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REGULATIONS, COSTS, AND UNCERTAINTY IN EMPLOYER PROVIDED HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

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REGULATIONS, COSTS, AND UNCERTAINTY IN EMPLOYER PROVIDED HEALTH CARE

Thursday, October 13, 2011
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and the Workforce
Washington, DC

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2175, Rayburn House Office Building, Hon. Phil Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, Thompson, Walberg, DesJarlais, Hanna, Bucshon, Andrews, Kucinich, Kildee, Hinojosa, Tierney, Altmire, and Holt.

Staff present: Jennifer Allen, Press Secretary; Andrew Banducci, Professional Staff Member; Casey Buboltz, Coalitions and Member Services Coordinator; Ed Gilroy, Director of Workforce Policy; Benjamin Hoog, Legislative Assistant; Marvin Kaplan, MemberWorkforce Policy Counsel; Ryan Kearney, Legislative Assistant; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Todd Spangler, Senior Health Policy Advisor; Linda Stevens, Chief Clerk/Assistant to the General Counsel; Alissa Strawcutter, Deputy Clerk; Aaron Albright, Minority Communications Director for Labor; Daniel Brown, Minority Junior Legislative Assistant; Jody Calemine, Minority Staff Director; Brian Levin, Minority New Media Press Assistant; and Michele Varnhagen, Minority Chief Policy Advisor/Labor Policy Director.

Chairman ROE. A quorum being present, the Subcommittee on Health, Employment, Labor and Pensions will come to order.

Good morning, everyone. I would like to welcome our guests and thank our witnesses for being with us today. We have assembled a fine panel and look forward to your testimony.

It has been stated time and again, if you like your current health plan, you will be able to keep it. Let me repeat that; if you like your plan, you will be able to keep it.

Those remarks were delivered by President Obama and similar sentiments were expressed during the many months of Congress' effort to reform health care. The promise was made to the public, a public concerned about the changes a government takeover of health care would impose on their businesses and families.

As it turns out, there was reason for concern. Rules released by the Obama administration contradict that statement. The health

care law allows Americans to keep their health care coverage, so long as their health care plan doesn't make any significant changes. The reality is health care plans constantly change out of necessity. And now when they change, Americans will be at risk of losing their existing health care plan, like it or not.

I think the 31 years I was in practice, I don't recall a year that we didn't change our health care plan some. It changed almost every year.

As I have learned through many years of practicing medicine, health care is an extremely personal matter. Though most people recognize the importance employers play in the delivery of health care, they prefer to keep the details between themselves and their doctors.

The idea of a federal government intervening in that relationship between the patient and his or her health care provider is downright terrifying to many individuals.

Perhaps that is why the president promised so adamantly that reform would not disrupt the health care millions of Americans rely upon and wish to keep. The linchpin of this promise was an exemption or grandfathered provision in the law.

This was intended to provide relief from new rules and regulations for insurance plans in effect the day the president signed the bill into law. Unfortunately, in just 3 months, the administration defined the terms of the grandfather provision so narrowly that it became meaningless.

By the administration's own estimates, up to 80 percent of small-employer plans and between 34 and 64 percent of large-employer plans will not retain their grandfathered status, meaning millions of workers face significant changes to their health care.

Employers have confirmed this startling fact. In May of 2011 survey by Price Waterhouse Coopers, 51 percent of the employers surveyed did not expect their plans would keep their grandfathered status.

Each year, as employers grapple with the constraints brought on by an unsustainable health care costs, they must choose from a range of difficult options, including reduced benefits and lower wages. The ability to adjust and manage the benefit plans of their workers has offered employers an opportunity to minimize disruption and modify care to best meet the needs of the workplace.

That flexibility is severely undermined by the new law and its flawed grandfather regulation. Today, even a modest change can trigger a loss of a benefit plan's exempted status.

Employers are faced with an impossible decision: pay more to keep their current coverage, buy higher-cost insurance that is subject to the law's new mandates, or drop coverage entirely. As is often the case, good intentions can lead to bad consequences.

This is certainly true for much of the law's complex scheme of rules, mandates, and price controls. Take, for example, the medical loss ratio provision, which was designed to limit the corporate profits of insurance companies to ensure consumers received the most value for every dollar they spend.

However, the regulation implementing this provision actually creates a disincentive for insurance providers to attack waste and abuse, leading to higher premiums and co-pays for American con-

sumers. If these regulatory challenges weren't creating enough uncertainty in our workforce, employers and workers continue to confront higher health insurance costs.

Despite the president's promise that his reform plan would lower premiums by up to 2,500 dollars for the average family, the facts reflect a different reality. A recent study by the Kaiser Family Foundation reports that premiums increased by 9 percent this year. A separate study estimates employer health care costs will increase by 8.5 percent next year.

It is clear our system of employer-provided health care is experiencing dramatic changes due in large part to a deeply flawed health care law. Today's hearings provide members of the subcommittee an important opportunity to examine these changes, their impact on workers and employers, and to discuss the solutions our nation needs to chart a better course.

Again, I look forward to the witnesses' testimony.

I now yield to Mr. Andrews, the senior Democrat member of the subcommittee, for his opening remarks.

[The statement of Mr. Roe follows:]

Prepared Statement of Hon. David P. Roe, Chairman, Subcommittee on Health, Employment, Labor and Pensions

Good morning, everyone. I would like to welcome our guests and thank our witnesses for being with us today. We have assembled a fine panel and we look forward to your testimony.

It was stated time and again: "If you like your current [health care] plan, you will be able to keep it. Let me repeat that. If you like your plan, you will be able to keep it." Those remarks were delivered by President Obama and similar sentiments were expressed during the many months of Congress' effort to reform health care. The promise was made to a public concerned about the changes a government takeover of health care would impose on their businesses and families.

And it turns out, there was reason for concern. Rules released from the Obama Administration contradict that statement. The health care law allows Americans to keep their health care coverage—so long as their health care plan doesn't make any significant changes. The reality is, health care plans constantly change out of necessity, and now when they change, Americans will be at risk of losing their existing health care plan—like it or not.

As I have learned through many years of practicing medicine, health care is an extremely personal matter. Though most people recognize the important role employer play in the delivery of health care, they prefer to keep the details between themselves and their doctors. The idea of the federal government intervening in the relationship between a patient and his or her health care provider is downright terrifying to many individuals.

Perhaps that is why the president promised so adamantly that reform would not disrupt the health care millions of Americans rely upon and wish to keep. The linchpin of this promise was an exemption or "grandfather" provision in the law. This was intended to provide relief from new rules and regulations for insurance plans in effect the day the president signed his bill into law.

Unfortunately, in just three months, the administration defined the terms of the grandfather provision so narrowly that it became meaningless. By the administration's own estimates, up to 80 percent of small-employer plans and between 34 to 64 percent of large-employer plans will not retain their grandfathered status, meaning millions of workers face significant changes to their health care. Employers have confirmed this startling fact.

In a May 2011 survey by Price Waterhouse Coopers, 51 percent of the employers surveyed did not expect their plans would keep their grandfathered status.

Each year, as employers grapple with the constraints brought on by unsustainable health care costs, they must choose from a range of difficult options, including reduced benefits and lower wages. The ability to adjust and manage the benefit plans of their workers has offered employers an opportunity to minimize disruption and modify care to best meet the needs of the workplace.

That flexibility is severely undermined by the new law and its flawed grandfather regulation. Today, even a modest change can trigger a loss of a benefit plan's exempted status. Employers are faced with an impossible decision: pay more to keep their current coverage, buy higher-cost insurance that is subject to the law's new mandates, or drop coverage entirely.

As is often the case, good intentions can lead to bad consequences. This is certainly true for much of the law's complex scheme of rules, mandates, and price controls. Take, for example, the Medical Loss Ratio provision, which was designed to limit the corporate profits of insurance companies to ensure consumers received the most value for every dollar they spend.

However, the regulation implementing this provision actually creates a disincentive for insurance providers to attack waste and abuse, leading to higher premiums and copayments for American consumers.

If these regulatory challenges weren't creating enough uncertainty for our workforce, employers and workers continue to confront higher health insurance costs. Despite the president's promise that his reform plan would lower premiums by up to $2,500 for the average family, the facts reflect a different reality. A recent study by the Kaiser Family Foundation reports that premiums increased by 9 percent in 2010 and are expected to increase by an additional 8.5 percent next year. Democrats in Washington got their government-run health care, and the American people are left with broken promises.

It is clear our system of employer-provided health care is experiencing dramatic changes due in large part to a deeply flawed health care law. Today's hearing provides members of the subcommittee an important opportunity to examine these changes, their impact on workers and employers, and to discuss the solutions our nation needs to chart a better course. Again, I look forward to the witness testimony, and will now yield to Mr. Andrews, the senior Democrat member of the subcommittee, for his opening remarks.

Mr. ANDREWS. Well, good morning, Mr. Chairman. Thank you for your courtesy for assembling such a fine panel.

The chairman talks about dramatic changes. He is right. The middle class of this country has seen a lot of dramatic changes in the last couple years. Fifteen million people are without work.

This is another day that is—for many people, this is going to be the day the foreclosure is executed and they lose their home. Half the people in this country surveyed this year said the American dream is either dead or on life support.

That is the problem we should be talking about, unemployment. The president came before the Congress more than 1 month ago and put forward a proposal to put people back to work, to put construction workers back to work building roads and bridges and wiring schools for Internet access, a proposal to put people back to work by cutting taxes for small business who hire people, a proposal to put people back to work by stimulating consumer demand, by avoiding a 1,500 dollar tax increase that will hit middle class families on January 1, if Congress doesn't act.

To put forth a plan that would keep police officers and firefighters on the job and teachers in the classroom. This committee, this majority has not spent 1 hour on that proposal in the last month. That is what the committee should be doing.

Instead, what we are doing is relitigating, regurgitating, rearguing the same old argument about the health care bill. Now I understand that part of the catechism from the other side is the health care bill is a job killing health care bill, filled with job killing regulations, and that job killing regulations are the reason why America's economy is stagnant and the middle class' American dream is dying.

That is not true. A survey by the Small Business Majority this July asked 1,257 small business owners to name the two biggest problems they face; 13 percent of them said government regulations; 50 percent said lack of demand.

The Bureau of Labor Statistics looked at layoffs that occurred last year in 2010 around the country. And they looked at the cause of those layoffs, as to why they occurred.

Here is what they found: 2,971 of those layoffs, 0.2 percent, were attributable to government regulation; 384,505 layoffs, 30 percent, were due to lack of demand for the service or product the business was selling.

The job killing health care bill, since President Obama signed the law in March of 2010, the economy has added 2.4 private sector jobs—2.4 million private sector jobs. Five hundred thousand of them have been in the health care industry.

We should be having a hearing today about how to have the economy create jobs for the American people, not relitigating the same old tired argument about the health care bill. Now chairman, I look forward to an exchange on the issues about the health care bill.

But I would urge Chairman Klein and you and Speaker Boehner to put on the floor of the House of Representatives the president's jobs proposal, amended as you wish. But let it come up for a vote. That is the business we should be doing for the country here this morning.

I yield back.

Chairman ROE. I thank the gentleman for his opening remarks.

Pursuant to Committee Rule 7-C, all members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for up to 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing.

Now it is my pleasure to introduce our distinguished guests. We have a great panel today.

Grace-Marie Turner is president of the Galen Institute, a public policy research organization that she founded in 1995 to promote an informed debate over free market ideas for health reform. She is the editor of "Empowering Health Care Consumers Through Tax Reform," and produces a widely read weekly electronic news letter, "Health Policy Matters."

Dennis Donahue is the national practice leader for employee benefits at Wells Fargo Insurance Services. He is a member of the Council of Insurance Agents and Brokers, and a Trade Association for Commercial Insurance and Employee Benefits Brokers. Mr. Donahue has over 30 years in the benefits business.

Mr. Ron Pollack is the founding executive director of Families USA. Families USA's mission is to achieve high quality affordable health coverage for everyone in the U.S. Prior to his current position at Families First, Mr. Pollack was the dean of the Antioch School of Law.

Robyn Piper is the founder and president of Piper Jordan, a San Diego based consulting firm that helps Fortune 1,000 companies craft employee benefit solutions. She has overall responsibility for

the firm's business operations, including its regional operations at several business units, life, disability and health care consulting, voluntary work site, limited benefit health, and franchise solutions.

Welcome. Before I recognize you to provide your testimony, let me briefly explain our lighting system. You have 5 minutes to present your testimony. When you begin, the light in front of you will turn green. With 1 minute left, the light will turn yellow. And when your time is expired, the light will turn red, at which point I would ask you to wrap up your remarks.

I won't gavel you. I will let you finish your thoughts. After that, members will each have 5 minutes for questioning and the chairman will attempt to stay with the 5 minutes.

I will now start with Ms. Turner.

STATEMENT OF GRACE–MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Chairman Roe, Ranking Member Andrews and members of the committee for the opportunity to testify today about the impact of regulations on costs and uncertainty in employer provided health coverage.

The Affordable Care Act's potential impact on jobs and economy has been a subject of debate and controversy from the start, as Mr. Andrews pointed out. Yet a recent U.S. Chamber of Commerce study found that 33 percent of business owners cited uncertainty about the health law as either the biggest or second biggest reason they are not hiring new workers.

Dennis Lockhart, the president of the Federal Reserve Bank of Atlanta, said in a speech recently, "We have frequently heard strong comments to the affect my company won't hire a single additional worker until we know what health insurance costs are going to be."

So I think this uncertainty of future regulations and costs is a huge factor impacting job creation. The new health law will add new costs, by forcing employers to either provide workers with expensive, government approved insurance or pay a fine. Many employers anticipating these costs are simply unwilling to add new workers.

The health law also discourages small businesses from becoming mid size businesses because of the mandate that they provide health insurance kicks in when they have 50 or more employees. Small businesses are the engine of job growth in our economy.

But a recent survey found that 70 percent have no plans to increase hiring in the next year. Certainly lack of demand is a big factor. But also the uncertainty of future regulations and health costs is a big factor.

As for those companies that have more than 50 workers, the burden of having to buy government approved health insurances discourages them from hiring all but essential staff. Larger companies are already pairing back on entry level jobs and are using automation to avoid adding the costs of mandatory health insurance for lower income workers.

McDonalds and CVS, for example, are replacing some human order takers and cashiers with electronic systems. This especially harms entry level jobs for those who need to get the skills to enter

the workforce. It is not the surprising then that the unemployment rate among teenagers is about 25 percent. The jobs they need are evaporating.

Many people argue that the Affordable Care Act's regulations are necessary to keep employers from cutting benefits or imposing higher health costs onto their employees. But employees actually pay a price for higher health costs. The cost of health coverage are part of employee compensation.

A recent Rand study found that most of the pay increases that employees have received over the last 10 years have been consumed by health costs.

I would like to briefly mention two particular regulations resulting from the Affordable Care Act, grandfathering and the medical loss ratio, which others will discuss today as well. While most companies hoped they would be able to preserve much of their existing coverage under the grandfathering provisions, the administration's own estimates indicate, as you said, Mr. Chairman, that most employers will not be able to maintain their grandfathered status.

The grandfathering rules really block employers into a corner. They can't make changes other than minor modifications to their health plans in order to keep costs down, without being forced to comply with expensive Affordable Care Act regulations that increase their health care costs, a real Catch 22.

Health care costs are directly related to the creation of new jobs. Higher health care costs put additional pressures on the employers' bottom line and increase the cost of hiring new workers, in turn discouraging job creation.

This is bad news for the economy and bad news for unemployed workers. The ACA already is costing jobs in the health broker community because of misguided regulations concerning the medical loss ration requirements. 21 percent of independent health insurance agency owners have already been forced to downsize their businesses. And many are anticipating even more cuts in the future.

HHS rules require that their commissions be counted against insurers' allowable administrative costs, even though they are independent and none of their commissions actually go to the insurers. Bipartisan legislation has been introduced, as well, to address this issue.

Chairman Roe, your leadership on health reform is particularly important because of your experience as a physician and because you have first hand experience with the damage that government controlled health care can do through Temcare.

Your support for repeal of the Independent Payment Advisory Board, for example, shows your commitment to control of doctors and patients over medical decisions. You have made it very clear that this is a priority.

And I know Doctors Bucshon and Dr. Desjarlais and Dr. Heck on this committee, as well as, of course, the others on the committee, are also concerned about making sure that we keep doctors and patients in control of medical decisions. That means less government control and less regulation.

Thank you for the opportunity to testify.

[The statement of Ms. Turner follows:]

Prepared Statement of Grace-Marie Turner, President, Galen Institute

Executive summary

• The unemployment rate is stuck at 9.1 percent, and there is good reason to believe that PPACA is a major contributor to the jobs picture. Employers fear the costs, mandates, and regulations of hiring new workers as a result of PPACA.

• While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions of the law, a survey by Aon Hewitt Consulting found almost all will not. The administration's own estimates indicate most employers will not be able to maintain grandfathered status.

• The grandfathering rules box employers into a corner. They cannot make changes, other than minor modifications, to their health plans to keep costs down without being forced to comply with expensive PPACA regulations that increase their health costs.

• Health costs are directly related to creation of new jobs. Higher health costs put additional pressures on the employer's bottom line and increase the cost of hiring new workers, in turn discouraging job creation. This is bad news for the economy and for unemployed workers.

• Many people argue that PPACA's restrictions are necessary to keep employers from cutting benefits or imposing higher health costs onto their employees. But employees actually pay the price for rising health costs.

• A recent RAND study found that most of the pay increases that employees have received over the last ten years have been consumed by health costs. The typical family had just $95 a month more to devote to non-health spending in 2009 than a decade earlier. Had the rate of health care cost growth kept pace with general inflation, the family would have had $545 more per month in spendable income—a difference of $5,400 per year.

• PPACA already is having a direct impact on jobs in the health broker industry because of misguided regulations concerning the Medical Loss Ratio requirements in the law.

Health costs are a jobs issue. It is in the interest of both employers and employees to keep health costs down, and the grandfathering and MLR regulations issued by HHS restrict their ability to do that.

Regulations, Costs, and Uncertainty in Employer Provided Health Care: Saving Jobs from PPACA's Harmful Regulations

Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions October 13, 2011 By Grace-Marie Turner, Galen Institute

Thank you Chairman Roe, Ranking Member Andrews, and members of the Committee for the opportunity to testify today about the impact of regulations on costs and uncertainty in employer-provided health coverage and particularly the impact of provisions in the Patient Protection and Affordable Care Act (PPACA) on employers, employees, and job creation in America.

Impact on job creation

PPACA's potential impact on jobs and the economy has been the subject of debate and controversy from the start. The president promised it would be a boon to both; former Speaker Nancy Pelosi said the law would create 400,000 jobs "almost immediately." Others argued, however, that the law's costs and mandates would make businesses much less likely to hire new workers.

That debate should now be over.

The Heritage Foundation's James Sherk, a senior policy analyst in labor economics, recently released a paper[1] comparing the rate of net job growth before and after PPACA's passage in March of 2010. The findings show that job creation came to a virtual halt after the health law was enacted.

The low point of the recession came in January 2009, when U.S. employers shed 841,000 jobs in just that one month. But the economy slowly started to recover over the next 15 months; private employers began hiring workers at an average rate of 67,600 per month (net of layoffs). The economy's high point came with the April 2010 report, when 229,000 jobs were added.

But the health law was signed into law in late March, and the hiring freeze began. In the following months, the economy added an average of just 6,500 net private sector jobs per month—less than a tenth of the pre-ObamaCare average.

This doesn't prove that the health law is a major cause of the problem. But there is no question that the jobs recovery stalled after ObamaCare passed, with no new

jobs created in August and unemployment stuck at 9.1 percent. There's good reason to believe that the health law is a major contributor to the hiring halt.

In a recent U.S. Chamber of Commerce study, 33 percent of business owners cited uncertainties about the health law as either the biggest or second-biggest reason they're not hiring new workers.

Those findings were backed up by the words of Dennis Lockhart, president of the Federal Reserve Bank of Atlanta, in a speech: "We've frequently heard strong comments to the effect of 'My company won't hire a single additional worker until we know what health-insurance costs are going to be.'"[2]

The health law discourages hiring in several ways. First, it adds unknown costs to hiring new workers. Companies already must consider the cost of taxes for Social Security, Medicare, unemployment insurance, and workers' compensation when hiring new staff. Combined with health benefits, these costs explain why a $50,000-a-year employee costs a company $62,500 to $70,000 (according to MIT business professor Joseph Hadzima).[3] The health law will add new costs by forcing employers to either provide workers with expensive, government-approved insurance or pay a fine. Employers anticipating these costs are simply unwilling to add new workers.

