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BARRIERS TO LOWER HEALTH CARE COSTS FOR WORKERS AND EMPLOYERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MAY 31, 2012

Serial No. 112–62

Printed for the use of the Committee on Education and the Workforce

Available via the World Wide Web:
www.gpo.gov/fdsys/browse/committee.action?chamber=house&committee=education
or
Committee address: *http://edworkforce.house.gov*

U.S. GOVERNMENT PRINTING OFFICE

74–392 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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C O N T E N T S

	Page
Hearing held on May 31, 2012	1
Statement of Members:	
Andrews, Hon. Robert E., ranking member, Subcommittee on Health, Employment, Labor and Pensions	4
Roe, Hon. David P., Chairman, Subcommittee on Health, Employment, Labor and Pensions	1
Prepared statement of	3
Statement of Witnesses:	
Fensholt, Edward, J.D., senior vice president, director, compliance services and health reform advisory practice, Lockton Benefit Group	6
Prepared statement of	8
Hall, Jody, owner, Cupcake Royale & Verité Coffee	18
Prepared statement of	20
Ramthun, Roy J., president, HSA Consulting Services, LLC	12
Prepared statement of	14
Streitberger, William, vice president of human resources, Red Robin Gourmet Burgers, Inc.	23
Prepared statement of	25
Additional Submission:	
Chairman Roe: PowerPoint slide, "Tax Changes"	52

BARRIERS TO LOWER HEALTH CARE COSTS FOR WORKERS AND EMPLOYERS

Thursday, May 31, 2012
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. David P. Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, Wilson, Thompson, Walberg, DesJarlais, Rokita, Bucshon, Noem, Heck, Ross, Andrews, Kildee, Hinojosa, Holt, Scott, and Altmire.

Also present: Representative Miller.

Staff present: Andrew Banducci, Professional Staff Member; Katherine Bathgate, Deputy Press Secretary; Adam Bennot, Press Assistant; Casey Buboltz, Coalitions and Member Services Coordinator; Molly Conway, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Benjamin Hoog, Legislative Assistant; Barrett Karr, Staff Director; Ryan Kearney, Legislative Assistant; 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; Tylease Alli, Minority Clerk; Jody Calemine, Minority Staff Director; John D'Elia, Minority Staff Assistant; Richard Miller, Minority Senior Labor Policy Advisor; Megan O'Reilly, Minority General Counsel; and Michele Varnhagen, Minority Chief Policy Advisor/Labor Policy Director.

Chairman ROE. Call the meeting to order, and today before we get started we have a guest here today that I would like to introduce from my home state. It is William Bell.

And William, if you would stand up just so people can see you here?

William is—today he drew the short straw. He gets to shadow me all day today for the Foster Youth Shadow Day program, and he—William entered foster care at age 15 and he represents now 3,000 young people in Nashville, Tennessee here in Washington. Their foster care youth have come from all over the country.

William is doing great. He is in one of our technology centers studying to be an electrician and will finish in 6 months.

And, William, welcome today to our hearing. [Applause.]

A quorum being present, the Subcommittee on Health, Employment, Labor, and Pensions will come to order. Good morning, everyone.

I would like to thank our witnesses for being here and offering their thoughts during today's subcommittee hearing on health care costs.

With 160 million Americans acquiring health insurance through an employer-sponsored plan, job creators clearly play a critical role in the nation's health care system. As a result, employers know all too well the difficult challenges of expanding access to affordable health care.

To help control the cost of offering insurance employers have traditionally maintained a great deal of flexibility over the design of their health benefits plan they provide. This has led to some tough decisions, especially during times when a business is struggling to make ends meet. However, preserving an employer's ability to navigate a complex health care market even during an uncertain economic environment has served us well for decades.

Many employers have found consumer-directed health care as one way to better manage costs on behalf of workers. One particularly popular choice is to pair a high deductible health plan with a health savings account. This allows individuals to guard against the cost of catastrophic medical treatment while also setting aside a portion of their pretax income to pay for future medical expenses.

Demand for consumer-directed health plans is on the rise. For example, America's Health Insurance Plans report an estimated 13.5 million individuals had a health savings account last January, compared to just 3.2 million in 2006.

The popularity of health reimbursement accounts and flexible spending accounts among workers is also growing, and employers have shown their support, as well. According to the Kaiser Family Foundation, nearly 70 percent of employees with a workplace-sponsored health savings account received employer contributions.

Consumer-directed health plans offer common-sense options to help millions of individuals secure a benefit plan that meets their health care needs at an affordable price. Unfortunately, recent policy changes threaten the success of these important plans.

President Obama's 2010 health care law placed an arbitrary cap on contributions to flexible spending accounts, severely limiting the annual amount workers are allowed to save. The law also prohibited the use of flexible spending accounts and health savings accounts when purchasing over-the-counter medications, forcing individuals to spend more time and money visiting their doctor to obtain prescriptions.

Additionally, a bulletin released by the administration suggests government bureaucrats are crafting an unusual accounting scheme that will severely undervalue the contribution workers and employers make to a health savings account, which may actually discourage employers from offering this benefit in the future.

I am pleased that the Ways and Means Committee is considering legislation today that will help roll back a number of these harmful policies, reflecting a commitment by this Congress to dismantle the job-destroying health care law. However, even though more than 12,000 pages of rules and regulations have been written there are

still many unanswered questions surrounding the law that make it virtually impossible for any employer, large or small, to plan for the future.

We still don't know how the administration will ultimately define the "essential health benefit." Up to now the administration has operated in the regulatory shadows and outside the formal rulemaking process, delivering uncertainty instead of the facts on its regulatory proposal. We still don't know why the administration chose not to fulfill the intent of the law's grandfather provision, choosing instead to raise regulatory roadblocks that will significantly alter the health care of millions of Americans.

And we don't know what small businesses will do now that a highly touted tax credit has proven to be a failure. A Government Accountability Office study reveals the small business tax credit has helped few employers, thanks in part to the costly administrative burden. As the Associated Press reports, the tax credit "has turned out to be a disappointment."

Forcing the nation into a costly government-run health care scheme is perhaps the greatest obstacle to more affordable health care. The American people deserve every opportunity to pursue new initiatives that will lower health care costs.

We should empower individuals and employers to create a health care plan that best fits the needs of their families and workplaces. Unfortunately, the 2010 health care law stands in their way.

As members of Congress we have a responsibility to examine federal policies and hear directly from those who live with the consequences. I am pleased that we have a number of employers who will share their thoughts on health care costs, as well as various experts to help inform the subcommittee of the technical aspects of the policies we will address today. I look forward to our discussion.

I will now recognize my distinguished colleague, Rob Andrews, the senior Democratic member of the subcommittee, for his opening remarks.

[The statement of Chairman Roe follows:]

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

Good morning, everyone. I would like to thank our witnesses for being with us and offering their thoughts during today's subcommittee hearing on health care costs.

With 160 million Americans acquiring health insurance through an employer-sponsored plan, job creators clearly play a critical role in the nation's health care system. As a result, employers know all too well the difficult challenge of expanding access to affordable health care.

To help control the cost of offering insurance, employers have traditionally maintained a great deal of flexibility over the design of the health care benefits they provide. This has led to some tough decisions, especially during times when a business is struggling to make ends meet. However, preserving an employer's ability to navigate a complex health care market, even during an uncertain economic environment, has served us well for decades.

Many employers have found consumer-directed health care as one way to better manage costs on behalf of workers. One particularly popular choice is to pair a high deductible health plan with a health savings account. This allows individuals to guard against the cost of catastrophic medical treatment while also setting aside a portion of their pretax income to pay for future medical expenses.

Demand for consumer-directed health plans is on the rise. For example, America's Health Insurance Plans reports an estimated 13.5 million individuals had a health savings account last January, compared to just 3.2 million in 2006. The popularity of health reimbursement accounts and flexible spending accounts among workers is

also growing, and employers have shown their support as well. According to the Kaiser Family Foundation, nearly 70 percent of employees with a workplace-sponsored health savings account received employer contributions.

Consumer-directed health plans offer commonsense options to help millions of individuals secure a benefit plan that meets their health care needs at an affordable price. Unfortunately, recent policy changes threaten the success of these important plans.

President Obama's 2010 health care law placed an arbitrary cap on contributions to flexible spending accounts, severely limiting the annual amount workers are allowed to save. The law also prohibited the use of flexible spending accounts and health savings accounts when purchasing over-the-counter medications, forcing individuals to spend more time and money visiting their doctor to obtain prescriptions.

Additionally, a bulletin released by the administration suggests government bureaucrats are crafting an unusual accounting scheme that will severely undervalue the contribution workers and employers make to a health savings account, which may actually discourage employers from offering this benefit in the future.

I am pleased the Ways and Means Committee is considering legislation today that will help roll back a number of these harmful policies, reflecting a commitment by this Congress to dismantle the job-destroying health care law. However, even though more than 12,000 pages of rules and regulations have been written, there are still many unanswered questions surrounding the law that make it virtually impossible for any employer—large or small—to plan for the future.

We still don't know how the administration will ultimately define an "essential health benefit." Up to now, the administration has operated in the regulatory shadows and outside the formal rulemaking process, delivering uncertainty instead of the facts on its regulatory proposal.

We still don't know why the administration chose not to fulfill the intent of the law's grandfather provision, choosing instead to raise regulatory roadblocks that will significantly alter the health care of millions of Americans.

And we don't know what small businesses will do now that a highly touted tax credit has proven to be a failure. A Government Accountability Office study reveals the small business tax credit has helped few employers, thanks in part to its costly administrative burden. As the Associated Press reports, the tax credit "has turned out to be a disappointment."

Forcing the nation into a costly, government-run health care scheme is perhaps the greatest obstacle to more affordable care. The American people deserve every opportunity to pursue new initiatives that will lower health care costs. We should empower individuals and employers to create a health care plan that best fits the needs of their families and workplaces. Unfortunately, the 2010 health care law stands in their way.

As members of Congress, we have a responsibility to examine federal policies and hear directly from those who live with the consequences. I am pleased we have a number of employers who will share their thoughts on health care costs, as well as various experts to help inform the subcommittee of the technical aspects of the policies we will address today.

I look forward to our discussion. I will now recognize my distinguished colleague Rob Andrews, the senior Democratic member of the subcommittee, for his opening remarks.

Mr. ANDREWS. Thank you, Mr. Chairman. The term "senior" is so grave.

Okay. Thanks for your friendship and thanks for this opportunity.

William, welcome to Washington. You are shadowing a person with a lot of integrity and ability and we are very hopeful that you will be able to achieve great things in your life. Welcome. We are happy to have you with us.

I would like to also thank the witnesses for being here and begin with a couple of points in which I would part company with the chairman's statement, and then talk about some things we have in common that I hope we can work on today to find some solutions to our country's problems.

I do agree that the—we are disappointed with the number of businesses that have taken advantage of the tax credit thus far to buy health insurance for their employees. I think the record will show the reason for that is the credit isn't quite generous enough and it doesn't extend to enough employers. And frankly, if we could find a way to make it reach more small businesses in a more dramatic way, it might increase the uptake, and that is something we should work on together.

With respect to the proposition that we don't want to force people into a government-run health plan, I agree completely. And that is why the 2010 law does not do that at all. What it does is create more choices and more attractive options for employers and individuals to find the health care that best suits their families.

There is no government health plan created by the 2010 law. What there is are marketplaces set up around the country called exchanges that, if you think about it, they are almost like a Costco or a Sam's Club, where you can go into a marketplace and increase and leverage your purchasing power to get more for your business or your family.

And finally, we heard that it is a job-destroying health care law. This is part of the narrative of the season. It is the campaign season.

The fact is, of course, that private sector employers have added more than 4 million new private sector jobs since the law went into effect in March of 2010. Now, let's talk about what we agree on.

We want to do something so that we can control rising health care costs for employers and families while improving the quality of health care for employers and families and not rationing it or limiting it in any way. And I think there are three strategies that would help us achieve that objective.

One is to encourage more people to take personal responsibility for their own health care—diet, exercise, wellness checkups—a sense where we all are the CEO of our own health care plan, in that respect. To the extent that we can educate and encourage people to do that, I think there is essential unanimity on that point.

Second, we need to change the way hospitals and doctors and medical organizations deliver health care. Right now, if you run an MRI center and I run an MRI center—I am very glad I don't run one; I wouldn't be very good at it—if I do more procedures than you do I make more money than you do, particularly for Medicare. The more procedures you do the more money you make.

We really ought to have a payment system that measures the quality of how well we work. If your MRI system or business has an outstanding track record of identifying problems early on and helping someone heal and recover from them, you should be rewarded for your success rate and encouraged to do that; and if I am not so good at it, there ought to be some economic consequences for me. So changing the way hospitals and health care providers provide health care is another important thing that we have to do.

And then finally, I think that we can help achieve this goal of more affordable health insurance for employers, and families, and individuals by having more competition in the health insurance marketplace. Virtually every American lives in a health insurance marketplace where only one or two or sometimes three health in-

surance underwriters have 90 or 95 percent of the market. This is not true of our cell phones; this is not true of the groceries we buy; this is not true of the coffee that we buy; it is not true of the restaurants we eat at; it is not true of the hotels that we stay at; it is not true of the banks that we put our money in.

Competition works in the American economy and there is not enough competition among health insurance underwriters.

I believe the new law facilitates the progress toward each of those three points. It can encourage wellness; it can encourage reform of our delivery system; and it can encourage fruitful competition among health insurance plans to provide the best deal for employers and for families.

These are the issues on which we should focus, and I know we have four witnesses this morning who can help us in a very significant way.

I thank you for traveling to be here and I look forward to your testimony.

Chairman ROE. Thank you.

It is now my pleasure to introduce—excuse me. Pursuant to 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 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

It is now my pleasure to introduce our distinguished panel.

First is Mr. Ed Fensholt. He is the senior vice president and director of compliance services at Lockton Companies LLC, Lockton's Benefit Group, in Kansas City, Missouri, and you have—your group has testified here before. We welcome you back.

Roy Ramthun is the president of HSA Consulting Services, in Washington, District of Columbia.

Welcome.

Jody Hall is the founder and owner of Cupcake Royale, in Seattle, Washington. I have had the privilege of summiting Mt. Rainier four times, so I have been out in your great state many times. That doesn't say much about my intelligence, but anyway I enjoy it.

Bill Streitberger is the vice president of human resources at Red Robin International, in Greenwood Village, Colorado.

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 the—you will turn green; when 1 minute is left the light will turn yellow; and when your time is expired the light will turn red at which point I will ask you to wrap up your remarks as best you are able to.

After everyone has testified members will each have 5 minutes to ask questions of the panel.

I will now begin with Mr. Fensholt?

STATEMENT OF ED FENSHOLT, SENIOR VICE PRESIDENT, LOCKTON COMPANIES, LLC

Mr. FENSHOLT. Chairman Roe, Ranking Member Andrews, and members of the committee, my name is Edward Fensholt and I am

a senior vice president of Lockton Companies, LLC, the world's largest privately-held insurance brokerage and consulting firm. We provide employee benefits expertise to 2,500 mostly middle market employers.

We and our clients appreciate the stated goal of the Affordable Care Act and very much appreciate the efforts made to date by federal agencies to take employer concerns into account in crafting regulations and other guidance. Yet there is no question that the act has, to this date, bent the health insurance cost curve north, not south, and the forecast in that regard is growing darker.

