hill* titled, "Health Care Law Could Leave Families with Higher Costs," you stated that CMS is looking into the issues of: 1) application of the health care tax credit to the individual and to the family; and 2) when employer makes an offer of health insurance, whether it is also binding on the

family. You mentioned that CMS anticipates future guidance to clarify these issues. Would you elaborate on when you expect that guidance and the specific issues that will be covered?

Answer: The IRS recently clarified this issue in a regulation proposed on August 12, 2011. According to the proposed rule, the statute provides that the coverage is unaffordable if the required employee contribution for self-only coverage exceeds 9.5 percent of household income. More information regarding this issue can be found in Treasury Proposed Regulations § 1.36B, issued by the IRS on August 12, 2011. That proposed regulation can be accessed here: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf.

10. In response to a question from Congressman Altmire, you stated that CMS is currently working with the Department of the Treasury and the Internal Revenue Service to estimate how many small employers have claimed the small business health care tax credit, and you expect to have that information soon. Would you please provide that estimate in response to these questions?

Answer: We are currently working with our colleagues at the Department of Treasury and the IRS to determine the number of small employers who have claimed the small business health care tax credit on their tax returns and will share with them your request that they provide that information when it is available. As you know, many businesses receive extensions to file their income tax returns with September or October deadlines, so the IRS is still actively receiving and processing returns.

11. You said the health care tax credit was targeted to the smallest businesses (those with fewer than 50 employees) because they had lower rates of health insurance coverage. However, many small businesses with more than 50 employees that offer health insurance may not be able to afford it if the premiums continue to increase. Do you think the tax credit should apply to more small businesses?

Answer: The tax credit is designed to encourage both small businesses and small tax-exempt organizations to offer health insurance coverage to their employees for the first time, or to maintain the coverage they already offer. It is targeted at small businesses and small tax-exempt organizations that primarily employ moderate- and lower-income workers, which are the businesses least likely to offer health insurance to their workers.

12. In response to a question from Congressman Altmire, you said that under the employer mandate, you expect employers to continue to offer coverage, and that some studies have predicted even more employers will offer coverage. What if the employer mandate results in higher costs and fewer employers offering coverage?

Answer: Employers with fewer than 50 full-time employees are exempt from the employer responsibility provision. The vast majority of businesses (96 percent) that would be subject to the employer responsibility provisions (those with 50 or more workers) already offer coverage. Employers use the offer of health insurance as a significant recruitment and retention tool no matter the size of the business. Employers will continue to seek out top talent and the new law makes it easier for them to do so by tackling health costs and supporting small businesses.

The Congressional Budget Office (CBO) has estimated that the Affordable Care Act will have very little impact on the number of individuals receiving employer-sponsored health insurance. In particular, CBO estimates that "the number of people obtaining coverage through their employer will be about 1 million lower in 2019 through 2021 under PPACA and the Reconciliation Act than under prior law" (compared to a baseline of 162 million or 163 million). CBO adds that "Some commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage [...]. However, the legislation leaves in place substantial financial advantages for many people to receive insurance coverage through their employers, and it provides some new incentives for employers to offer insurance coverage to their employees."[1]

As CBO points out, studies by a number of independent think tanks have reached similar conclusions. "Analysts at the Urban Institute estimated that employer-based coverage would have diminished by about half a million people, on net, if the legislation had been fully implemented in 2010. Analysts at RAND estimated that the number of workers offered, although not necessarily enrolled in, employment-based coverage would increase, on net, by about 14 million when the health care legislation was fully phased in."[2]

13. If a small employer currently offers a very basic or mini-med plan, and the Minimum Essential Benefit package requires the employer to offer a far more comprehensive package of benefits, won't the employer have the incentive to drop insurance and put his employees into the exchange?

Answer: Employers use the offer of health insurance as a significant recruitment and retention tool no matter the size of the business. Right now, qualifying small businesses and small tax-exempt organizations can receive assistance of up to 35 percent of the cost of covering employees. This maximum percentage rises to 50 in 2014. In 2014, State-based Exchanges will provide small businesses with affordable, high-quality coverage options so that they may have the same type of choices that large employers have when purchasing insurance.

14. Do you support allowing employers to continue offering a basic, limited benefit plan under PPACA that would allow employees to take home more of their wages as salary and a smaller amount for their health insurance coverage?

Answer: The Affordable Care Act ensures Americans have access to high-quality, affordable health insurance. To achieve this goal, the law ensures that new plans available in the new Exchanges, and in the individual and small group markets, offer a package of essential health benefits that are comparable in scope to what employers typically offer today.

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[1] http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

[2] CBO quote taken from: http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf
CBO cites an Urban Institute study available here and this RAND study: Christine Eibner, Peter S. Hussey, and Federico Girosi, "The Effects of the Affordable Care Act on Workers' Health Insurance Coverage." *New England Journal of Medicine*, vol. 363, no. 15 (2010), p. 1394.

15. Do you believe the Minimum Essential Benefit package will cost small businesses, most of which currently offer employees catastrophic or very basic coverage, more than they currently pay because of the expense of additional required benefits?

Answer: One of the goals of the Affordable Care Act is to provide all Americans with access to high-quality and affordable health insurance via Affordable Insurance Exchanges - coverage that provides real protection against unexpected medical costs.

Beginning in 2014, Exchanges will operate SHOP, which will offer small businesses and their employees new choices. Through SHOP, employers can offer employees a variety of Qualified Health Plans (QHPs). SHOPs will provide side-by-side comparisons of QHPs -- their benefits, premiums, and quality -- and enable small businesses to offer their employees a choice of QHPs from several insurers, much as large employers can. Small business owners will be able to decide whether and when to participate in a SHOP. SHOPs can save businesses money by spreading insurers' administrative costs across more employers. In addition, many small businesses may be eligible for small business tax credits when they offer health coverage to their employees through a SHOP. In fact, the CBO estimates that about 12 percent of people with coverage in the small group market will benefit from the tax credit in 2016. For that 12 percent, the cost of insurance is estimated to be 8 to 11 percent lower than it would have been without the Affordable Care Act.[3]

16. Brian Vaughn, who testified at the hearing, is just one small business owner who has stated that he will restructure his workforce to avoid PPACA's many mandates. In fact, he stated that there will be very few full time jobs in the restaurant industry after PPACA goes into effect, because only his management staff will be full time, and the remaining employees will work 29 hours per week or less to avoid triggering the employer mandate. Do you think PPACA's employer mandate is encouraging job creation and economic growth?