The health law also discourages small businesses from becoming mid-size businesses because the mandate to provide insurance kicks in once you reach 50 or more employees. This is profoundly wrongheaded. Small business is the engine for job growth in America, but a recent survey found that 70 percent have no plans to increase hiring in the next year.

As for those companies that already have 50 or more workers, the burden of having to buy expensive government-approved policies or pay penalties discourages them from hiring all but essential staff. Indeed, larger companies are doing everything they can to pare back on entry-level jobs and are using automation to avoid the added cost of mandatory health insurance for lower-income workers. McDonald's and CVS drug stores, among many other large companies, are replacing some human order-takers and cashiers with electronic systems.

This especially hurts entry-level would-be workers who need jobs so they can get the skills to enter the workforce. Is it any surprise that teen unemployment has now hit 25 percent? The jobs they need are evaporating because of the president's health overhaul law.

Employees pay the price of higher health costs

Many people argue that the PPACA's regulations are necessary to keep employers from cutting benefits or imposing higher and higher health costs onto their employees. But employees actually pay the price for these higher health costs.

The cost of health coverage is part of employee compensation. A recent RAND study found that most of the pay increases that employees have received over the last ten years have been consumed by health costs.

Between 1999 and 2009, a median-income family of four that received health insurance through an employer saw their real annual earnings rise from $76,000 to $99,000 over the ten year period. But nearly all that gain was consumed by rising health care costs, according to the paper by David Auerbach and Arthur Kellermann of RAND.[4]

After taking into account the price increases for other goods and services, they said the typical family had just $95 a month more to devote to non-health spending in 2009 than they had a decade earlier. By contrast, the authors say that if the rate of health care cost growth had not exceeded general inflation, the family would have had $545 more per month in spendable income instead of $95—a difference of $5,400 per year. Workers are paying the price for higher health costs.

Many companies have introduced plans that engage their employees as partners in managing health costs, giving them more control over health care and health spending decisions. These companies have had success in holding down health cost increases. A 2011 survey for the National Business Group on Health on "purchasing value in health care" found that companies that offered account-based health plans, such as Health Savings Accounts or Health Reimbursement Arrangements, had coverage costs that were $900 lower than average for employee-only coverage and $2,885 lower for Preferred Provider and Point of Service (PPO/POS) plans.[5] "The cost of [account-based health plan] coverage is considerably more affordable than either PPO/POS plan or HMO plan coverage in 2011," the survey found. These premium savings benefit both employers and employees.

The number of people with HSA/HDHP (high-deductible health plan) coverage rose to more than 11.4 million in January 2011, up from 10 million in January 2010, 8 million in January 2009, and 6 million in January 2008.[6]

Of course consumer-directed plans are only one option of the wide array of policy choices offered in the private marketplace. But many employees and employers

value this choice. Flexibility, rather than the top-down regulations PPACA is imposing, is essential for employers and employees to find ways to hold down health costs.

Grandfathered health plans

Many employers said that assurances their health plans would be "grandfathered" was a key reason that led to their support or to their taking a neutral stance on passage of the PPACA.

People who have and value their health coverage were also reassured. Surveys have shown that 88 percent of Americans are satisfied with their health coverage.[7] While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions, a survey by Aon Hewitt Consulting found almost all will not.[8]

"If you like your health insurance, you can keep your health insurance," the president repeatedly promised. Even administration experts now admit this promise will not be kept. The Department of Health and Human Services expects that, by 2013, between one-third and two-thirds of the 133 million people with coverage through large employers will lose their grandfathered status. And up to 80 percent of the 43 million people in small employer plans will lose their grandfathered protection. Up to 70 percent of those with coverage in the individual market would be forced to comply with expensive new federal rules within a year.[9] Few of them are likely to lose coverage in the short term, but most will lose the coverage they have now.

The grandfathering rules box employers into a corner. They cannot make changes, other than minor modifications, to their health plans to keep costs down without being forced to comply with expensive PPACA regulations that increase their health costs.

Health costs are the issue

The human resources consulting firm Towers Watson released a survey of large employers regarding health costs.[10] Seven out of ten of the employers surveyed expect to lose grandfathered health status in 2012—subjecting them to all of the new regulations and mandates under the new health law. Of even greater concern, nearly three in ten employers (29 percent) are unsure whether or not they will continue offering coverage to their current workers after all of the provisions of the new health law take effect.

Towers Watson reports that overall health plan costs are projected to rise at a 5.9 percent rate in 2012, continuing to rise faster than the rate of overall inflation. Because of rising health insurance costs and the other cost pressures that employers face, a majority of firms say they will be forced to increase the employee share of premiums in 2012. Only one percent of firms say they will be able to decrease the employee share of premium contributions next year.

Health costs are directly related to creation of new jobs. Employers continue to face a fragile economy. Higher health costs put additional pressures on their bottom line and increase the cost of hiring new workers, in turn discouraging job creation. This is bad news for the economy and for unemployed workers.

What all employers must cover

Under the Affordable Care Act, all health plans—whether or not they are grandfathered plans—were required to provide certain benefits for plan years starting after September 23, 2010, including:[11]

- Restrictions on lifetime limits on coverage for all plans. Starting in 2014, insurance plans must provide coverage without imposing any annual or lifetime limits on the amount paid to individual beneficiaries. During the transition years between now and 2014, however, insurance firms can impose annual limits, subject to HHS rules. The HHS regulations issued last June dictated how high these limits must be. In 2011, insurance companies can continue to impose an annual limit, but it must be at least $750,000 per enrollee. In 2012, the limit will have to be at least $1.25 million, and in 2013, $2 million. In 2014 there can be no limit on payouts for any individual's care.[12] This is the particular regulation that has led to at least 1,578 waivers being issued by HHS, primarily covering limited benefit plans offered by employers such as McDonald's who said the higher cost could force them to drop the coverage altogether.[13]
- No rescissions. Plans may not rescind coverage after enrolling a participant, except in the case of fraud or limited circumstances.
- No coverage exclusions for children under age 19 with pre-existing conditions, and no pre-existing condition exclusions for anyone starting in 2014.[14]
- Group health plans that provide dependent coverage are required to extend coverage to adult children up to age 26 with no conditions on dependency.

A recent employer survey said that 28 percent of employers believe that compliance with PPACA rules already is increasing their health cost.[15]

Restrictions on plans hoping to keep grandfathered status

What do plans have to do in order to maintain their grandfathered status? A Health and Human Services Department fact sheet describes the restrictions.[16]

Compared to policies in effect on March 23, 2010, employers:

- cannot significantly cut or reduce benefits
- cannot raise co-insurance charges
- cannot significantly raise co-payment charges
- cannot significantly raise deductibles
- cannot significantly lower employer contributions
- cannot add or tighten an annual limit on what the insurer pays
- cannot change insurance companies. (This rule was later amended to allow employers to switch insurance carriers as long as the overall structure of the coverage does not violate other rules for maintaining grandfathered plan status. The amended rule specifically directs that the new insurance carrier must precisely match the same terms of coverage that were previously in place.)

These rules mean, for example, that health plans and employers with plans in effect on March 23, 2010, lose their exempt—or grandfathered—status if they were to raise co-payments by the greater of $5 or a medical inflation rate plus 15 percent. Deductibles couldn't go up more than medical inflation plus 15 percent. In addition, employers couldn't cut the amount of the premium that they contribute by more than 5 percent.

Plans that lose their grandfathered status become subject to all of the requirements in PPACA, including first-dollar coverage for preventive care, required coverage for certain clinical trials, quality reporting requirements, and implementation of internal and external appeals processes.

A survey by Aon Hewitt Consulting found that ninety percent of companies said they anticipate losing grandfathered status by 2014, with the majority expecting to do so in the next two years. The study found that among those companies with self-insured plans, 51 percent expect to first lose grandfathered status in 2011 and another 21 percent expect to lose it in 2012. The survey

found that "Most employers would rather have the flexibility to change their benefit programs than be restricted to the limited modifications allowed under the new law."[17]

Why employers need flexibility

The employment-based health system in the United States has evolved from decisions made during World War II that gave favored status to health insurance offered through the workplace. Our system of employer-based health insurance is underpinned by generous tax incentives that allow employers to deduct the cost of health insurance as a part of their employee compensation costs and through a separate tax provision that shields the value of the policy from being taxed as income to the worker. These dual tax incentives have provided strong incentives for people to get their health insurance at work and have led to the system in which 158 million Americans get health insurance through the workplace.

Employers work very hard to find the balance in keeping the cost of health insurance as low as possible while offering the benefits that employees want and need. Part of the way they are able to do this is by seeking bids from competing insurers and amending and adjusting benefit structures. But under the grandfathering rules, employers are very limited in their ability to adjust current benefits without losing their grandfathered status. This also means they are limited in what they can do to help keep costs down.

The U.S. Chamber of Commerce, the largest U.S. business advocacy group, presented written comments on the grandfathering rules in August 2010, saying its first concern is with the restriction on cost-sharing. "By so severely restricting changes in cost-sharing, the regulations will effectively force plans to lose grandfathered status in order to remain solvent," the Chamber wrote.[18]

Medical Loss Ratio regulations as job killers

PPACA already is having a direct impact on jobs in the health broker industry. Janet Trautwein, Executive Vice President and CEO of the National Association of Health Underwriters (NAHU), reported in recent testimony before the House Energy and Commerce Subcommittee on Health that "the economic outlook for many health insurance agents and brokers across the country continues to be bleak. As health insurance companies renew and revise their agent and broker contracts for the coming year, it is clear that the financial situation for many of these business owners is getting worse."[19]

She reported that: "NAHU recently surveyed its members and found that 21 percent of independent health insurance agency owners have been forced to downsize

their businesses, including laying off employees. Twenty-six percent have also had to reduce the services they provide to their clients * * * Five percent of respondents who were not principals in their agencies have already lost their jobs due to producer revenue reductions caused by the MLR regulation, and agency owners report that if their compensation continues to plummet more job loss will follow."

The main reason for this is a rule imposed by the Department of Health and Human Services involving the Medical Loss Ratio (MLR) which mandates that health insurance carriers spend 85 percent of their premiums for large groups and 80 percent of their premiums for individual and small group policies on direct medical care.

The HHS rule requires health plans to treat independent agent and broker compensation as part of health plan administrative costs—even though they aren't employed by health insurance carriers. Brokers and agents run their own businesses, hire their own employees, and pay all of their own office expenses, working for their clients to find the best and most affordable health insurance, usually from a range of health carriers.

None of the compensation goes to the health insurer, yet HHS rules require that it be counted against the insurer's allowable administrative cost.

Agents bring a great deal of value to their clients, yet this clumsy rule is shoving them aside. Not only do they help individuals and small businesses find the most appropriate and affordable policy from many competing carriers, but they also help companies find and establish wellness and disease-management programs and navigate the often-complex claims process. They are a crucial element in the equation of helping businesses find the most appropriate and affordable health policies for their employees.

Agents and brokers often act as an external human resources department for companies. Many smaller companies do not even have an HR department so, as the Congressional Budget Office has noted, agents and brokers often "handle the responsibilities that larger firms generally delegate to their human resources departments—such as finding plans and negotiating premiums, providing information about the selected plans, and processing enrollees."

Janet Trautwein testified that NAHU "members are spending significant amounts of time educating their clients about the new law's provisions and helping them comply with its resulting regulations. Regardless of what the final outcome of PPACA may be, the need for licensed, trained professionals to help individuals, employers and employees with their health insurance needs will always be there. So we need to make sure this industry survives." She made it clear that "PPACA-related regulations * * * are costing American jobs and hindering American business owners every single day. In every state, as a direct result of the new law's MLR provisions, agency owners are reporting that they are reducing services to their clients, cutting benefits and eliminating jobs just to stay in business. In some instances, they are simply closing their doors." NAHU recommends "eliminating independent producer commissions from the MLR calculation," adding that this "will go a long way toward providing uniform and needed relief to all health insurance markets—and the consumers who reside within them—during the transitional period as PPACA requirements are fully implemented over the next three years."

Relief from the grandfathering regulation

It is in the interest of both employers and employees to keep health costs down, and the MLR and grandfathering regulations issued by HHS are just two examples of rules that are restricting their ability to do that. Health costs and jobs are at stake.

I understand that legislation is being drafted to reverse the interim final regulation issued by HHS addressing grandfathering. Reversing this regulation would give employers the flexibility they need to manage their health costs and find the balance between health costs, wages, and hiring new workers. In addition, Reps. Mike Rogers and John Barrow of Georgia have introduced legislation, the Access to Professional Health Insurance Advisors Act of 2011, to remove independent health insurance producer commissions from what is currently defined as premiums for MLR calculation.

Chairman Roe, your leadership on health reform issues is particularly important because of your experience as a physician and because you have first-hand experience with the damage of government-controlled health care through TennCare. Your support for repeal of the Independent Payment Advisory Board is both important and relevant. You have made it very clear in your work that you believe health care is best provided when doctors and patients—not Washington bureaucrats—are in charge of decisions. It is fortunate that Drs. Bucshon, DesJarlais, and Heck are also

serving with you on this committee to provide physician leadership in Congress to restore the proper control over health care decisions to doctors and patients.

Thank you for the opportunity to testify today, and I will be happy to answer your questions.

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Chairman ROE. Thank you, Ms. Turner.

Mr. Donahue?

STATEMENT OF DENNIS M. DONAHUE, MANAGING DIRECTOR, WELLS FARGO INSURANCE SERVICES USA, INC., TESTIFYING ON BEHALF OF THE COUNCIL OF INSURANCE AGENTS AND BROKERS

Mr. DONAHUE. Chairman Roe, Ranking Member Andrews and members of the committee, good morning. Again, my name is Dennis Donahue. I am the managing director and national practice leader of employee benefits for Wells Fargo Insurance Services USA. And I am testifying today on behalf of the Council of Insurance Agents and Brokers.

The Council represents the nation's leading commercial insurance agency and brokerage firms, with members in over than 3,000 locations, placing more than $200 billion of U.S. insurance products and services, including group health insurance.

The Council's members help employers provide their employees with the health coverage they need at the cost they can afford, serving tens of thousands of employer-based health insurance plans, covering millions of American workers.

We appreciate the opportunity to testify today. And I will focus my comments on two particularly troubling aspects of the Patient Protection and Affordable Care Act, compliance with grandfathering and the medical loss ratio, MLR, provisions.

With respect to grandfathering, under PPACA, a core objective was to allow everyone who had coverage the law was enacted to keep that coverage. To this end, group health plans that existed on March 23, 2010, are grandfathered, and are, therefore, exempt from some of the law PPACA requirements, provided that these grandfather plans comply with certain constraints on their evolution that have been imposed by HHS, DOL and the Treasury Department.

To retain grandfathering status, for example, a plan cannot increase the percentage of co-insurance changes, significantly increase a planned participant co-pays, decrease the employer contribution by more than a specified amount or impose new or decreased annual dollar benefit limits. A grandfathered plan must also satisfy extensive record keeping and disclosure obligations to preserve its status.

As straightforward as some of these rules and limitations might seem, it is never that simple for an employer that is trying to maintain their grandfathered plan. For practically any contemplated change in the design of a health benefit plan, the sponsor of that plan must seek some type of professional guidance if they wanted to ensure that the change does not jeopardize the plan's grandfathered status.

This will likely have been done annually, because, as you mentioned before, the plan tends to make changes every year. And all of it costs employers time and money. It is naive to think that employee benefit plans are stagnant elections made by employers.

Plans change historically. And they evolve as the markets evolve, with new cost containment measures, plans designed to promote more cost effective treatments, the changing of those insurance companies, their networks, deductibles, covered expenses and so forth.

As consultants advising employers on compliance, we have received countless questions on the grandfathering rules alone. And many employers now hesitate to make any changes for fear for running afoul of these rules.

All of this complexity costs employer health plans time and money. The clients with which we work, particularly those between 50 and 100 employees, do not have the administrative resources and the expertise to make the requisite grandfathering assessments.

Many of those client employers are now actively evaluating whether to abandon offering these benefits at all, as they see the cost of compliance sky rocketing.

There is also a number of other changes that would be implemented starting in 2014. Employers are equally concerned about how they and their employees would be able to absorb the cost of these additional requirements.

With regard to the MLR, the medical loss ration requirements, our clients have also expressed concern about the effect of the MLR provision, that it may have on health insurance premiums in areas where health insurance carriers are leaving the marketplace because they are unable to meet the MLR requirements.

In addition, the imposition of the MLR requirement creates some counterintuitive disincentives. For example, insurance carriers are discinentivized from negotiating better deals with medical providers and from developing new wellness programs because of all the associated expenses of such initiatives. And those will fall on the bad side—on the denominator side of the MLR equation.

While any potential benefits that reduce their medical costs will actually further exacerbate the administrative cost issues in the short term. And they will certainly stifle innovation.

More parochially, there is concern among health insurance agents and brokers about the impact of MLR. It will have on our business and on our jobs,.as carriers cut back and restructure commissions in order to meet MLR's administrative cost caps.

Employers, too, are concerned, because they do not want to lose the readily access that they have to professional advice. And some have to come to rely upon their agents and brokers, particularly in light of the difficult of navigating new PPACA requirements, as discussed earlier.

For these reasons, the council supports H.R. 1206, the Access to Professional Health Insurance Advisers Act of 2011, a bill introduced by Representative Rogers to help ensure that the MLR does not lead to the loss of agent or broker jobs, thus depriving consumers of the expertise that agents and brokers provide.

Thank you, again, for the opportunity to testify today. And I am happy to answer questions.

[The statement of Mr. Donahue follows:]

Prepared Statement of Dennis M. Donahue, on Behalf of the Council of Insurance Agents and Brokers

The Council of Insurance Agents & Brokers ("The Council") is grateful to Chairman Roe, Ranking Member Andrews, and other members of the Subcommittee for holding this hearing to examine the impact of regulations, costs, and uncertainty on employer-provided health care. We appreciate the opportunity to testify, in particular, concerning compliance with the grandfathering and minimum medical loss

ratio ("MLR") provisions of the Patient Protection and Affordable Care Act ("PPACA").

Specifically, I will share my knowledge regarding some of the costs to employer-based health plans to comply with these provisions, based on my experience as a professional employee benefits consultant and health insurance broker to mid-sized employers who offer health coverage to their employees. The costs and burdens of compliance are considerable.

My job title is Managing Director, National Practice Leader for Employee Benefits, for Wells Fargo Insurance Services USA, Inc. I am testifying today on behalf of The Council, of which I am a member as well as former Chairman of the Council of Employee Benefit Executives. The Council is the premier association for commercial insurance and employee benefits intermediaries in the United States. The Council represents leading commercial insurance agencies and brokerage firms, with members in more than 3,000 locations placing more than $200 billion of U.S. insurance products and services, including group health insurance. The Council's members help employers provide their employees with the health coverage they need at a cost they can afford, serving tens of thousands of employer-based health insurance plans covering millions of American workers. As such, our membership has a thorough understanding of the group health insurance market, and has had a unique opportunity to observe the challenges group health plans have faced thus far in the PPACA implementation process.

Wells Fargo is the fourth largest insurance broker in the United States and the fifth largest in the world. The majority of our commercial insurance customers are small and mid-sized employers, typically 50 to 500 employees. On a personal note, I have 34 years in the employee benefits industry and I am a national resource for approximately 1,000 employee benefit professionals within our firm.

Overview

Recognizing that the grandfather and MLR provisions were included in PPACA with a view toward helping consumers of health insurance, I am here today to tell you that these provisions, as they have been implemented, are not cost-free. This is especially so for smaller employers and health plans that lack the staff and resources to devote to ensuring that their plan complies with the myriad restrictions on grandfathered plans, which range from limits on changing co-payment amounts, co-insurance charges and other cost-sharing amounts, to making changes in the types of benefits that are offered. This may sound more straightforward than it is. However, for practically any contemplated change in the design of a health benefit plan, the sponsor of that plan must seek some type of professional guidance if they want to ensure that the change does not jeopardize the plan's grandfathered status. This will likely have to be done annually because plans tend to make changes each year, and all of it costs employers money and time.