The act requires health care plans to cover individuals they did not cover in the past, eliminate lifetime and annual dollar maximums, and provide a great many preventive care services, including, beginning several months from now, contraception drugs and devices at no out-of-pocket cost to the enrollee. These mandates have increased our clients' health plan costs 2 to 3 percent on average to this point. For some sectors the increase is more.

In 2014 or shortly thereafter plans must reduce waiting periods to 90 days and automatically enroll eligible full-time employees in coverage. Reductions in waiting periods will add up to 25 percent to the cost of plans that now have a 6-or 12-month waiting period, which is not uncommon in the construction and trucking industries.

Our actuaries expect the automatic enrollment requirement to add 4.4 percent to health insurance costs—more than that in the retail, restaurant, and hospitality sectors.

The act levies billions of dollars in excise taxes against health insurance, pharmaceutical and medical device manufacturing industries, and on third party payers of self-insured medical claims. The taxes on health insurers and TPAs alone amount to $20 billion in 2014. Insurers we have talked to and our own actuaries estimate that the price of group health insurance in 2014 will rise $10 to $15 per employee per month as a result of these excise taxes.

Of great frustration to our clients are the act's many additional administrative burdens. Under federal law and regulations today a simple group health care plan is required to supply up to more than 50 separate notices, disclosures, and reports to enrollees or the federal government, many of these more than once. The Affordable Care Act added more than a dozen of these.

Here are some of them: Plans are or will be required to notify enrollees regarding the plan's retention of grandfathered status, the plan's temporary waiver from the annual dollar limit prohibitions, and the availability of health insurance exchanges, just to name a few. Employers must report the value of medical plan coverage on Forms W-2, not to reflect a taxable event but simply because Congress wanted to collect the information.

Plans must supply a four-page, double-sided summary of plan coverage in a very hardwired format and at specific times not only to enrollees but to individuals who are merely eligible for coverage. And plans face fines of up to $1,000 per violation of this requirement.

The "play or pay" mandate imposed on all but the smallest employers in 2014 and beyond requires significant and frequent reporting by employers regarding the employer's specific medical cov-

erage offerings, a roster of eligible and enrolled employees, and the full-time or part-time status of those employees, the cost of the employer's coverage offerings, and the employer's and the employee's respective shares of that cost, the actuarial value gauged against benchmarks of the employer's coverage offerings, and the number of months during the year during which an employee and each of his enrolled dependents were covered by a plan sponsored by the employer.

In conclusion, our clients are already drowning under the cost of providing robust health insurance to employees. Rather than tossing employers a lifeline, the Affordable Care Act is in many ways an anchor, albeit a well-intentioned one, by piling on additional costs and burdens.

An Oliver Wyman report out yesterday reveals that two-thirds of employers surveyed say health insurance cost trend is unsustainable even if the trend is reduced 5 percent. And here the ACA is adding cost.

Our clients simply do not understand, Mr. Chairman, why at a time when they struggle to supply this valuable fringe benefit, now the most expensive element of compensation next to wages, Congress would make the process more expensive and more complicated rather than less so.

Thank you.

[The statement of Mr. Fensholt follows:]

Prepared Statement of Edward Fensholt, J.D., Senior Vice President, Director, Compliance Services and Health Reform Advisory Practice, Lockton Benefit Group

Chairman Roe, Ranking Member Andrews and members of the Committee, my name is Edward Fensholt and I am a Senior Vice President of Lockton Companies, LLC. Lockton is the largest privately-held insurance brokerage and consulting firm in the world. Domestically, Lockton employs 2,300 associates in 24 offices nationwide who serve the insurance risk needs of approximately 9,000 employer clients from coast to coast. Lockton Benefit Group ("LBG") is the employee benefits consulting arm of Lockton Companies, LLC, and provides employee benefits consulting services to approximately 2,500 of those clients.

LBG provides consulting expertise related to qualified and nonqualified retirement plans, group life and disability insurance programs, voluntary supplemental benefits, dental, vision, and comprehensive group medical benefit packages. The majority of our 2,500 employee benefits clients employ us to assist in the design and administration of their group medical insurance programs.

I am the Director of LBG's Compliance Services Division, and also lead our Health Reform Advisory Practice, a multi-disciplinary team of professionals formed to steer our clients through the federal health reform initiative. On behalf of Lockton I thank you for the opportunity to appear here today to share our observations and our clients' views regarding the impact of aspects of last year's health reform law on the group health plans sponsored by our clients.

Most LBG clients are "middle market" employers, employing between 500 and 2,000 employees. Our clients include private and governmental employers, and employers across many industry segments, including construction, healthcare, manufacturing, transportation, retail, professional services firms, and the hospitality/entertainment industry.

More than half of LBG's clients maintain self-insured group health plans. The others purchase group health insurance from licensed insurance companies.

The PPACA Imposes Additional Costs on Employment-Based Health Insurance

The Patient Protection and Affordable Care Act of 2010 ("PPACA") is a sweeping piece of legislation affecting the health insurance marketplace, the Medicaid program, the Medicare program, and health care providers from doctors to nurses to hospitals and community health clinics. It affects health insurers, group insurance plans (both insured and self-insured), the employers who offer them, and the em-

ployees and their dependents enrolled in those plans. My comments today are confined to the cost impacts on the latter, that is, the impact of the PPACA on employers who sponsor group health insurance plans, and the employees and dependents who receive coverage through those plans.

Let me say at the outset that neither Lockton nor the vast majority of its clients have any quarrel with the stated goal of the PPACA, that is, to provide health insurance protection to millions more Americans who want or need it, but cannot afford it. We and the law's proponents may disagree on how that should be provided, who should bear the administrative burden, who should pay for the new entitlements and how to allocate the nation's financial resources to provide them. But we appreciate the stated goal behind the measure.

As a firm heavily engaged in analyzing the statutory and regulatory construct of the PPACA, and advising and shepherding our clients through that construct, we have respect for and appreciate the efforts of the federal administrative agencies working hard to implement the law as Congress has mandated they must. In listening to and speaking with officials from the Labor Department, the IRS and the Department of Health and Human Services, and analyzing the guidance they have issued thus far, it's clear that federal regulators are making a strong effort to listen to the employer community, to understand the concerns of employers, and to endeavor to balance the needs of employers with the needs of those individuals the PPACA was intended to benefit.

That said, there's no question the PPACA has, to this date, bent the health insurance cost curve north, not south. As additional taxes, fees and mandates on employer-based health coverage come on line, we fear the health insurance affordability forecast will continue to deteriorate. Let me mention a few examples for the Committee.

2011 Coverage Mandates

Health plans are already complying with the obligations to cover adult children to age 26 (even if married and non-dependent upon the employee), to waiver preexisting condition restrictions on newly enrolled children, and to eliminate lifetime and annual dollar maximums on what the PPACA terms "essential health benefits." Most plans in our book of business have lost grandfathered status under the PPACA, subjecting them to additional mandates such as the obligation to cover a wide-variety of preventive care services—including, beginning several months from now, well women care, including contraception drugs and devices—at no out-of-pocket cost to the enrollee.

The increase in health insurance costs to employers in our book of business, to implement these mandates, has been 2-3 percent. For some sectors the increase is more, for some it is less.

There is also a new nondiscrimination rule that applies to fully insured medical coverage. Lockton has clients—such as regional and national restaurant chains, retail establishments and other employers in the hospitality industry—who currently supply typical medical coverage to corporate staff and select others (such as restaurant, store or hotel managers) but cannot afford to offer the same level of coverage, at the same rate of employer subsidies, to hourly employees. Maintaining the status quo, however, might subject these employers to excise taxes of $100 per day per hourly employee who does not receive an equivalent offer of coverage.

It is possible, depending on how federal regulators flesh out the requirements of the nondiscrimination rule, that these employers will simply have to terminate their existing group coverage. However, the nondiscrimination rule has yet to be interpreted by the regulatory agencies, and therefore our actuaries have not yet estimated the cost impact of this mandate.

2014 Coverage Mandates

Additional coverage mandates apply beginning in 2014. For example, health plans must reduce waiting periods to 90 days, and auto-enroll eligible full-time employees in available employer-based coverage.[1] Depending on the employer's industry segment, these additional expenses can be substantial. For example, our clients in the construction and transportation industries—where we find 6-month or even 12-month waiting periods—can expect to see significant cost increases. Our actuaries tell us these clients with 6-month waiting periods currently should see a cost in-

[1] Federal regulators recently deferred the compliance deadline for the automatic enrollment rules, concluding guidance regarding how to implement the requirement will not be ready by 2014.

crease of an additional 4% in 2014; those with a 12-month waiting period should see a cost increase of nearly 25%.

Our actuaries tell us that, across all industry segments other than retail and hospitality, our clients can expect to experience a 4.4% cost increase attributable to the automatic enrollment requirement.[2]

Taxes and Fees

To at least partially offset the cost of the health reform law, Congress (in the PPACA) levied excise taxes against the health insurance, pharmaceutical and medical device manufacturing industries, and on third-party administrators (TPAs) of medical claims. Of course, health insurers and TPAs will simply pass along these additional costs in the price of their products.

The taxes on health insurers and TPAs amount to $20 billion in 2014. Insurers we've talked to, and our own actuaries, estimate that the price of group health insurance in 2014 will rise $10-15 per employee, per month (or about 2-3 percent) on account of these excise taxes alone.

Health plans are also subject to a $1 per covered life fee in 2012, increasing to $2 per covered life next year and beyond (subject to inflation-based adjustments), to pay for "comparative effectiveness research," or research into medical "best practices."

Administrative Burdens

Of great frustration to our clients are the many additional administrative burdens, and their attendant costs, imposed by the health reform law. The majority of our clients want to continue to supply health insurance, but they struggle with the cost and the federally-imposed complexity of plan administration.

For example, under federal law and regulations today, a simple group health plan is required to supply up to more than 50 separate notices, disclosures and reports to its enrollees and the government (many of those more than once). Virtually every aspect of plan administration, from enrollment to benefit summaries to specific eligibility and benefit requirements, to claim processing times and the timing, form and cost of post-employment coverage, are now under (primarily federal) statutory or regulatory dictates.

The PPACA has added more than a dozen additional notice and disclosure obligations to health plan administration. This frustrates our clients immensely. They do not understand why, at a time when they struggle to supply this valuable fringe benefit—which is now the most expensive element of employee compensation, behind wages—Congress would make the process more expensive and more complicated, rather than less so.

A full 80 percent of our clients said, in responding to a survey we conducted last year, that they were "concerned" or "very concerned" about the additional administrative complexity created by the PPACA. They tell us the additional costs, complexity and uncertainty wrought by the PPACA affect their ability to hire additional workers, or to retain full-time employees.

Here are just some of the additional administrative obligations imposed upon health plan sponsors by the PPACA:

- Plans are (or will be) required to notify enrollees regarding the plan's retention of grandfathered status under the PPACA, the plan's obtaining a waiver from the annual dollar limit prohibitions, the right of enrollees to designate certain physicians as a child's primary care physician, the availability of health insurance exchanges, the plan's participation in the Early Retiree Reinsurance Program, and the retroactive loss of coverage due to misrepresentation or fraud.
- Employers must report the value (employer- and employee-paid) of medical plan coverage on Forms W-2, not to reflect a taxable event, but simply because Congress wanted to collect the information. Because many employees change their level of health coverage during the taxable year (due to marriage, domestic partnership, divorce, birth or emancipation of a covered child, etc.), employers must track the changes in values of the coverage, to ensure accurate reporting.
- Although the Employee Retirement Income Security Act (ERISA) already required most employers to supply health plan enrollees with a "summary plan description" summarizing their health coverage, the PPACA imposes an additional requirement to supply a four-page (double-sided) summary of plan coverage, in hardwired format and at specific times, to not only enrollees but also to individuals

[2] In modeling the effect of the automatic enrollment provision, our actuaries assumed that 75% of employees who are newly eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will opt out of coverage.

merely eligible for coverage. Health plans face fines of up to $1,000 per violation of this requirement.

• The "shared responsibility" obligations imposed on all but the smallest employers in 2014 and beyond will significantly ratchet up the administrative obligations on employers subject to those obligations. o Many employers will face substantial complexity in determining when their employees are considered "full-time" for PPACA purposes, triggering an obligation on the employer to offer them at least "minimum essential coverage" or risk various penalties. The challenge will be particularly acute for seasonal employers. While the administrative agencies—the IRS in particular—have done an admirable job working to strike a balance between pragmatism and the PPACA's literal requirements, we expect the process to remain significantly burdensome.

In order for federal authorities to coordinate employers' "shared responsibility" obligations with the availability (to the uninsured) of taxpayer subsidies in the new health insurance exchange, federal and state authorities will need employers to submit detailed reports on a regular basis, reports reflecting:

• The employer's specific medical coverage offerings,

• A roster of eligible and enrolled employees, and the full-time or part-time status of the employees,

• The cost of the employer's coverage offerings, and the employer's and employees' respective shares of that cost,

• The actuarial value, gauged against designated benchmarks, of the employer's coverage offerings, and

• The number of months (during the year) for which an employee, and each of his enrolled dependents, were covered by a plan sponsored by the employer.

Last week came word from Washington that the IRS is re-evaluating how to assess the "affordability" of an employer's coverage offering to a full-time employee. Under the PPACA, if the employer's offer of coverage requires the employee to pay more than 9.5 percent of his or her household income for coverage, the coverage is considered "unaffordable" and the employee may qualify for taxpayer-supplied subsidies to buy insurance in a health insurance exchange. If that occurs, the employer will incur a $3,000 annual nondeductible penalty with respect to that employee.

The legislative history to the PPACA is scant, but what history exists is clear that the "affordability" test was to be applied to employee-only coverage, not family coverage. The IRS has initially said this is how it interpreted the statute.[3]

Now comes word that the IRS might, in fact, require that family coverage meet this affordability test. If federal authorities are going to require employers to heavily subsidize a full-time employee's family coverage, so that family coverage does not cost the employee more than 9.5 percent of his or her household income, the number of employers exiting the group insurance market, and dumping their employees into the health insurance exchanges, will be far greater than the Congressional Budget Office has estimated to date. That has profound implications for the dollars budgeted to supply taxpayer-funded subsidies in the exchanges.

The flight from the group insurance marketplace will most acute in industries where the employees tend to be modestly paid, hourly workers. Employers will opt to pay the relatively modest $2,000 per full-time employee penalty for offering no insurance, rather than pay larger subsidies for health insurance for the employees and their dependents. Congress can also expect to see many employer sectors transition full-time employees to part-time status, to take the employees out of the penalty equation.

What Employers Appreciate About the PPACA

This is not to say that employers are concerned about every aspect of the insurance reforms reflected in the PPACA. Some employers who buy group insurance (as opposed to self-insuring medical coverage) will receive refunds this August from insurers who failed to reach specific medical loss ratios in the given state.

And the PPACA supplies greater leverage to employers to encourage employees to make lifestyle changes to improve their health. The law allows employers to require unhealthy employees to pay an additional amount—up to 30 percent of the total cost the employee's coverage, up from 20 percent under pre-PPACA rules—for their health insurance, to account for the additional risks they pose to the health plan.

[3] The IRS has also indicated a willingness to allow employers to utilize W-2 wages as a surrogate for "household income" in the affordability calculation.

Conclusion

Lockton greatly appreciates the opportunity to appear before you today. In assessing the impact of the health reform legislation, we urge you to place yourselves not only in the shoes of those Americans who need access to affordable insurance, but in the shoes of the employers who supply valued coverage to 160 million of us.

Employers are burdened and frustrated by aspects of the health reform law that add costs and complexity to their health plans, and may lead some of them to eliminate group coverage and full-time jobs.