Answer: The employer responsibility requirement does not take effect until 2014. Businesses with fewer than 50 full time employees are exempt from the employer responsibility provision. Many other provisions of the Affordable Care Act such as the small business tax credit are already improving the affordability, accessibility, and quality of health insurance available to small businesses and their employees. As the Affordable Care Act moves toward full implementation, small businesses will benefit from new protections against discriminatory rating practices and greater pooled purchasing of coverage through Affordable Insurance Exchanges. As noted previously, the vast majority of businesses (96 percent) that would be subject to the employer responsibility provisions (those with 50 or more workers) already offer coverage, and businesses with fewer than 50 workers are exempt from the provision.

Additionally, our current health care system can inhibit entrepreneurship and small business formation by locking workers -- especially those with families or with any sort of health problem --into jobs at large firms that offer family coverage and have a big enough risk pool to absorb the cost of covering pre-existing conditions. This "job lock" causes some workers to stay at large firms even if they would be more productive working at a small business or becoming an entrepreneur.

[3] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

By providing health security for every American and eliminating exclusions for pre-existing conditions and price discrimination against those who are sick, health reform will make it easier for small businesses to attract the best workers and easier for entrepreneurs to strike out on their own.

17. As of July 1, there were ten states where the federal government will be taking over rate review under authority granted by PPACA to determine if rate increases are reasonable. How long will this takeover last? Do you think the federal government will be better able to determine whether rate increases are "reasonable"?

Answer: As of September 1, 2011, the Federal government is conducting rate review in six States and partnering with two States to conduct rate review.[4] A State that does not meet the regulatory standard for an effective rate review program may seek a redetermination at any point. If the State is determined to meet or exceed the definition, rate review would transition to the State. CMS will continue to accept information from States and monitor States in order to ensure correct classification, and can reevaluate the status of this list as changes are made in each State.

Section 2794 of the Public Health Service Act requires the Department, in conjunction with the States, to develop a process for the review of unreasonable rates. As detailed in the rate review regulation (CMS–9999–FC), which was finalized on May 19, 2011, States with effective rate review systems must conduct reviews of proposed rates equal to or greater than the applicable threshold (10 percent from September 2011 to August 2012). If a State lacks the resources or authority to conduct the required rate reviews, the Department will review all rates equal to or greater than the threshold. Consumers will be given access to new information for all rate increases equal to or greater than the threshold. That regulation is available here: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf.

To determine whether a State met standards outlined in the final rule, the Department reviewed all available documentation, and reached out to State regulators and staff to verify the information and to obtain any updates. The Centers for Medicare & Medicaid Services (CMS) will continue to accept information from States and monitor States in order to ensure correct classification. States can submit new information to CMS at any point and CMS can reevaluate the status of the effective rate review determination as changes are made in each State on an ongoing basis. Finally, section 2794 appropriated $250 million to assist States that seek to operate an effective rate review program.

18. Will the subsidies for insurance on the exchanges apply to the employer or the employee?

Answer: There are two types of assistance available to purchase coverage in Exchanges. First, individuals and families with household incomes between 100 and 400 percent of the federal poverty level purchasing coverage on the individual market through Exchanges are eligible for premium tax credits. Second, eligible small businesses that choose to offer their employees the option of purchasing coverage through a SHOP are eligible for a tax credit to help offset the cost of providing

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[4] http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

coverage. In 2014, the maximum credit is 50 percent of a small business' premium costs and 35 percent of the employer's premium costs for small tax-exempt employers.

19. Is there an incentive for employers to keep their employees together to purchase coverage in the SHOP market, rather than letting the employees seek individual coverage through the exchanges?

Answer: As previously mentioned, employers use the offer of health insurance as a significant recruitment and retention tool. Employers will continue to seek out top talent and the new law makes it easier for them to do so by tackling health costs and supporting small businesses. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses. SHOP will ease the administrative burden associated with providing health coverage to employees, providing choices for employees while preserving employer control over the level of assistance they provide to their employees.

20. Will cost sharing for Minimum Essential Benefits be permitted?

Answer: Section 1302 of the Affordable Care Act allows cost sharing for qualified health plans and other plans. Regulations specific to the Essential Health Benefits have yet to be issued so I am unable to comment on this matter in more detail at this time.

21. In response to a question from Chairwoman Ellmers, you mentioned that you are "very aware and tuned into the need to make sure that the package of essential benefits is an affordable package." How will the determination be made as to what is "affordable"?

Answer: While the law calls on HHS to provide details regarding essential health benefits, this will be a team effort. As HHS moves forward, we will consider the report regarding employer-sponsored health insurance coverage provided by the Department of Labor on April 15, 2011. HHS has also asked the Institute of Medicine (IOM) for their recommendations on a process for defining and updating these benefits. The IOM has a long history of providing independent, objective expert guidance to federal agencies and we expect their report in September.

Most importantly, we look forward to hearing from the American people, doctors, nurses, Members of Congress and all interested stakeholders. Beginning this fall, HHS will launch an effort informed by the IOM's recommendations to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue.

22. You said that you believe employers will continue to offer insurance for the reasons they have offered it since the 1940s, but particularly to stay competitive. What would the incentive be to continue insurance if their competitor(s) drop(s) insurance?

Answer: Employers use the offer of health insurance as a significant recruitment and retention tool. Employers will continue to seek out top talent and the new law makes it easier for them to do so by tackling health costs and supporting small businesses. Additionally, employers enjoy a tax benefit for

providing coverage and large employers that are subject to the employer mandate will have an incentive to purchase coverage for their employees to avoid the penalty.

As previously mentioned, the Congressional Budget Office (CBO) has estimated that the Affordable Care Act will have very little impact on the number of individuals receiving employer-sponsored health insurance. In particular, CBO estimates that "the number of people obtaining coverage through their employer will be about 1 million lower in 2019 through 2021 under PPACA and the Reconciliation Act than under prior law" (compared to a baseline of 162 million or 163 million). CBO adds that "Some commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage [...]. However, the legislation leaves in place substantial financial advantages for many people to receive insurance coverage through their employers, and it provides some new incentives for employers to offer insurance coverage to their employees."[5]

23. When do you expect the 105(h) non-discrimination rules to be issued? Are Medicare, Tricare or other programs excluded from this calculation?

Answer: I believe you are referring to regulations implementing section 2716 of the Public Health Service Act, as added by section 1001 of the Affordable Care Act, which applies to new fully-insured group health plans, rules and definitions similar to those that apply to self-insured group health plans under section 105(h) of the Internal Revenue Code relating to discrimination in favor of highly compensated individuals. While regulations related to this provision have not yet been issued, the Department of the Treasury issued Notice 2010-63 on September 20, 2010 and Notice 2011-1 on January 3, 2011, soliciting comment on issues related to the implementation of these nondiscrimination rules. Notice 2010-63 can be found here: http://www.irs.gov/pub/irs-drop/n-10-63.pdf and Notice 2011-1 can be found here: http://www.irs.gov/pub/irs-drop/n-11-01.pdf. Because we are still in the rulemaking process, I am unable to comment on the timing of these regulations.