At the same, these health plans may lack the resources to pay the higher premium costs that may be associated with losing grandfathered status. In particular, loss of grandfather status means a plan may have to provide new benefits such as preventive services for free. These plans may also have to implement new or different claims appeal and external claims review processes. And there are a number of other changes that would have to be implemented starting in 2014. Employers are concerned about how they and their employees would be able to absorb the costs for these additional requirements.

Our clients have also expressed concern about the effect that the MLR provision may have on health insurance premiums in areas where health insurance carriers are leaving the market because they are unable to meet the MLR requirements.

And finally, there is concern among health insurance agents and brokers about the impact the MLR will have on their businesses and their jobs, as carriers cut back and re-structure commissions to meet the MLR's administrative cost caps. Employers too are concerned, because they do not want to lose ready access to the professional advice they have come to rely upon from their agents and brokers. For these reasons, The Council supports H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011, a bill introduced by Rep. Rogers to help ensure that the MLR does not lead to the loss of agent and broker jobs, thus depriving consumers of the expertise agents and brokers offer.

Discussion

I. The Impact of PPACA Grandfathering Provisions on Employer Health Plans

Under PPACA, group health plans that existed on March 23, 2010 (the law's enactment date) are "grandfathered" and are, therefore, exempt from some of the law's new requirements. The U.S. Department of Health and Human Services, Department of Labor, and Treasury Department (collectively, the "Departments") issued a

rule last year to implement the grandfather provision, and that rule basically establishes a list of things a health plan can and cannot do while remaining grandfathered, in addition to imposing new recordkeeping and notification requirements. I think of the requirements as a list of "do's and don'ts," as follows:

A Grandfathered Group Health Plan:

Cannot—	Can—
• Eliminate all benefits to diagnose or treat a particular condition	• Change carriers
• Increase percentage co-insurance charges	• Change premiums
• Increase co-pays, fixed amount cost-sharing "significantly" (med. infl. +15%)	• Make sure structural changes to plan (e.g., self-insured to insured)
• Decrease employer contribution >5%	• Change provider network
• New or decreased annual dollar benefit limits	• Change prescription formulary
• Switch employees' plans or engage in mergers, etc. to avoid compliance	• Make changes to comply with other laws

The Departments' rule characterizes the permitted changes as ones that are "routine" in nature for health plans. It is naive to think that employee benefit plans, especially the medical, are stagnant elections made by employers. Our clients have multi-year objectives that attempt to ward off the rate of continued medical inflation. Plan changes historically evolve as the markets evolved with new cost containment measures, plan designs to promote more cost-effective treatments, the changing of carriers, networks, deductibles, covered expenses, and so forth. But in today's economic environment, it is not unusual for our clients to contemplate cost structure changes beyond those the rule treats as "non-routine." When faced with a decision whether to keep offering insurance to employees or whether to give up in an age of incredible health cost increases, employers do contemplate the possibility of having to increase the employee's contribution by more than 5%, for example, a change that will cause loss of grandfather status.

And as straightforward as some of these decisions might seem, it is never that simple for an employer that is trying to maintain a grandfathered plan. As consultants advising these employers on compliance, we have received countless questions from our clients in the year since the grandfather rule was adopted. Employers now hesitate to do something as basic as moving a group of employees from one health plan to another if the company is re-aligning its staff among different geographic locations or has undergone a corporate re-structuring, for fear of running afoul of the grandfather rule. They seek our advice for this and nearly every other type of change they consider making to their health plans, just to make sure they do not unwittingly end up affecting the plan's status.

The grandfather rule includes recordkeeping and disclosure obligations, as I previously mentioned. These include a requirement that health plans maintain the records necessary to prove their grandfathered status, which entails keeping the paperwork describing each and every health plan benefit and each and every cost or contribution as they existed on March 23, 2010, and for any and every change, for an indefinite period of years thereafter. This is a dichotomy as health plans, and employee benefits in general (as a condition of one's overall compensation package), are viewed by employers as prospective, not retrospective. Tied to employee's compensation, they are unique and employer-specific in their design. These new recordkeeping rules will be especially burdensome and expensive for employers that have multiple locations and employee classes, all with varying benefit levels for purpose, that continue to evolve as our U.S. healthcare delivery system evolves.

All of this complexity costs employer health plans time and money. And many of our clients say they are daunted by the grandfather rule's requirements. The companies we work with, particularly those with 50 to 100 employees, do not have the administrative resources and expertise to make assessments about whether changes will cause loss of grandfather status, or when it becomes uneconomical to even try to maintain grandfather status. Admittedly, their inquiries and their resulting challenges mean business for my employer; but there is no doubt that our clients spend money on consulting fees for grandfathering compliance matters that they did not have to spend two years ago. That's an administrative expense that does not grow their business, and the Subcommittee is probably aware of the well-known data in-

dicating that small businesses create more than 60% of the new jobs in our country.[1]

One might ask why plans do bother attempting to maintain grandfathered status? The reason is because they may also be unable to afford the cost of the plan if they lose grandfather status. This is the case because a non-grandfathered plan may have to provide new benefits the plan sponsor did not anticipate (having to offer when it sought to design a plan that the employer and its employees could actually afford). Our clients are most concerned about the cost of needing to provide preventive services for free rather than with a co-pay, and the cost of having to implement new or different claims appeal and external claims review processes. Both of these new requirements would have to be implemented now if a plan loses grandfathered status. There are several other new requirements that go into effect for non-grandfathered plans starting in 2014, including having to provide a mandated benefits package and minimum 60% employer contribution for company plans with fewer than 100 employees. Thus, there can be considerable new costs involved if a plan loses grandfather status, especially for small businesses.

II. The Impact of the Medical Loss Ratio

From my perspective as a consultant to employers and as a professional insurance broker, the minimum MLR, which caps the amount of non-claims-related expenses a carrier can have at 15% or 20% depending on the market, is raising concerns among employers about what the MLR may ultimately do to their insurance premiums, and raises concerns about the impact on agents and brokers and the services we provide to employers.

A. IMPACT ON EMPLOYERS

Our employer-clients have expressed concern that the MLR mandate will lead to less carrier competition and higher healthcare costs in some markets. In smaller markets where carriers do not enjoy the economies of scale that allow them to meet the administrative caps under the MLR mandate, carriers are abandoning the market altogether. As evidence, we have already seen the exodus of two prominent insurance carriers, The Guardian Life and The Principal, both of which have provided medical benefits to small employers for many decades, have withdrawn their medical plan offerings altogether. Both have signed agreements with their former competitor, United Healthcare, to transition employee coverages. Under the law, carriers must calculate their MLR in each market in each state where they operate. Recent reports, including a U.S. Government Accountability Office study from July 2011, reveal that more carriers are pulling out of, or plan to pull out of, some markets because they cannot meet the MLR mandate in those locations.[2]

Stories like these mirror the concerns our clients are expressing to us, about the future of competition and choice among quality health plans. As we have seen in so many other industries, the simple law of economics tells us here that diminished competition may lead to higher premium prices for employers seeking to provide healthcare for their employees.

B. IMPACT ON HEALTH INSURANCE AGENTS AND BROKERS

The Council's agent and broker members are generally paid for their services by insurance carriers on a commission basis. The MLR calculation obviously affects these arrangements because it requires commissions paid by carriers to agents and brokers to be categorized as "other non-claims costs." Since a carrier will now pay rebates to subscribers if the carrier fails to limit its non-claims costs to 15% or 20% of premium revenue (depending on the market), the MLR requirement has put stress on agent and broker commissions. The 2011 GAO report found that "almost all insurers [GAO] interviewed were reducing brokers' commissions and making adjustments to premiums in response to the PPACA MLR requirements."[3]

My experience bears this out, as we are seeing carriers cut commissions or try to move to models that shift some or all of the administrative cost directly to the

[1] U.S. Small Business Administration fact sheet, available at *http://www.sba.gov/advocacy/7495/8420.*

[2] U.S. Government Accountability Office Report to Congressional Requesters, "Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements," GAO-11-711 (July 2011), at 19 (hereafter, "GAO Report"). And these revelations pertain to carriers selling policies in the individual market, a market for which states can at least ask HHS for temporary relief on the minimum MLR where they fear the requirement will destabilize the market. No such relief is available for the small group insurance market that small employers rely on, so there are fears about what may be on the horizon for that market.

[3] GAO Report at 18.

policyholder so that these amounts do not get counted as administrative and distribution costs for the carrier. This is particularly true for brokers servicing the individual and small business markets, which are already seeing their compensation slashed by 20-to-50 percent. It also happens that these markets are where agent and broker services are desperately needed by consumers and entrepreneurs, who find it difficult to navigate a complicated health insurance marketplace that will become even more complicated, unfortunately, as we approach 2014 and small businesses have to figure out what to do in the Exchange context.

Despite what some observers might suggest, for employers, purchasing health coverage is not like buying an airline ticket. There are a host of variables to be considered that are unique to each employer. Company size, specific workforce health care needs, financial resources, available options, coverage costs, and the need or desire for additional programs such as wellness measures, are among the many factors that must be balanced by employers attempting to find health coverage. Thus, for many employers the personalized needs for compliance, communications and enrollment, can only provide limited support with toll-free telephone numbers and websites. That will remain true even when the Exchanges start operating in 2014. Without the professional advice of agents and brokers to guide them in the complicated process of selecting health coverage, employers may simply throw up their hands and not offer coverage, or settle for coverage that is less than a good fit for their employees.

Prior to MLR, our services were covered within a component of the premium. While it may seem simple to just assume that small businesses can pay more in fees in lieu of carrier commissions, these new line items may be difficult for small businesses to take on in such challenging economic times. This may also adversely affect employers' willingness and ability to work with agents and brokers for services they have historically outsourced to us.

The foregoing reasons highlight the importance of continuing to have a robust agent/broker presence in the group health market. It is important for policymakers to consider the costliness of regulatory measures that create downward pressure on commissions paid by carriers to agents and brokers, such as the MLR mandate. These measures can lead to fewer agents and brokers in business, fewer employer-broker relationships, lower quality and less tailored health care for employees, and potentially severe PPACA compliance problems and costs for employers that are left to navigate the system without the assistance they need.

All of these concerns have prompted The Council to support H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011, which was introduced by Rep. Rogers and presently has 129 co-sponsors. By excluding agent/broker compensation from the MLR calculation, H.R. 1206 will help to ensure that the MLR does not lead to the loss of agent and broker jobs, thus depriving consumers of the expertise agents and brokers offer.

III. Conclusion

It is very important for policymakers to understand the costs and burdens associated with laws and regulations for all parties involved. I hope this hearing and my testimony contributes to that understanding as it relates to PPACA's grandfathering and MLR provisions. Again, I appreciate the Committee's willingness to examine these important issues and the opportunity to testify on behalf of The Council's members.

Chairman ROE. Thank you, Mr. Donahue.

Mr. Pollack?

STATEMENT OF ROB POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK. Thank you, Mr. Chairman, Dr. Roe, Ranking Member Andrews, distinguished members of this panel.

I am delighted to testify at today's hearing, because I believe that Affordable Care Act improves America's jobs and job markets. Health care, as you know, is one of the fastest growing job sectors in America's economy.

And with 30 to 40 million people projected to gain health care coverage as a result of the Affordable Care Act, it will give a boost to that sector. According to the Bureau of Labor Statistics, as Con-

gressman Andrews indicated, more than 500,000 jobs were created in the health care and social assistance sector since the Affordable Care Act was enacted into law.

The Bureau of Labor Statistics projects that nearly four million jobs will be created in that sector over the course of the next decade. And it will aid the job market because it will end job lock, people who cannot leave a job because they or a family member have a health condition, and they can't become entrepreneurs because they are afraid they are not going to be able to get health care coverage.

So I want to make three points with respect to my testimony. First, by making insurance companies more accountable, the Affordable Care Act is improving the cost effectiveness of health coverage for employers and consumers.

Number two, in contrast to a variety of cost shifting proposals offered in the House this year, most notably the Ryan Plan, the Affordable Care Act initiated significant steps to decelerate the rise of health care costs, rather than shifting costs onto those people who can't bear that load.

And third, the Affordable Care Act provides very substantial and direct cost relief to small businesses and consumers.

Now one quick area of background; over the course of the last 10 years, 2000 to 2010, we have seen a big decrease in the portion of the American public that have employer sponsored insurance. From 2000 to 2010, even though the population increased by 26.6 million people, we have seen a decrease of 12.6 million people with employer sponsored insurance.

So in 2000, over 65 percent of the American public had employer sponsored insurance. In 2010, it was about 55 percent—55.3 percent.

And why is that happening? Because, of course, premiums have sky rocketed during that period. In the year 2000, the average premium for family coverage, employer sponsored insurance, was $6,772. By 2010, it was $13,871. And as we learned from the Kaiser Foundation, it is now over $15,000.

So here is how the Affordable Care Act is going to improve that. First, it improves that accountability of insurance companies, so that we get greater cost effectiveness on the premium dollar. And that is what the medical loss ratio system is about.

When I buy insurance, either for myself or as the director of a small business—we have 50 employees—I want to make sure that my dollars are spent as cost effectively as possible. And from my perspective, having more of the dollars spent on advertising, marketing, administration and profits, as opposed to really providing health care, that is not efficiency.

And so the medical loss ratio is going to improve that. And we have seen that it has already had a significant improvement in a number of states.

And by making sure that excessive premium rates proposed by insurance companies get reviewed by the states—and they now have the wherewithal to do that—that too is going to improve cost effectiveness.

Second, the House has offered a variety of cost shifting proposals, but not anything with respect to diminishing and decelerating

costs. The Affordable Care Act does that. I have outlined how it does that. So I am not going to repeat that here.

Last, the Affordable Care Act provides significant subsidies to help make coverage more affordable, both for small businesses and for individuals. With respect to small businesses, it provides tax credit subsidies for businesses with fewer than 25 workers, with average wages below $50,000. There are more than four million businesses who are eligible for those tax credits. And those tax credits will increase in 2014.

Eighty percent of all small businesses with up to 25 workers are eligible for the tax credit. For individuals and families, they will receive tax credit subsidies. Those between 133 percent of poverty and 400 percent of poverty for a family of four is $90,000. They will be eligible for tax credit subsidies that will help to make premiums more affordable.

And lastly, let me just say that as more and more people gain health care coverage, that 32, 34 million that CBO projects will occur, it is going to decrease the hidden health tax that all of us who buy insurance have to pay because we ultimately experience a cost shift to pay for the costs of the uninsured.

Thank you, Mr. Chairman.

[The statement of Mr. Pollack follows:]

Prepared Statement of Ron Pollack, Executive Director, Families USA

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: Thank you for inviting Families USA to testify today at this very important hearing about health care reform, employers and consumers. Since 1982, Families USA has worked to promote high-quality, affordable health care for all Americans. We are pleased to be invited to testify about how the Affordable Care Act will offer concrete help to employers, their workers and their families. The strength of the U.S. labor market is inextricably linked to the scope and size of America's health care industry. According to the Bureau of Labor Statistics, more than 500,000 jobs have been created in the health care and social assistance sector since the passage of the Affordable Care Act. According to Bureau of Labor Statistics projections, nearly 4 million jobs will be added to the health care and social assistance sector between 2008 and 2018.

The Affordable Care Act Will Spur Job Growth

Our economy needs a jolt and policymakers should do as much as possible to encourage hiring and spur growth. When fully implemented, the Affordable Care Act will help promote economic growth by giving workers the freedom to move to new jobs at small firms and start-up companies without hinging their decision solely on the ability of the new employer to provide health care coverage to workers. In our current health care system, people with health conditions have a difficult time finding coverage in the individual market. Uncertainty about whether they'll be able to find affordable coverage leads many Americans to make decisions about which job to choose or whether to stay in a job based on whether the job provides health coverage. This phenomenon is known as "job lock."

Workers who have health problems are less likely to leave a job that offers health coverage. One study found that chronically ill workers who rely on their employers for health coverage are about 40 percent less likely to leave their job than chronically ill workers who do not rely on their employers for coverage. Another study found that workers with a history of health problems such as diabetes, cancer or heart disease, and those who have substantial medical bills, stay at their jobs significantly longer because of their job-based health coverage. And job lock has a particularly strong effect on workers who have family members with chronic illness. Research has shown that workers who rely on their employer to provide insurance for chronically ill family members stay in jobs they might otherwise leave. One study found that women with job-based coverage who have a chronically ill family member who depends on that coverage are 65 percent less likely to leave their job than women with job-based coverage who have a chronically ill family member who does not depend on that employer coverage.

The fear of going without health coverage discourages individuals from leaving their existing jobs and starting new businesses on their own, especially if they have pre-existing conditions or if they have a family member with a health condition. Productivity is hurt when the new ideas, new products and competitiveness that new businesses bring to the economy are lost. The Affordable Care Act will reduce the problem of job lock: individuals will no longer have to base their employment decisions on whether a job offers health coverage.

Employer-Based Health Coverage Declining Due to Rising Insurance Premiums

The number of Americans who receive their health insurance through their employer has dropped precipitously in recent years. In the year 2000, approximately two-thirds of the population (65.1 percent, or 181.9 million) had employer-based health coverage. Ten years later, in 2010, a little more than half of the population (169.3 million, or 55.3 percent) had coverage through their job or the job of a family member. Once implemented, the help provided by the Affordable Care Act to employers and consumers is likely to change this trend.

This trend is driven, in large part, by rising health insurance premiums. Between 2000 and 2010, premiums for job-based family coverage more than doubled, increasing from $6,348 to $13,770. These premiums continue to rise, growing to $15,073 by 2011. As premiums rise, it becomes more challenging for employers to offer quality, affordable health coverage to their workers, and employers are forced to make difficult decisions about such coverage.

Employers often respond first with efforts to control their health care costs without eliminating benefits entirely. Some employers attempt to control health care costs by "thinning" health benefits—offering plans with higher deductibles, copayments, and co-insurance, as well as plans that cover fewer benefits. Others cut costs by placing limits on which employees are eligible for coverage or by asking employees to pay more for coverage for spouses and children of employees (dependent coverage). In addition, many employers have stopped offering coverage to part-time, temporary, or seasonal workers.

The decline in employer-based coverage has been further exacerbated by the economic downturn that began in 2007. Millions of Americans lost their jobs during the recession and, for many, the loss of a job also meant the loss of health insurance coverage. And while the safety net of public health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP), provides coverage to some who lose their job-based coverage, current eligibility rules limit who qualifies for coverage based on income and family status. Because of these eligibility rules, Medicaid and CHIP act as a highly effective safety net for children during economic downturns but do not work nearly as well for adults.

Evidence of the critically important role that Medicaid and CHIP have played in protecting children can be seen in data from the Census Bureau. Between 2000 and 2010, enrollment in Medicaid and CHIP increased by 20.5 million, growing from 28.1 million to 48.6 million. More than half of this increase in enrollment was among children. Between 2000 and 2010, the number of children enrolled in Medicaid and CHIP rose from 14.9 million to 26.1 million, an increase of more than 11 million.

Faced with the loss of job-based health coverage, those who don't qualify for public health coverage must make a tough decision: Those who are eligible for COBRA continuation coverage under federal law (or "mini-COBRA" continuation coverage under state law) may be able to keep their job-based health coverage. Those who do not qualify for COBRA may be able to purchase coverage on their own through the individual market. However, COBRA premiums are often unaffordable, and the cost of individual market coverage is often prohibitive, as well. In addition, in most states, insurers are currently free to deny coverage or charge people more in premiums based upon their age, health status, and even gender. As a result, many who lose their job-based coverage remain uninsured.

Accordingly, the number and percentage of uninsured Americans has risen substantially in the last decade. Between 2000 and 2010, the number of uninsured grew by 13.3 million, rising from 36.6 million to 49.9 million. During this same period, the proportion of the population who went without health insurance grew by 3.2 percentage points.

The Affordable Care Act will help cut the cost of health care and lower costs for employers and consumers in three ways: First, the law will make insurance companies more accountable, giving states and the federal government more tools to hold down the cost of insurance premiums. Second, the Affordable Care Act contains a range of tools to control ever-escalating health care costs that will improve quality and make care more efficient. Third, the Affordable Care Act will provide concrete help to employers, in the form of tax credits and new regulated marketplaces to pur-

chase insurance, and help to health care consumers, in the form of premium subsidies and out-of-pocket spending caps.

The Affordable Care Act Will Make Insurance Companies More Accountable

The Affordable Care Act includes critical protections to hold insurance companies accountable for consumers' and businesses' premium dollars. The medical loss ratio (MLR) standards in the law ensure that a reasonable share of premiums go toward medical care and quality improvement, instead of marketing, administration, and excessive profits. This measure to cut out wasteful spending is particularly important for small businesses and individuals who buy coverage on their own, since they do not have sufficient negotiating power with major insurance companies to ensure fair premiums.