We welcome the opportunity to work with you to mitigate these burdens on the employer community.

Chairman ROE. Thank you.

Mr. Ramthun?

STATEMENT OF ROY RAMTHUN, PRESIDENT, HSA CONSULTING SERVICES

Mr. RAMTHUN. Chairman Roe, Ranking Member Andrews, and other members of the committee, I would like to thank you for this opportunity to testify before your subcommittee today. My name is Roy Ramthun and I am a private consultant here in the Washington, D.C. area.

I would like to take this opportunity to discuss one of the bright spots in health coverage benefits, that known as account-based health plans—health insurance plans paired with an HSA or HRA. These are the fastest-growing product in the market for employer-based group health plans.

It is my opinion that account-based health plans have helped to arrest the decline in employer-based health coverage. That said, I am uncertain that even account-based health plans can overcome the new employer responsibilities and costs of complying with the Patience Protection and Affordable Care Act. I will touch on some of these issues during my testimony today.

Account-based health plans now account for about 15 percent of all employer-sponsored health coverage. The consulting firm Towers Watson states that nearly 60 percent of employers have implemented account-based health plans and that number will increase to 70 percent by 2013. Twelve percent of employers now offer total replacement plans, where account-based health plans are the only option offered to employees.

What is fueling this growth? Certainly one of the reasons is the dramatic increase in health insurance costs over the past decade. Milliman Incorporated recently reported that health care costs for the typical family of four are projected to reach over $20,000 through an employer-sponsored PPO plan this year.

In contrast, companies with at least half of their workers enrolled in an account-based health plan report that their per-employee costs are over $1,000 lower than companies without an account-based health plan. This is hard evidence for bending the cost curve that is so elusive for the rest of our nation's health care system.

Several insurance carriers have similarly reported dramatic savings for employers that switch to account-based health plans. This potential for reducing health care spending was recently confirmed by researchers at the RAND Corporation.

Their analysis suggests that the health care spending in the U.S. could drop by $57 billion per year if account-based health plans grow to represent half of all employer-sponsored in the U.S. They estimate that the annual savings would be as high as $73.6 billion if all these individuals were enrolled in HSA plans.

But account-based health plans are not just about saving money. It is also about how the money is saved—by changing how employees think about their health and taking action to improvement. In my written testimony I address some of the common misperceptions about account-based health plans, including that account-based health plans don't cover preventive services and generally offer skimpier coverage, that individuals will forego needed care just to save money, that individuals will go bankrupt due to high out-of-pocket costs, and that patients will be overcharged and unable to navigate the complex world of health care.

Why isn't every company offering account-based health plans? Well, they may have to if the so-called "Cadillac plan" tax goes into effect in 2018.

I believe that companies have few other options as effective as account-based health plans to keep their costs below the thresholds where the excise tax will affect them. However, other issues are or will create challenges much sooner than 2018.

For example, employees with HSAs, HRAs, and even FSAs must now obtain a prescription from their doctor to seek reimbursement for over-the-counter medicines. In 2014 the health reform law will require employer-based health plans to limit their plan deductibles to no more than $2,000 for single persons and $4,000 for family persons. Many employers are already offering account-based health plans with deductibles above these limits.

Also in 2014, the law will require employer-based health plans to provide a minimum actuarial value of at least 60 percent. While this sounds reasonable, recent guidance issued by the Internal Revenue Service and HHS proposed to devalue the typical employer contributions to HSAs and HRAs when determining whether a plan provides the minimum actuarial value. Thus, some account-based health plans might not meet the minimum 60 percent standard.

In my written testimony I cite statements from the American Academy of Actuaries and the Congressional Budget Office suggesting that this policy should be changed. I agree completely and I believe that employer and employee contributions to HSAs should be valued at the full amount of the contributions, not adjusted.

Another issue of concern is the new minimum medical loss ratio requirements. Unfortunately, the regulations do not adequately take into account HSA or HRA contributions, thus making it extremely challenging for account-based health plans to meet the MLR requirements, limiting the availability of these plans to small-and medium-sized employers in the future.

In closing, strategies like account-based health plans that reduce employer health benefit costs free up money that companies can use to stimulate the economy by raising wages, creating jobs, or making critical investments for the future. We also need to ensure that workers will be permitted to keep the coverage they have, as was promised throughout the health reform debate.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to provide this testimony today. I look forward to the opportunity to discuss these issues in greater detail and am pleased to answer any questions you may have.

Thank you.

[The statement of Mr. Ramthun follows:]

Prepared Statement of Roy J. Ramthun, President, HSA Consulting Services, LLC

Chairman Roe, Ranking Member Andrews and the other members of this Committee, I would like to thank you for this opportunity to testify before the Subcommittee on Health, Employment, Labor and Pensions about the barriers to lower health care costs for workers and employers. My name is Roy Ramthun, and I am a private consultant in nearby Silver Spring, MD. My consulting practice focuses primarily on helping employers, financial institutions, and consumers to better understand and take advantage of the benefits offered by consumer-driven health care programs such as Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and their associated health insurance plans.

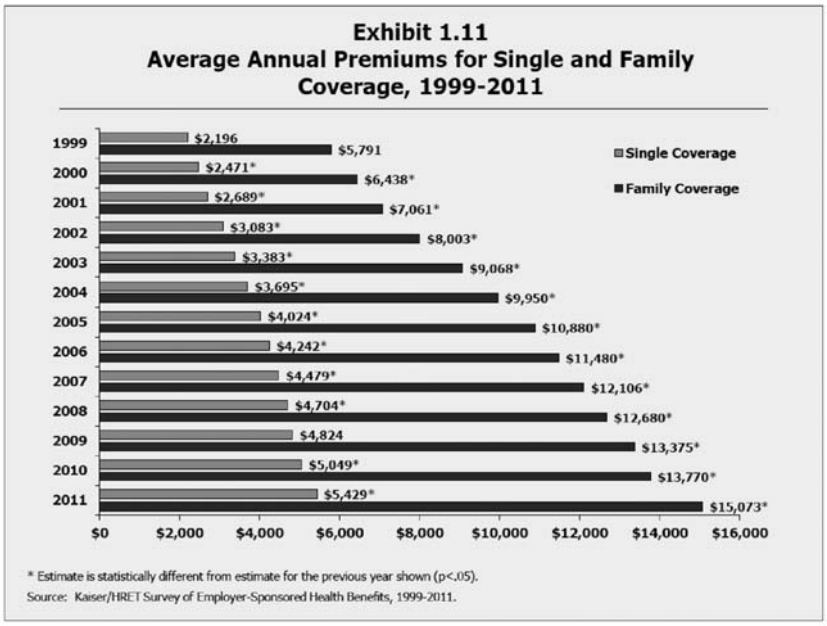
I have had the distinct honor to serve our country in positions at the Department of Health and Human Services (HHS), the Treasury Department, the White House, and the U.S. Senate Committee on Finance. While at the Treasury Department, I led the implementation of the Health Savings Account program after its enactment in 2003. I started my own consulting practice after leaving the White House in 2006 to devote my full time and attention to this program and related issues.

Account-based health plans—health insurance plans paired with HSAs and HRAs—are the fastest growing product in the market for employer-based group health plans. There is no disputing the fact that the number of employers offering group health plan coverage to their employees has declined as the cost of providing coverage has increased. It is my opinion that account-based health plans have helped arrest this decline. That said, as employers wrestle with the decisions whether or not to continue sponsoring health insurance benefits, I am uncertain that even account-based health plans can overcome the new employer responsibilities and costs of complying with the Patient Protection and Affordable Care Act. I will touch on some of those issues during my testimony today.

Account-based health plans are approximately 10 years old, but have grown substantially over the past decade. Estimates vary, but account-based health plans now account for about 15 percent of all employer-sponsored health coverage. The Employee Benefit Research Institute (EBRI) says approximately 21 million Americans were covered by an account-based health plan in 2011, up 40 percent from 2010. The number is certainly higher for this year as the number of Americans covered by HSA-based plans is approximately 13.5 million, as reported just this week by America's Health Insurance Plans (AHIP). There is no reliable survey of HRA-based plans, but my best guess is that another 11-12 million Americans are covered by these plans.

The consulting firm Towers Watson states that nearly 60 percent of employers have implemented account-based health plans, and that number will increase to 70 percent by 2013. Twelve percent of employers now offer "total replacement" plans—where account-based health plans are the only option offered to employees—up from 7.6 percent in 2010. Enrollment by employees in account-based plans has nearly doubled in the past two years, from 15 percent in 2010 to 27 percent in 2012.

What is fueling this growth? Certainly one of the reasons is the dramatic increase in health insurance costs over the past decade. According to the 2011 Kaiser Family Foundation/Health Research & Educational Trust annual survey of employer benefits, the cost of family coverage more than doubled over the previous 10 years (see exhibit below). Other surveys suggest that costs may be even higher. For example, Milliman Inc. recently reported that health care costs for the typical family of four are projected to reach $20,728 through an employer-sponsored preferred provider organization (PPO) plan this year. The 6.9 percent increase over 2011 is actually the lowest rate of increase Milliman has seen in the 10 years of this study.



Contrast that to the experience of employers who have account-based health plans. According to Towers Watson and the National Business Group on Health, companies that successfully move their employees into account-based health plans can achieve significant savings on their health benefit costs. For example, companies with at least half of their workers enrolled in an account-based health plan report that their per-employee costs are over $1,000 lower than companies without an account-based health plan. This is hard evidence for "bending the cost curve" that is so elusive for the rest of our nation's health care system.

Similarly, Aetna reported late last year that employers who switched to account-based health plans as their only plan option had saved $21.8 million per 10,000 members over the past five years. Aetna found that employers who offered an account-based health plan along with other traditional plan options (e.g., PPO, HMO) also had realized savings, but not as significant—only $8 million per 10,000 members over five years.

Finally, Cigna published a study earlier this year concluding that employers can save an average of $9,700 per employee over five years by switching to account-based health plans. Given these results, Cigna believes that if the share of Americans enrolled in account-based health plans rose to 50 percent and achieved the same results as this study, the U.S. could save $350 billion over 10 years and the level of patient care would improve.

This potential for reducing health care spending was recently confirmed when researchers at the RAND Corporation published in the journal Health Affairs the results of their analysis of the potential impact of account-based health plans on the American health care system. The RAND analysis suggests that if account-based health plans grow to represent half of all employer-sponsored insurance in the United States, health care spending could drop by $57 billion annually—about 4 percent of all health care spending among non-elderly Americans. The study acknowledges that HSAs are far more cost-effective, and estimates that if all of these people were in HSA plans, the annual savings would be as high as $73.6 billion. I believe that is a conservative estimate.

But account-based health plans are not just about saving money. It's also about how the money is saved—by changing how employees think about their health and taking action to improve it. I would like to take a few moments to clear up some common misperceptions about account-based health plans.

First, research is increasingly suggesting that lifestyle behaviors account for approximately three-quarters of health care spending in the U.S. This is likely to only get worse as diet, obesity, lack of exercise, and smoking take its toll on our bodies

and our health care system. Fortunately, account-based health plans cover preventive care services and usually do so without applying a deductible or other out-of-pocket expense. In fact, preventive care was included in the original design of HSAs, long before the PPACA made it a requirement of all health plans. Data from Aetna, Cigna, EBRI, and others suggests that utilization of preventive care services is higher when individuals are enrolled in account-based health plans. Additional data suggests higher compliance with disease management and treatment regimens for individuals with chronic conditions. While there is always a risk that people will seek less care when spending their own money (several studies have raised this concern), I am not aware of any evidence to suggest that the health status of individuals enrolled in account-based health plans has declined, and in most cases it appears to be improving. Obviously, this is an issue to monitor for the future.

Second, individuals enrolled in account-based health plans are more engaged in their health care. The most recent survey by EBRI suggests that enrollees in account-based health plans are more likely to: (1) check whether their plan would cover their care; (2) talk to their doctor about treatment options and costs; (3) talk to their doctor about prescription drug options and costs; (4) ask for a generic drug; (5) check the price of service before seeking care; (6) use an online cost-tracking tool; and (7) develop a budget to manage health care expenses. Similar findings have been reported by insurance carriers.

Third, HSA-qualified account-based health plans provide true catastrophic protection by virtue of their annual limits on out-of-pocket expenses. Under the PPACA, these limits will be applied to all plans starting in 2014, but account-based health plans already provide this protection and have been doing so since 2004. These limits apply both to medical and pharmacy expenses and therefore provide an extremely important benefit to people with chronic conditions and/or high annual health care expenses. Most people don't understand that their traditional pharmacy coverage likely does not have any limit on out-of-pocket prescription expenses.

Fourth, covered benefits and services are generally identical to traditional plans, not "skimpier" as some critics believe. What is different is the amount of covered benefits paid by the account-based health plan. So while the exact same benefits may be covered by each plan, the account-based health plan may only cover 60 or 70 percent of the cost of covered benefits, whereas a traditional HMO or PPO plan may cover 80 or 90 percent of the cost of covered benefits, on average. However, the difference in out-of-pocket costs for covered benefits is typically offset almost dollar-for-dollar by a difference in premiums. For example, a plan with a higher deductible (by $2,000) will typically have a premium that is $2,000 lower. Many people understand this concept when applied to their auto and homeowners insurance policies, but the concept is relatively new to many people for their health insurance.

Fifth, even though individuals enrolled in account-based health plans typically have higher out-of-pocket expenses, they still receive the benefit of the discounted prices for medical services negotiated by their insurance plan. For example, a patient may have an office visit with his or her personal physician. While the physician may charge $150 for each office visit, he usually accepts a discounted fee of $70 to $100 depending on the insurance plan. In these cases, the patient would pay only $70 to $100, not the full $150 charged by the physician.

Sixth, there is a growing industry of companies providing complementary information and services to help people manage their medical care and health care finances. Companies like Compass, Medibid, BidRx, Direct Labs, Healthcare Blue Book, change:healthcare, IF Technologies, INSNET, and others are responding to the needs of patients by providing better information about the price and quality of health care services. Another industry is responding to the demand for "wellness" services to help people maintain and improve their health to avoid disease and chronic conditions. These companies would likely not exist without the growing consumer demand for better value for their health care dollar.

Finally, even though individuals enrolled in account-based health plans are typically subject to higher up-front deductibles, most employers are providing a contribution of funds to the associated HSA or HRA which helps lessen the sting of the deductible. Data from the most recent Kaiser Family Foundation/HRET survey indicates that workers enrolled in HRA plans receive an annual employer contribution to their HRA of $861 for single coverage and $1,539 for family coverage, on average. Workers enrolled in HSA plans receive an annual employer contribution to their HSA of $886 for single coverage and $1,559 for family coverage. With HSAs, unspent funds automatically roll over each year. However, approximately 30 percent of workers enrolled in HSA plans receive no contributions from their employer. Although I believe these individuals primarily work for smaller companies, we all should be mindful of government policies that may discourage employer contribu-

tions in the future, such as changes to tax policy and how health plan actuarial values are calculated.

Why isn't every company offering account-based health plans? They may have to if the so-called "Cadillac plan" tax in PPACA goes into effect in 2018. I believe that companies have few other options as effective as account-based health plans to keep their costs below the thresholds where the excise tax will affect them ($10,200 for single coverage; $27,500 for family coverage). The recent surveys suggest that private employers are taking action and moving to account-based health plans, but public and non-profit employers appear to be lagging.

The one exception is the State of Indiana. Indiana has been offering account-based health plans to state employees since 2006. In 2012, its seventh year for account-based plans, 90 percent of Indiana state workers with its health insurance coverage participate in an account-based health plan. The state says these plans have already reduced the state's overall health benefit costs by more than 10 percent, and only 2 percent have switched back to a traditional plan.