24. The Chairwoman mentioned that small businesses are confused by PPACA and its vague regulations, and are having difficulty complying with them. You responded that there will be tools called "navigators" available in the exchanges to help people understand how to access the exchanges. However, small businesses are trying to understand the law now, comply with provisions and regulations that are currently in effect, and plan for implementation of the law before 2014. What tools are available now to help them?

Answer:

As we have implemented these new programs and processes, we have pursued them in an open and transparent manner. CMS has published extensive information on our rulemaking and other decisions on the CCIIO website and on the consumer-oriented www.HealthCare.gov to ensure that information is widely available for public input and understanding.

[5] http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

Agencies across the Administration have participated in efforts to inform small businesses about the provisions of the Affordable Care Act. Within the Center for Consumer Information & Insurance Oversight (CCIIO), we have met with a wide range of stakeholders including chambers of commerce, agents and broker organizations, and other small business organizations, both to identify questions that should be addressed and to explore additional ways to communicate with small businesses. We have worked with the Small Business Administration to inform small businesses about the benefits of the Affordable Care Act, including the creation of Exchanges and the Small Business Health Options Program (SHOP). As States develop the Exchanges with Federal support, they are identifying communications strategies to reach eligible individuals, employers, and employees.

We also understand the importance of brokers in this market and, in conjunction with the Department of the Treasury, we released a new round of outreach that targeted small businesses and brokers on September 7, 2011. The message is simple - the new Small Business Health Care Tax Credit is worth up to 35 percent of the health insurance premium costs a small business incurred in 2010 for insuring its employees. As part of this outreach effort, the attached letter was sent to thousands of agents and brokers, highlighting the availability of the credit, applicable filing deadlines, and encouraging them to talk to their clients who may be small businesses. .

Also, small employers can use the website, HealthCare.gov, to find easy-to-understand information on the Affordable Care Act. HealthCare.gov includes a glossary of health insurance and health reform terms, an implementation timeline, summaries of provisions of the Act, frequently asked questions, press releases, a tool to search for and compare the health insurance plans available for purchase in each zip code, and much more information.

Employers can also find information on the Department of Labor's dedicated ACA web page at www.dol.gov/ebsa/healthreform/, which includes regulations and other guidance, frequently asked questions, fact sheets as well as information on upcoming compliance assistance events.

The Exchanges will also build partnerships with and award grants to entities known as "Navigators," who will reach out to employers and employees, consumers, and self-employed individuals to:

- Conduct public education activities to raise awareness about qualified health plans;
- Distribute fair and impartial information about enrollment in qualified health plans, premium tax credits, and cost-sharing reductions;
- Assist consumers in selecting qualified health plans;
- Provide referrals to an applicable consumer assistance program or ombudsman in the case of grievances, complaints, or questions regarding health plans or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate.

States may allow agents and brokers to serve as Navigators in the SHOP.

25. A recent article in *U.S. News and World Report* said that an HHS rule mandates that states collect "raw claims data sets" from insurers on all individuals with private coverage purchased either individually or through small employers. Exactly what information does HHS propose be collected from insurers on individuals with private coverage, and what is the projected use of this information?

Answer: On July 15, 2011, the Department published proposed rules on the three risk mitigation programs included in the Affordable Care Act to help protect insurers against risk selection and market uncertainty: reinsurance, temporary risk corridors, and risk adjustment. To implement effectively the risk-adjustment program set forth in the Affordable Care Act, this type of data is needed to support the risk-adjustment determination and to make certain the competitive field is level among carriers and stabilize premiums in the individual and small group market.

HHS considered three possibilities for data collection: (1) A centralized approach in which issuers submit raw claims data sets to HHS; (2) an intermediate State-level approach in which issuers submit raw claims data sets to the State government, or the entity responsible for administering the risk adjustment process at the State level; and (3) a distributed approach in which each issuer retains its data and provides self-determined risk scores to the risk adjustment entity. In the proposed rule, the Department proposes implementing number (2) and is seeking comment on this approach and its alternatives.

Response to Questions Submitted for the Record to
Timothy Stoltzfus Jost, Professor of Law, Washington and Lee University School of Law
Hearing: "Small Businesses and PPACA: If They Like Their Insurance, Can They Keep It?"
Subcommittee on Healthcare and Technology
House Committee on Small Business, July 28, 2011

Timothy Stoltzfus Jost

Thank you Chairwoman Ellmers for the opportunity to expand on my remarks presented to the Subcommittee on July 28, 2011, in response to these questions. Your questions and my answers follow:

1. During the hearing, you mentioned that the move to exchanges - and the associated competition and pooling – would solve cost problems, and cited the Urban Institute study. However, these are one time improvements. Pooling happens once. Competitive pressure starts. After that, it is the pace of health care costs – which are constant – that matter. Won't these continuing costs eventually overwhelm the one-time gains from the exchange and pooling?

Most developed countries control health care costs through regulatory price controls and budget limits. The Affordable Care Act takes a different approach to controlling the costs of private health care. It relies on competition among health insurers through the exchanges to bring down health insurance costs, and indirectly health care costs. Whether or not this strategy will work remains to be seen, but it is the way American way. I would agree that the effects of pooling will primarily be experienced immediately. But I can see no reason why competition could not continue to bring down costs over time. One can certainly think of industries, like consumer electronics, where competition has brought down costs continuously as it has improved quality. I know of no a priori reason why this could not be true in health care, although we all know how difficult controlling health care costs in the United States has been.

2. You cited a study that projected the average employee contribution would decrease under PPACA's exchanges. You then said the Minimum Essential Benefits will not markedly change what employers offer. If a small employer currently offers a very basic or "mini-med" plan, after the Minimum Essential Benefits regulations are issued, assuming they require more benefits than a mini-med plan, won't the employer's cost escalate?

The term "mini-med" or "limited benefit plan" is commonly used to refer not to the scope of benefits offered but to the dollar limits placed on those benefits. The minimum essential benefits requirement of section 1302 of the Affordable Care Act is addressed to the scope of benefits. In fact, the scope of covered benefits offered by employers today does not differ markedly based on size of employer, and is unlikely to do so in the future. See National Compensation Survey, 2008, Tables 12, 14, 16, 17, 18, at http://www.bls.gov/ncs/ebs/detailedprovisions/2008/ebbl0042.pdf

Section 1302 provides that the scope of the essential benefits under the Affordable Care Act must equal those provided under a typical employer plan. I do not, therefore, expect that the cost of providing benefits will escalate when the essential benefits requirement goes into effect.

Currently the scope of benefits offered by small employers is driven to a considerable degree by state benefit mandates. In many states these are numerous. North Carolina, for example, has more than 40 according to the Blue Cross/Blue Shield annual legislative survey. Because states must pay for any benefit mandate they impose on qualified health plans beyond the core federal essential benefits, it is quite possible that the burden that mandates place on health plans will in fact diminish after the essential benefit package is in place.