Without the Affordable Care Act, insurers could continue to raise rates for consumers regardless of how little they spend on medical care. Under the new law, if a company spends less than a set share of premiums delivering care, it will owe rebates to enrollees. Starting in 2012, up to 9 million Americans could be eligible for rebates worth up to $1.4 billion. These rebates will average an estimated $164 a year per person.

The MLR requirements are already helping families. For example, effective last month, 15,000 Aetna enrollees in Connecticut's individual market received a 10 percent decrease in their premiums due to the Affordable Care Act's MLR requirements. Aetna implemented this change because its MLR in Connecticut was just 54.3 percent in 2010, far below the 80 percent standard that individual and small group market insurers must meet under the Affordable Care Act. (This standard is set at 85 percent for large group carriers).

Connecticut is not the only state where carriers have demonstrated unacceptably low MLRs in recent years. A quarter of the 16 plans listed in Minnesota's individual market reported MLRs of less than 60 percent for 2010, with one company reporting a MLR of only 41 percent. That means, for every $10 this company collected in premiums, just a little over $4 was spent on medical care. For 2009, Anthem Health Plans of New Hampshire reported a MLR of just 63 percent in the individual market and Anthem Health Plans of Virginia reported a small group MLR of 67 percent. (Note that before the implementation of a national MLR standard, states may have used different methods for calculating carriers' MLRs. The state figures cited here may not include quality improvement as a medical expense.)

The rate review provisions are also essential to holding insurers accountable and keeping premiums reasonable for consumers. Carriers cannot increase rates by 10 percent or more without providing justification. The law also makes information on rate increases more transparent, including through a new section on HHS' healthcare.gov website that gives the public to access rate justification information for any rate increase of 10 percent or more.

Further, the rate review funding has already had a significant impact on affordability. For example, when Regence BlueCross BlueShield of Oregon proposed a 22.1 percent rate increase for individual enrollees in the spring of 2011, the state used grant funding from the Affordable Care Act to hold its first public rate hearing in 20 years and to scrutinize the underlying assumptions and calculations used by the insurer to formulate its proposed increase. As a result, the state determined the 22.1 percent proposed rate increase was unjustified and approved only half of the proposed increase (12.8 percent). In Connecticut, a 19.9 percent Anthem BlueCross BlueShield proposed rate increase in the individual market was denied outright, due to rate review at the end of 2010. Last month, the state's insurance department found another of the company's proposed rate increases unjustified and is granting only a 3.9 percent increase for the plan's rates, instead of the 12.9 percent hike the company sought to impose. The rate review provisions, along with MLR requirements, are holding insurers accountable for how they spend consumers' dollars and keeping premium increases in check.

The Affordable Care Act Will Help Slow the Growth of Health Care Costs

In addition to holding insurance companies accountable, the Affordable Care Act authorizes multiple initiatives and demonstration projects designed to improve quality and reduce the rise in health care costs. The law seeks to reduce costs through a range of solutions focused on doctors, hospitals, insurance companies, employers, and patients.

Unlike other approaches to reducing health care costs, these provisions do not resort to simply reducing payments for health care services or shifting costs to consumers through higher deductibles and copayments. Rather, the aim of these provisions is to provide higher-quality care more efficiently and with less waste. These provisions fall into the following categories:

Provisions designed to test ways that doctors and hospitals can better coordinate care, especially for people with chronic health problems: The current fragmented nature of our health care system leads, for example, to the unnecessary duplication of tests and procedures. Through better care coordination, much of the excess costs can be prevented.

Provisions that promote preventive services so costly complications can be avoided: The Affordable Care Act eliminates deductibles and copayments for preventive services in Medicare and private coverage. Preventive services include tests such as mammograms, Pap tests, colorectal cancer and diabetes screenings, autism screenings for children, as well as wellness check-ups and immunizations. If problems are identified early, and treated before they become serious, dollars can be saved.

Provisions that promote the sharing of unbiased information about which medical treatments work and which do not: Every day, new drugs and treatments are identified; they may be life-saving breakthroughs or they may have little benefit to patients. But busy doctors struggle to stay abreast of new developments. The law creates a new independent, nonprofit entity charged researching what drugs and treatments work best, so doctors have the information they need to provide the best possible care to patients.

Provisions that promote real competition among health insurance companies in more transparent insurance marketplaces: The Affordable Care Act will help people shop for the best health care plan for the price, and it will promote competition among different health care plans. Beginning in 2014, the establishment of state exchanges will provide regulated marketplaces where small businesses, the self-employed and eligible consumers can choose from a range of health insurance plans. In the new exchanges, insurance companies will have to clearly explain what care is covered and at what cost.

The Affordable Care Act Will Help Employers and Workers with the Cost of Health Care

Along with slowing the growth of health care costs and holding insurance companies accountable, the Affordable Care Act will provide much-needed financial relief to millions of small businesses, families, and large employers.

While small businesses are the backbone of America's economy, our health care system has been failing them. The current system makes it difficult, if not impossible, for small business owners to provide their workers with quality, affordable coverage. The Affordable Care Act provides small businesses with fewer than 25 workers and average wages of less than $50,000 with a tax credit for employee coverage. More than 80 percent of all American small businesses (those with up to 25 workers) were eligible for this tax credit in 2010.

Other provisions of the Affordable Care Act will also provide critical assistance to small businesses struggling to afford health coverage. For example, the SHOP exchanges will create a new competitive marketplace where small employers and their workers will be able to see transparent information about health plans on a user-friendly website. In the SHOP, employers and workers will be able to choose from a variety of plans that meet strong quality standards so that they know they're getting good value for their money. In addition, new consumer protections, such as those that prohibit insurers from imposing lifetime or annual dollars caps on how much they'll pay for enrollees' care, will ensure that the coverage that small employers buy actually works for them and their workers when illness strikes.

Lower- and middle-income individuals and families will get help with the cost of care in two ways: 1) a new tax credit to assist with the cost of health insurance premiums; and 2) protections on how much they spend on out-of-pocket costs.

The new premium tax credits will help both insured individuals who struggle to pay rising premiums and uninsured individuals who need help to be able to purchase coverage. Generally, the premium tax credits will be available to individuals and families who have incomes between 133 and 400 percent of poverty (between about $30,000 and $90,000 for a family of four in 2011). The credits can be used to purchase insurance in the new health insurance exchanges. People who have an offer of health coverage from their employer may be eligible for a premium tax credit if their employer's plan would be unaffordable for them. Approximately 28.6 million Americans will be eligible for the tax credits in 2014; more than half (52 percent) are currently insured.

The Affordable Care Act will also protect how much consumers must spend out of pocket each year on health insurance deductibles and copayments for covered benefits. It is estimated that the number of people who are "underinsured," that is, who have high medical costs as a share of their income, will be cut by 70 percent due to this provision in the Affordable Care Act. Too many lower- and middle-class

families are only one health crisis away from financial devastation. For example, the average hospital charge nationally for a stay associated with a heart attack is nearly $63,000, and for people with inadequate coverage, their share of these costs can quickly drive them into bankruptcy. The law will mean that insurance coverage actually covers the medical bills. A family of three with an income between 100 and 200 percent of poverty (or about $18,500 and $37,000) would not have to pay more than $3,967 out of pocket for their care in one year. Moreover, the law will provide some additional cost-sharing subsidies for low-income families who purchase insurance in the new exchanges.

The Affordable Care Act Does Not Shift Costs to Consumers

Many of the deficit reduction proposals under discussion this year in Congress do nothing to address the underlying causes in the rise in health care costs. Instead, many deficit plans merely shift the burden of health care costs from the federal government either to states, or to consumers, or to both. For example, cutting federal Medicaid spending—either through a block grant or reduced funding for states—would ultimately increase the number of uninsured Americans. That would raise health care costs for the rest of us. Family coverage costs an extra $1,000 or more a year, on average, to pay for health care costs for the uninsured. A growth in the uninsured results in an increase in the "hidden health care tax" for those who have insurance, because health care providers must pass along the costs of caring for the uninsured. Repealing the tax credits in the Affordable Care Act would effectively increase taxes on middle class families and leave them with no assistance to purchase health insurance. If the tax credits were repealed, the increased tax burden on these families would total $777 billion between 2012 and 2021. The Affordable Care Act is designed to slow the growth in health care costs while providing concrete assistance to businesses and families to pay for the cost of insurance.

Chairman ROE. Thank you, Mr. Pollack.

Ms. Piper?

STATEMENT OF ROBYN PIPER, PRESIDENT, PIPER JORDAN

Ms. PIPER. Thank you, Chairman Roe and Ranking Member Andrews and members of the committee for the opportunity to testify today.

I would like to start by stating that I am in a privileged position to represent primarily Fortune 1000 employers. However, my firm itself is a small employer. So my testimony today is going to bring forth the challenges that are experienced by both large and small employers.

Flexibility is a key element in a successful employer sponsored benefits program. Although it has been said that grandfathering allows plans to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status, we have recognized the opposite impact.

In evaluating plan design, employers who wished to maintain grandfathering have many limitations that must be followed. Is it very important to note that these limitations are not applied annually and further restrict employers.

Plan modification is the main method applied by benefits professionals in order to control costs and to improve health of the employees, by customizing around the demographics and around abuse and utilization. Although the administration has shown support for such value based insurance design, a pursuit in maintaining grandfather status restricts the employer from applying such techniques to drive improvements within the plan.

An example; one of our large employers made the decision to lose grandfathering very recently. They did so partially based on the fact that their outpatient service costs were 9 percent higher than

national trend, benchmarked by their issuers benchmark, primarily due to non-emergency E.R. costs.

There were 47 claimants with three or more E.R. visits, two with nine visit in 1 year, more than $1,000 in costs. To protect that plan from the abuse and utilization of non-emergency related E.R. visits, we had to increase the deductible, to protect the entire population that is on that plan, not just the 49 people that I am referring to.

Loss of grandfathering took place. Grandfathering restrictions do limit the ability for benefits professionals to properly protect the plan for all participants.

To maintain status requires acceptance of necessary rate increases and budget increases for employee benefit spending. And such acceptance stands contrary to what PPACA's supporters wish to accomplish

In weighing this decision whether to lose grandfather status or not, employers must consider the additional requirements that come along with non-grandfather status. While some of these requirements simply are not problematic for employers, others have caused concern.

First of all, an employer will have to deal with cumbersome appeals provision. Any flip in compliance can cause consequences, which is a significant issue that needs to be considered by every single employer.

For a small employer, the compliance with appeals could require addition of staff, as well as to the planned cost administratively.

Secondly, there is a consequence for discrimination testing, although the effective date and related sanctions have been delayed. Without clear guidance, an employer will attempt to comply at this point. But even that attempt may fail to comply once those regs are set.

Lastly, preventive care must be covered without cost sharing. Large employers really have not had a tremendous issue with this. However, small employers and employees with hourly employees who are covered under a limited plan have struggled.

For employers maintaining grandfather status last year, primarily large—and again, depending on the type of employer group, PPACA provisions added an additional one to 4 percent to the premium cost. For non-grandfathered plans, the steepest increases and continue to be received by small employers, myself included, and employers offering limited benefit health plans.

As many employers are financially incented to lose grandfather status in order to control costs, this has resulted in higher deductibles and higher cost shift to those employees. These design changes are necessary to control unnecessary utilization, to control employer premium spending, and to reduce the risk of penalties in 2014.

Job stability and continuation will be an issue for hourly employees. While the IRS Notice 2011-36 proposes safe harbor, whereby employers could use a look back period to determine for old time employees for a coverage period, there is still a significant risk to employers who do not strictly define hours and position.

Many employers right now are entertaining the implementation of specific job hour limits in order to protect the organization from penalties. Hour limits will reduce the employees' take home pay.

A well circulated Q&A document posted on HealthReform.com tells the consumer that the new insurance regulation will not drive up health insurance costs. This Q&A is still posted. And we know that this statement is not entirely true.

PPACA provisions, employer burdens and general health care trends have caused loss of grandfather status and have most certainly caused health insurance costs to increase. It has been said that the grandfather provision was put in place to keep employers offering insurance and to prevent employers from cutting benefits.

Contrary to popular debate, a mass majority of employers want to continue to offer meaningful benefits. And grandfathering was not needed to enforce that measure. The grandfather provision has created cumbersome restriction on many employers and added unnecessary costs to many plans, creating an adverse scenario than desired by the administration.

A number of thoughtful considerations have been provided to the administration as it relates to unduly restrictive rules and the need for clarification, for example, on wellness programs. To date, employers and advisers have not been provided with a response.

Employers have been forced to operate under good faith that we are in compliance and understand that there is risk to such an assumption. There is tremendous need for guidance from the administration.

Grandfather provisions have not rewarded the most generous employers. In many instances, employers finding the great ease of compliance right now are those that offer the least generous plan.

Thank you for the opportunity to testify.

[The statement of Ms. Piper follows:]

Prepared Statement of Robyn Piper, President, Piper Jordan

Executive Summary

- The goal of grandfathered status was to preserve the ability of American people and employers to keep their current plan if desired. Unfortunately, many employers did like the health plan they offered but have been forced to either lose grandfathered plan status due to restrictive limitations or are seriously considering losing status in the near future.
- The impact of maintaining grandfathered plan status, in addition to the loss of grandfathered plan status, has had significant impact on American workers. As many employers have been challenged with maintaining status, plan enhancements and cost-containing measures have been delayed. For those workers employed by organizations that have chosen to lose grandfathered status, many have witnessed increased premiums and cost-shifting.
- The decision to maintain grandfathered plan status or to lose grandfathered plan status brings numerous burdens to employers. Many of these employers were already offering generous plans to their employees. These burdens include additional time needed for already lengthy renewal cycles and significant consideration around additional procedures, rules, and reporting that would be required if status is lost.
- Employers have recognized financial impact in maintaining grandfathered status. Additional PPACA enhancements, the inability to apply value-based insurance designs, and the inability to continue appropriate cost-sharing measures with employees have added to an already heavy burden on employers. Unfortunately, employers anticipate health plan increases from year to year. However, PPACA, especially for small and midsize employers, has created substantial financial burdens.
- Employers and advisers are making plan status decisions without firm guidance; operating under "good faith" that they are in compliance with PPACA. Operating under these conditions causes legal expense over the constant pursuit of answers and great concern over making a decision that will cause detriment to the company once final guidance is received.

Thank you Chairman Roe, and members of the Committee for the opportunity to testify today about the impact recognized by employers and employees under the "grandfathering" provisions of the Patient Protection and Affordable Care Act (PPACA).

It is important to note that we must distinguish between types of employer groups and the unique challenges they face under PPACA. To overgeneralize will be a disservice to this hearing. PPACA has impacted the following employer structures: large employers which primarily employ full-time employees and currently offer employer-sponsored coverage; multi-size employers which have a full-time and benefit-eligible population but also have a significant hourly, non-benefit eligible employee population; and, small employer groups. Examples of their unique challenges will be included in this testimony.

Grandfathered regulations were issued to make good on a promise that individuals and businesses could keep their current plan, to provide consumer protections to Americans in order for them to control their own health care and to provide stability and flexibility to insurers and to businesses.[1] Unfortunately, and especially in the group market, these promises have not been widely recognized and, instead, we have experienced a near opposite effect. This is especially true when reviewing the initial assumptions made as to which employers would maintain or lose grandfathered plan status. It was assumed that large employers would likely maintain status for Due to many factors such as increased employer burdens and cost, the opposite result has been recognized.

PPACA burdens are felt by many employers and certainly through many provisions of the law. According to the HR Policy Association, the Administration is recognizing these burdens and has expressed a willingness to work with employers in minimizing burdens under PPACA. As stated in a recent press release, on a Health Care Policy Committee call, several regulatory proposals were described which attempt to streamline the massive information swap between employers, exchanges, and the federal government. Yvette Fontenot, Deputy Director of the Office of Health Reform at HHS, noted that large multi-state employers simply "may not have the capacity to deal with that many reporting requirements." Fontenot recognized that allowing state exchanges to regulate employer ERISA plans would cause problems for plan sponsors and that the administration is trying to minimize potential burdens because it "wants employers to continue to offer coverage."[2] Such recognition is greatly appreciated but it is only one step towards many needed corrections.

Employer Concerns

Flexibility is a key element in a successful employer-sponsored benefits program. Although it has been said that grandfathering allows plans to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfathered status 1, again, we have recognized the opposite impact. In evaluating plan design, employers who wish to maintain grandfathering must not raise co-insurance charges, nor may they "significantly" raise comore than 5 percent. It is very important to note that these limitations are not applied annually which further restricts employers. Modifying plan deductibles, co-insurance, co-payments and contributions is the main method applied by benefits professionals in order to control costs and to improve the health of their employees by customizing plans around demographics and abuse in utilization. The Administration has shown support for such value-based insurance design. A pursuit in maintaining grandfathered status restricts the employer from applying value-based design techniques to drive improvements within the plan. One of our large employers, who made the decision to lose grandfathered plan status this year, did so partially based on the fact that their outpatient service costs were 9% greater than the issuer's benchmark primarily due to usage of emergency rooms (ER). There were 47 claimants with three or more ER visits and two claimants with pain-related conditions who had nine visits each averaging over $1,000 in claims each visit (over $18,000 in total costs for only two claimants). Clearly, our employer needed to protect the plan for all participating employees and, therefore, has elected to increase the deductible for ER visits. Grandfathering restrictions do not allow benefits professionals to properly protect the plan for all participants.

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[1] "Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and 'Grandfathered' Health Plans," U.S. Department of Health and Human Services, HealthReform.gov, *http://www.healthreform.gov/newsroom/ keeping—the—health—plan—you—have.html.*

[2] "Administration Wants to Work With Employers to Minimize Burdens Under PPACA, HR Policy Association, *http://www.hrpolicy.org/issues—story.aspx?gid=33&sid=4606&miid=3*

The term "health insurance" has received little other than poor press over the past two years and this has placed pressure on employers to make careful decisions that create the least amount of employee noise. This has added length to the renewal process as it has been difficult for employers to make final program decisions. Typically, for large employers, the renewal process begins approximately six months prior to the actual renewal date. For most of our sponsors, that process now begins approximately eight months prior to renewal which taps into employer made the difficult decision to lose grandfathered status in exchange for protecting the plan itself and making appropriate and necessary plan changes. Their next challenge is to develop a careful communication campaign around changes and loss of grandfathering. Employees have been well-advised that loss of grandfathering means that the plan they are being offered either significantly reduces their benefits or increases their out-of-pocket spending above what it was when PPACA was enacted1. Employers and advisers must spend money and resources in developing a positive campaign. Although annual communication strategy has always been a part of the renewal process, the task is even tougher in terms of receiving a positive employee response.

Employers need to be in a position of strength for 2014 to avoid the stiff penalties that PPACA has indicated. Most of our employers offer plans ranging between a 70% to a 90% actuarial value. PPACA states that a 60% actuarial value is the minimum in order to avoid penalty exposure. Advisers and employers are working with 60% actuarial models to run penalty analysis. Ultimately, most employers will begin to offer a 60% actuarial plan in order to protect themselves from high, and still slightly vague, penalties for "unaffordable" plans. It seems unfair for the Administration to set the standard at 60% but penalize employers with loss of grandfathered plan status as employers make necessary plan changes that will eventually lead to their 2014 benefit offering.

It has been frequently noted that the pursuit to maintain grandfathered status does not allow for normal annual plan evaluation or the ability to implement value-based design methods. To maintain status requires acceptance of necessary rate increases and budget increases for employee-benefit spending. Such acceptance seems contrary to what PPACA's supporters wished to accomplish.

In weighing the decision of whether to lose grandfathered status or not, employers must consider the additional requirements that come with non-grandfathered status:

- Comply with additional standards for internal claims and appeals and external review.
- Not discriminate in favor of highly compensated individuals for insured health plans.
- Cover emergency services without pre-authorization and treat as in-network.
- Allow designation of gynecologist, obstetrician or pediatrician as primary care provider.
- Cover immunizations and preventive care without cost-sharing.