In the 22 other states where enrollment in account-based health plans is voluntary, only 2 percent of government employees have signed up. Last year, Arizona, Louisiana, Minnesota, Utah and West Virginia joined 18 other states that already offer an account-based health plan. If Indiana's program continues to hold down costs while satisfying state employees, more states can be expected to try account-based health plans.

Barriers to Future Growth

For larger employers, cost pressures will continue under the PPACA as the "Cadillac plan" tax looms in 2018. However, other issues are or will create challenges much sooner than 2018. For example, employees with HSAs, HRAs, and even Flexible Spending Accounts (FSAs) must obtain a prescription from their doctor to seek reimbursement for over-the-counter medicines. The irony is that these medications have been approved by the U.S. Food and Drug Administration (FDA) as safe and effective for purchase without a prescription. But a provision in the PPACA requires individuals to obtain a prescription for these products or they will have to pay income tax plus a 20 percent penalty if they use their HSA, HRA, or FSA funds to pay for these medicines. This provision has been in effect since January 1, 2011.

In 2014, the PPACA will require employer-based health plans to limit their plan deductibles to no more than $2,000 for single persons and $4,000 for family policies. Many employers are already offering account-based health plans with deductibles above these limits, especially employers that have been offering account-based health plans for several years. If companies are required to lower their deductibles, they will likely see their costs go up and will have to raise their premiums offset the lower out-of-pocket costs. This would send account-based health plans in the wrong direction!

Also in 2014, the PPACA will require employer-based health plans to provide a minimum actuarial value of at least 60 percent. This means the plan must be designed to pay at least 60 percent of the cost of the benefits covered by the plan, and the employee/patient must pay the remaining 40 percent. While this sounds reasonable, recent guidance issued by the Internal Revenue Service (IRS) and HHS reflects a bias against account-based plans in favor of traditional first-dollar coverage plans. The guidance proposes to devalue the typical employer contributions to HSAs and HRAs when determining whether a plan provides the minimum actuarial value. Thus, even if an employer is providing the same amount of total contributions, the plan might not meet the minimum 60 percent standard.

Here is an example of how this could happen. Consider an employer that is providing coverage through a traditional PPO group health plan at a cost of $5,000 per employee. The company then chooses to switch to an account-based health plan and lowers its per-employee premium costs to $4,000 but contributes the $1,000 savings to each employee's health savings account. From the employer's perspective, his total costs remain $5,000 per employee. But under the IRS/HHS guidance, the employer's $1,000 contributions to employees' HSAs will not receive full credit (e.g. might be cut in half or more) towards the plan's actuarial value, putting the employer at risk of not meeting the minimum actuarial value of 60 percent. This again sends the wrong message to employers about account-based health plans.

In its comment letter to HHS dated May 16, 2012, the American Academy of Actuaries said the following:

"This adjustment * * * could have the effect of discouraging employers from contributing to HSAs/HRAs. For a given amount of employer spending toward health insurance, a higher [actuarial value] likely would be achieved by devoting more of those dollars directly toward a health insurance program than to an HSA/HRA. To the extent that HSAs encourage plan enrollees to seek cost-effective care, discour-

aging this option may run counter to goals of achieving more effective use of health care dollars."

Likewise, in its 2008 report analyzing major health insurance proposals, the Congressional Budget Office (CBO) said that:

"* * * the actuarial value of consumer-directed plans would include the expected value of any contributions that an insurer or employer sponsoring the plan would make to an enrollee's account—so that contribution could be set to make the overall actuarial value of the consumer-directed plan equal to the value of a conventional health plan."

I agree completely with the Academy and CBO. I believe that employer contributions to HSAs should be valued at the full amount of the contribution, not "adjusted." In addition, employee contributions made through payroll deduction should be counted as well and in full (not "adjusted"). Currently, the guidance does not provide any credit for employee contributions.

Another issue that will impact the availability of account-based health plans to some companies is the new minimum medical loss ratio (MLR) requirements under the PPACA. This issue impacts plans sold by insurance carriers to small and medium-size companies. Unfortunately, the MLR regulations do not take into account HSA or HRA contributions, thus making it extremely challenging for account-based health plans to meet requirements they were not designed to meet. I have been seeking changes to the regulations to reflect the unique circumstances of account-based health plans, but no changes have been made so far.

In closing, we should all keep in mind that premiums paid by employers for workers' health benefits are another form of compensation in lieu of wages earned by employees. Strategies like account-based health plans that reduce employer health benefit costs free up money that companies can use to stimulate the economy by raising wages, creating jobs, or making critical investments for the future. We also need to ensure that workers will be permitted to keep the coverage they have, as was promised throughout the health reform debate.

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to provide this testimony today. I look forward to the opportunity to discuss these issues in greater detail with you. I would be pleased to answer any questions you have.

Thank you.

Chairman ROE. Thank you.

Ms. Hall?

STATEMENT OF JODY HALL, FOUNDER AND OWNER, CUPCAKE ROYALE

Ms. HALL. Thank you.

Chairman Roe, Ranking Member Andrews, and members of the subcommittee, I am honored to be here today to testify. My name is Jody Hall and I own a business called Cupcake Royale, in Seattle, Washington. It is a cafe and bakery.

I am also a leader in a group called the Main Street Alliance of Washington that represents over 2,000 small business owners because we—our voices weren't heard in groups like NFIB. And that was pulled together about 3 or 4 years ago.

And I founded my business in 2003. When we opened our first shop we took a big risk. We were the first cupcake bakery outside of Manhattan to open.

The risk paid off. Our made-from-scratch cupcakes were an instant hit and we since have expanded to five locations. I am actually here—we started building our sixth location yesterday—and am taking time out because I believe in this issue. We employ currently 72 employees, 45 FTE equivalents, and soon we will cross that 50-FTE threshold.

This year I was honored as Business of the Year by the Greater Seattle Business Association and just wanted to talk a little bit

about this. I build my business on the notion that a good business supports a strong local economy and gives back to the community.

The community includes our employees. If I treat my employers well they will treat our customers well and our business will do well as a result.

This includes health care coverage. Since 2004 we have offered health care coverage to our employees who work 28 hours a week or more and we pay 75 percent of the cost. It is an important part of our business values but it is also a huge challenge.

Between 2004 and 2010 we were faced with rate increases that exceeded 20 percent—30 percent and up to 40 percent in 2009. In 2011 our health care costs more than $67,000.

Before I started my business I worked in corporate America for a little coffee company called Starbucks and one of the biggest surprises I faced when I left my Starbucks corporate job was how little benefit I got as a small business owner. Basically I paid twice the amount for half the coverage as a small business owner, and that was a big shock. And even now businesses our size have very little bargaining power.

The ACA's state insurance exchanges are finally going to change that. A state exchange will give me the opportunity to band together with thousands of other small business owners across Washington State to get access to better health care at better rates.

Joining a group with hundreds of thousands of participants will be a big leap in risk pooling, economies of scale, and negotiation clout. We finally would be able to tap into the kind of insurance that Starbucks and Microsoft have had all along. And by adding competition of an exchange this will create efficiency and cost savings in the private sector and hopefully bring costs down, I would imagine, if we are a good competitor.

On top of the state exchanges, other parts of the ACA are already helping small businesses. The 80/20 value for premiums rule is one example. Under this rule rebates for this year alone are estimated at $1.3 billion and checks are due out in the mail, which will add a nice shot in the arm for the economy.

There also health care law—there are also the health care law's rate review provisions, which are helping bring much-needed transparency to the proposed rate hikes. These provisions are making a difference. My rate increase this year was a lot lower, and I have heard this from other small business owners.

I would like to make a point about employer responsibility. The part of this law is sometimes claimed to be a barrier to job creation, and I don't see it this way at all. As a business owner who offers health care coverage, the real barrier for me is when other businesses my size—or dare I say bigger—don't offer health care I am forced to subsidize their costs.

This health care cost shifting actually costs my business hundreds of dollars per employee per year, and this is not fair competition. The only way to fix this free-rider problem is through a system that combines personal responsibility and shared responsibility, a system where all businesses above a certain threshold pitch in and nobody takes a free ride.

On the note of the business tax credit, I think that there is an opportunity to make this work for more businesses. For example,

my business is a restaurant. We are open 7 days a week; we staff 16 hours a day. It is hard for restaurants to have less than 25 FTEs. So I think by expanding that to 50 or 75 that would be an opportunity to create a tax credit for a lot more businesses.

So in conclusion, the Affordable Care Act is taking critical steps to lower health costs and bring affordable and quality coverage within reach for small businesses. And this will allow—this kind of work is allowing small businesses like me to focus on not how I am going to pay for my health care but how I am going to grow my business, hire people, and strengthen our local economies.

Thanks for your time.

[The statement of Ms. Hall follows:]

Prepared Statement of Jody Hall, Owner, Cupcake Royale & Verité Coffee

Chairman Roe, Ranking Member Andrews, and members of the HELP Subcommittee, thank you for the invitation to testify before your subcommittee on the topic of barriers to lower health care costs for business owners and workers. I appreciate the opportunity to share my experiences and perspective on these issues as a small business owner.

My name is Jody Hall. I own Cupcake Royale, a cupcake bakery and café business in Seattle, Washington. I'm also a leader in the Main Street Alliance of Washington, a statewide network of local, independent small businesses in Washington State that gives small business owners like me a voice on the most pressing public policy issues facing our businesses.

I founded my business in 2003. When we opened our first shop in Seattle's Madrona neighborhood with 10 employees, we were taking a risk. It was the country's first cupcake bakery to open outside of New York City. The risk paid off. Our made-from-scratch-daily cupcakes were an instant hit. Over the years, we've expanded to five locations in Seattle and neighboring Bellevue.

Cupcake Royale is recognized as a local institution. We're proud to employ 72 people (adding up full-time and part-time workers, we have 45 full-time equivalents). This year, I was honored as the Small Business Person of the Year by the Greater Seattle Business Association. I'll be rushing to get home to Seattle tonight to take care of the final details for opening a new store in July near Pike Place Market in downtown Seattle. That will be our sixth location, and I expect we'll be hiring another 15 employees for the new store as we continue to grow.

From day one, I built my business model on the notion that a good business supports a strong local economy and gives back to the community that supports it. We partner with Washington farmers and producers as much as possible: our flour comes from a handful of wheat farmers in Eastern Washington who mill it specially for our needs and our dairy is local along with fresh fruit from nearby farmers. And we donate over 40,000 cupcakes a year to help raise funds for local non-profits.

I also built my business on a commitment to treating my workers like family. That includes offering health care coverage. We offer health care to all employees who work over 28 hours a week and we pay 75 percent of the cost. It's an important part of our business values to offer health care. The way the costs have risen over the last decade, it's also been a huge challenge. Between 2004 and 2010, we were faced with rate increases routinely exceeding 20 percent—reaching as high as 40 percent in 2009. In 2011, our health care costs were more than $67,000.

We've got to take steps as a country to get these costs under control. Small businesses—and the country as a whole—can't afford the cost of doing nothing. And we've got to do it in smart ways that ensure decent quality, promote informed choice, and guarantee good value for our health care dollars. That's why I support the Affordable Care Act and the measures it includes to lower health care costs while promoting quality, choice, and value for small businesses and our employees.

Barriers to Lower Health Care Costs: How the Health Care Reform Law Helps

Some of the biggest barriers we face to getting decent health coverage as a small business stem directly from our size. Before I started my business, I worked in corporate America for 13 years, and one of the biggest surprises when I decided to go out on my own and start my own enterprise was how little we got in terms of health care benefits for almost twice the dollars (and these plans only covered medical—not dental and vision, which were included in my corporate packages). When we

have to brave the health insurance market on our own, whether with the 10 employees we started with or the 72-plus we have now, we're still too small to have any bargaining power, effective risk-pooling, or economies of scale.

A State Health Insurance Exchange

The state insurance exchanges made possible by the Affordable Care Act are going to change that. A state insurance exchange will give us the opportunity to band together with thousands of other small businesses across Washington State. There are more than 120,000 private sector firms in Washington State with fewer than 100 employees that could be eligible to join the exchange, and these firms employ almost 900,000 people.[1]

I can't wait for Washington's exchange to open its doors for enrollment. Joining a pool with hundreds of thousands of participants will be a huge improvement in risk-pooling, efficiencies of scale, and negotiating clout for my business and for small businesses across the state. We'll finally be able to tap into the kind of bargaining power that big companies like Starbucks and Microsoft enjoy.

Other Provisions of Health Care Reform that Put Downward Pressure on Insurance Rates

The health insurance exchange is the biggest thing I'm looking forward to from the health care reform law, but there are also other provisions that are taking effect already and helping to put the brakes on rising insurance premiums.

One example is the 80/20 value for premiums rule, or "minimum medical loss ratio" requirement, which requires health insurers to spend at least 80 percent of our premium dollars on actual health care costs or pay a rebate to consumers. For small business owners who know that offering good value to our customers is critical to our survival, the idea that we deserve a basic guarantee of value from our health insurance companies is common sense. The first rebate checks are due in the mail this summer and independent researchers have estimated that health insurance customers are going to get back in the vicinity of $1.3 billion in premium overpayments. That's a nice shot in the arm for small businesses and other insurance purchasers. And it doesn't even count downward adjustments in rate hikes taken by insurers to comply with the 80/20 rule and avoid owing even more in rebates.

Another example is the health care law's support for more careful review of proposed rate increases. In Washington, where we already have strong rate review laws on the books, this part of the law is allowing our state to strengthen its systems for collection, analysis, and reporting of data, and to increase transparency for consumers.[2] For small businesses in the many states across the country that didn't already have strong laws like Washington's, the rate review rules are doing even more to bring much-needed scrutiny to double digit rate hikes by requiring insurers to publicly post the justifications for their proposed increases and ensuring review of these proposed increases by insurance experts.

These early provisions of the health care law are making a difference. My rate increase this past year was a lot lower than I'd come to expect from my experience over the past five years. And I've heard stories of small business owners across the country who've seen their rates held flat this year. Some have even had their rates cut, while keeping the exact same coverage.[3]

Employer Responsibility and Reducing Health Care Costs

The employer responsibility provision of the ACA is another way the law will help lower insurance costs for businesses like mine. This piece of the law is often presented as a problem for small businesses. I believe the opposite is true. As a business owner who's doing the right thing and offering health coverage to my workers, the real problem for me is that when other businesses my size (and bigger) don't offer health care, I'm forced to subsidize their health care costs. The shifting of uncompensated health care costs to businesses that pay for health insurance costs my business hundreds of dollars per employee per year. How is that fair?

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[1] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2010 Medical Expenditure Panel Survey—Insurance Component; Table II.A.1(2010) Number of private-sector establishments by firm size and State: United States, 2010, *http://www.meps.ahrq.gov/mepsweb/data—stats/summ—tables/insr/state/series—2/2010/tiia1.htm;* Table II.B.1(2010) Number of private-sector employees by firm size and State: United States, 2010, *http://www.meps.ahrq.gov/mepsweb/data—stats/summ—tables/insr/state/series—2/2010/tiib1.htm*

[2] "Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities," HealthCare.gov, *http://www.healthcare.gov/news/factsheets/2010/08/rateschart.html*

[3] "Health care reform: good for business," The Baltimore Sun, April 1, 2012, *http://www.baltimoresun.com/news/opinion/oped/bs-ed-obamacare-business-20120401,0,6828504.story*

Opponents of the health care law argue that the employer responsibility requirement will hurt job creation. I disagree. More than 9 out of 10 businesses with 50 or more employees already offer health coverage.[4] Think about it this way: for every business around the 50 FTE threshold that doesn't already offer coverage, there are multiple others that do. Right now, the barrier to job creation for the businesses that do offer health care—like mine—is the fact that we're subsidizing the ones that don't. The only way to fix this is through a system of shared responsibility where all businesses above the threshold pitch in and nobody takes a free ride at the expense of the rest of us.