3. In your testimony, you stated that all of the reasons that employers have offered employer-sponsored insurance since the 1940s will continue after PPACA goes into effect. Most large employers will probably continue to offer coverage. But don't you think many small business owners will, as Mr. Vaughn testified, find it difficult to offer health insurance or pay the penalty, and also keep their current employees and create new jobs?

I think it is difficult to project at this point how small employers will respond to the implementation of the Affordable Care Act. The Rand Corporation, for example, has predicted a dramatic expansion of small employer coverage.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf The Urban Institute also projects that costs will drop for small employers and offer rates increase.
http://www.rwjf.org/files/research/72530quickstrike201106.pdf Many small businesses do not now offer health insurance, and it is likely that many will continue not to do so after 2014, even if their cost of offering coverage drops. It is also possible that small employers who pay very low wages but now offer insurance will decide to drop insurance and let the government pay for the health care of their employees instead. Some studies project that this will happen.

One can argue that employers should not be responsible for providing health insurance for their employees. In many other countries, employers have no responsibility to do so. Since the 1940s, however, we have largely relied on an employment-based health insurance system and it has served us well. The ACA offers an alternative to Americans whose employers do not provide health benefits—refundable means-tested tax credits. But employers who do choose to continue to offer coverage will continue to receive the generous tax subsidies they do now, and it is likely that the vast majority of them will continue to offer coverage.

One has to wonder, however, about what is fair. If one employer provides health insurance for its employees but a competitor down the street does not, do they compete on a level playing field? If one employer offers family coverage, and the spouse of one of its employees, who is covered under that insurance, works for a competitor down the street who does not provide coverage, is that fair? Many employees of businesses that do not offer insurance today are on Medicaid, covered at public expense. Many others are uninsured. The uninsured pay for only about a third of their health care. The rest of the costs are shifted to the government or to Americans who are insured and their employers. Perhaps we should not think only about Mr. Vaughn, but also about who is paying for the health care needs of his employees.

4. What percentage of small business owners do you believe qualify for and receive the small business health care tax credit?

A study conducted by the Small Business Majority and Families USA estimated that 4 million small businesses were eligible for the tax credit and 1.2 million for the maximum credit in 2010.
http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf I have no idea how many have applied for the credit, although in some markets where the tax credit has been

extensively publicized, take up has reportedly been high. http://www.bcbs.com/news/bcbsa/bcbsa-applauds-efforts-to-make-tax-credits-more-available-for-small-businesses.html Unfortunately, studies show that many eligible businesses do not know the tax credit is available. A study by the Small Business Majority found that only 43 percent of small businesses were aware of the tax credit. The NFIB study presented at the hearing also found that fewer than half of all small businesses were aware of the credit. If employers do not know about the tax credit, they will not take advantage of it.

It would be very helpful if members of Congress, including in particular the members of this Subcommittee, would actively educate small businesses in their districts about the availability of the credit as a constituent service. I know of nothing my own congressman has done to this end, although I contacted his office and offered to help with this.

5. Like Mr. Vaughn, who testified at the hearing, many small business owners face the choice between offering health insurance or paying the electric bill. As he said, he is president of his company and "must decide how much of the company's income can be used to pay for wages and benefits and how much has to be used for daily operations. There is only so much money and, first and foremost, we all have to cover our daily expenses." Do you think most small businesses are in a cash position that easily allows them to offer health insurance or pay the penalty?

Most small businesses currently offer health insurance, including 59% of businesses with 3 to 9 workers, 76% with 10 to 24, 92% of 25 to 49, and 95% with 50 to 199. http://ehbs.kff.org/pdf/2010/8085.pdf Since all of the incentives that currently exist for offering health insurance—generous tax subsidies, employee demand, reduced absenteeism, and increased productivity—will continue to be in place after 2014, most small businesses are likely to continue to offer health insurance. Indeed, if insurance becomes more affordable through the exchanges or employees value it more because of the minimum coverage requirement, coverage may increase as the Urban Institute and Rand predict.

Many small businesses will continue to be unable to afford health insurance. The penalty only applies to employers with more than 50 full-time or full-time equivalent employees who do not offer health insurance, so most small businesses that do not currently offer health insurance will be exempt. Some mid-size employers, however, will have to decide whether to offer insurance or pay the penalty. No employer will owe a penalty, however, unless an employee of the employer seeks insurance at public expense. The penalty is effectively a charge on "freeloaders." Employers who cover their employees adequately don't have to worry about it. Those who choose to have the taxpayers pay to insure their employees will have to help out.

6. In your testimony, you stated that after 2014, "...large employers, not small employers will face a penalty if they don't offer insurance." What is your definition of a small business?

The statutory definition found in IRC section 4980H(c)(2)—an employer with 50 or more full-time or full-time equivalent employee.

7. Small business owners have been telling us that they cannot afford to create full time jobs under PPACA. As Mr. Vaughn testified at the hearing, "Prior to health care reform, I had the flexibility to hire more workers, pay them a wage and offer them access to this moderate [health] coverage. Now I am being told by Washington that I have to offer all my full time employees Washington-defined health coverage or pay a penalty. Because of the cost of offering this prescribed coverage and the size of the penalty, I will have no choice than to restructure my workforce in a way that protects me

from losing everything I worked for." Do you think small businesses should be permitted under PPACA to offer a mini-med plan indefinitely, and not just under the current temporary waivers?

As of July 15 of this year HHS had granted limited benefit or "mini-med" plan waivers for plans covering about 3.2 million Americans. http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html This is less than 2 percent of the 170 million Americans covered by employment-based health insurance. The vast majority of employers already offered conforming coverage or have begun to do so.

Some of the limited benefit plans granted waivers offer relatively adequate coverage. Others border on fraud and are literally worse than nothing. Plans that offer only $2000 in benefits, that do not cover the first day of hospitalization, or that have loss ratios of under 50 percent are not really insurance. They merely deceive people into believing that they have insurance until they actually get sick or injured and find out that they are on their own. To add insult to injury, some employers who offer mini-meds do not contribute to the cost of these plans. The entire plan is paid for by the employee, and the premiums the employee pays almost equal the benefit limits. The employee would be better off simply putting the money in the bank to pay for routine expenses. The only coverage for catastrophic events is bankruptcy. I do not believe that this coverage should continue to remain available. It is a cruel joke. If such plans disappear after 2014, Americans will be better off.

8. Mr. Vaughn said that the employer mandate saddles businesses with new requirements that actually encourage businesses not to expand their businesses and not to create jobs. The Committee has heard this from many small businesses. Do you think the employer mandate employee threshold should be increased to apply to businesses of 100 or more, or 200 or more, so that small firms with 50 employees can add workers without being subject to the mandate or a penalty?