The requirements related to emergency services and designation of primary care providers have not been significant issues for employers. However, the other requirements have been significant. First of all, an employer will have to deal with the cumbersome appeal provisions. This requires attention to strict time zones. It also requires a number of other administrative tasks including timely notices which, for a small benefits department, even in large organizations, is cumbersome. For a small employer, all this could require the addition of staff as well as add to plan cost administratively. Some companies do not want to give up the ability to handle appeals to a carrier/TPA organization. This is due to the fact that they do not want to relinquish control. Any slip could result in compliance consequences. This is a expanded standards for appeals adds an additional burden to an already tasked human resource area. Secondly, there is the consequence of discrimination testing although the effective date and related sanctions have been delayed. Without clear guidance, an employer will attempt to comply at this point, but even with an attempt, the effort may not comply. Lastly, preventive care must be covered without cost-sharing. Large employers have not had much difficulty adapting this into their plan design. However, employers with hourly employees, and offering limited-benefit health plans, have had significant issue. Even with a waiver on annual limits, employers wishing to make plan enhancements to their limited-benefit health plan, resulting in loss of grandfathered status, have been met with 11% to 22% premium increases to accommodate the unknown usage that may occur once cost-sharing measures are removed. Although claim history will illustrate that, even when preventive care is included in limited-benefit health plans, the member claim frequency is low—regardless of the strength of the benefit. However, as carriers are preparing for the unknown with removal of cost-sharing, we have seen premium increases as high as 22% for preventive care. Small employers are also at risk for premium in-

creases due to loss of cost-sharing. As a small employer who received a 25% increase at renewal, I can strongly testify that PPACA and loss of grandfathering status can have a profound effect on certain employer groups.

Financial Impact

It has been well-noted that PPACA provisions and loss of grandfathered status has caused an increase to health insurance premiums. For employers maintaining grandfathered status last year, depending on type of employer group and plan, PPACA provisions added an additional 1% to be, received by small employers and employers offering limited-benefit health plans. For both small and large employers last year, some struggled with removing lifetime limits. For a majority of employers, this made very little impact. However, there were some employers that were required to continue care for members that had exceeded their lifetime maximum. While employers felt good about bringing members back into a plan, it is important to understand some of the consideration that took place between issuers, employers and advisers in order to handle increases in claim spending. One example is a very large employer of ours with a member who had exceeded their lifetime maximum due to hemophilia. This member's medicine was more than $35,000 a month. Significant work was done in an attempt to reduce the employer's increased pharmacy exposure. Unfortunately, tremendous relief was not available. Employers need help in controlling these costs. Financial burdens have been placed on employers but we have not recognized an increase in resources to reduce these burdens.

Impact to Employees

As many employers are financially incented to lose grandfathered status in order to control costs, this has resulted in higher deductibles and higher cost-shift to employees. This is primarily happening with the large employer sector. These design changes are necessary to control unnecessary utilization, to control employer premium spending and to reduce the risk of penalties in 2014. However, these design strategies have had a financial impact to the employee typically in the form of increased out-of-pocket costs.

Job stability and continuation will be an issue for hourly employees. As many hourly employees work unpredictable schedules, and have enjoyed the ability to do so, there is risk to an employer who has an hourly employee that consistently increases and decrease hours worked. While IRS Notice 2011-36 proposes safe harbor whereby employers could use a look-back period to determine full-time employees for a coverage period, there is still a risk to employers who do not strictly define hours and position. Many employers are entertaining the implementation of specific job hour limits in order to protect the organization from penalties. Hour limits will reduce the employee's take home pay which most certainly will negatively impact employees.

A well-circulated Q&A document posted on HealthReform.gov[3] tells the consumer that the grandfathered rule will allow them to keep their current coverage if they like it. Further, they are told that the new insurance regulation will not drive up health insurance costs. This Q&A is still posted on HealthReform.gov even though we know these two statements to not be entirely true. PPACA provisions, employer burdens and general health care trend have caused loss of grandfathered status and has most certainly caused health insurance costs to increase.

Summary

It has been said that the grandfathered provision was put in place to keep employers offering insurance and to prevent employers from cutting benefits. Contrary to popular debate, a mass majority of employers want to continue offering meaningful benefits and grandfathering was not needed as an enforcement measure. The grandfathered provision has created cumbersome restrictions on many employers and added unnecessary costs to many plans, creating an adverse scenario than desired by the Administration. A number of thoughtful considerations have been provided to the Administration as it relates to concerns around the grandfathered provision. Such considerations include the unduly restrictive rules and the need for clarification on wellness programs. To date, employers and advisers had not been provided with a response. Employers have been forced to operate under good faith that they are in compliance and understand that there is risk to such an assumption. There is tremendous need for guidance from the Administration. Grandfathered provisions have not rewarded the most generous employers. In many in-

[3] Questions and Answers: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans, HealthReform.gov, *http://www.healthreform.gov/about/grandfathering.html*

stances, employers finding the greatest ease with compliance are those who offered the least generous plans.

Thank you for the opportunity to testify today. I will be happy to answer your questions.

Chairman ROE. Thank you, Ms. Piper.

Mr. Andrews?

Mr. ANDREWS. Thank you, Mr. Chairman. I agree with you that the witnesses were very well prepared, did a very nice job today. And we appreciate all four of you.

Ms. Turner, my understanding of the word freeze is that things stay the same; numbers don't change. So if there is a freeze in a number, it doesn't change. You say on page three of your testimony that when the health care law was signed into law in late March of 2010, a hiring freeze began in the country.

Are there more private sector jobs today or fewer than there were in March of 2010?

Ms. TURNER. I think it is sort of a term of art, hiring freeze. And it is essentially you begin to see the trend in hiring going in a much different direction.

Mr. ANDREWS. It is a term of art? How would you define the term freeze?

Ms. TURNER. Well, the term freeze would basically mean no new jobs. But when you talk about——

Mr. ANDREWS. No new jobs.

Ms. TURNER. But when you talk about 6,000 new jobs in 1 month in an economy that needs 14,000 new jobs in order to begin to get people back to work, that hardly seems to be——

Mr. ANDREWS. Well, I think most people would agree with your definition of no new jobs. But, of course, the facts are from the Bureau of Labor Statistics that in March of 2010, when the law was signed, the economy had 106,916,000 private sector jobs. And in September of 2011, the last month for which there are data, it had 109,349,000 jobs.

That is an increase of 2.433 million private sector jobs. Is that a freeze?

Ms. TURNER. But when you have to also account the new workers that have entered the workforce——

Mr. ANDREWS. But is it—no, I understand that. That is about the percentage and the rate. Is it a freeze?

Ms. TURNER. Well, you have to look at it in terms of the number of jobs that are required to move the unemployment rate. And the fact that the unemployment rate has been stuck at 9.1 percent shows that we are not creating enough new jobs to even keep pace with the new workers that are entering the workforce.

Mr. ANDREWS. But you would admit that there are 2.4 million new private sector jobs since the health care law was signed?

Ms. TURNER. But there are also——

Mr. ANDREWS. Is that yes or no?

Ms. TURNER [continuing]. Entered the workforce——

Mr. ANDREWS. But is it yes or no?

Ms. TURNER. There are new workers entering the workforce, but not enough to account——

Mr. ANDREWS. I understand. I understand. Let me ask you this; you make the comment that there is good reason to believe that the health care law is a major contributor to the hiring halt. That is the halt that added 2.4 million new jobs.

So on what basis do you believe there is good reason to believe that the health care law has led to this hiring halt?

Ms. TURNER. This was a study done by James Sherk at the Heritage Foundation, looking at hiring patterns between the beginning of the Obama administration and the point that the Affordable Care Act was enacted, and then, from then until 15 months later, when the study was done.

There was an increase of about 67,000 jobs, net private sector jobs, a month being created before the Affordable Care Act was enacted. After that, only 6,500 a month.

Mr. ANDREWS. I know. I read your testimony. I know that you said that.

How would you respond to the Wall Street Journal's July survey of business economists—and I am quoting—"the main reason the U.S. companies are reluctant to step up hiring is scant demand, rather than uncertainty over government policies, according to the majority of economists."

Are they wrong?

Ms. TURNER. There is a faltering economy. People don't have money, many of them because they don't have jobs. It is a very cyclical——

Mr. ANDREWS. I absolutely agree. Would more people have jobs if we hired construction workers to build roads and bridges?

Ms. TURNER. Absolutely, but——

Mr. ANDREWS. Would more people have jobs if small businesses got a tax cut when they hire people?

Ms. TURNER. Absolutely, as long as——

Mr. ANDREWS. Would more people have jobs if we didn't have a $1,500 tax increase on middle class families on January 1st?

Ms. TURNER. As long as it is not being pushed onto future taxpayers?

Mr. ANDREWS. Would more people have jobs if we stopped the layoffs of police officers and teachers?

Ms. TURNER. As long as we are not pushing the cost of——

Mr. ANDREWS. Under the health care law, if a business has 50 or fewer full time employees, what do they have to do?

Ms. TURNER. They don't have to provide health insurance.

Mr. ANDREWS. They don't have to do anything, do they?

Ms. TURNER. Well, certainly many other regulations they must comply with.

Mr. ANDREWS. No, but under the health care law, is there anything a business with fewer than 50 or more full time employees has to do?

Ms. TURNER. No, but each one of the individuals in that business all must have health insurance.

Mr. ANDREWS. I understand.

Ms. TURNER. So even though the employer——

Mr. ANDREWS [continuing]. An employer's ad. So if you have fewer than 50 people, you don't have to do anything, right?

Ms. TURNER. As far as mandatory health insurance, no. But that is on the employer. It still is on the individual employee to have health insurance.

Mr. ANDREWS. I fully understand that.

Thank you, Mr. Chairman.

Chairman ROE. Dr. Bucshon?

Mr. BUCSHON. Thank you, Mr. Chairman. Thanks to Chairman Roe for holding this hearing, which I see directly related to job creation and retention in the United States.

The fact of the matter is about 65 percent of the American people want us to be having this discussion about the Affordable Care Act. In fact, since enacted in March 2010, it is becoming increasingly less popular with the American people, now that we are, as was famously quoted, we found out what is in it.

Businesses in my district are telling me that the Affordable Care Act and what will happen in 2014 is one of the top concerns they have with their ability to expand their business, start a new business or create jobs. So I think this is a very good hearing to discuss that.

Ms. Turner, in your opinion, the overreaching scope of the grandfather regulation, do you think that is an attempt by the administration to effectively eliminate the possibility of grandfather status, forcing all the plans to be subjected to the insurance market mandates in the Affordable Care Act?

Ms. TURNER. Dr. Bucshon, it is difficult to know the administration's motivations. But you can certainly look at the impact. Many businesses, many employers supported passage of this Affordable Care Act, or at least were neutral, because they were told, don't worry, this is not going to affect you; you are going to be able to be grandfathered in; your plan will be fine.

And when the rules and regulations were written, many of them were shocked to find out how difficult it would be. And even the administration's own estimates indicate that between 51 percent of large employers and 80 percent of the small employers would lose their grandfather status before the Affordable Care Act triggers in.

So I do think there is an effect in—the cause and effect is very clear.

Mr. BUCSHON. One of the biggest concerns I have about the MLR is not the MLR itself, but a precedent being sent about I think the federal government telling private businesses how to manage their finances. And from what I am hearing, the brokers, the people that are actually selling health insurance and stuff, are the ones being affected significantly by this.

Again, the intent of the MLR is really not happening, about what the—I think the original intent.

So, Mr. Donahue, do you have any comments about that, about how that is, you know, affecting the industry in general?

Mr. DONAHUE. I agree with your assessment that yes, historically, insurance companies selling medical coverage have not had their own sales force. And they have outsourced that distribution responsibility to agents and brokers.

Within that MLR, part of the operations that they need to contain is regarding that cost for distribution, and as a result, putting pressure on the insurance companies to dissect various elements of

administration, their own retention, the cost of their doing business.

The cost of doing business is distribution of their product and services. As a result, many insurance companies are reducing the commissions payable to agents and brokers.

It is not that we just provide the transaction and the sale of that. But it is the value that we serve in representing the customer as part of the overall remuneration we receive from insurance companies, which is actually the premium paid for by employers.

So employers are, indeed, paying for our engagement. But it is more than just the transaction. We are there with our customers, who are very thin in their operations, providing them with communications, compliance, enrollment, all those backroom services that human resources pushes off their desk onto ours.

And it is going to be very, very difficult for us to continue to provide that value added service in the way MLR is constructed.

Mr. BUCSHON. Thank you very much.

I yield back.

Chairman ROE. Thank you.

Mr. Tierney?

Mr. TIERNEY. Thank you very much. Thank the witnesses as well.

Mr. Pollack, I just want to clarify something with you. I know that premiums have gone up about 9 percent, according to the Kaiser Family Foundation. Is that correct, in the last year?

But only 1 to 2 percent of that increase is attributable to the Affordable Care Act? Would that also be accurate?

Mr. POLLACK. Yes. I think yes. Kaiser Family Foundation said that they estimated that only 1 to 2 percent was related to the Affordable Care Act. And the provisions, of course, they were talking about was that it enabled young adults to stay on their family policies up to their 26th birthday. And there are no longer lifetime limits.

And mind you, these are extraordinary benefits for families across the country. And yet for the cost implications to be so small is remarkable.

Mr. TIERNEY. I guess, Ms. Turner, you were talking with Mr. Andrews about the job creation on this. And I think you finally agreed with, after some back and forth, that about 2.4 million private sector jobs have been created since the enactment of the law.

I wonder if you knew that over 500,000 jobs have been in the health care sector. Did you know that?

Ms. TURNER. Yes, sir.

Mr. TIERNEY. And I know that particularly, because a lot of them are in Massachusetts, where we have, as my friends and I say, Romney-care, which has been just wonderful for that state. And most people there highly favor it.

And it has created a lot of jobs. Of the 10 million projected jobs—of the four million projected jobs over the next 10 years, we are expecting a lot of them to be in Massachusetts as well. So it is too bad we couldn't spend some time here concentrating on the creation of jobs, as opposed to fantasizing about what might be, what is never going to happen, in terms of any of these laws passing that are being proposed.

Mr. Donahue, let me talk to you a little bit about the medical loss ratio. Do you think it is a good thing or a bad thing that the law requires transparency and accountability for insurance companies?

Mr. DONAHUE. Oh, I think it is a very good thing. And——

Mr. TIERNEY. Do you——

Mr. DONAHUE. We have historically been transparent, as far as the components of where——

Mr. TIERNEY. Who is we?

Mr. DONAHUE. We? Sir, the representation that I have.

Mr. TIERNEY. Right. But I am talking about insurance companies, because they notoriously have not been transparent and accountable on this. Unless of course—I don't know. Do you think it is a good idea for insurance companies, say some in Georgia or in other places, to pay 50 cents or more towards administrative costs, and less than 50 cents on actual health care costs to people?

Do you think that is a good idea?

Mr. DONAHUE. I can't speak on behalf of the insurance company perspective. I can assure you, though, from the broker's standpoint, we have full transparency.

Mr. TIERNEY. Right. Now the National Association of Insurance Commissioners did not recommend that brokers be allowed to be counted in that 80 to 85 percent. Isn't that correct? They did not make that recommendation to the secretary?

Mr. DONAHUE. I am not sure that was a recommendation. I don't know.

Mr. TIERNEY. All right, well then we will——

Mr. POLLACK. Mr. Tierney, may I just say that National Association of Insurance Commissions looked into the very issue that Mr. Donahue addressed earlier. And I like brokers.

But what they found is that they—and I am quoting—"we have not observed any problem with consumer access to insurance or producers as a result of the medical loss ratio."

So while I understand the fears that might exist within the industry, the National Association of Insurance Commissions, made up of Democrats and Republicans—it is not intended to be a partisan arm—found there was no evidence to that.

Mr. TIERNEY. Well, look, the General Accountability Office did a study and they questioned like three people, some portion of whom decided that they thought it might be a problem. And people have started using that.

But, in fact, employment of agents/brokers is up 5,500 over the last year, since—but the fact is what medical loss ratio is supposed to do is make these insurance companies pay more towards health care, or we call it medical expense of the bill, for your premium. I think that is what consumers expect.

And we expanded it a little bit out when it got over to the Senate, because they are who they are. And they added in quality improving activity. But also, that was to be based on or grounded on evidence based practices that would increase the likelihood of desired health outcomes. So that is the aspect on there.

I am not sure, Mr. Donahue, where I see brokers and agents as anything other than administrative cost, and how you make the ar-

gument that it is a medical expense. Can you tell me how you think brokers and agents qualify as a medical expense?

Mr. DONAHUE. If you think about it from the employer's perspective, and the employers desire to help.

Mr. TIERNEY. No. I want to think about it from the consumer's perspective, all right? Is that a medical expense for me,that the company's sales agent or broker is out there on the job selling for the—for the company?

Mr. DONAHUE. Is it is an expense associated with your participation in that medical program.

Mr. TIERNEY. But it is not a medical expense. It is not going to make me healthier. It is not going to fix my diabetes. It is not going to fix my pneumonia or anything of that nature.

That is what we mean when we say medical expense.

Mr. DONAHUE. From the consumer's perspective, employer and employee participants, they are not distinguishing between whether it is a claim for a medical provision or it is part of the overall administration in getting that plan done correctly.

Mr. TIERNEY. But the law is distinguishing that. The law is saying you can no longer spend money on lobbyists and CEO bonuses and huge salaries and other administrative costs, and take that out of the premium, instead of giving health care to the employee.

Do you have a problem with that?

Mr. DONAHUE. Again, I can't answer on behalf of the insurance company. I can speak from our role as advisers and advocates on behalf of the workforce and the employers that sponsor those health benefits.

Mr. TIERNEY. Look, again, as Mr. Pollack says, we are all friends of agents and brokers. The question is why should the person get less health care because the company tries to push that off in a different direction?

Thank you.

Chairman ROE. I thank the gentleman for yielding.

Mr. Thompson?

Mr. THOMPSON. Thank you, chairman.

Mr. Donahue, I want to pick up on health insurance agent and broker commissions, because my perspective, having grown up in a small business—not insurance, let me clarify, sporting goods—that those individuals actually really play a key—have always, in my experience, played a key role of finding the best policies, finding the best buy, of actually controlling health care costs, because they are shopping it.

You know, they are working in their broker role. Would you agree with that? Or am I completely off base?

Mr. DONAHUE. I certainly agree with that. And as I referenced before, we are very much the back room on behalf of our customers, regardless of their size. We provide them guidance on compliance and help them navigate the myriad of the obligations that are in front of them at this point.

We are involved on problem resolution at every degree, even to the individual claimant, helping them navigate the sophisticated health system. And from a layman's standpoint, if you don't understand, you are usually at a disadvantage.

Mr. THOMPSON. It seems PPACA—the provisions of that are going to take away that important toll, which has been somewhat of a safety check, or a check of getting the best prices for our businesses.

Ms. Piper, the grandfather regulation improves extraordinary limits on the kinds of changes employers can make to their health plans without triggering insurance mandates. Have you encountered a situation where this regulation has proven very disruptive to normal planned administration?

Ms. PIPER. As benefit professionals, you know, we are trained to look at many factors when we are handling any medical plan renewal. And traditionally, we started maybe 6 months prior today. For the groups that we represent, we are talking 8 months prior.

There is a tremendous amount that needs to be thought through as it relates to health care reform. And that has increased the time.

And I make that point because many companies have to make decisions before we receive guidance. And that was particularly true last year. You know, first of all, you grab as much data as you possibly can.

Secondly, there are budget meetings that have to happen at the employer level. And you walk a fine line between balancing the corporate budget and avoiding employee noise when you make any benefit changes.

To not be allowed to follow standard protocol—and again, in my testimony, I identified this is what you do ever year. You look at your deductibles. You look at your co-pays. You look at the co-insurance. You look at the claims that come in.

As an employer, I sit here. And last year, I didn't have the opportunity to choose whether I remained grandfathered or not. It was made for me by my insurance carrier.

We had a 24.99 percent increase. And we were told that much of it had to do with PPACA provisions. But that choice was taken away from us.

And I did. I moved us to a high deductible health plan. And was there noise? Yes, there was. And do I know that a couple of employees had claims that year that incurred more out of pocket costs? I did. I see it.

So to not be allowed to operate and have that standard protocol is contrary to everything that we have talked about with value based design. So yes is my answer. I am a tremendous advocate for health and wellness programs.

We are waiting for information to come back on how we can operate with those wellness programs within the restrictions of grandfathering rules. We have to understand that employees have to be a part of the solution.

And I see trends all day long. And I see what is brewing. I look at how much we try to get people to get their wellness screenings. And very few people do. And that is just fact.