Opportunities to Keep Moving Forward on Health Care

Does more need to be done to fully fix health care for small businesses? Yes. I believe we need to build on the new health care law and take further steps to help small businesses, not tear it down and throw us back into the broken health insurance marketplace that visited rate hikes of 20, 30, and 40 percent on businesses like mine.

One opportunity to move forward that I would encourage you to support is an expansion of the ACA's small business health care tax credit. Not enough businesses are benefiting from the credit in its current form. While some elected officials are using this news as an excuse to criticize the credit and the whole ACA, that's not helpful to small businesses. If you want to help us, it would make more sense to ask the question, "What can we do to make this credit work for more of our small businesses?"

For my own business, we're not eligible for the credit because we have more than 25 full-time equivalents (FTEs). Why not expand that FTE requirement to 50, 75, or even 100 employees? Under a recent proposal to expand the credit, I could be eligible for a credit of about 8 percent of my health care costs—around $5,000. If you've built a bridge and you find out not enough cars can get across, you don't blow it up, you find a way to build it wider. You have an opportunity to do that with the small business health care tax credit. I hope you will take it.

Alternative Proposals: Will They Work for Small Businesses?

Opponents of the Affordable Care Act say they want to replace it with something else. Some of these ideas sound good as talking points, but what will their real impact be on small businesses?

We hear a lot about the idea of "letting health insurers sell across state lines." This sounds fine, but in reality this is a back-door way to get around basic protections put in place at the state level to make sure when we buy an insurance policy, it's worth more than the paper it's written on. "Across state lines" is really an invitation to insurance companies to throw quality and value out the window and start selling junk health insurance. If you want to give small businesses more bargaining power, that's what the state insurance exchanges in the ACA will do—without compromising the basic standards of quality and value we have in place now. The state of Georgia passed a "cross state lines" law last year and it didn't work: not a single out-of-state insurer applied to sell a new product in the state.[5]

Another "alternative" we hear a lot about is health savings accounts. They're marketed on the idea that they will make people make more responsible choices about health care utilization. But the reality is HSAs are another form of high-deductible, low-coverage insurance, which for many people in many years means paying a monthly premium to basically be uninsured. This is not a solution, either—it's just shifting more risk and shifting more costs onto small businesses.

Conclusion

The Affordable Care Act is taking critical steps forward to address the barriers to lower health care costs and bring affordable, good quality health coverage within reach for small businesses. Many businesses are already seeing the benefits as early provisions of the law take effect. We have even more to look forward to with the establishment of the state health insurance exchanges and other provisions that are still on their way.

We need to keep building on the foundation of the ACA, not tear it down. Small businesses across Washington State and across the country can't afford to go back

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[4] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2010 Medical Expenditure Panel Survey—Insurance Component; Table I.A.2(2010) Percent of private-sector establishments that offer health insurance by firm size and selected characteristics: United States, 2010, *http://meps.ahrq.gov/mepsweb/data—stats/summ—tables/insr/national/series—1/2010/tia2.htm*

[5] "No out-of-state insurers offer plans in Georgia," Atlanta Journal-Constitution, April 30, 2012, *http://www.ajc.com/news/no-out-of-state-1428329.html*

to the broken health care marketplace we faced before reform. We need to keep moving forward.

By taking full advantage of the opportunities created by the Affordable Care Act, we can break down the barriers to lower health care costs and finally level the playing field for small businesses. Then business owners like me will be able to focus our full attention on building our businesses, creating jobs, and strengthening our local economies. Thank you.

Chairman ROE. Thank you, Ms. Hall.

Mr. Streitberger?

STATEMENT OF BILL STREITBERGER, VICE PRESIDENT OF HUMAN RESOURCES, RED ROBIN

Mr. STREITBERGER. Chairman Roe, and Ranking Member Andrews, and committee, my name is Bill Streitberger and I am the vice president of human resources for Red Robin, and I appreciate the opportunity to speak with you today. Red Robin is a casual dining restaurant chain with more than 460 locations across the United States. We were founded in 1969 in Seattle by an independent business man, and during more than 4 decades of history we have expanded to 42 states and also operate in two provinces in Canada.

We pride ourselves in being, you know, America's gourmet burger experts with over 24,000 team members across the country. Every day we serve, you know, millions of guests.

Red Robin has been able to grow our business at a fairly steady pace, opening new restaurants every year even during the recent weak economic conditions. In fact, in the last 2 years, even in a recessionary—with the recessionary environment that saw a number of our restaurant concepts—competitors close locations or even go out of business all together we were able to open 30 new restaurants and still have another 12 on the books to open this year.

This is important to us for a number of ways. First, opening new restaurants allows us to grow our revenues, which in 2011 surpassed $900 million. Secondly, by expanding to new communities we serve even more of our guests, but more importantly, opening new restaurants allows us to add to our growing family of team members, creating new jobs at each location and in the communities we serve.

This doesn't include the job expansion that takes place in our home office in Greenwood Village, Colorado, just south of Denver, as the growing restaurant base creates the need to grow in the corporate support function and the additional business that we are able to give to over 8,700 vendors and other outside entities who we count on for all of our food, supplies, services, and oversight that we need to develop and run our businesses. We try very hard to buy everything American.

There is another benefit to a healthy, profitable, growing Red Robin business, and it is manifested in the way we give back to our communities where we do business. One example of this is the great work of our Red Robin Foundation, an internal resource. And because of this foundation many of our team members receive support when disaster strikes, family emergencies, and even a scholarship fund when there is an opportunity for a college education.

In addition, we support our corporate giving program, such as contributions to National Center of missing and Exploited Children, Special Olympics, and countless other local foundations that our team members and the restaurants organize. We are proud to say that we like to give back and part of being a good neighbor.

But running restaurants is not a high-margin business. Red Robin's net income, as a percentage of revenues, was less than 3 percent in the last—each of the last 3 years. After we have paid our team members, our vendors, our landlords, and all other expenses including payroll, property, state, and federal taxes, we use the remaining cash to reinvest in our business, including opening new restaurants that create more jobs and support the surrounding communities.

When health care and other costs increase we have fewer resources to reinvest and grow the business. We can't simply pass along higher costs to our customers. As you and your constituents know too well, very few Americans have been immune to the intense economic pressures in recent years and there is very little appetite during these difficult times for even marginal increase in retail prices.

In regards to health care specifically, taking care of our team members is part of living our values as a company. We have thousands of team members who are eligible to participate in the health and welfare plans. In addition to providing these team members with these health care benefits we try to create and promote a well-being to all of our people, such as our LiveWell program, which is—not only encourages healthy choices but also provides channels outside the company such as athletic events, volunteerism, to promote a healthy and fulfilling lifestyle.

But health care coverage remains an essential component of our benefit programs. During the last 3 years Red Robin's health care cost per employee increased more than 6 percent every year. This is a much greater pace than the growth of our guest sales, same store sales, or net income.

Increasing the burden of health care costs through the 2014 mandates can negatively impact the ability of companies to grow and offer benefits to other employees, forces companies like Red Robin to decide on whether to reduce benefits and maintain affordable coverage, or accept the burden of increased company contributions, limiting our ability to continue to grow and create new jobs. Either way, we feel it can be a lose-lose for Red Robin and for our existing and prospective new team members.

We hope you will consider the adverse impact of these mandates on health care coverage and costs and—that these can have on an employer like Red Robin. I know I speak for our folks in our restaurants and office when I say that we are excited about the prospect of opening new and additional restaurants in new communities, creating new jobs, and welcoming even more folks into the family.

As long as we can maintain our financial health, manage our business profitably, and overcome any economic and other pressures effectively we will continue to grow, and serve more guests, and serve more communities in the years to come.

I want to thank you for your time and your opportunity, again, to speak with you.

[The statement of Mr. Streitberger follows:]

Prepared Statement of William Streitberger, Vice President of Human Resources, Red Robin Gourmet Burgers, Inc.

Chairman Roe, my name is Bill Streitberger and I am the Vice President of Human Resources for Red Robin. Red Robin is a casual dining restaurant chain with more than 460 locations in North America. We were founded in 1969 in Seattle, Washington, and during our more than four decades of history we've expanded to 42 U.S. states and we also have restaurants in two Canadian provinces. We pride ourselves in being "America's Gourmet Burger Expert," and our 24,000 Team Members across the country every day treat our guests with what we at Red Robin call our "Unbridled" spirit, which includes living our values of Honor, Integrity, Constantly Seeking Knowledge and, most importantly, Having Fun.

On behalf of all of my fellow Red Robin Team Members, I want to thank you for the opportunity to appear here today to share our thoughts on the potential impact of health care reform on all of us as employees, our many guests and the communities we serve.

In the many years since our first restaurant began serving guests on the University of Washington campus, despite the many challenges to maintaining a successful and profitable restaurant company, Red Robin has been able to grow our business at a fairly steady pace, opening new restaurants every year, even during the recent weak economic conditions. In fact, in the last two years, even in a recessionary environment that saw a number of restaurant concepts close locations or even go out of business altogether, Red Robin opened more than 30 new company-owned and franchised restaurants, and we have another dozen or so new company-owned restaurant openings planned for this year. This is important to us in a number of ways. First, opening new restaurants allows us to grow our revenues, which in 2011 surpassed $900 million. Secondly, by expanding into new communities, we can serve even more of our guests, who, by the way, continue to thank us whenever we open our first Red Robin in any neighborhood. But most importantly, opening a new restaurant allows us to add to our growing family of Red Robin Team Members, creating on average approximately 70 new jobs every time we open a new location. This doesn't include the job expansion that takes place at our home office in Greenwood Village, Colorado, as the growing restaurant base creates the need for growth in the corporate support function, and the additional business that we give to nearly 8,700 vendors and other outside entities who we count on for all of the food, supplies, services and oversight we need to develop and run our restaurants.

There's another benefit to a healthy, profitable and growing Red Robin business, and it's manifested in what we give back the communities where we do business. One example of this is the great work of the Red Robin Foundation, an internal resource that was created in the spirit of our "Unbridled" culture. Because of our foundation, many of our Team Members receive support when disaster strikes, help when there's a family emergency and scholarship funds when there's an opportunity to get a college education. In addition, with the support from our corporate giving programs such as our past contributions to National Center for Missing & Exploited Children and the Special Olympics, to the countless local fundraisers that our Team Members organize at our restaurants, we are proud to say that giving back is part of being a good neighbor.

Unfortunately, the rising costs of running our business, including significant and escalating health care costs, make the prospects for continued profitability, job creation and contributions to our communities increasingly difficult. Running restaurants is not a high margin business. Red Robin's net income as a percentage of revenues was less than three percent in each of the last three years. After we've paid our people, our vendors, our landlords, and all of our other expenses including payroll, property and state and federal taxes, we use remaining cash to reinvest in our business, including building new restaurants that create more jobs and support the surrounding communities. When health care and other costs increase, we have fewer resources to reinvest and grow our business. And we can't simply pass along higher costs to our consumers. As you and your constituents know too well, very few Americans have been immune to the intense economic pressures in recent years, and there is little appetite during these difficult times for even marginal increases in retail prices.

In regards to health care specifically, taking care of our Team Members is part of living our values as a company. We have thousands of Team Members who are

eligible to participate in our health and welfare benefit plans. In addition to providing these Team Members with health care benefits, we try to be creative to promote the well-being of our people, such as our LiveWell program that not only encourages healthy choices, but also provides channels outside the company such as athletic events and volunteerism to promote a healthy and fulfilling lifestyle. But health care coverage remains an essential component of our Team Member benefits. During the last three years, Red Robin's healthcare costs per employee increased more than 6% every year—a much greater pace than growth in our guest visits or same store sales. Increasing health care costs through mandates that can negatively impact the ability of companies to offer attractive benefits to employees forces companies like Red Robin to decide either to reduce benefits and maintain affordable coverage or accept the burden of increased company contributions—limiting our ability to grow the business, attract talented people to our organization and add to our payrolls. Either way, it's a lose-lose for Red Robin and for our existing, and prospective new Team Members.

We hope you will consider the adverse impact that mandates on health care coverage and costs that are not thoughtful and balanced will have on employers like Red Robin. I know I speak for my many fellow Red Robin Team Members when I say that we are excited about the prospect of opening additional restaurants in new communities, welcoming even more Team Members into our family and serving our communities in the years to come.

Again, thank you for the opportunity to share our views and work with the Committee.

Chairman ROE. Well, thank the panel for their testimony.

And I will now ask Mr. Andrews if he has any questions.

Mr. ANDREWS. I do, thank you.

I would also like to thank the panel for their preparation and for great testimony today.

Mr. Streitberger, did I pronounce your name correctly?

Mr. STREITBERGER. Yes, sir.

Mr. ANDREWS. Welcome.

I am very sympathetic with your discussion of trying to find ways to reduce the cost growth that you have experienced so you can open more stores and hire more people. I think that is something we all have in common.

I want to ask you some questions about the problem in the broader context, though, that—you have 24,000 employees. About how many of them are eligible to enroll in your health plan?

Mr. STREITBERGER. According to the—being at full time about 8,000. We hire a great deal of students, part-time workers.

Mr. ANDREWS. Of the 8,000 that are eligible to enroll do you know how many choose to enroll?

Mr. STREITBERGER. Around 6,000.

Mr. ANDREWS. And if I were making—and tell me if this number is off, but if I were making $25,000 or $30,000 a year is that the typical wage of someone who is eligible to enroll in your plan?

Mr. STREITBERGER. Yes.

Mr. ANDREWS. Okay. If I was trying to enroll my family, not just myself but my family, what would my monthly premium be?

Mr. STREITBERGER. Well, we have several plans, and depending on how you chose——

Mr. ANDREWS. Let's say I chose the least expensive one. I know you have a high and a low.

Mr. STREITBERGER. The least expensive would be around $350 a month.

Mr. ANDREWS. Okay. So for a person making $30,000 a year gross it would be $350 a month—their share—to enroll in the plan?

Mr. STREITBERGER. Yes.

Mr. ANDREWS. Okay. That is a difficult thing to do, I am sure you are aware——

Mr. STREITBERGER. Correct.

Mr. ANDREWS. I want to ask you what—let's talk about your part-timers for a minute, that one of your part-timers—I am sure some of your part-timers are older workers, too, that——

Mr. STREITBERGER. Some are, correct.

Mr. ANDREWS. I have gone to restaurants like yours and do see people in their late 50s, early 60s, sometimes older. I am sure some are there because they like the work experience; others really have to work and that is why——

Mr. STREITBERGER. Sure.

Mr. ANDREWS. Let's take a case of a 61-year-old woman who feels a pain in her side, she is one of your part-time employees, so she is not eligible to be in your plan, right?

Mr. STREITBERGER. Well, they need to average the 30 hours or more, correct.

Mr. ANDREWS. Okay. So she is 25 hours a week, let's say. She is not——

Mr. STREITBERGER. Sure.

Mr. ANDREWS [continuing]. Eligible to be in your plan. Or she is over 30 and just can't afford it because of the cost that we just talked about.