As I noted earlier, 95 percent of employers with more than 50 employees now offer coverage. I would assume that Congress decided that the remaining 5 percent could and should offer coverage, or pay a penalty if their employees had to seek coverage at taxpayer expense. As large employer is otherwise defined in the statute to include employers with more than 100 employees, this threshold would make sense as well.

9. In Medical Loss Ratios, do you think that insurance broker commissions should be included as part of the 80% calculation for health care, or the 20% for administrative expenses? If you said the 80% for health care, do you think insurance brokers will be forced out of business as a result?

Compensation paid to brokers and agents for marketing insurance has always been considered an administrative expense. Broker and agent fees are certainly not a health care expense. The NAIC and HHS concluded that Congress understood that commissions were an administrative expense, and thus classified them as such for the medical loss ratio rule.

The NAIC recently conducted a study to determine the potential effect of the MLR rule on brokers and agents. http://www.naic.org/documents/committees_b_110607_hcrawg_report.pdf It queried states that have state MLR rules similar to the federal rule and found that these states have seen no adverse effect on access to agents and brokers. It also found that while some insurers have cut commissions, others have not. For. example, data provided to the NAIC by NAHU showed that commissions have not been cut in North Carolina by the insurers for which NAHU provided data over the past four years. Because commissions have been written as a percentage of premiums in the

past, moreover, commissions have been rising rapidly for some time as premiums have risen. Current cuts in commissions may be simply a return to more normal levels.

No one likes to see their income cut, and everyone would like to have Congress protect their income. Brokers and agents are not exception. Brokers and agents provide valuable services to small businesses, but I have seen no evidence yet that small businesses are suffering from the MLR rule by losing access to their services.

In fact, there is strong evidence that consumers are benefiting from the rule. Some insurers are already moderating their premium increase requests to avoid having to pay rebates to consumers. Had the medical loss ratio requirement been in effect in 2010 (it is not effective until this year), consumers would have received between 1.3 and 2 billion in rebates, almost $450 million of which would have gone to small businesses.
http://www.naic.org/documents/committees_b_110607_hcrawg_report.pdf
https://ir.citi.com/26MByRrEaOyRCT1ZcYVa6lJpgIc%2F7pmh7WJrHPzv6hs%3D If broker and agent commissions are removed from the MLR, premiums for small businesses will go up and rebates to small businesses will go down dramatically. According to the NAIC study, rebates to small groups would have dropped in 2010 by over two thirds to $126 million. Small businesses will pay much of the cost of protecting the income of agents and brokers.

10. In your testimony, you stated that "small businesses need to cover the essential benefits package. It is not clear to me that that is going to be a major expense." What do you expect to be included in the Minimum Essential Benefits package?

The categories of services that must be covered by the essential benefits package are listed in ACA section 1302.
(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.
The exact services that will be included in the package remain to be determined, but must equal the scope of benefits covered by the typical employer plan. I expect that HHS will carefully consider the cost of services as well as the need for services as it constructs the essential benefits package.

11. The budget analysis of CMS's own actuary, Richard Foster, found that the health care law would raise, not lower, national health expenditures. Doesn't it follow that if the national health expenditure is larger, the health insurance that covers those expenditures must also be larger?

No, it does not. The CMS actuary projected that the ACA would increase the number of Americans covered by health insurance by 34 million, but increase the cost of the total health care system only by nine tenths of one percent between 2010 and 2019.
http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf Per person costs thus, in fact, would decrease. Specifically, the Actuary projected that the expenditures for private insurance

and employer-sponsored insurance would decrease from the level that they would have been at absent reform.

One other important fact must not be forgotten—growth in health care expenditures creates jobs. Indeed, health care is one of the greatest engines for job creation in our country. http://www.bls.gov/emp/ep_table_201.htm Many of these jobs are in small businesses—physician's and dentist's office, home health agencies, independent drug stores. Small business pay for health care, but they also provide health care. More people who need health care will be receiving it because of the Affordable Care Act. The people and small businesses who provide it to them will have jobs (and profits) because of the Affordable Care Act.

12. The Institute of Medicine (IOM) is expected to release its recommendations for the Minimum Essential Benefits package by this fall. Jonathan Gruber, an economist who helped create the state plan in Massachusetts, told the IOM panel that a 10% rise in the cost of the essential benefits package would increase the cost of government subsidies by 14.5%, or $67 billion, while reducing the share of the insured by 4.5%, or 1.9 million, through 2019. Do you think increasing the cost of government subsidies while only reducing the share of the insured by 4.5% is a good tradeoff?

Although I don't know the assumptions on which Dr. Gruber's statement was based, it seems reasonable to believe that if the cost of insurance goes up, the cost of public subsidies will go up and the number of people insured go down. The ACA, however, stipulates that the essential benefits package must equal the current typical employer benefits package, so this situation should not occur if the law is followed.

13. Dr. Holtz-Eakin testified that the numerous regulations promulgated pursuant to the law should be made cleaner and in a way that doesn't leave the business community so perplexed. What reforms to the PPACA regulatory process would you recommend?

I have read every regulation that has been issued under the insurance reform provisions of the Affordable Care Act because I have written a blog about each of them at www.healthaffairs.org/blog. I would imagine I am one of the few Americans who has read all of them. On the whole, I have found the regulations to be sensible, cost-conscious, and quite clearly-written. The agencies have tried very hard to make compliance with the law no more difficult than necessary. Our health care system is incredibly complex and any attempt to reform it while preserving its basic free market orientation will also be incredibly complex. We could have established a single-payer system with a fraction of the regulations. Other countries have done so. But that is not the path we have chosen. Using private businesses to provide a publicly-funded service to the public is inescapably a regulation-intensive enterprise, because it is necessary to ensure that public funds are well spent and that the public receives high-quality, low-cost services. But the departments implementing the Affordable Care Act are doing a responsible job in doing so, trying to minimize unnecessary burdens.

14. Do you think that small businesses are disproportionately affected by the various mandates, penalties and taxes in the health care law? And if so, will this affect their ability to increase employee wages, purchase new equipment and hire new workers?

I know of no taxes under the law that fall disproportionately on small businesses. The penalties will fall only on larger businesses—those with more than 50 employees—most of whom already offer insurance. Small businesses will be able to take advantage of the exchanges and very small businesses get the benefit of the small employer tax credit. I do not believe small businesses are

affected disproportionately by the ACA in an adverse way, indeed they disproportionately benefit from the law.

One other issue must be considered. Many people who currently work for large businesses would prefer to start their own small business will but cannot do so because they fear they will lose their health insurance if they leave their job. They will now be able to fulfill their dream and count on the premium tax credits to help out until they get on their feet. We may well see a flowering of small business entrepreneurship under the ACA that will create jobs and help get our economy back on its feet.