And to not be able to function and to be able to try to get employees in that group where they take responsibility for their own health—and we will need that as a nation, regardless of what happens out of these hearings or regardless of what happens over the next couple of years.

Citizens have to take responsibility for their own health care. And grandfathering has restricted that protocol.

Mr. THOMPSON. Thank you.

Are we going to be able to do a second round, do you think? I will ask my question then.

Oh. Well, the Kaiser Foundation survey was referenced by one of my colleagues. And you know, the 2011 Kaiser Family Foundation survey found only that half, 56 percent of workers, were in plans that predate Obamacare's enactment.

And the loss of employees pre-Obamacare coverage is occurring even faster than the administration's own estimates. It was concluded half of all employers, and as many as 80 percent of small businesses will be forced to give up their current coverage by 2013.

And just as important, by giving up their pre-Obamacare plans, both employers and employees will be subject to costly new mandates that increase premiums. As a reminder, candidate Obama said repeatedly his bill would cut premiums by an average of $2,500 per family, meaning premiums would go down, not merely just go up by less than projected.

The campaign also promised that those reductions would occur within Obama's first term. A New York Times article entitled "Health Plans From Obama's First Debate," dated July 23rd, 2008, includes a quote from Mr. Obama's campaign economic adviser, Mr. Jason Furman, stating, "We think that we could get to $2,500 in savings by the end of the first term, or be very close to it."

And it appears the administration is now doubling down, whereas on September 29th, ABC News reports that the White House Deputy Chief of Staff Nancy-Ann DeParle insists families will see savings by now 2019. Quote—"Many of the changes in the Affordable Care Act are starting this year and in succeeding years. And by 2019, we estimate that the average family will save around $2,000."

Well, this is obviously not what we were hearing about, this administration health care plan, for the past 3 years. It just appears that the president's promise just isn't holding up.

Chairman ROE. Hold that thought. And we will get back to it.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Mr. Chairman.

And thank you to the panelists for coming to be with us this morning.

My first question is to Mr. Pollack. And the reason that I am concerned about this is because the area that I represent is about 10 percent younger than the average nationally. And so I am talking about—I am concerned about the 30 percent of young adults which are uninsured, representing more than one in five of our total uninsured population.

Young adults have the lowest rate of access to employer-based insurance, often because they have entry level or part time jobs, or jobs in small businesses. The ACA has started to increase access to insurance for young adults by allowing young adults to remain on their parents' health plan until age 26.

According to the Census Bureau, 2011 current population survey, the ACA is working. So Republicans' proposal to repeal the Pa-

tients' Bill of Rights, what would happen to the advances we have achieved for these young adults?

Mr. POLLACK. Well, you know, I appreciate your focus on young adults, because, as you know, young adults have for many years been the part of the age cohorts that are most likely to be uninsured. And the Affordable Care Act is going to help that group in a very significant way.

Now you, of course, mentioned one of the key ways. And we have already seen the evidence of this. And this is that young adults, up to their 26th birthday, can stay on their parents' policy.

And the current population survey tells us that 1.2 million young adults gained health care coverage over the course of the last year. That is very impressive.

But starting in 2014, beyond the ability to stay on a parent's to your 26th birthday, young adults, as you mentioned, are the ones who have the greatest difficulty getting jobs. They are more likely to be in entry level jobs. They are likely to be paid lower than others.

And they are likely to have fewer fringe benefits like health care coverage. And they now can go into this new marketplace, the so-called exchange. And because of their modest income, they will receive tax credit subsidies that will make insurance premiums far more affordable.

As I said, those premium subsidies will go up for with families of four, up to $90,000. So a lot of these folks are going to be eligible for those tax credit premium subsidies.

But in addition to that, they will get significant protection in terms of their out of pocket costs when they seek health care. Because people with incomes up to 250 percent of the federal poverty level—and for a family of four, we are talking about annual income of $56,000. There will be a significant limitation on how much they have to pay out of pocket when they get care.

So the group that you are referring to is really going to helped disproportionately by the Affordable Care Act.

Mr. HINOJOSA. Thank you.

My next question is for Dennis Donahue. On page eight of your written testimony, you relate a story of one of your clients, a large employer dealing with an employee who exceeded their lifetime limit because of hemophilia. And their medicine costs the plan more than $35,000 a month.

What kind of tremendous relief were you looking for? The ability to drop the coverage of that employee in the middle of treatment, or to reinstitute any arbitrary limit for that individual's care?

What would happen to the worker if he or she couldn't get the medicine they needed to stay alive?

Ms. PIPER. I am glad that you brought this up, because what you just asked me is not the intent of that example at all.

The intent of the example that I used for this particular employer—and this employer had probably about 35,000 employees. You have about 5,000 that are eligible for the employer sponsored plan. And then you have another 30,000, 35,000 that are eligible for a limited benefit plan.

In going through the renewal last year, when we took a look at lifetime limits—and this is the only client that I had that was im-

pacted. There was a hemophiliac that had exceeded their maximum. There was no complaining about taking that employee back in.

The problem was the medicine was $35,000 a month, or $33,000. I am not looking at it currently. The relief that I talked about was what do we do in situations like that? That is a high ticket item. You know, employers have a certain bucket of money, and it doesn't grow every year.

You have employers that have seen huge decreases to their profit margins. They are trying to keep coverage out there for their employees. They are trying to—every employer that I have tries to keep the same percentage of contribution.

It is not this game where everybody just tries to just dump on to the employees. In this particular example that I laid out for you, it was a 6 hour meeting with the insurance carriers. We sat there and went through their specialty pharmacy.

We simply couldn't find any relief. Maybe $8,000, $9,000—and I don't have that stat in front of me that we actually gave, that I could actually provide you.

But it had to be absorbed into the plan. So again, there was no complaining about taking that person back in. It is simply a statement out there that where are the resources that we can try to reduce the drug costs or help people like that, instead of simply passing along that high of an amount on to an employer.

So that was my point on that.

Mr. HINOJOSA. I wish that thethat last point you made would be taken very seriously by my friends on the other side of the aisle. And that is, reducing the cost of prescription medication. I think that that is a very serious problem for young and senior citizens.

With that, I yield back.

Chairman ROE. Thank you. I thank the gentleman for yielding.

Mr. Hanna?

Mr. HANNA. I would like to yield my time to Mr. Thompson.

Chairman ROE. Gentleman yields his time to Mr. Thompson.

Mr. THOMPSON. I thank my neighbor from up north for yielding.

Mr. Chairman, I want to ask unanimous consent to enter into the record two articles that basically, you know, provides what President Obama said in his campaign and, frankly, what the administration has recently said, moving the bar in terms of that $2,500 cost number to 2019.

[The information follows:]

Sep 29, 2011 1:46pm

New Study Underlines Unfulfilled Promises of Health Care Bill

A new study by the Kaiser Family Foundation underlines that many of the promises surrounding President Obama's health care legislation remain unfulfilled, though the White House argues that change is coming.

Workers at the Flora Venture flower shop in Newmarket, NH, remember when presidential candidate named Sen. Barack Obama, D-Ill., promised that their health care costs would go down if they elected him and his health care plan was enacted.

On May 3, 2008, the president told voters that he had "a health care plan that would save the average family$2,500 on their premiums."

Last year workers at the flower shop saw their insurance premiums shoot up 41 percent.

"I basically work for the health care payments," says manager Pat Cowhig, whose husband has medical issues.

The Kaiser Family Foundation shows family premiums topped $15,000 a year for the first time in 2011, increasing a whopping 9% this year, three times more than the increase the year before. The study says that up to 2% of that increase is because of the health care law's provisions, such as allowing families to add grown children up to 26 years old to their policies.

So what about that $2,500 in savings the president pledged? White House deputy chief of staff Nancy-Ann DeParle insists families will see that savings — by 2019.

"Many of the changes in the Affordable Care Act are starting this year, and in succeeding years," DeParle told ABC News, "and by 2019 we estimate that the average family will save around $2,000."

DeParle said that the "big increases that occurred last year were probably driven by insurance plans overestimating what the impact would be and maybe trying to take some profits upfront before some of the changes in the Affordable Care Act occur.

The Kaiser study also indicates employers are switching plans and shifting costs onto employees. Half of workers in smaller firms now face "deductibles of at least $1,000, including 28 percent facing deductibles of $2,000 or more," according to the study.

Flora Venture's new policy increased the deductible employees pay to $5,000.

Doesn't that fly in the face of the president's promise that "if you like your health care plan you can keep your health care plan"? ABC News asked DeParle.

She said no — the president wasn't saying the legislation would guarantee that everyone can keep his or her preferred plan, just that the legislation wouldn't force anyone to change.

"What the president promised is that under health care reform, that he would make it more possible for people to have choices in these (health insurance) exchanges," DeParle said. "And that's going to be what will help businesses bring costs down. Right now, they're just struggling. That's one reason why they're shifting costs to employees."

DeParle said that "once health care reform fully takes hold in 2014 and beyond, employers will have more tools and more ability to help bring down costs," she said, including the new health insurance exchanges.

-Jake Tapper

The New York Times
Prescriptions
The Business of Health Care

OCTOBER 2, 2011, 12:32 PM

New Survey Projects Higher Employee Health Premiums

By BRUCE JAPSEN

Companies next year will push more health care costs onto their workers, who may see an increase of nearly 11 percent in what they have deducted from their paychecks for health insurance, according to a new annual study by Aon Hewitt, a large Chicago benefits consultancy.

As companies struggle to control costs in a tough economy, the 2012 annual employee premiums are expected to jump on average 10.6 percent, to $2,306. That figure has doubled since 2005, when workers at larger companies paid on average $1,192 annually per employee and paid about 17 percent of the company's costs, according to Aon Hewitt data.

The employee share projected for next year is a contribution of 22 percent of the $10,475 employer cost of the health plan. This year, workers are paying 21.3 percent of the total cost, or $2,084 of the $9,792 total company-paid premium.

"The reality is that employers, particularly in this economy, are doing everything they can to get net company cost levels that they can budget for and afford," said Jim Winkler, a managing principal with Aon Hewitt, a unit of Aon Corp. "Employers are shifting costs to employees to be able to afford to offer benefits."

The per-employee cost figures are the company-paid premiums of the average worker. A single worker with no dependents or a spouse might pay less. A worker with dependents might pay more. Less than a week ago, the Kaiser Family Foundation released its annual survey of big and small employers, showing a 9 percent increase in 2011 premiums for employer-sponsored insurance.

The survey comes at the peak of so-called open enrollment season, which generally runs through mid-November, when companies disclose to workers their benefit options for the following year. Obama administration officials have asserted that the new federal health care law will help to contain costs in coming years. And other studies, like a preliminary one by Mercer, have shown a more moderate increase — around 5 to 7 percent — expected for next year.

Analysts attribute health care cost increases to employment trends that have left young adults unemployed at nearly double the rate of older Americans. That means fewer healthier workers are paying premiums while not using medical care services as much as

older workers.

"Claims that tend to occur are from relatively unhealthy people with heart disease, diabetes and the ever-challenging issues of obesity, making interactions with the health care system more expensive," Mr. Winkler said. "Companies are not hiring 22-year-olds who are healthy to offset the costs of the 58-year-old with diabetes and heart disease."

When workers do use the system, they are going to pay more out of pocket as well. Employers, who continue to create benefit plans with higher deductibles and copayments, are leaving workers with out-of-pocket costs that are projected to jump 13 percent to $2,275 in 2012, from $2,007 this year.

Aon Hewitt's data comes from a database of about 350 large American employers that spend more than $52 billion annually on health care benefits for some 14.4 million employees and their dependents. The database includes large and midsize employers with more than 1,000 workers and in some cases, hundreds of thousands of workers.

Companies say they are trying to reward employees for healthier lifestyles in hopes of tempering the rise in health care costs, but they aren't there yet.

"If we played our cards right, I don't think we should need to cost-shift," said Andrew Webber, president and chief executive officer of the National Business Coalition on Health, which includes some of the nation's biggest employers as members.

Employers need to provide stronger incentives for workers to use primary medical care and preventive health care services.

"I don't think employers are doing their jobs," Mr. Webber added. "We should be getting aggressive. They need to sign up to fill out the health risk assessment and if you are chronically ill, you will have to automatically enroll in a disease management program."

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Mr. THOMPSON. Ms. Turner, obviously costs are just one aspect where Obamacare is falling short. Can you elaborate on other points that may put employer based coverage at risk?

Ms. TURNER. The cost of health coverage was the main issue that employers were concerned about. That was one of the reasons that they supported health reform.

So if we don't get costs down, then I think employer coverage is increasingly at risk. One of the other provisions that I think puts employer coverage at risk is the employer mandate, oddly, because employers are required to pay for incredibly expensive government required health insurance, which may cost as much as $15,000 to $20,000 for a family.

And their option is to pay a $2,000 fine or a $3,000 fine if their employees go to the exchange. The economics—and we have seen from a number of independent studies, McKenzie and others, Towers Perrin, who have said that employers are seriously considering dropping employer based coverage, because they see the economics are just so much more attractive.

So I think that is a very big risk that many more employees could lose their health insurance as a result of this law, because the mandates are so perverse.

Mr. THOMPSON. And I think the administration, as I have read, is banking on saving $77 billion from computerized medical records. Frankly, I don't think, having worked in health care and worked around computerized medical records, there is always a legacy cost to that.

I don't think the administration realized that it is just not a one time thing. And also reducing administration costs in insurance industry would yield up to $46 billion. I would argue that most health care providers I know, at least 50 to 60 percent of their overhead cost is compliance with Medicare billing.

So that is not something we are talking about, but that may be something we could do about. And then improving prevention programs and chronic disease management, $81 billion is the numbers I have read.

You know, that is just one side of health care. I am curious, panel, for health care providers, what are the variables under PPACA that may drive up costs of delivering care? And specifically two things I would like your opinion on; one is compliance costs, which are significant, 150—I think my last count over 150—at least over 100 new bureaucracies were created——

Ms. TURNER. One hundred fifty nine,

Mr. THOMPSON. Yes. You would, you know—and then also the fact that we are going to put 18 million more Americans on Medicaid, that only pays 40 to 60 percent of cost. That is a huge cost driver, my opinion. But I want to get the experts' opinions on those two issues, compliance and expanded Medicaid.

What does that do to the costs of delivering care?

Ms. TURNER. If I might start, with Medicaid, the Affordable Care Act will add as many as 16—some estimates say 25 million more people to Medicaid. And with the additional incremental growth or expected growth in the program, that is going to mean that between 85 and 90 million people are going to be on Medicaid, which is one of the lowest paying health plans in the country.

And those costs have traditionally been shifted to employers. So the cost shifting is a huge issue. Obviously, compliance costs, but maybe Ms. Piper or Mr. Donahue could talk more specifically about those.

Mr. THOMPSON. Mr. Donahue?

Mr. DONAHUE. Compliance from the employers' standpoint is quite arduous. As I reference before, most of our customers are spread very thin now dealing with an additional layer of compliance. Just in the current environment, pre-health care reform, our customers are dealing with over 2,100 different state statutes.

And if they are an employer of multi-sites, they have got to look at the variations of benefits from region to region, coincide and comply with those benefits that states mandates. And what we are also concerned with is once essential benefits are designed, how will the states weigh in relation to state mandated benefits, in comparison with essential benefits?

And how many special interest groups will be lined up making sure that their coverages, their diseases, their equipment is indeed covered. This will add a tremendous of complexity to the whole scenario, and the cost burdens associated with that.

Mr. POLLACK. Mr. Thompson, you raised the question of Medicaid. I know that this committee does not have jurisdiction over Medicaid.

But as I was citing earlier in my testimony, there has been a sharp drop in the number of people, and certainly the percentage of people who get their coverage through an employer. And this occurred over the course of the last decade.

It has nothing to do with the Affordable Care Act. This is what occurred between 2000 and 2010. Had it not been for Medicaid, we would have a huge increase, far above what we have already seen, in terms of the number people who are uninsured.

And——

Mr. THOMPSON. But——

Mr. POLLACK. And what is important about that point that you raised is that that is where the cost shift takes place, when we have more and more people joining the ranks of the uninsured.

Mr. THOMPSON. Just reclaiming my time, and I understand that, but I also see that that has shifted—cost shifted back to commercial insurance. That is one of the primary drivers.

Just a point of clarification, a quick question, yes or no answer, if the chairman will give me a little leniency here.

It was part of your testimony. I just want to clarify I heard what you said, that under PPACA that an individual who makes $90,000 a year—trust me, in the Pennsylvania Fifth Congressional District, that is a whole lot of money—depending on family size, is now under PPACA, is eligible for taxpayer subsidy.

Mr. POLLACK. Yes. And I said for $90,000,that is for a family of four.

Mr. THOMPSON. A family of four, that is a whole lot of money. So thank you.

Chairman ROE. I thank the gentleman for yielding.

Mr. DONAHUE. If I may make one more comment about——

Chairman ROE. Actually, we will get to that. I will give you a chance, Mr. Donahue, in just a minute.

Mr. Kildee?

Mr. KILDEE. Thank you, Dr. Roe.

Mr. Pollack, some claim that the immediate consumer protections included in the health care reform law, such as the coverage of young adults up to age 26 and the coverage of preventive care, are an enormous burden on health plans and employers. Could you talk about the benefits, not just to the individual, but the societal benefits of those provisions?

Mr. POLLACK. I think all of us, and I presume that is true of the physicians on this panel, know that we want a health care system, not a sickness system. And by promoting preventive care, we promote a health care system, so that people get exams each year. They get tests so that at the outset of a pain, or the outset of a disease, we can detect what is wrong before the disease spreads and becomes a whole lot worse.

So certainly from the perspective of improving America's health care system, this is something we should savor. I think all of us have said at one time, to one another, we want to promote preventive care.

Now there are some additional costs, obviously, that are associated by people going to a physician and getting a check up and having tests. But the real costs in America's health care system are for people with major illnesses and especially for people with chronic illnesses.

And you want to maintain these folks' health before the problems get a whole lot more serious and you need a heroic intervention, which is going to be very costly and is not good for somebody's health.

And I would say since this panel cares about employment and jobs, the more we are able to keep people in the job because they are healthy, that is going to be significant help to our economy.

Mr. KILDEE. You know, it is interesting, the first wave of thanks I got—as you know, the bill was quite controversial, the division in the Congress. But the first wave of thanks came to me from the young people and their parents who were being carried up to age 26.

That touched their lives immediately, made it easier, by the way, for them to seek employment, too, made it easier for many of their employers. It seemed to have a pretty strong societal positive effect.

And it is just refreshing when you go back home, because sometimes you don't get thanks. You get some other expression of thought.

Mr. POLLACK. And Mr. Kildee, I have to say that since I am no longer in that age group under 26—just barely above that now—I think about my children. And as a parent whose thankfully has three children, to know that they have health care coverage makes me sleep a whole lot better.

So it is not just those young adults who no doubt are grateful. And I am glad you are being thanked for it. But for all of us who are parents who can sleep better at night because we know that our children have health care coverage, this is an extraordinary improvement.

Mr. KILDEE. Thank you very much, Mr. Pollack.

Mr. ANDREWS. Will the gentleman yield? Will the gentleman yield?

Mr. KILDEE. Be happy to yield.

Mr. ANDREWS. I wanted to ask Ms. Piper a question. I was alarmed when I heard about the 24.99 percent increase that you in your own firm had. And your broker told you it was because of the ACA.

What exactly about the ACA was the problem that caused the increase? Did they tell you?

Ms. PIPER. A little. I am probably—you know, because I do represent employers, of course, I don't ask many questions. I go straight to the source.

I am my own broker in many cases. But there was a broker involved here. You know, certainly they said that—and I did see it in smaller employers. 1 to 2 percent was where we really were with large employers. Some of my small employers say they have an increase——

Mr. ANDREWS. But what reason did they give you for your firm?

Ms. PIPER. Well, up to 8 percent was for age 26. And I am a California employer, lifetime limit.

Mr. ANDREWS. How many employees do you have?

Ms. PIPER. I have got 13.

Mr. ANDREWS. Do you have anybody with kids under 26?

Ms. PIPER. My business partner is the only one that has children under age 26.

Mr. ANDREWS. And didn't California law already require that?

Ms. PIPER. I don't write any other business in California. I write large groups.

Mr. ANDREWS. I think it did.

Ms. PIPER. I would be a bad case.

Mr. ANDREWS. How did that change boost your premium? I don't understand. I thought California already requires.