She gets a pain in her side, she goes to the emergency room today and they find out she has had appendicitis attack. She needs to have her appendix removed.

She has no health insurance. What should we do? As a country, what should our policy be about what happens to her and who pays for it?

Mr. STREITBERGER. Well, I believe that the country already has a safety net for folks that are in positions like that.

Mr. ANDREWS. What is the safety net?

Mr. STREITBERGER. Well, a lot of these folks use Medicaid and Medicare.

Mr. ANDREWS. Let's assume she is not eligible for Medicaid, which is, frankly, typical of a lot of people. Medicaid enrollment, before the new law, of course, was usually 100 percent at poverty, which in my state meant about $18,000 a year for a family of four. Now, we changed that in the new law but she is probably not eligible for Medicaid under present law. So what should we do?

Mr. STREITBERGER. Again, that is something that we try and offer to all of our folks. They can, you know, in a case like this——

Mr. ANDREWS. No, I am not saying what you should do. Don't misunderstand me. I am not presupposing you should pay for it. I am saying, what should we as a country do to solve that problem?

As I see it there are really a couple of options. We could say, "Well, sorry, you can't get the appendectomy because you don't have insurance." I don't think you would want to see that happen, would you?

Mr. STREITBERGER. No.

Mr. ANDREWS. Okay. The second thing that we could do is expand a public program like Medicaid to include her in it. For in-

stance, we could include families making up to $30,000 or $35,000 a year under Medicaid. Would you think that is a good idea?

Mr. STREITBERGER. Well, I think one of the ways to help this, as you mentioned in your statement, was to look at ways of driving the costs of health care down——

Mr. ANDREWS. No, but I understand that and I am all for that, but I am talking about this woman in this circumstance who needs this appendix taken out today. You think we should enroll her in Medicaid and increase the Medicaid eligibility limit?

Mr. STREITBERGER. If that gets some folks the coverage, sure.

Mr. ANDREWS. Which is what we did in the Affordable Care Act.

Do you think that she should be required to have health insurance for herself or not?

Mr. STREITBERGER. No.

Mr. ANDREWS. If she is not required, who—and let's say we don't get the Medicaid increase that we talked about—who should pay her hospital bill?

Mr. STREITBERGER. Well again, I am not a tax person or a politician, but——

Mr. ANDREWS. No, but you are a citizen and a taxpayer——

Mr. STREITBERGER [continuing]. You know, people need to take personal responsibility for their actions and it is a matter of choices.

Mr. ANDREWS. Okay. But if she makes——

Mr. STREITBERGER. People spend money on houses——

Mr. ANDREWS [continuing]. If she makes the choice not to buy the health insurance for whatever reason, she is not covered Medicaid under this example, who should pay the bill?

Mr. STREITBERGER. Again, that is not something I can help you with.

Mr. ANDREWS. Well, I am not—it is not really an expert question. I mean, all of us as citizens, I think, have a stake in that answer. There are two choices, right? We could have some publicly taxed and funded program that pays for her health care or we should—or we could—three choices—we could require her to do it and subsidize her purchase, or we could require you to do it, as her employer. Which of those three would you like to see us do?

Mr. STREITBERGER. That is something that we are taking a hard look at to see what we as a business can afford.

Mr. ANDREWS. I understand. Thank you very much.

Mr. STREITBERGER. Thank you.

Chairman ROE. Thank you, Mr. Andrews.

Dr. DesJarlais?

Mr. DESJARLAIS. Thank you, Mr. Chairman.

And as I sit and listen to that conversation I noticed the ranking member when we started out saying that the ObamaCare was not a government health care plan—it was not a government takeover of health care—but in that dialogue that I just heard it sounds like he is saying exactly that, the government needs to take more responsibility and make sure that these people are taken care of. So in other words, I think that is exactly what the ranking member is insinuating with that last line of questioning is that personal responsibility is not really the answer, it is more government respon-

sibility, if I understood it correctly. And certainly he could chime in if he would like.

Mr. ANDREWS. Would the gentleman yield?

Mr. DESJARLAIS. Yes, I would.

Mr. ANDREWS. Yes. I didn't want to interrupt his time.

I actually think it is a combination of people with very low incomes being in Medicaid and having some personal responsibility, people with somewhat higher incomes being in a private plan, which is what the law requires.

Mr. DESJARLAIS. Okay. And again, we can look at the track record right now of our government health care, Medicaid, Medicare, and even the V.A., and I think that there is not anyone sitting up here that can't agree that it is an abysmal failure in terms of economics. The Medicare program, whether you are Democrat, Republican, the CBO, AARP, is going broke in 10 years.

And we are suggesting somehow that the federal government can step in, take over our health care services in this country and somehow run them efficiently without rising costs and while maintaining a quality of care that is acceptable to patients and their doctors. And I just don't see, personally, how this is going to work, considering there has been no model set forth to this point that has done that. And I have been a family practice physician for 20 years and I can say that in my experience, talking with businesses around Tennessee's poor district that they are very afraid of this health care law and what it is going to do to their ability to provide the services.

Ms. Hall, you had stated that, you know, you like to treat your employees well and they will treat customers well, and I think that is very true. But we have a couple of examples in businesses that I visited—Valmont Industries is a large business. They have got 5,000 or 6,000 employees. They pay up to $12,000 a year per employee, which is a lot of money for a health care plan.

But under the new ObamaCare they could pay a $3,000 penalty and not have to provide that health care, and these employers would probably get a lesser plan and be put into the public health care exchanges. They don't want to have to do that and it concerns them greatly, but you can do the math. That is $9,000 per employee difference over 6,000 employees. There is going to be some bean-counters in that company that are going to do the math and see that it just doesn't make sense to provide those employees with health care.

We have a smaller company that is in the same boat. They have got a little less than 500 employees, and they would pay the $2,000 penalty if they dropped their employees' health care coverage and their company would save a couple of million dollars. It is hard to look at that and see where it doesn't make sense to do that.

So I do think that this health care law does create a situation where employees are going to lose the coverage that they had. And we had a little discussion earlier—I think Dr. Roe mentioned health savings accounts, and I think Mr. Fensholt was talking about—or maybe it was Mr. Ramthun was talking about health savings accounts. And really, that is kind of what we need to be getting to is personal responsibility, and when people have health savings accounts and have skin in the game and they have to help

make their own decisions then that is the kind of responsibility, I think, that we need from the American citizens and not the federal government, who is burdening all your companies with increased regulation.

Mr. Fensholt, you talked about what—you know, they are piling on regulations—what you have to do just to provide your health care—for your employees with the new regulations, and it is these increased regulations that are driving up health care costs. And frankly, the health care in this country is driving our national debt, so the solutions that we need moving forward do not come from ObamaCare; it is going to come from repealing ObamaCare and taking stepwise fashions and personal responsibility.

And, Ms. Hall, you said that you provide 75 percent of the health care coverage to your employees but the cost was only $67,000?

Ms. HALL. We have 45 FTEs and they are all, you know—our average age is probably 23, and some of them are obviously covered under other plans or opt out even though we highly encourage them to be involved.

Mr. DESJARLAIS. Okay. Well——

Ms. HALL. And obviously our costs are lower because we have a younger workforce.

Mr. DESJARLAIS. Okay. So your example doesn't fit with some of the other companies' examples, but I am out of time already and I think we might get to two rounds so I will ask more questions next time.

Chairman ROE. Thank you.

Mr. Kildee?

Mr. KILDEE. Thank you, Mr. Chairman.

Ms. Hall, I agree with you that instead of repealing the health care reform law we should instead work together to make it better. Specifically, you mentioned the small business tax credit. How would you change this tax credit to make it more accessible for small businesses like your own? Are there other aspects of the law that you would like to see changed that might make it easier for businesses like you by providing——

Ms. HALL. Yes. I mean, I think that there is—the 25 FTE requirement has a salary cap of—is it $50,000 per employee, and 25 is—like for us folks, I mean, to run one Red Robin needs more than 25 employees, yet we might have—let's say your revenues are $5 million and your profits are 3 percent of that. That is a lot of burden to ask for—and to look at expanding that, especially for restaurant and hospitality, where we employ 7 days a week, you know, 16, sometimes 24 hours a day. I think a lot more businesses will participate.

And over 360,000 businesses did participate. That is more than all the members in NFIB combined. So it is still a decent level of participation, but we could expand that and really look at solutions.

We are problem solvers up here. I started my own business, and we are all thinkers around how to make things better. Let's figure out a way to address that and make it a more powerful incentive and opportunity to give a little—get a little money back for doing the right thing by providing health care.

Mr. KILDEE. Do you belong to any small business association back in Seattle, or——

Ms. HALL. Right.

Mr. KILDEE. In that group do you find some small businesses who do feel that this bill, which passed by this Congress, can be helpful both to themselves, to their employees, and to the public in general? Some people picture this as something that small business looks upon as not in any way with redeeming factors. What do you find amongst the small business people you associate with?

Ms. HALL. Right. The Main Street Alliance was formed after health care policy was being written and we were finding—and it spans across several states. I think it might be 15 to 20 states. I am not quite sure. But in Washington there are over 2,000-plus small business owners, and the reason that this alliance was started was because we were misrepresented as small business owners.

And what I said earlier around health care costs, I was at Starbucks. I can't remember exactly what I paid. It was a similar situation. The company paid 75 percent and I paid 25, and I got dental, vision, and amazing health care.

And when I went to start my own business, obviously I paid almost twice that just for the health care coverage. So it is astonishing that the engine of our economy, which is small business, has to have this—we have to pretty much throw our health care out the window. We have to walk away from affordable, quality health care to be able to start our own business.

And that is why this—the Main Street Alliance was formed, because we were being completely misrepresented. We want quality, affordable health care for all, and we don't have access to that. So the public option, I thought, was a great—and something I fought hard for.

But the exchanges, I think, will also provide a great opportunity for bargaining power. And we are very excited in Washington State to participate in that and actually shop and say no to the one, two, or three insurance providers that get to just kind of set rates at will and increase rates without any accountability. So we finally will have some clout, and that is exciting.

And I would say that I speak for every business in the Main Street Alliance. We are all aligned around this issue. It is one of the galvanizing forces of creating this alliance.

Mr. KILDEE. You mentioned also that this past year your rate increase was less than in previous years. Can you expand on this? Do you attribute this in any way to the health care reform law?

Ms. HALL. I think part of that has to do with the 80/20 rule. And our health insurance went up only 6.8 percent, which is phenomenal. I mean, I think the lowest it has gone up is 15 percent, and it usually is more like 20 to 30 percent. So it is amazing. Like, I was actually relieved at only 6.8 percent.

And yes, I do think some accountability around spending 80 percent of that money on actual health care, versus marketing, and admin, and things like that, is helping to keep those rates at the—at an appropriate level, and also accountability and where those rate increases are coming from.

Mr. KILDEE. Thank you very much.

Ms. HALL. That the ACA brought. Thanks.

Mr. KILDEE. Thank you.

Chairman ROE. Thank you.

Dr. Heck?

Mr. HECK. Thank you, Mr. Chairman.

And likewise, I thank all the committee members and the panel members for being here today. You know, we heard Dr. DesJarlais talk about the impact on large employers and potentially not providing insurance because it would become more cost effective for them to actually pay the fine than to provide the insurance.

And I also have a small—I have a small employer in my district, iMAGiNE Communications, that has 11 employees who historically has paid 100 percent of their employees' health care, and recently they have had to bring it down to 50 percent because of increasing costs, and they are uncertain as to how much longer they might even be able to do that. And I would agree with the opening comments of the ranking member and some of the other folks that have talked about the small business tax credit, that the requirements to qualify for the credit are too stringent and that they phase out too quickly for a lot of small companies to benefit.

But regardless, at full implementation the Affordable Care Act is going to require increased coverages from businesses, whether it is the mandated services, whether it is the number and types of people who must be covered, or how much the employer must contribute to that coverage. And what I find even more shocking is that even if you do all that as an employer, if one of your employees opts out and gets insurance on and exchange and receives a subsidy you can still be fined even for doing all the right things.

So I would ask, you know, Mr. Streitberger—which, by the way, didn't know you were going to be here today, but I actually ate Sunday at one of your restaurants——

Mr. STREITBERGER. Thank you very much.

Mr. HECK [continuing]. In my district. The burger was delicious. Love the bottomless fries, although my cholesterol doesn't.

What would you say is the biggest impediment in providing low-cost health coverage for your employees? And in a perfect world, which laws or regulations would you change to make coverage more affordable for you and your employees?

Mr. STREITBERGER. Well, I think what would be a big help—and it was mentioned by Mr. Andrews—is that if we had more competition in the marketplace—we, as a public company, we have a great deal of competition every day. We are used to it; we deal with it and it puts us in a place to do a better job and offer better services. I think that would be a great help.

I also manage the other side of our insurance business on workers comp, and in dealing with those two sides of the business one thing that hasn't been mentioned and has—and in business we are very concerned about, and that would be tort reform. I mean, everything that we deal with usually has a lawyer attached to it, which does drive up costs. I am sure physicians do more testing to make sure that they are making the best decision possible, and we see that it really can ratchet up the business.

So I think, again, the competition helping to drive the cost down so that we can offer more care, more affordable care to our team

members. And then also, you know, the outside impact of any business, and that would be on that side, the tort reform.

Mr. HECK. Thank you.

Thank you, Mr. Chair. I yield back.

Ms. HALL. If I could add to that, actually, I think one of the biggest impediments to health care costs is the fact that not everybody has to have health care. And I think that if we were all involved with some kind of level of personal responsibility as well as shared responsibility from the employer side we are going to get preventative care and we are not going to go to the E.R. when we need help. And if there is a safety net for those that need it I think that would actually, from what I understand, bring health care costs in check and down.

Chairman ROE. Would the gentleman yield some of your time? Just to clear the record up, there were 309,000 small businesses that the Treasury Department said that is incorrect; the number counted individual partners at firms, not actually employees. The real number that GAO found was 100 and—I have got it here somewhere—70-something-thousand. So it was 170,300.

Ms. HALL. Oh, I have from the White House fact sheet that it was, in 2011, 360,000.

Chairman ROE. Dr. Holt?

Mr. HOLT. Thank you. Thank you, Mr. Chairman.

I am not sure whom to ask this question of, but let me start with Mr. Fensholt. What evidence to do you have that the Affordable Care Act is responsible for the increase in premiums that employers are—and employees are finding?

Mr. FENSHOLT. Well, part of the business of insurance is you have very smart people—actuaries and underwriters—who look at various laws like the Affordable Care Act and the coverage mandates and they ask themselves, "If we have got to begin to cover, for example, adult children to age 26 even if living apart from the employee, even if married, even if gainfully employed themselves, what additional cost is that going to impose on our plans?" They do the same thing for the abolition of lifetime and annual dollar limits on essential benefits. And they come up with an estimate.

What we have seen, in talking to health insurance underwriters and our own actuaries, is that—and about half of our bulk of business are self-insured plans, so there we are dealing with our own actuaries and their claims history. And now we have a little track record under these provisions, as well. So now you are actually tracking claims incurred by the additional enrollees, claims incurred that are required to be paid where they wouldn't have been paid before. And you can assess a cost to that, and that is where those numbers come from.

Mr. HOLT. Yes. And there is a cost, but there is additional revenue because you will have more people brought into the coverage. Isn't that true?

Mr. FENSHOLT. Well, the way this tends to work is that—let's take, for example, the case of the adult children who gain coverage. The adult children who get enrolled under this provision tend to be the ones who need the coverage. That is why their parents enroll them.