Health reform's grandfathering rules likely to raise costs

By Judith Messina

Bloomberg News

President Barack Obama's push for health care legislation had a key pledge: People who liked their coverage could keep it. As a practical matter, it might not be so easy.

June 23, 2010

When it became clear this past March that the new health care reform law would grandfather existing health plans, employers breathed a sigh of relief. It seemed that President Barack Obama had kept his promise: People who liked their coverage could keep it. Grandfathered plans had to conform to some new rules, but they were exempt from costly mandates such as providing preventive care without co-pays. Many small business owners believed grandfathering would preserve their ability to contain costs.

Last week, however, the Department of Health and Human Services, the Labor Department and the Treasury burst employers' balloon, issuing regulations that would set limits on how much plans can modify their coverage and still be grandfathered.

Experts say the new regulations make holding costs down even more of a Sisyphean challenge for small businesses: If they make changes in their current plans to save money, they risk losing their grandfathered status and will be forced to comply with new mandates that are expected to increase costs.

"They're taking away your bargaining ability, and that's going to be used to the advantage of insurance companies," says Saul Brenner, a senior tax partner and head of the international tax division at accounting and advisory firm Berdon.

Under the new rule, businesses would not be able to change carriers, raise employees' percentage of cost-sharing, or increase co-pays and deductibles by more than a set amount if they want to keep their grandfathered status. If, in fact, they lose their favored status, their plans will be considered "new," and they will have to offer all of the bells and whistles of reform.

Some of those bells and whistles are already incorporated into many plans, such as providing emergency services without prior authorization, or are inconsequential, such as reporting wellness initiatives to HHS starting in 2012. But others—such as a mandate to cover clinical trials and ceilings on cost-sharing starting in 2014—are expected to add momentum to already steeply rising costs.

HHS defends the new rules, saying they allow employers to make routine changes to grandfathered plans, but not to dramatically reduce benefits or increase cost-sharing to the detriment of employees. But by HHS' own estimate, as many as 80% of small businesses in the country will lose their grandfathered status by 2013 under the new rule.

At this point, the grandfathering limits are still a proposal, and the government is seeking comments through mid-August. Experts say they are unlikely to change substantially.

The prohibition on changing carriers, in particular, takes an important cost-control tool away from small businesses, which already lack the flexibility and leverage of larger companies. Many change carriers every couple of years in search of better rates or new offerings as insurers offer deals to drum up new business. Westchester broker Alex Miller says that for most of his small business clients, trying to keep their grandfathered status is probably not worth it, especially if rates continue to climb 15% to 20% a year as they have in New York. With limits on cost-sharing, employers could get further behind every year.

"I think a small handful of my clients will stay put because they have a unique health care plan, such as an indemnity plan that is no longer sold," says Mr. Miller, president of Millennium Medical Solutions Corp. in Armonk. "But for the great majority of my clients, how are they going to take a 20% [premium] increase and not make any changes?"

What's clear is that the costs and benefits will be different for each employer, especially with the economy still in the doldrums. Experts say businesses should calculate the trade-off between being grandfathered with limited room for changes, and being able to shift costs but also being subject to more mandates that will raise costs.

"It comes down to comparing what you keep or give up by keeping your grandfathered plan or moving to a new one," says Joe Torella, president of the employee-benefits division of HUB International Northeast. "Cost has to become the largest question mark."

http://www.crainsnewyork.com/article/20100623/SMALLBIZ/100629939

Small-Business Health Care Tax Credits Are Having A Minuscule Impact

July 4, 2011
Sally Pipes
Forbes

The Small Business and Entrepreneurship Council recently surveyed 304 small business owners about how satisfied they were with the new healthcare reform law's tax credits.

Nearly 90% had not applied for the credits. Some had no idea they existed, others were deemed ineligible, and more than a fifth found that they "offered no real benefit." Only 7% of small businesses were actually using the tax credits earmarked specifically for them.

What gives? Why aren't small enterprises taking President Obama up on his offer to help them "afford the cost of covering their workers?"

In short, because the president's "help" is relatively worthless. Worse, other components of the law threaten to make health coverage even more expensive for American small businesses.

As many firms have learned firsthand, it's nearly impossible to qualify for ObamaCare's tax benefits. Through 2013, only employers with fewer than 10 employees and average wages of less than $25,000 a year are eligible for the full 35% credit. The credit's value decreases as a company's workforce increases beyond 10 employees — and as its average annual salary rises above $25,000.

Further, companies with more than 25 workers — or with an average salary of over $50,000 — are ineligible.

In 2014, the maximum credit will jump to 50% for qualified employers. But the salary limits will stay the same. At that time, the credits can only be used for government-approved coverage purchased through ObamaCare's new insurance exchanges. By 2016, they expire altogether.

Given this barrage of restrictions, it's no wonder the Congressional Budget Office estimates the credits will impact just 12% of folks in the small-group market.

Even for those who qualify, the tax credits may not be worth the trouble. Because they diminish as companies grow, a small business may have to choose between hiring new employees and keeping the tax benefit.

In other words, ObamaCare's credits may actually discourage small firms from creating jobs.

Early evidence indicates that small businesses aren't responding to the health law's handouts. According to a January 2011 Discover Small Business Watch survey, fewer small businesses offer health coverage now than before ObamaCare's tax credits were in place.

That's because the credits do little to assuage business-owners' chief concern — the rising cost of health benefits.

Nearly 70% of small businesses polled by Discover said that it's difficult to find affordable healthcare for themselves and their employees. About the same number of business-owners believe that ObamaCare will make health insurance less affordable, according to the Small Business and Entrepreneurship Council.

It appears that they're right. A new report from PricewaterhouseCoopers projects that employer health costs will rise 8.5 percent in 2012, thanks in part to the health reform law. That's on top of an 8% projected hike this year.

Ordinary workers are feeling the pain, too. Since last year, their share of healthcare premiums has risen to 15.1 percent of the total cost — an increase of 1.2 percentage points. At firms with less than 200 employees, the average worker's annual contribution toward his health insurance has shot up more than 38% — from $625 to $865.

One reason for the cost hikes, according to PwC, is that ObamaCare encourages healthcare providers to consolidate in order to form Accountable Care Organizations, which are intended to better coordinate patients' care, starting initially with those on Medicare. But consolidation also reduces competition. That can yield higher prices. Indeed, the Robert Wood Johnson Foundation found that hospital consolidation in the 1990s drove up inpatient prices 5%.

Over the past decade and a half, small businesses have created almost two-thirds of new jobs. But their growth has slowed to a crawl in the wake of the recession. ObamaCare's tax credits were intended to reverse that trend. But they've done no such thing.

Meanwhile, by inflating the cost of health care, the rest of the law has undermined any chance the credits had of helping small businesses pay for health coverage.

President Obama tried to buy small businesses' support for his health overhaul with an over-hyped tax giveaway. Thus far, his offer is one they've been all too happy to refuse.