Ms. PIPER. Well, I can only tell you what I was told. It was up to 8 percent for certain provisions. And then I was told that the biggest piece of itm the 24.99, was not all attributed to PPACA, first and foremost.

Mr. ANDREWS. Right.

Ms. PIPER. So there was standard trend there, which was 9 percent.

Mr. ANDREWS. Right.

Ms. PIPER. Then you had 4 to 8 percent. Now remember in California, you are pretty much a small employer. You are all in one bucket.

Mr. ANDREWS. Right.

Ms. PIPER. So there was a fairly fair amount that was applied for certain provisions. Then wellness, we are moving cost share. I have been told over and over and over again that that was the biggest——

Mr. ANDREWS. No, that is a different point. What other ACA reasons attributed to 24 percent? That is what I am asking.

Ms. PIPER. 24.99 percent was the total overall. So they didn't give me a breakdown of what percentages applied. They me not random numbers, but they gave me 4 to 8 percent for lifetime maximum. Right?

They gave me 11 to 15 percent for cost share removal on the preventive. And the rest of it being standard trend.

Mr. ANDREWS. Did you ever have an employee hit the lifetime policy limit?

Ms. PIPER. Did I ever have anyone that exceeded? No, I have not. In fact——

Mr. ANDREWS. A little odd that they would charge you with that.

Thank you.

Ms. PIPER. Only one that I——

Chairman ROE. Thank the gentleman for yielding.

I will finish the questioning by making a brief statement.

The problem with the American health care system, after practicing medicine for over 30 years, was that it cost more and more and more for patients to come and see me, to go to the hospital to get the care they need. Cost is number one.

Number two, we have a group of people in our country that didn't have access to affordable health insurance coverage. They couldn't afford it. Let us say a carpenter in my area that worked and maybe the wife worked in a diner. And they make $35,000, $40,000 a year together.

They can't pay $1,000 a month in health insurance coverage. That is a problem I saw in my state.

Thirdly, we have a liability issue in America, forcing up the costs. And I can assure you as an obstetrician, when I saw my health care—when my liability insurance went from $4,000 a year when I started practice in 1977 to $74,000 a year, with no top in sight, when I left practice, that is a huge problem in defensive medicine.

And lastly, health care decisions should be made by a patient, their family and a doctor, not an insurance company and certainly not the federal government mandating what should be done. That should be a decision made by them.

Having said that, I looked at this. And I have read the bill. And I know Mr. Andrews has read the bill. Twenty seven hundred pages and now 10,000 pages of rules that I am not going to read. I am going to—I plead ignorance on the first 2,700 pages. But I am not going to read the next 10,000 pages of rules that we have to abide by to do this.

The simplest financial transaction on the Earth is a patient coming to see me. I perform a service and they pay me. It didn't get any more complicated than buying a loaf of bread. That is how hard it is to come to the doctor.

All this extraneous stuff has added cost without value to the patient. When I get to the examining room and see that patient, it hasn't added any value. I could have taken two paragraphs and done what the 2,700 pages has done by doing two things.

The 26 year old, I agree with that. I have had three kids, as you have Mr. Pollack, that when they got out of college, they didn't have health insurance coverage. And I bought them individual policies.

The problem with this is this bill changed for someone my age. I used to have to pay six times what it was actuarially to a young person who was healthy. Now it is three to one. For those who don't have a parent paying for that, their costs have gone up.

So you have actually made it more expensive for some young people to get affordable health insurance coverage.

Number two, and Mr. Foster at CMS said this, we think it will expand Medicaid by as much as 25 million people. The estimates of CBO were 15 million. That is where that number came from. And the 24.5 million came from CMS, their estimates, because I asked Secretary Sebelius when she was here in front of our committee.

So those two things could have done that without all this complicated stuff that we are talking about. What I think we need to do—and Ms. Piper, you have said this clearly—is we have got to change the incentives in medicine.

We have to change the way we pay for it or you will never get control. And I think a high deductible plan with a health savings account does it. I used that; 84 percent of my 300 employees in my practice used that.

It has helped hold the costs down. We have been innovative in how to do that. This will be taken away from us with the Affordable Care Act. We are not going to be able to move and help hold our costs down.

Another company in my district has been able to use some very, very innovative things. And they have had one small premium increase in 5 years. And they have done this by doing if—let us say you were a hypertensive, diabetic, smoking obese patient. You were a train wreck waiting to happen.

What they did was they paid you if you lowered your hemoglobin A1c, if your nicotine level was normal, if you went on a weight loss program. They switched the incentives from sickness to wellness.

And it absolutely made a difference. There is no question about that. We need to get—and back to Mr. Donahue, I am going to give you a chance to answer. You wanted to.

For 30 years, I have used your business. It was very helpful to us to use a broker to be able to help us wade through this insurance every—we didn't have an HR department, so we used you.

So you wanted to answer a question a minute ago and I cut you off.

Mr. DONAHUE. Thank you.

No, I was just going to weigh in about the Medicaid expansion that was referenced by a number of the speakers here. It is one thing that we are not considering, though, although Medicaid provides very cost effective reimbursement in the way physicians are reimbursed, our concern with the movement into Medicaid expansion, that there will be enough providers to cover that kind of population, considering potentially the lack of interest of those providers entering into Medicaid-based patients.

So it is very disconcerting. Where are those providers?

Chairman ROE. 31 percent or 32 percent of primary care providers, as I am, are not accepting Medicare.

Mr. DONAHUE. Yes. So if you look at current statistics as to how many are actually embracing Medicare patients, it is especially disconcerting with the potential Medicaid expansion. And how are those individuals going to be serviced?

Chairman ROE. Let me clarify what I said, new Medicare patients.

Mr. DONAHUE. Yes, yes.

Chairman ROE. My time has expired.

Mr. Andrews, for any——

Mr. ANDREWS. Mr. Chairman, Mr. Holt has arrived here. And I wanted to know if he wants to take question time.

Chairman ROE. Dr. Holt?

Mr. HOLT. With the chairman's permission.

Mr. ANDREWS. Thank you, Mr. Chairman.

Mr. HOLT. It is an important hearing as much for what it doesn't bring as for what it does. But, you know, I would like to ask something about these claims that I keep hearing from constituents that this health care reform is responsible for the increase in premiums.

I have looked and I have looked. And in the letters that the insurance companies send for why premiums are going up and that sort of thing, if they ever cite specifics, it is things that haven't even taken effect yet, and won't for a long time.

And so it seems to me that the increase in premiums that are real, that our constituents are feeling, are the best argument I have seen yet for why this legislation was and is necessary. So Mr. Pollack, let me ask you—and I know you have addressed this to

some extent, but let me ask you how much of the premium increases that people are seeing around the country can be attributed to the law, as passed?

Mr. POLLACK. I appreciate your asking that question. A number of members of this distinguished panel raised the Kaiser Family Foundation study, which showed that premiums increased over the course of the last year. By the way, if you look at the history of the past decade, this was an extraordinary increase.

It was larger than the year before, to be certain. But as I cited earlier in the testimony, in the year 2000, average cost of premiums for family coverage purchased through an employer was $6,772, in the year 2000.

In the year 2010, it was almost $14,000. And in the previous year, it went up to $15,000. So it is not a significant change in the pattern at all.

But most importantly, the Kaiser Family Foundation, which released the numbers that so much—you know, so much of this discussion is based on, said that only 1 to 2 percent of the increase in premiums is attributable to the Affordable Care Act.

And they asserted two things that occurred with respect to the Affordable Care Act. One that we have discussed at great length here, is that young adults can now stay on their parents' policy up to their 26th birthday.

Of course, that does increase premiums. But it is a very cost effective purchase and we have seen tremendous benefits for those young adults as a result; 1.2 million young adults were added to health insurance coverage over the course of the last year.

And the other is there is no longer a lifetime limit in the payout by an insurance company. And when you have a lifetime limit, it is insurance that doesn't insure. Because what you want to be protected against is that you are going to be bankrupted from very high costs.

And if you have a lifetime limit, for those people who need insurance the most, all of a sudden they have got no insurance, even though they have paid premiums for a long period of time.

Those were the two factors that increased premiums by 1 to 2 percent, according to the Kaiser Family Foundation. And I would say that was well worth it.

Mr. HOLT. Thank you.

Ms. Piper, when you say that all—that is actually the word you use, I believe—of the large employers have made a decision to drop the grandfather coverage, how many employers does that include?

Ms. PIPER. All of my large employers, not nationally speaking.

Mr. HOLT. Yes, all of yours, which is one or two or——

Ms. PIPER. No, we represent probably 40. I also represent franchise organizations. So when you get to that level and when you drill down, I would consider those to be more small employers.

Mr. HOLT. Large enough sample that you probably can understand something of their motivation. If the cost of complying with the additional provisions of the Affordable Care Act are so cost prohibitive and burdensome to the clients, should we believe that employers chose to accept these additional burdens and costs rather than make the modest adjustments that would be appropriate perhaps to their existing plan?

Ms. PIPER. Well, when we have gone through renewals, especially on the large employer side—and I understand that to be your question, acceptance—yes, you laid out the law and we are following it. To make the small adjustments that were allowed is not reasonable in a renewal, not if you are trying to contain costs.

Mr. HOLT. Why not? Why not reasonable?

Ms. PIPER. Well, you know, looking at the example that I gave earlier—and I am not sure that you were here at the time. But we had a large employer who was 8 to 9 percent above the national trend on outpatient expenses.

Forty seven employees went to the E.R. for non-emergency related issues. Three times a piece we had two that were abusive to the point of nine times a piece. There is a $75 co-pay on the—or deductible on the plan design.

To meet the allowances that we were provided, you simply can't. We could not maintain grandfathering. And overall, this is a very large employer. I have to get them into a position of strength for 2014.

They have 26,000 hourly workers that are very low wage. When you look at the penalties that could be assessed against them for unaffordable penalties, that is large. So all large employers that we represent——

Mr. HOLT. Go ahead and wrap up your answer, if you would, please.

Ms. PIPER [continuing]. Are looking at high deductible health plans, which is a cost shift. It is a cost shift, because we need to get them to that position of strength, so they can look at a 60 percent actuarial value to minimize their penalty risk in 2014.

Mr. HOLT. Thank you, Mr. Chairman.

Chairman ROE. Thank you, Dr. Holt.

Mr. Andrews?

Mr. ANDREWS. I would again like to thank the panel for obviously a lot of time preparing for this morning and very, very good testimony. Thank you for taking time out of your businesses and your work to do this work.

We talked about two Americans today. And we didn't talk about one American. We talked about the American who has a $33,000 a month drug bill who is hemophiliac, which is just stunning. And the question in the air was what to do about that problem.

And the Affordable Care Act does provide an answer. It says that if that person works for a very small employer, they will be able to go into the exchange, buy health insurance as good as mine, at at a price that is affordable given their income, and not run into an annual or a lifetime policy limit, and have the insurance cover the cost of the drug.

And that cost will be spread upon all the participants in the exchange of that state. In my state, that will be about a million people, which is a cost that has to be borne. But spreading it over a million people is a pretty rational strategy.

A person works for a larger employer, that larger employer is in a more difficult situation, unless they can get into the exchange. And I predict to you that by 2017, one of the issues will be whether Congress should encourage states to open up their exchanges to

more people, because they are going to want to spread those costs that way.

The second person we talked about—Dr. Roe talked about his constituent who is a carpenter, whose spouse is waitress at a diner, making $35,000 a year. What this law says for them is if they work for a business with more than 50 employees, they are going to get covered at work, with coverage as good as mine.

If they work for a smaller business—I think they would in his case—they would be able to go into the exchange, buy a policy with a contribution from themselves that is reasonable given their income.

Now whether this is good for the country or bad for the country is debatable and yet to be seen. But the American we didn't talk about today is the unemployed carpenter, the unemployed waitress, the unemployed teacher, and the unemployed real estate sales person.

And that is who we should be talking about. I will tell you, the president has put forward a plan that addresses what we hear is the consensus among the real job creators in this country, which are small business people. Employers with 50 or fewer employees create two thirds of the jobs created in America, two thirds.

And what they are telling us and what they are telling researchers is lack of demand is the main problem in their business. The president has put forward a plan that would put demand in the economy by employing construction workers, putting them back to work.

But we haven't taken a vote on that. And he has put forward a plan that says we will cut the taxes of that small business if they hire an employee. But we haven't taken a vote on that.

It says that we will avoid a shock to the demand in the economy by postponing a tax increase on middle class families of $1,500 a year January 1st. But we haven't taken a vote on that.

It says that we will avoid a shock to demand in the economy by not laying off more teachers and police officers and firefighters. But we haven't taken a vote on that.

This is the issue affectingeffecting the country. If you want to vote no, vote no. If you want to amend the plan, to come up with a better idea, that is the way the legislative process works.

But I think it is the height of irresponsibility to deprive the House the chance to vote on that plan. And with all due respect, that is the American we should be talking about today, in addition to the ones that we did.

Mr. Chairman, I appreciate the scope of this hearing. I did ask unanimous consent to include in the record two articles, one "Misrepresentations, Regulations and Jobs," by Bruce Bartlett, an alumnus of the Bush and Reagan administrations. And the second is the "Kaiser Report" press release that has been cited.

[The information follows:]

The New York Times

Misrepresentations, Regulations and Jobs

By BRUCE BARTLETT

Bruce Bartlett held senior policy roles in the Reagan and George H.W. Bush administrations and served on the staffs of Representatives Jack Kemp and Ron Paul.

Republicans have a problem. People are increasingly concerned about unemployment, but Republicans have nothing to offer them. The G.O.P.opposes additional government spending for jobs programs and, in fact, favors big cuts in spending that would be likely to lead to further layoffs at all levels of government.

TODAY'S ECONOMIST

Perspectives from expert contributors.

Republicans favor tax cuts for the wealthy and corporations, but these had no stimulative effect during the George W. Bush administration and there is no reason to believe that more of them will have any today. And the Republicans' oft-stated concern for the deficit makes tax cuts a hard sell.

These constraints have led Republicans to embrace the idea that government regulation is the principal factor holding back employment. They assert thatBarack Obama has unleashed a tidal wave of new regulations, which has created uncertainty among businesses and prevents them from investing and hiring.

No hard evidence is offered for this claim; it is simply asserted as self-evident and repeated endlessly throughout the conservative echo chamber.

On Aug. 29, the House majority leader, Eric Cantor of Virginia, sent a memorandum to members of the House Republican Conference, telling them to make the repeal of job-destroying regulations the key point in the Republican jobs agenda.

"By pursuing a steady repeal of job-destroying regulations, we can help lift the cloud of uncertainty hanging over small and large employers alike, empowering them to hire more workers," Mr. Cantor said.

Evidence supporting Mr. Cantor's contention that deregulation would increase unemployment is very weak. For some years, the Bureau of Labor Statistics has had a program that tracks mass layoffs. In 2007, the program was expanded, and businesses were asked their reasons for laying off workers. Among the reasons offered was "government regulations/intervention." There is only partial data for 2007, but we have data since then through the second quarter of this year.

The table below presents the bureau's data. As one can see, the number of layoffs nationwide caused by government regulation is minuscule and shows no evidence of getting worse during the Obama administration. Lack of demand for business products and services is vastly more important.

Mass Layoffs Caused by Government Regulation

Reason for layoff	2008	2009	2010	2011/First Half
Government regulation	5,505	4,854	2,971	1,119
Percentage of layoffs	0.4	0.2	0.2	0.2
Lack of demand	516,919	824,834	384,565	144,746
Percentage	34.1	39.1	30.6	29.7
Total private nonfarm separations	1,516,978	2,108,202	1,257,134	486,482

Bureau of Labor Statistics

These results are supported by surveys. During June and July, Small Business Majority asked 1,257 small-business owners to name the two biggest problems they face. Only 13 percent listed government regulation as one of them. Almost half said their biggest problem was uncertainty about the future course of the economy — another way of saying a lack of customers and sales.

The Wall Street Journal's July survey of business economists found, "The main reason U.S. companies are reluctant to step up hiring is scant demand, rather than uncertainty over government policies, according to a majority of economists."

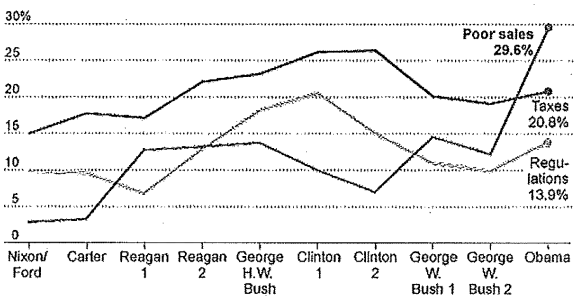
In August, McClatchy Newspapers canvassed small businesses, asking them if regulation was a big problem. It could find no evidence that this was the case.

"None of the business owners complained about regulation in their particular industries, and most seemed to welcome it," McClatchy reported. "Some pointed to the lack of regulation in mortgage lending as a principal cause of the financial crisis that brought about the Great Recession of 2007-9 and its grim aftermath."

The latest monthly survey of its members by the National Federation of Independent Business shows that poor sales are far and away their biggest problem. While concerns about regulation have risen during the Obama administration, they are about the same now as they were during Ronald Reagan's administration, according to an analysis of the federation's data by the Economic Policy Institute.

It's the Economy, Not Taxes or Regulations

The single most important problem reported by small businesses, by presidential term



Source: Economic Policy Institute analysis of data from National Federation of Independent Business, through second quarter, 2011.

Academic research has also failed to find evidence that regulation is a significant factor in unemployment. In a blog post on Sept. 5, Jay Livingston, a sociologist at Montclair State University, hypothesized that if regulation were a major problem it would show up in the unemployment rates of industries where regulation has been increasing: the financial sector, medical care and mining/fuel extraction. He found that unemployment rates in these sectors were actually well below the national average. Unemployment is much higher in those industries that one would expect to suffer most from a lack of aggregate demand: construction, leisure and hospitality, business services, wholesale and retail trade, and durable goods.

Gary Burtless, an economist at the Brookings Institution, asserts that if businesses were really concerned about rising regulations, they would be investing now to avoid them. But there is no indication that this is the case. "The real reason for anemic investment and hiring is that businesses are not confident there will be enough potential customers to justify expansion or even routine capital replacement right now," he says.

In my opinion, regulatory uncertainty is a canard invented by Republicans that allows them to use current economic problems to pursue an agenda supported by the business community year in and year out. In other words, it is a simple case of political opportunism, not a serious effort to deal with high unemployment.

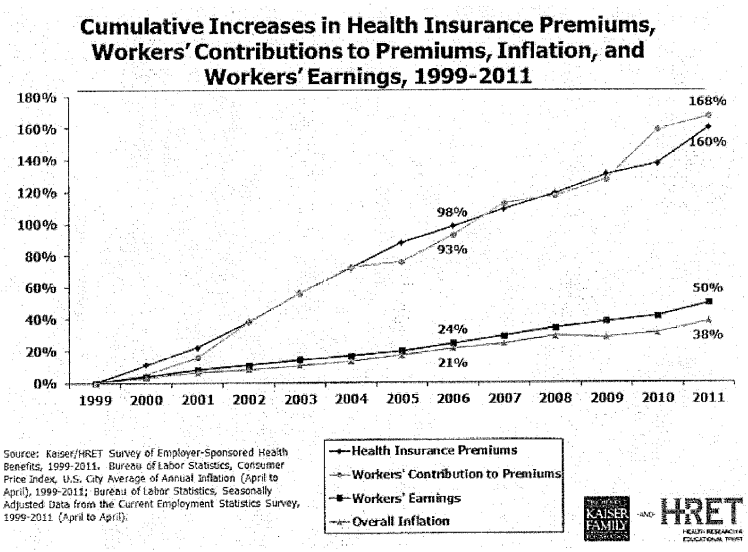
PULLING IT TOGETHER...

from Drew Altman, Ph.D., President and CEO

< Back to Index Page Pulling It Together via RSS SHARE

Rising Health Costs Are Not Just a Federal Budget Problem

Premiums for employer-provided health insurance, where 150 million Americans get their coverage, jumped 9% in 2011 while workers' wages grew just 2%, according to our annual employer survey. The average family policy now costs more than $15,000 per year, more than the cost of a Chevy Aveo or a Ford Fiesta. Since we began doing this survey thirteen years ago, worker contributions to premiums have increased 168%, wages 50%, and inflation 38%.