The adult children of—who are healthy, the parents tend not to do that. So that mandate tends to attract some of the worst risks in that age category.

Mr. HOLT. Yes, and isn't that the point, that expanding coverage, bringing more people into the pool, will address that very concern?

Mr. FENSHOLT. If you get significantly more healthy people into the pool than sick people into the pool. That is the goal. That is not happening in this context.

Mr. HOLT. Oh, that is very much what is under this law. That is very much——

Mr. FENSHOLT. Oh, that is the intent of the law.

Mr. HOLT [continuing]. What is under consideration right now.

I would yield to the ranking member.

Mr. ANDREWS. Thanks for yielding 1 second.

Mr. Fensholt, do you favor the individual mandate, then?

Mr. FENSHOLT. I can't speak for my company.

Mr. ANDREWS. Understood. What is your personal opinion about it?

Mr. FENSHOLT. My personal feeling is that the individual mandate makes some sense.

Mr. ANDREWS. Thank you.

Mr. FENSHOLT. Thank you.

Mr. HOLT. Mr. Streitberger——

Mr. STREITBERGER. Yes, sir?

Mr. HOLT [continuing]. I would like to pursue Mr. Andrews' example of your employee earning $25,000 a year and ask you what you mean by "personal responsibility." You said you would like to bring personal responsibility into this.

Mr. STREITBERGER. Sure.

Mr. HOLT. Let me pursue this for a moment. Let's look at the executives in your country—in your company. Are there any of the executives in the company who don't carry health care insurance?

Mr. STREITBERGER. There are some that don't carry it through Red Robin.

Mr. HOLT. But do you know any that don't carry health care——

Mr. STREITBERGER. No.

Mr. HOLT [continuing]. Insurance?

No.

Is there any reason to think that this $25,000-a-year employee would be less interested in having health care coverage than the executives?

Mr. STREITBERGER. First, many of those $25,000 to $30,000 income team members do carry the insurance, and that is where I was going with——

Mr. HOLT. But my question is, is there any reason why they would be less interested in carrying——

Mr. STREITBERGER. Sure. Many of them make personal choices——

Mr. HOLT. Not to be insured?

Mr. STREITBERGER [continuing]. Not to be insured because the money is spent on brand new cars, trips, tattoos. I mean, they have other choices. And having raised three children of my own I know at that age—the average age of our team members they feel they

are a little invincible and they make other decisions with their money.

Mr. HOLT. So the personal responsibility that you are talking about, does that apply to this woman getting appendicitis? Is that——

Mr. STREITBERGER. Again, we are in a hypothetical situation——

Mr. HOLT. Did she fail to take responsibility for her appendix?

Mr. STREITBERGER. With our team members they have the ability to request schedules that could get them to that. In his situation why someone would request to be part time all the time and then have a health situation, again, we offer choices to our team members, full time and part time. And if she chose, for reasons I can't explain, to stay part time then that is, again, a personal choice.

Mr. HOLT. And it is your choice not to make it more affordable to her than you already do so that you can hire more employees who will not have this coverage.

Mr. STREITBERGER. No, sir. We pay between 60 and 70 percent of the premiums currently, and as the gentleman from Lockton mentioned, we are one of those self-insured companies, but we——

Mr. HOLT. Yes, but you want to grow.

Mr. STREITBERGER. We want to grow and create more jobs, yes, sir.

Mr. HOLT. More jobs that have that inadequate coverage.

Mr. STREITBERGER. More jobs that have the opportunity to take out health care, yes, sir.

Chairman ROE. Mr. Wilson?

Mr. WILSON. Thank you, Mr. Chairman. Mr. Chairman, I have been joined, too, by a foster person. Very proud Jasmine Thompson is here as part of the shadowing program. [Applause.]

And we are looking forward to a big day, spending the day with you.

Additionally, Mr. Streitberger, I have a high regard for Dr. Heck's judgment regarding burgers, and so I just want to invite you that the Southeast——

Mr. ANDREWS. Would the gentleman yield?

I am just wondering how this bottomless fry thing fits into the wellness discussion, as someone who is addicted to the french fries and would love the bottomless fries?

Mr. WILSON. The ranking member is actually correct on this. This is good. [Laughter.]

But you are welcome to the Southeast, so please expand.

Mr. STREITBERGER. Yes.

Mr. WILSON. In fact, with 460 locations we welcome you.

What are some of the programs that your company has been promoting to keep health care costs low for your employees?

Mr. STREITBERGER. Every year we look at plan design, based on the wants and needs of our team members, what are their usage. This past year we went to what we call a high-low plan—high premium, low deductible, and vice-versa, which the low plan offering lower premiums, again, to our team members and giving them that choice on how to manage their health care.

And as I mentioned previously, we are self-insured, so we, as a company, take the risk. Our stop-loss is at $250,000, meaning for each covered individual we write a check for the first $250,000

every year, and then in a plan if it should go catastrophic. And that helps us, by taking that risk, to keep our premiums low.

And what has helped that also is last year when we did this, knock on wood, we had very good—we didn't have a lot of high-risk claims come our way. As Ms. Hall, we have a younger workforce, in general, and don't see a lot of issues that way. So that helps. But these are all the things that we do.

Also, our wellness program. We try and promote better living, health care in the sense of wellness programs, exercising, diet, other activities, you know, for mental wellness—anything that we can think of to try and help them live a healthier, better life, which would drive down our costs.

Mr. WILSON. Thank you very much.

Mr. STREITBERGER. Yes, sir.

Mr. WILSON. Mr. Ramthun, why do you believe more employees are now selecting the consumer-directed health care plans? And how do you feel that we should be encouraging health savings accounts?

Mr. RAMTHUN. I think more and more employees are choosing them one, for the premium cost. It is much lower than a traditional plan.

Secondly, they get to keep some of the money. Some of the money that used to go to the insurance now goes into their own pocket. If they don't spend it they get to keep it; that money accumulates from 1 year to the next.

So we need to make sure that those plans continue to be available for workers going forward, and there are ways to make that opportunity even better. Several bills have been introduced in Congress to do that that would actually expand HSAs.

Mr. WILSON. And you are explaining this fully to employees so they know how to participate in the program and have a deduction on their pay stub?

Mr. RAMTHUN. When my clients ask me to come in I absolutely explain all of these things to them. They tend to not understand that it is their money in the first place. This would otherwise be wages that they would be getting and, you know, they could go out and buy insurance on their own.

To Mr. Andrews' question earlier about what could we do to help people with that responsibility, well, number one is the tax treatment of insurance that is not acquired through the employer. People who buy insurance on their own get absolutely no tax benefit except when they deduct their medical expenses, and the Affordable Care Act has made that harder.

The threshold for deducting any medical expenses is going up to 10 percent of income where it has been at 7.5 percent. And there you can only deduct the amount that is above that threshold.

So there is a huge incentive to get their coverage through the employer; many of them still don't take it. One way we could help them if they chose not to purchase that coverage through their employer is to give them the equal tax benefit if they buy the insurance on their own.

Mr. WILSON. And that really leads to Mr. Fensholt, In regard to companies dropping health insurance, what do you see as, with the health care takeover, what the consequence will be?

Mr. FENSHOLT. Well, we are going to see, we think, a substantial erosion over time in the employer group market, and that will start primarily on the smaller end of the spectrum. We have many clients tell us substantially this: They say, "I am not going to be the first to go but I am not going to be third."

And so if you look at how easy it is for employers to drop coverage and reap substantial savings—out of our bulk of business on average a client would save about 44 percent off their current health insurance spend by dropping coverage. The only thing keeping them in the game is that they feel they need to attract and retain employees. The moment one of their strong competitors goes out of this market they are not going to hang around and incur that expense.

So we think that when the Budget Office in Congress estimated that by decade's end maybe 4 million or 5 million Americans net will lose their coverage, we think they have grossly underestimated that.

Mr. WILSON. Thank you very much, Mr. Chairman.

Chairman ROE. I thank the gentleman for yielding.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Chairman Roe.

I have a statement and some questions I want to ask but I want to yield 1 minute to our Ranking Member Andrews.

Mr. ANDREWS. Thank you, my friend. I just want to ask Mr. Ramthun to follow up on something he said about tax deductibility for uninsured people.

Do you know what the median income is for an uninsured person in the country?

Mr. RAMTHUN. I do not.

Mr. ANDREWS. Median family income is in the 30s. It is somewhere between $32,000 and $38,000 a year. Let's say you take a person with $35,000-a-year income and they go out to—in my district family health insurance would cost them $12,000 to $15,000 to buy a family policy. If that were fully deductible the in-pocket benefit of that for them would be at a maximum about 15 to 20 percent of that. In other words, if it was fully deductible, given what their tax liability is.

So how do you buy a—how do we help a family with a $35,000 income by giving them a $5,000 or $6,000—it wouldn't be that much, excuse me. It would be 20 percent—it would be $2,500 off of that. It would still cost them $10,000. How does that help them?

Mr. RAMTHUN. Well, you could also get them a tax credit.

Mr. ANDREWS. Well, that is what the Affordable Care Act does. Thank you.

Mr. HINOJOSA. Thank you.

I am very pleased that the chairman and Ranking Member Andrews called this hearing. I was part of a family business and I was president of the company and always the one to negotiate the insurance policies for our employees, and there were 300.

So I came here before this health care reform took place and I saw how we had to stop paying 100 percent of the insurance for our employees and went to 50 percent by the employees and 50 percent by the company because the premiums had been escalating. And I saw that some of the things that are being said by

the other side are predictions about the negative impact of the Affordable Care Act, and what I see is that the health care sector has led the way with more than 579,000 new jobs because of the increase in people getting insured.

The premiums for employer-sponsored coverage increased by only 9 percent in 2011, but if we look at the previous decade we saw that the premiums increased by 113 percent between the period of 2001 and 2011. The health care came in in 2010. So that means that during the 8 or 9 years without the reform on health care we already had close to 100 percent increase. So let's not blame this health care reform bill on what happened previously and continued to happen, because I was the one that negotiated those insurance policy premiums with the insurance companies and I know that it wasn't working.

So I am going to address my first question to Ms. Hall.

In your testimony, you stated that your business insurance was twice as expensive and included no dental or vision. In your testimony, I saw that you stated Republicans have offered an alternative to offer insurance across the state lines. The problem is—or with that, in my opinion, is that any time an insured has a problem with a claim they would need to go to the insurance commissioner of that state in which it is issued. Companies would simply all set up shop in the state where the consumer protection laws are the weakest, and so that wouldn't allow this program to work.

So my question to you is, if you were offered a cheap plan from an insurance company based on the Mariana Islands how pleased would your employees be when they have a problem with their claim?

Ms. HALL. I don't think they would be pleased at all. I think that you don't know what you are buying if you are going across state lines and you don't have an insurance commissioner you could go to to——

Mr. HINOJOSA. Being a businessman, I have a lot of friends who had their self-insurance but they were always offshore and there were lots of things about their insurance policies that were not good for the employees. So that is why I am concerned as to our not letting this health care go ahead and be implemented over—until 2014 and that we can see a bigger pool, as was said by Congressman Holt and others. Once we get the pool much bigger and sharing in the cost it is going to be much better.

And I will say this, that in my own experience in my congressional district where we have a very high national poverty level of folks who are uninsured—40 percent, one of the highest in the whole country, compared to 16 percent for our nation's uninsured, it is beginning to work. A lot more people are insured.

So I thank you all for coming and giving us an opportunity to listen to your point of view.

I yield back.

Chairman ROE. Thank the gentleman for yielding.

Dr. Bucshon?

Mr. BUCSHON. Thank you, Mr. Chairman. I was a practicing cardiothoracic surgeon for 15 years prior to coming here, just for background, so everyone on the panel knows where I am coming from.

I want to clear up a couple of assumptions that are always made, one recently made by Mr. Holt that someone with appendicitis, if they didn't have insurance, wouldn't get surgery. And I just want to let everybody know, including everybody in the country, that is absolutely, totally false, that people that have severe medical problems come to the emergency room and get taken care of regardless of their ability to pay. Hospitals are required to do that. Physicians ethically, because of our oath to our patients, do that.

Myself, personally, have operated on many, many patients that had no insurance or had the best insurance money can provide, and physicians treat all of those patients the same. So I wanted to clear that up.

The other thing is this assumption that because you have health insurance coverage all of a sudden you have miraculously developed personal responsibility for your actions. I have had patients with the best insurance that money can buy and they take no care of themselves at all. They don't take their medicine, they smoke, and they don't follow advice of physicians.

I have had people that have no health insurance that are diligent about taking care of themselves. They get their medications because there are ways for people who don't have insurance to do that and they do the best job they possibly can to take care of themselves.

That is not a direct connection, that if we suddenly provide people with health insurance we will change people's moral character or their behavior. That is not true, in my view.

The other question is I—first question, just briefly, for Ms. Hall, do you think the uninsured or the Medicaid population overutilize the E.R. the most? Which group?

Ms. HALL. The underinsured or——

Mr. BUCSHON. Uninsured.

Ms. HALL. Uninsured or——

Mr. BUCSHON. Or Medicaid?

Ms. HALL. I wouldn't know.

Mr. BUCSHON. It is the Medicaid population. And the reason is because the uninsured come to the emergency room when they truly have an emergency, and if you provide services for free with no skin in the game people take it willy-nilly, they just show up whenever they want because guess what, it is free. That data has been proven out many, many times.

So this assumption that providing—expanding the Medicaid system is suddenly going to save us money in the health care system is actually, in my view, going to have the complete opposite effect. You are going to see a flood of patients coming to the emergency room because it is free. So I wanted to clear that up.

So, Ms. Hall, has your business discussed dropping their private health insurance plan?

Ms. HALL. Have we discussed that?

Mr. BUCSHON. Yes. Have you looked at the options of financially what will happen if you drop you plan or versus you don't if PPACA is fully implemented?

Ms. HALL. We haven't looked at the options of dropping our health care coverage, but we have had to make adjustments with these rate increases to—usually——

Mr. BUCSHON. You have never even discussed—you never even had on one piece of paper the cost without covering it and the cost if you do? Because I would say as a business person that would be something that is on everybody—everybody that I talk to, that is on their list. They look at that. You have never done that?

Ms. HALL. Absolutely not. I think the most important thing that we can do—and this is something I learned from Howard Schultz, CEO of Starbucks, directly, is if we take care of our people they take care of our customers——

Mr. BUCSHON. Fair enough.

Ms. HALL [continuing]. They take care of your shareholders.

Mr. BUCSHON. Fair enough.

Mr. Streitberger, first of all, my son loves your hamburgers. I know people have said that, but it is true.

Mr. STREITBERGER. Thank you.

Mr. BUCSHON. Evansville, Indiana, he wants to go there every time.

Mr. STREITBERGER. Thank you.

Mr. BUCSHON. And you may or may not be willing to step out on a limb on this—has your company, that you are aware of, looked at your options under PPACA as far as what type of health insurance coverage versus none that your company provides?

Mr. STREITBERGER. All options we are currently investigating, yes, sir——

Mr. BUCSHON. So the answer is, which is consistent with every business person I have talked to, is that an astute business person that runs a business has looked at all of these options and will make their decision partially based on their competition, as was pointed out by Mr. Fensholt, and based on a number of factors. But if the financial advantage is so massive that they can't compete they will have no choice.

The other thing is, finally, just to finish up, I would—as a physician I would recommend that anyone, including members of Congress, that can avail themselves to a city emergency room to visit and to get in—really get in the trenches on health care and see exactly what actually is happening and—because a lot of people want to talk about this issue in the abstract. I have been there. A lot of other members have been there. And you really can't get a good assessment for some of these things without being there. If you can avail yourself to that opportunity it would be a good thing.