Sally C. Pipes is President, CEO and Taube Fellow in Health Care Studies at the Pacific Research Institute. Her latest book, The Truth About Obamacare, *was published in 2010.*

http://blogs.forbes.com/sallypipes/2011/07/04/small-business-health-care-tax-credits-are-having-a-minuscule-impact/

Healthcare law could leave families with high insurance costs

By Julian Pecquet - 07/21/11 12:43 PM ET

A major provision of the healthcare reform law designed to prevent businesses from dropping coverage for their workers could inadvertently leave families without access to subsidized health insurance.

The problem is a huge headache for the Obama administration and congressional Democrats, because it could leave families unable to buy affordable health insurance when the healthcare law requires that everyone be insured starting in 2014.

Some of the administration's closest allies on healthcare reform warn this situation could dramatically undercut support for the law, which already is unpopular with many voters and contributed to Democrats losing the House in the 2010 midterm elections.

"It's going to be a massive problem if it comes out that families have to buy really expensive employer-based coverage," said Jocelyn Guyer, deputy executive director at Georgetown University's Center for Children and Families.

"If they don't fix this -- and by 'they' I mean either the administration or Congress -- we're going to have middle-class families extremely unhappy with [healthcare] reform in 2014, because they'll basically be facing financial penalties for not buying coverage when they don't have access to any affordable options."

At issue is a so-called "firewall" in the law that denies subsidies to workers whose employers offer quality, affordable coverage.

The firewall applies to plans with premiums that cost less than 9.5 percent of a worker's income. If a worker has to dole out more than that amount to buy coverage, the employer coverage is considered unaffordable and the worker is eligible for subsidies to buy coverage on the new exchanges.

Initially, advocates thought the threshold also applied to family coverage. If premium costs paid to cover a worker's family cost 20 percent of a worker's income, for example, the worker and his or her family should be eligible for subsidies.

But in calculating the bill's cost last year, Congress's Joint Committee on Taxation (JCT) took the law to mean that employers and their families aren't eligible for subsidies as long as the individual plan is affordable — regardless of the price of the family plan.

This means the costs to an employee for covering his or her family could be too high to afford for many working families.

"If you've got employer-based coverage that's affordable for the employee only," Guyer said, "the family is expected to take the employer coverage even if it"s totally unaffordable and no one in the family is eligible for the exchange subsidies."

The glitch is causing heartburn for advocates who worry that it could leave thousands of children and spouses uninsured and subject to penalties for not having insurance.

"The JCT read of the language is disturbing and we hope the administration doesn't read the language that way," said Bruce Lesley, president of the children's advocacy group First Focus. "It would put dependent coverage, children and spouses at grave risk."

The Obama administration is expected to clarify shortly — through Treasury Department regulations — who's eligible for subsidies.

An administration official told The Hill, "These matters will be considered in future regulations."

Healthcare reform proponents say they've quietly been talking to the administration for months about the issue.

"We've talked to them — a lot — about this," said Judith Solomon, vice president for health policy at the liberal Center on Budget and Policy Priorities. "We've made our views known."

While advocates say changing the policy is a no-brainer, the costs could be a hurdle.

One new study, by the Employment Policies Institute, estimates that changing the policy could cost taxpayers $50 billion per year. But if the administration leaves the policy as is, "millions of families will be stuck in a no-man's-land without affordable coverage through their employer or the exchange."

"Whichever interpretation holds," the study concludes, "the consequences are significant."

Others dispute those figures. They argue that employers will offer affordable coverage for whole families and point out that many children who aren't covered by employer family plans are eligible for Medicaid or the Children's Health Insurance Program.

"It's really not clear to me how much of an impact it would be [to change the policy]," Solomon said. The $50 billion-per-year figure "seems very high to me."

Source:
http://thehill.com/blogs/healthwatch/health-reform-implementation/172765-healthcare-law-may-leave-families-with-high-insurance-costs

July 27, 2011

The Honorable Renee Ellmers
Chairwoman
Healthcare and Technology Subcommittee
Small Business Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Cedric Richmond
Ranking Member
Healthcare and Technology Subcommittee
Small Business Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Ellmers and Ranking Member Richmond:

On behalf of Associated Builders and Contractors (ABC), a national association with 75 chapters representing more than 23,000 merit shop construction and construction-related firms with nearly two million employees, I am writing in regard to the subcommittee hearing titled, "Small Businesses and PPACA: If They Like Their Coverage, Can They Keep IT?"

Providing quality health care benefits is a top priority for ABC and its member companies. Throughout the health care reform debate, ABC advocated for policies that reduce the cost of health care for employers and their employees. ABC called on Congress to advance common-sense proposals that would address the skyrocketing cost of health insurance, especially for employer-sponsored plans and the rapidly rising number of uninsured Americans. ABC believes true reform should provide greater choice and affordability and allow private insurers to compete for business.

Unfortunately, the massive and complex health care law, known as the Patient Protection and Affordable Care Act, does not effectively address any of those issues. Costs have not been lowered and costly new mandates and taxes have been imposed on an important but struggling sector of the economy: small businesses. Small business owners have watched insurance premiums increase or have had their plans discontinued, forcing some to purchase more expensive policies or drop their coverage.

Additionally, ABC has expressed concerns about the regulatory burdens imposed by the massive health care law. The outcomes of many of the health care-related federal rulemakings are currently unclear, creating an environment of uncertainty in our industry that makes it difficult for firms to adequately plan for the future.

ABC urges Congress to move forward with legislative proposals that will provide employers and their employees with health care solutions that are both practical and affordable. ABC supports the following initiatives:

- ✓ **Allowing Americans to buy insurance across state lines.** This would be particularly helpful to those who work in the construction industry, as the unique nature of construction work demands that benefits be portable.
- ✓ **A tax deduction for the self-employed and for employers.** ABC supports raising the self-employed health care deduction to 100 percent and maintaining the tax deductibility of health insurance premiums for all employers.
- ✓ **Small Business Health Plans (SBHPs).** SBHPs give small businesses the power to pool together to offer health care at lower prices—something many corporations and labor unions already are permitted to do.

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- ✓ **Health Savings Accounts (HSAs).** HSAs are tax-free savings accounts for medical expenses that allow more small business owners to obtain affordable health coverage for themselves and their employees. ABC supports expanding access to high-deductible health plans and HSAs, as well as increasing HSA contribution limits.

- ✓ **Flexible Spending Accounts (FSA).** FSAs, or "cafeteria plans," allow employees to set aside money (pre-tax) each year to be used for medical expenses such as co-pays, deductibles and services not covered under their base insurance plan. If an employee does not use all of the money contributed to his or her FSA by the end of the plan year, the remaining amount is forfeited to the employer. This limitation should be changed to allow workers to take control of their health care costs and plan for the future.