Critics of the national health reform law passed in 2010 like to blame everything but the weather on "Obamacare," but regardless of how you feel about the Affordable Care Act, its effect on premiums this year is modest. Most of the law's provisions don't go into effect until 2014. The two biggest changes this year allow young adults up to age 26 to stay on their parents' insurance policies and require some insurance plans to cover preventive services at no cost to patients. These are

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Chairman ROE. Without objection, so ordered.

I thank the gentleman. And I think this panel has been very informative. And I will finish or conclude by saying that I agree with Mr. Pollack. What I would like to see in this country is that all Americans have affordable health insurance coverage, or as close to 100 percent as we can get.

I share that. I came to Congress to try to do that. Unfortunately, I wasn't included in the discussion of it very much. But I still want that aim and that goal is there, to provide affordable coverage with quality health care for all Americans.

I would love to see that in my lifetime. A few things that I think we can do—and I have mentioned, we held a hearing—and Mr. Andrews had an opening statement—in Evansville, Indiana. It is the only health care hearing that has been held outside the Beltway.

And there was some very enlightening things that happened there when we talked about jobs. And I absolutely agree that the number one issue in America today are jobs and putting our people

back to work, because that solves a lot of our problems, if you have a job.

An IHOP owner testified there and said, look, I have 12 IHOPs and about 700 employees. He said, I gross $58,000 per employee. And I net $3,000. And I found out in the restaurant industry, that is pretty good. Because a McDonald's franchisee came in and said he nets $1,200.

So $3,000 per employee, says I have over 50 employees. I have 700. So now if I drop my people into the exchange, if I pay for this insurance that is mandated by the government, because I have got over 50 employees, I am upside down $7,000 per employee.

If I then pay the fine, which is not tax deductible, I have just spent all my profit, $2,800. He said, I either make no profit or I am $7,000 short. What do I do, Dr. Roe?

I said, well, the best thing I can tell is you charge me $10 for a pancake that nobody will buy and you will lose jobs. I think that is what will happen.

And there is a real issue out here, the consequences of what we did, instead of letting the market work. In a high deductible consumer plan—I have this right here, which is a health savings account. I don't call the insurance company if I need to get health care. I don't ask for some clerk on the phone to approve my care.

I go in and do this. And in Indiana right now, Mitch Daniels, the governor there, is trying to do the same thing. He is trying to put consumers in charge of these decisions, not the government and certainly not an insurance company. I couldn't agree more with every one of you.

So I totally agree with that. That is how a health savings account works. And Mr. Pollack, you should look at that for your business.

I will finish by thanking the ranking member and also point out a survey that just came out yesterday from the United States Chamber of Commerce, Third Quarter Small Business Study. Despite its passage more than a year and a half ago, the challenges presented by the Patient Protection and Affordable Care Act continue to grow, with 51 percent of respondents citing the bill as a top concern in October, an increase from 39 percent in July.

And the president's jobs plan—certainly it is not the time to go into all that. But small business owners say there's little to be excited about in President Obama's jobs plan. More than three in four small business owners have an unfavorable opinion of the plan. And two thirds have a strongly unfavorable view of the plan.

So businesses out there are not excited about that. I think both sides—we have differing opinions—want to get our people back to work. And Mr. Andrews is absolutely right I think that demand drives it.

And just to give you a very simple view of that is if I go to church on Sunday and people say Dr. Roe, I can't get an appointment with you for 4 months, and I go back to my office and ask the receptionist; all the doctors are booked for 4 months; it is time to hire a new doctor.

But if I go back to my office on Monday and I have got appointments on Friday, I don't care how many tax cuts, breaks, every-

thing else you give me, I don't have any demand for my services. I am not going to hire a new doctor.

That is just the way it works. You are correct about that.

I appreciate this great panel. And you all have done a wonderful job. I hope that you will continue. We hope to have you back.

And without further, this meeting is adjourned.

[Additional submission from Dr. Roe follows:]

harris INTERACTIVE

REPORT

U.S. Chamber of Commerce
Q3 Small Business Outlook Survey

October 12, 2011
Survey Dates: September 29th – October 6th, 2011

Methodology

The Q3 U.S. Chamber Small Business Outlook Survey was conducted online September 29 to October 6, 2011 by Harris Interactive among 1,330 Small Business Executives (defined as executive level position in a company with fewer than 500 employees and annual revenue less than $25M)

- N=508 U.S. Chamber of Commerce Members
- N=822 Non-U.S. Chamber of Commerce Members, weighted to be representative of the small business population

Sampling error: +/- 2.5 percentage points. This report contains data from this survey and references data collected in the Q1 and Q2 U.S. Chamber of Commerce Small Business Study.

Key Summary Points

I. The Small Business Outlook for the U.S. Economy Continues to Decline

- Among executives from small businesses, during the last three months there has been little improvement, and some decline, in overall attitudes about the economy. Nine-out-of-ten small business owners now believe the U.S. economy is on the wrong track.
- Compared to findings from Q2, fewer small businesses plan to hire additional employees—only 17% of small businesses expect to add employees over the next year.

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- After general economic uncertainty, the greatest obstacles to hiring more employees are uncertainty about what Washington will do next, lack of sales, and the requirements of the new health care law.

II. Uncertainty Continues to be the Biggest Challenge for Small Businesses

- The majority of small businesses (52%) still perceives their top issue and biggest challenge as the general economic climate; however, challenges presented by recent legislation and over-regulation continue to elicit concern from small businesses.
- Despite its passage more than a year and a half ago, the challenges presented by the Patient Protection and Affordable Care Act continue to grow, with 41% of respondents citing the bill as a top concern in October (an increase from 39% in July).
- What do small business leaders want Washington to do? More than three-out-of-four say they would rather have Washington stay out of the way than provide a helping hand. 86% say they would rather have more certainty from Washington than more assistance (7%) to deal with the economy.

III. President Obama's Jobs Plan Falls Flat

- Small business owners see little to be excited about in the President Obama's jobs plan. More than three-in-four small business owners have an unfavorable opinion of the plan and two-thirds have a strongly unfavorable view of the proposal.
- Owners of small business rate the individual elements of the Chamber's six-point jobs plan as highly effective. Specifically, small businesses think that the individual elements—to produce more American energy, speed up the permitting process, and provide tax incentives that create jobs and the proposal that would expand trade—would all be effective ways to create jobs. 80% of respondents see increased American energy production as effective for job creation.
- In head-to-head tests, executives from small businesses strongly prefer the components of the U.S. Chamber's plan over President Obama's, with 85% expressing support for the Chamber's six-point plan and 15% for the President's American Jobs Act.

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Analysis

I. The Small Business Outlook for the U.S. Economy Continues to Decline

There is no improvement in general attitudes about the economy among small business owners. Only one-third of small businesses think that their local economy is headed in the right direction, and nationally nine-out-of-ten small business owners believe the U.S. economy is on the wrong track.

Right Direction v. Wrong Track

*Q3 Results Only

When asked about current economic challenges and who's responsible, 44% of small businesses surveyed place the blame on generic "bureaucrats in Washington."

While small businesses say they remain confident in the direction their own businesses are heading (see chart above), many are unsure if the best days for their businesses are ahead of them or behind them (see chart on right).

Best Days Behind or Ahead

*Q3 Results Only

The percent who say they are confident that the best days for their small businesses are ahead of them declined from Q2 to Q3.

This uncertainty is having an impact on employment among small businesses polled. The new survey data shows a decline in the percent of small business owners

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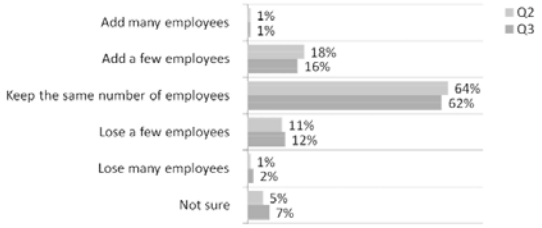
who intend to add more employees over the next year, with 62% saying they don't expect to add to their payrolls and only 17% reporting that they would add more employees in the next year (this is down from 19% in July).

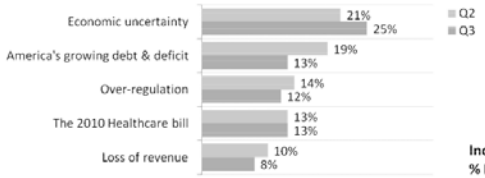
Plans to Add Additional Employees in the Next Year



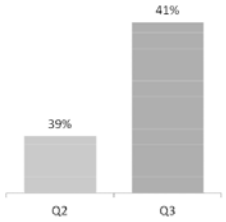
II. Uncertainty Continues to be the Biggest Challenge for Small Businesses

Owners of small businesses still perceive their biggest challenge to be general economic uncertainty. However, pressure from Washington through recent legislation and over-regulation is also considered a significant hurdle to their success and to their ability to hire new employees.

Top Challenges Facing Small Business



Increasing Challenges of Healthcare Law
% Most Concerned with 2010 Healthcare Bil



Despite its passage nearly a year and a half ago, the challenges presented by the Patient Protection and Affordable Care Act continue to grow, with 41% of respondents citing the bill as a top concern in October (an increase from 39% in July).

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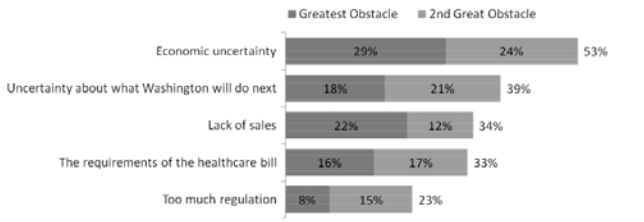
When asked what specific obstacles are preventing small business from hiring, a similar story unfolds. Beyond general economic concerns, nearly one-in-five respondents point to uncertainty about what Washington might do next as a major obstacle to hiring new employees.

Top Obstacles to Hiring New Employees



*Q3 Results Only

What do small business leaders want Washington to do? More than three out of four say they would rather have Washington stay out of the way than offer a helping hand. And, 86% say they would prefer Washington to provide more certainty opposed to more assistance (7%) to help deal with the economy.

What Small Businesses Want from Washington

Related questions reveal that small business owners do not believe that the national debt and deficit pose an immediate risk to their business, but that the uncertainty presented by the debt does present long-term issues, with 40% saying they believe it poses a long-term threat to their business.

More than three out of four (83%) agree that the bigger the debt gets the more unsure they feel about the future of their businesses.

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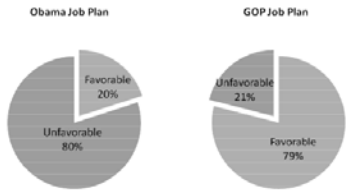
When asked to choose the biggest threat facing their business, between taxes, litigation and regulations; roughly half of the small businesses owners surveyed say regulations were the biggest threat. This survey found that 56% of respondents worry more about what regulatory move Washington will make next than regulations that are already on the books.

III. President Obama's Jobs Plan Falls Flat

Small business owners see little to be excited about in President Obama's proposed jobs plan, with 80% expressing an unfavorable opinion. The House GOP jobs plan, advocating lowering taxes and reducing spending to create jobs, is viewed very favorably by small business owners, with 79% having a favorable impression of the plan.

Favorability of Obama and GOP Job Plans



Note: Only asked in Q3 Wave

Small business owners rate the individual elements of the U.S. Chamber's six-point job plan as highly effective ways to create jobs. These include: producing more American energy, speeding up the permitting process, providing tax incentives that create jobs and expanding trade. 80% of small business respondents cite producing more American energy as an effective job creation proposal.

Note: Only asked in Q3 Wave

In head-to-head tests, respondents of the survey strongly prefer the U.S. Chamber's jobs plan over President Obama's plan.

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[Additional submissions of Mr. Andrews follow:]

AARP,
Washington, DC, October 28, 2011.

Hon. JOHN KLINE, *Chairman;* Hon. GEORGE MILLER, *Ranking Member,*
House Education and Workforce Committee, U.S. House of Representatives, Washington, DC 20510.

Hon. PHIL ROE, *Chair;* Hon. ROBERT ANDREWS, *Ranking Member,*
Health, Education, Labor and Pension Subcommittee, U.S. House of Representatives, Washington, DC 20510.

DEAR REPRESENTATIVES KLINE, MILLER, ROE AND ANDREWS: I am writing to you on behalf of AARP's millions of members and the millions of older Americans and their families who may benefit from recently enacted consumer protections in health plans that will enable individuals to have access to affordable, quality healthcare. AARP believes these provisions can promote more cost-effective care, improve pricing transparency, and increase health insurance companies' accountability for quality health care.

Grandfathered Plans' Status

In order to minimize the impact on current plans, §1251 of the Patient Protection and Affordable Care Act (ACA) provides that certain plans or coverage in effect as of March 23, 2010 (the date of the law's enactment), will be exempt from certain provisions of the Act. These plans, which may be either insured or self-insured group health plans or health insurance coverage purchased from health insurance issuers by individuals or groups, are referred to as grandfathered plans or coverage. The provisions that these plans or coverage are exempted from include (but are not limited to): prohibition of lifetime limits, prohibition on annual limits, prohibition on rescissions, extension of dependent coverage to children up to age 26, medical loss ratio provisions, prohibition of pre-existing condition exclusions, and prohibition of waiting period beyond 90 days (effective in 2014). Currently, a grandfathered plan must not make a substantial change to the plan or coverage benefits, cost-sharing, employer contributions, or access to coverage in order to maintain its grandfathered status; if a plan change exceeds those thresholds, the plan must then adhere to the patient protections from which they were previously exempt.

AARP is concerned that the elimination of the change threshold that would cause a plan or coverage to relinquish its status would deny patient protections even if substantial changes are made to the plans. The ACA was designed to provide patient protections and insurance reforms that safeguard individuals from practices that lead to limited access to covered services and significant out-of-pocket costs. Allowing grandfathered plans to make substantial changes to their plans and still avoid consumer protections indefinitely would eliminate important protections for large segments of the population. Repealing this provision would effectively create two tiers of insurance rules that will continue indefinitely, undermining risk pooling as well as consumer protections.

Medical Loss Ratio (MLR)

Section 1001 and Section 10101 of the ACA establish standards for the MLR. These sections require insurers or plans to spend 80 percent (individual and small group market) or 85 percent (large group market) of the premium revenue on medical services and quality improvement activities. Insurers or plans that do not meet these standards are required to provide consumers with a rebate of the difference. The intent of the ACA's MLR requirements is first, to establish greater transparency and accountability among health insurance issuers and second, to help ensure that consumers receive better value for their premium dollars. We urge you to retain the MLR provisions that help maximize the value of health insurance for consumers while at the same time recognizing issuers legitimate administrative costs.

Employer Mandate

According to §1513, §10106, and §1003 of the ACA, employers with at least 50 employees are required, beginning in 2014, to offer affordable minimum essential coverage or be subject to a penalty. AARP believes this requirement will help ensure adequate funding—including for individual subsidies—to make coverage more fair and affordable for everyone.

AARP therefore urges Congress to maintain these provisions that were designed to provide access to affordable, high quality care. If you have any questions, please

feel free to call me or have your staff contact Leah Cohen Hirsch on our Government Affairs staff at 202-434-3770.

Sincerely,

JOYCE A. ROGERS,
Senior Vice President, Government Affairs.

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News Release

September 27, 2011

For further information contact:
Craig Palosky, (202) 347-5270, cpalosky@kff.org
Rakesh Singh, (650) 854-9400, rsingh@kff.org

Average Annual Premiums for Family Health Benefits Top $15,000 in 2011, Up 9 Percent, Substantially More than the Growth in Worker's Wages, Benchmark Employer Survey Finds

About 2.3 Million Young Adults Added to Parents' Plan As a Result of Health Reform

At Small Firms, One in Four Covered Workers Face Annual Deductible of $2,000 or More

MENLO PARK, Calif. -- After several years of relatively modest premium increases, annual premiums for employer-sponsored family health coverage increased to $15,073 this year, up 9 percent from last year, according to the Kaiser Family Foundation/Health Research & Educational Trust 2011 Employer Health Benefits Survey released today. On average, workers pay $4,129 and employers pay $10,944 toward those annual premiums.

Premiums increased significantly faster than workers' wages (2.1 percent) and general inflation (3.2 percent). Since 2001, family premiums have increased 113 percent, compared with 34 percent for workers' wages and 27 percent for inflation.

"This year's nine percent increase in premiums is especially painful for workers and employers struggling through a weak recovery," Kaiser President and CEO Drew Altman, Ph.D. said.

According to Maulik Joshi, Dr.P.H., president of HRET and senior vice president for research at the American Hospital Association, "survey findings related to the impact of early provisions in health reform provide valuable insight for employers, providers, consumers, and policymakers as they prepare for additional provisions to take effect by 2014."

The 13th annual Kaiser/HRET survey of small and large employers provides a detailed picture of trends in private health insurance costs and coverage. This year's survey also looked at employers' experiences with several already implemented provisions of the 2010 health reform law affecting employer coverage.

In particular, the survey estimates that employers added 2.3 million young adults to their parents' family health insurance policies as a result of the health reform provision that allows young adults up to age 26 without employer coverage on their own to be covered as dependents on their parents' plan. Young adults historically are more likely to be uninsured than any other age group.

"The law is helping millions of young adults to obtain health coverage. In the past, many of these young adults would have lost coverage when they left home or graduated college," said study lead author Gary Claxton, a Kaiser vice president and co-executive director of the Kaiser Initiative on Health Reform and Private Insurance.

The study also finds 31 percent of covered workers are in high-deductible health plans, facing deductibles for single coverage of at least $1,000, including 12 percent facing deductibles of at least $2,000. Covered workers in smaller firms (3-199 workers) are more likely to face such high deductibles, with half of workers in smaller firms facing deductibles of at least $1,000, including 28 percent facing deductibles of $2,000 or more.

These numbers in part reflect the rise of consumer-driven plans, which are high-deductible plans that include a tax-preferred savings options such as a Health

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Savings Account or Health Reimbursement Arrangement. Over the past two years, more firms have started to offer these plans, and the share of covered workers enrolled in this type of plan has doubled, from 8 percent in 2009 to 17 percent in 2011. Plans that can be used with a Health Savings Account have lower premiums than other plan types, but must have annual deductibles of at least $1,200 for an individual and $2,400 for a family this year.

Other Findings Related to Health Reform

The survey finds that 56 percent of covered workers are in "grandfathered" plans as defined under health reform. Grandfathered plans are exempted from some health reform requirements, including covering preventive benefits with no cost sharing and having an external appeals process. To obtain this status, employers cannot make significant changes to their plans that reduce benefits or increase employee cost.

One in four covered workers (23 percent) are in plans that changed their cost-sharing requirements for preventive services as a result of a requirement of the health reform law that non-grandfathered plans provide certain preventive benefits without cost sharing. In addition, 31 percent of covered workers are in plans that changed the list of preventive services due to health reform.

Other findings from the study include:

- **Worker-only coverage.** Premiums for worker-only health coverage increased 8 percent in 2011 to reach $5,429 annually. Workers on average pay $921 toward this coverage.
- **Offer rate.** The share of firms offering health insurance to their workers is 60 percent this year, comparable to the levels in 2009 and earlier years. Last year's survey found an unexplained sharp increase in the share of the smallest firms (3-9 workers) offering coverage, boosting the overall offer rate; this year's results suggest that the one-year bump did not reflect a change in the long-term trend.
- **Cost-sharing for office visits and drugs.** Covered workers facing copayments for in-network physician office visits on average pay $22 for primary care and $32 for specialty care. For covered workers with three- and four-tier drug plans, average copayments are $10 for generic drugs, $29 for preferred brand-name drugs, $49 for non-preferred brand-name drugs, and $91 for specialty drugs.
- **Retiree health benefits.** Among large firms (200 or more workers), about one in four (26 percent) offer retiree health benefits in 2011, unchanged from last year and down significantly from 32 percent in 2007.

Full survey results are available online at http://ehbs.kff.org.

Now in its 13th year, the survey is a joint project of the Kaiser Family Foundation and the Health Research & Educational Trust. The survey was conducted between January and May of 2011 and included 3,184 randomly selected, non-federal public and private firms with three or more employees (2,088 of which responded to the full survey and 1,096 of which responded to a single question about offering coverage). A research team at Kaiser and HRET conducted and analyzed the survey, led by Kaiser's Gary Claxton and including researchers at the NORC at the University of Chicago (working on the project under contract to HRET). For more information on the survey methodology, please visit the Survey Design and Methods Section at http://ehbs.kff.org.

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[Whereupon, at 11:38 a.m., the subcommittee was adjourned.]