- ✓ **Health IT.** ABC supports advancing the widespread adoption of health information technology. Technology holds the promise of improving the quality of patient care, enhancing access to care, reducing medical errors and reducing health care costs.

- ✓ **Medical malpractice reform.** Unnecessary and frivolous lawsuits contribute to the increasing cost of insurance. Enacting tort reform will dramatically decrease the cost of health insurance for the American public.

ABC appreciates your attention to this important matter and looks forward to working with you on common-sense health care initiatives.

Sincerely,

Corinne M. Stevens
Senior Director, Legislative Affairs

Building Success. Together

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James S. Gandolfo
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July 28, 2011

The Honorable Sam Graves
U.S. House Small Business Committee
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Graves,

On behalf of the members of the HSA Council[1], I am advising you of our position on the recent final rule adopted by the Federal Reserve Board, known as (Regulation II) – that exempts HSAs from the interchange fee cap and the network exclusivity and routing requirements.

As you are well aware, these fees would have had a profound impact on health-related accounts, including Health Savings Accounts (HSAs). We are including, for further clarity, the attached memo.

While this does not directly address the "ObamaCare" impact on existing plan design, i.e. "you can keep the plan you have," this issue has such a substantial impact on this subject we believe it is essential to be part of the permanent record of the U.S. House Small Business Committee.

Further, there are at least three other issues that will have an impact on whether Americans will be able to keep their Health Savings Accounts, including the not-yet-released preventative care rule, the already issued minimum loss ratio rule and the not-yet-released actuarial value rule, which we will comment on in the near future, and hope that you will hold the record open for our forthcoming comments in these regards.

Sincerely,

J. Kevin A. McKechnie
Executive Director
HSA Council

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[1] The HSA Council is a joint project of the American Bankers Association and its insurance affiliate, the American Bankers Insurance Association. Its members are banks and their insurance and technology advisors dedicated to improving American healthcare by improving the distribution of HSAs through banks.

J. Kevin A. McKechnie
Executive Director
The HSA Council
kmckechn@aba.com

Memorandum

To: HSA Council Board Members

Date: July 20, 2011

SUBJECT: Federal Reserve's Regulation II on Interchange Fees and Network Exclusivity and Routing

The American Bankers Association HSA Council has concluded that HSAs are exempt from the entire scope of the Federal Reserve's Regulation II (REG II) on interchange fees and network exclusivity and routing because *bona fide* trust accounts (including all HSA accounts) are not included in the definitions of the types of accounts governed by the regulations.

Discussion

The Federal Reserve's regulations on interchange fees excluded *bona fide* trust accounts from the definition of the types of accounts governed by the regulations. The Council recommended this definition to the Fed and it was accepted.

In addition, the Fed also exempted Direct Deposit Accounts (DDAs) that operate as *bona fide* trusts if they were established as trust or custodial accounts under the IRS code. This should include every HSA account regardless of whether they are considered *bona fide* trust accounts.[1] [2]

§ 235.2 Definitions

(a) Account

(1) Means a transaction, savings, or other asset account (other than an occasional or incidental credit balance in a credit plan) established for any purpose and that is located in the United States; and

(2) Does not include an account held under a *bona fide* trust agreement that is excluded by section 903(2) of the Electronic Fund Transfer Act and rules prescribed there under.

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[1] Preamble (p. 42). "The final rule's definition of "account" excludes accounts established pursuant to *bona fide* trust arrangements."

[2] Preamble (p. 45-46). "The Board agrees with the commenters that a trust is a type of account structure rather than a purpose (such as a business purpose or personal purpose) for which the account is held. Therefore, the Board has revised its proposed definition of "account" to exclude *bona fide* trusts, consistent with EFTA Section 903(2). For purposes of Regulation E, the Board has stated that whether an agreement is a *bona fide* trust agreement is a question of state or other applicable law.62 The Board believes a similar approach is warranted under this rule. In general, *bona fide* agreements or arrangements are those done in good faith and not merely a device to evade a law.63 Accordingly, the Board has revised the definition of "account" to exclude accounts held under *bona fide* trust agreements that are excluded from the definition of "account" under EFTA Section 903(2) and rules prescribed thereunder. The Board has added comment 2(a)-2 to clarify that whether a trust arrangement is *bona fide* is a matter of state or other applicable law and that accounts held under custodial agreements that qualify as trusts under the Internal Revenue Code are considered to be held in trust arrangements."

The Fed also accepted the Council's recommendation regarding the definition of "electronic debit transactions" to only include transactions performed on an account.[3]

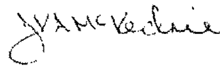
§ 235.2 Definitions

2(a) Account

1. Types of accounts. The term "account" includes accounts held by any person, including consumer accounts (i.e., those established primarily for personal, family or household purposes) and business accounts. Therefore, the limitations on interchange transaction fees and the prohibitions on network exclusivity arrangements and routing restrictions apply to all electronic debit transactions, regardless of whether the transaction involves a debit card issued primarily for personal, family, or household purposes or for business purposes. For example, an issuer of a business-purpose debit card is subject to the restrictions on interchange transaction fees and is also prohibited from restricting the number of payment card networks on which an electronic debit transaction may be processed under § 235.7.

2. *Bona fide* trusts. This part does not define the term *bona fide* trust agreement; therefore, institutions must look to state or other applicable law for interpretation. An account held under a custodial agreement that qualifies as a trust under the Internal Revenue Code, such as an individual retirement account, is considered to be held under a trust agreement for purposes of this part.

Sincerely,



Kevin McKechnie
Executive Director

[3] "The language in EFTA Section 920 does not provide for any exceptions to the section's provisions based on the purpose for which an account was established; moreover, Section 920(c)(2) defines "debit card" as including cards that may be used to debit an account "regardless of the purposes for which the account was established." Therefore, the Board does not believe that the statute exempts debit cards that access HSAs and other similar accounts solely because such accounts are established for health care-related purposes. Such cards and accounts, however, may be otherwise exempt from the Board's interchange fee standards if they qualify for another exemption. For example, as commenters noted, some HSAs and other similar accounts are structured as *bona fide* trust arrangements. Cards that access these HSAs would be exempt from the requirements of this part because they do not access "accounts," as the term is defined in § 235.2(a). In addition, some cards that access HSAs and other similar accounts are structured like prepaid cards where funds are held in an omnibus account (which is considered an "account" under § 235.2(a)) and the employee may access the funds using a prepaid card. Provided these cards are structured in such a way that qualifies them for the reloadable, general-use prepaid card exemption in the statute, these cards used to access HSAs and similar accounts will be exempt from the rule's interchange fee standards. *See* discussion of § 235.5(c). These cards, however, will be subject to the rule's network exclusivity and routing provisions. *See* discussion of delayed effective date related to § 235.7."