I yield back.

Chairman ROE. Thank the gentleman for yielding.

Mr. Ross?

Mr. ROSS. Thank you, Mr. Chairman.

Mr. STREITBERGER——

Mr. STREITBERGER. Yes, sir.

Mr. ROSS [continuing]. We don't have any of your restaurants in Florida, and I am apparently missing out, but——

Mr. STREITBERGER. We are coming there. We are coming there.

Mr. ROSS. I obviously haven't missed too many hamburgers, so I am pretty good there.

Profit per employee—are you familiar with that concept?

Mr. STREITBERGER. Yes, sir.

Mr. ROSS. And that essentially would be an alternative to 50 or more employees in order for the Patient Protection and Affordable Care Act to apply. And I came in late—has anybody asked you about that?

Mr. STREITBERGER. No, sir.

Mr. ROSS. Would you explain why that is a good idea?

Mr. STREITBERGER. Well, if I understand the question, we have—as a public company, and probably a lot of private companies, we look at our profitability in many different ways, and profit for employee, or in the case of health insurance, the cost per employee, and we try and keep that within a manageable rate for the organization as well as an affordable one for our team members, as well. And to Mr. Andrews' point, some, you know, may find it difficult to pay the premiums based on their annual salary——

Mr. ROSS. Well, that affects your margins. I mean, if you are on a——

Mr. STREITBERGER. Well, at 3 percent——

Mr. ROSS [continuing]. If you are a tech company and your profit per employee is, you know, several hundred thousand dollars, and in the food industry, you know, it is——

Mr. STREITBERGER. Yes. Our business isn't in the clouds. I mean, it is in our restaurants and we can't take our work, if you will, offshore. I mean, it stays here in the United States.

Mr. ROSS. Would you support a profit per employee, as opposed to a threshold of 50 or more employees?

Mr. STREITBERGER. Yes, sir.

Mr. ROSS. Mr. Fensholt, you talked about the grandfather provision and being able to keep your doctor. Is there anything in this act that would allow or require a doctor to keep a patient?

Mr. FENSHOLT. Not to my knowledge, sir.

Mr. ROSS. So it is somewhat unilateral, I guess. In other words, if the doctor is not going to get the reimbursement, if the doctor is not going to get the equitable fee for his services then he may not keep the patient regardless of how much the patient wants to keep the doctor.

Mr. FENSHOLT. I think that is a fair statement.

Mr. ROSS. And, Mr. Ramthun, I want to talk to you a little bit about the HSAs, and wellness, and portability. And I think there are a lot of factors that come into play because I think we as a country missed something when we decided to continue employee-provided health benefits, because we don't provide employer-provided auto insurance, property insurance, and most other insurances.

For some reason, since the end of World War II we have provided this as a benefit, and done so to the detriment of the employee and to the employer, and to the doctors. And it seems to me that a change in health policy would be to allow for wellness, as Ms. Hall spoke about being very important, and wellness being managed with HSAs that allow the employees to have some sense of responsibility

In other words, when I buy property insurance I get a discount if I have a smoke alarm, a fire alarm. I have some risk in it. I am paying the premium but I also have the discount because of my risk management.

It would seem to me that a policy in place that would allow for the interstate sale of health insurance programs—because we have interstate sale of a lot of investment products out there that are done, I think, very effectively through consumer advocacy enforcement, as well. But across state lines, health savings accounts, tax policy that incentivizes somebody to buy it, and incentives for wellness, and I think that we have got not only somebody who will manage their care better and bring down costs but also allow for portability so that the employer doesn't have to burden that cost and that the employee can take the advantage of not only the deduction but also the choice of policy they want. Would you agree with that?

Mr. FENSHOLT. That would be a winning combination. And as far as not being able to reach across state lines to talk to an insurance commissioner, it works in the driver's license system. If I am speeding in California and my license is back in Maryland they can pull up all the tickets that I have ever had in a matter of a few instances, so——

Mr. ROSS. Thank you——

Mr. FENSHOLT [continuing]. I think those insurance commissioners could work together to——

Mr. ROSS. Oh, no question about it.

Ms. Hall, you know, you talk about junk insurance companies selling across state lines. You know, I have got some concern. You mentioned that you would prefer a public option but a public option is essentially putting the federal government in the business of insurance competing against private industry.

Ms. HALL. Yes.

Mr. ROSS. And you think that is a good idea. And as I understand it, insurance is basically an actuarial assessment of risks—of lifetime risk that is backed by capital—capital in the form of cash, securities, or reinsurance. And yet, if you put the government into the business there is no cash, there is no securities, there is no capital. All there is is the obligation of the taxpayers, and you could have a subsidized market.

It would seem to me that a public option would be one of the worst things we could ever do for this country, and if that is the course you want to take then if the price of milk is too high why not put the federal government in the milk business?

Ms. HALL. I mean, the public option is off the table so that is no longer an issue. And I guess I disagree, that I think the government actually could create a really amazing insurance——

Mr. ROSS. A central government function, then?

Ms. HALL. I mean, I think that you take 50-plus years of learning of where we have come and create a system, I think, that can be more powerful across all states.

Mr. ROSS. I see my time is up, but I tend to disagree with you. I yield back. Thank you.

Chairman ROE. Thank the gentleman for yielding.

Mr. Rokita?

Mr. ROKITA. Thank you, Mr. Chairman. I thank the chair, and the members, and the witnesses for your time today. It is very educational. Not only do I learn about health care but I learn about

milk prices in a centralized economy. And by the way, I completely associate with Mr. Ross.

I had some follow-up questions based on earlier testimony and I want to focus first on Mr. Fensholt.

Sir, did you recall the discussion—excuse me—do you recall the discussion about the consumer protection all moving to one state—maybe the one state that has the lease, quote-unquote, consumer protection if we went to selling insurance across state lines? Do you recall that discussion just a little while ago?

Mr. FENSHOLT. Yes, sir.

Mr. ROKITA. Okay. I used to be in the consumer protection business. I was a state securities regulator, so I am very interested in that line of thinking from Ms. Hall's testimony. Do you agree with that?

Mr. FENSHOLT. I don't think so, sir. And certainly in our—in my business, what Lockton does, the bulk of our clients provide self-insurance. They are not subject to state regulation in any event.

So we look at health reform from the standpoint of these midsize to large employers that provide their own insurance, and they are subject only to the whims of the federal authorities. And our view and the view of our clients is those regulations are simply becoming too burdensome and too expensive.

Mr. ROKITA. Right.

Mr. Ramthun, do you have anything to add to that?

Mr. RAMTHUN. No, I don't. Sorry.

Mr. ROKITA. All right. Thank you.

And, Mr. Streitberger, do you have anything to add to that?

Mr. STREITBERGER. No, sir.

Mr. ROKITA. Okay.

Ms. Hall, do you have anything?

Ms. HALL. I think that letting insurance companies throw quality and value out of the window it seems like—the across state lines is just kind of a code for insurance companies to not comply with quality, affordable health care coverage.

Mr. ROKITA. So you don't believe that competition would occur inside the state?

Ms. HALL. It just seems like if I live in Washington I can go to my insurance commissioner to talk about what is going now. You know, insurance is a lot different than a driver's license. How many times do you call the Department of Licensing about your license? Once every 4 years.

Mr. ROKITA. Well, it is very different. I know that——

Ms. HALL. And you go to the doctor six times a year——

Mr. ROKITA [continuing]. But that is not my question, so I just wanted to see if you had anything to add to your testimony in light of what was said.

Again, to Mr. Fensholt, to offset the health reform law the Democrats included a host of new taxes and fees in the medical device industry and in the insurance industry.

Mr. FENSHOLT. Yes, sir.

Mr. ROKITA. I am a cosponsor of the Medical Device Repeal Act, for example. Many others in Congress are, as well. It is going to be heard next week for an up or down vote, so I am interested to know you and your members' opinions on the effect of these taxes

and fees. We have heard from the Congressional Budget Office that these new taxes will be passed through to consumers in the form of higher premiums.

Mr. FENSHOLT. No question about it.

Mr. ROKITA. And so consumers are going to be paying for these higher taxes, or we are going to have less devices, I would imagine.

Mr. FENSHOLT. Sir, with all due respect, I think this is one of the most disingenuous aspects of the Affordable Care Act. You can't levy billions of dollars in excise taxes—penalty taxes—against entire industry segments and expect those business people not to pass that cost on through in the price of their products.

In the case of the taxes and fees on insurance companies and third party claim payers, the insurance companies we deal with and our own actuaries, as I said in my testimony, expect both taxes and fees alone to amount to $10 to $15 per employee per month increase beginning in 2014.

Mr. ROKITA. Thank you, sir.

And then to Mr. Ramthun: Researchers from RAND recently wrote in Health Affairs that an increase in consumer-directed health plans could reduce annual health spending by about $57 billion. Are you concerned that the implementation approach by this administration—the approach they are taking with respect to consumer-directed health plans may actually discourage employers from offering these plans?

Mr. RAMTHUN. Absolutely. I am very concerned and outlined in my testimony several areas where the regulatory issues could cause those effects.

Mr. ROKITA. Okay. Thank you.

I yield back, Chairman.

Chairman ROE. Thank the gentleman for yielding.

Mr. Scott?

Mr. SCOTT. Thank you, Mr. Chairman. Could any of the panelists respond to the effect on individuals and small businesses of getting what is essentially the large group rate under exchanges rather than what they have to go through now?

Mr. FENSHOLT. I couldn't hear the question. I am sorry.

Ms. HALL. Yes. I missed——

Mr. SCOTT. The effect of the exchanges on the rates that would be paid by individuals and small businesses. Right now the large businesses get the smaller rates. By going under the exchanges wouldn't the individuals and small businesses be—have access to lower rates?

Ms. HALL. I mean, I am a small business owner, and yes, we would have access to lower rates, which is why we support this.

Mr. SCOTT. If we have an exchange, what is the expectation of the number of companies—insurance companies that would actually sign up with a reasonable panel of doctors? Does anybody——

Mr. STREITBERGER. I don't know.

Mr. SCOTT. If the insurance companies have access to the exchange, what would that do to their expenses? Would their expenses be lower, having access to an exchange, everybody going to an exchange rather than having the higher sales force to go out and try to sell insurance?

Ms. HALL. I imagine it would be much lower.

Mr. SCOTT. Thank you, Mr. Chairman. I yield back.

Chairman ROE. I thank the gentleman for yielding.

I will now take my 5 minutes. First of all, I just want to start by saying the problem has been clearly laid out. The number one problem of the American health care system is it is too expensive. That is number one.

Number two, it has been brought out we have a group of people who work who don't have access to affordable health care. And number three, we have a liability crisis. Those are the three big problems.

Let me just give you some down-to-earth examples of what is going on out in the real world. Our local hospital system has 9,000 employees. We have a medical school in our community. They just laid off 168 people and did not fill 90 jobs—250 good jobs went away.

A small, rural hospital, in anticipation of this, had to go borrow $800,000 from the county commission to pay operating expenses—not to buy a new CT scanner but to keep their hospital doors open. Why is this happening?

Well, the payer mix is changing in hospitals. You have the government-run plans, Medicare and Medicaid, which don't pay the cost of the care. And there are less private insurers not because of everything getting better, because the economy has been bad. That is why. People have lost their insurance and people are not going to the—so the payer mix is changed.

And I think it is great. I have supported the 26-year-olds on health insurance. That was one of the things I support to begin with. They don't use hospitals. They figured it out. They are not the ones that go. You provide the benefit but they don't spend the money in the hospital.

So I talked to our CEO at the local hospital, and that is going on all over the country, and you are going to see more and more of that. That is from the real world.

Secondly, the expansion of Medicaid in our state, the hospitals now tax themselves 2.5 percent of their gross revenue to make up the state part of the Medicaid plan because the state doesn't have the revenue to make its match. Well, if you expand that I don't know how we are going to pay for it in the state of Tennessee, so that expansion is causing great grief among our governors who have looked at this, and the expansion is 16-to 20-something million.

I agree, it is not government-controlled health care; it is government-regulated health care—incredibly regulated because I put up with it for over 30 years trying to jump through those hoops that they put out there. I think this—what we ought to be looking at is cost, and Mr. Ramthun had a great—his testimony showed that the one thing that has been bringing cost down for people are consumer-driven plans.

This is mine; I have a health savings account. That is a wonderful way to provide health care for my family because if I need something I don't have to call up the insurance company and say, "Can I get this done?" And if I take care of myself in wellness and so forth I keep the money, the insurance money doesn't keep the money.

Where have we seen this done in public policy? And I want—I know Mr. Rokita is gone, but the state of Indiana has done this. We have done this for about 400 employees in our practice, and they don't go back to conventional insurance. People like this.

And I would like to have Mr. Ramthun speak to that. When you look at the data it is overwhelming—at the money. It is a different concept. You have to think about, "Now I am in charge of this debit card. I don't have to call anybody or do anything."

Could you comment on that?

Mr. RAMTHUN. Well, it is very easy to blame the insurance for the rising costs of health care in this country, but the fact is that most of the employees get their coverage through self-funded employers, where the employer is the insurance company. So they are not layering on all these other costs that everybody thinks are excessive for insurance.

What they have seen is that the utilization of the health care services is what is driving this total spending growth. And so it is strategies of personal responsibility, wellness, prevention that are making a difference and why the consumer-driven plans are so successful. There is a financial reward at the end of the day for doing so because you get to keep some of the money that used to go to pay for your insurance.

I think we have lost the notion of what real insurance is, and so we insure ourselves for all kinds of routine, very low-cost things where there is absolutely no risk involved. That has got to change. Consumer-driven health care is doing that and why it is so promising as a strategy to bend the cost curve.

Chairman ROE. Yes. When the rule-makers looked at this, why would they treat HSAs differently when it has been shown that that is the one thing out there that is lower cost for people? Why would that be treated differently?

Mr. RAMTHUN. I don't think they fully understand exactly how these policies work, and they are used to dealing with traditional insurance, which I understand what they are trying to achieve through their regulations. These policies are different because they don't pay from the very first dollar and so there have to be some special considerations made, which I have yet to see in the regulations.

Chairman ROE. And the state employees in Indiana saved—the state of Indiana saved 10 percent, which is a huge amount of money.

Mr. RAMTHUN. Yes. And that has been documented by Mercer.

Chairman ROE. Yes. Huge amount. And only 2 percent of the employees chose to go back to traditional insurance. They stayed. When they found out and learned how to use it it is very, very good.

I see my time is expired.

Mr. Walberg?

Mr. WALBERG. Thank you, Mr. Chairman.

Appreciate reading the testimonies. Sorry I wasn't here to hear them.

But let me ask Mr. Fensholt, first, at this time 2 years ago in our state of Michigan, which led the nation into high unemployment and is still working its way out of it. Thankfully, in the last

2 years we have had new leadership in Lansing—new governor, new legislature—that have been doing, I think, things the right direction in reducing the heavy burden upon businesses—small businesses, especially, in the state.

So we have gone from a statewide average 2 years ago of 13 percent, last year 10.6 percent. My district was at almost 15 percent and has now dropped to a state average. We are at 8.3 percent now. Things are starting to turn.

But in your testimony you discuss how the additional complexities of the president's health care law will undermine the private sector's attempt to grow. Could you be somewhat specific in how many of your clients are concerned with how this health care law will affect their businesses? And secondly, have they discussed the option of laying off employees or dropping health care coverage all together?

Mr. FENSHOLT. Yes, sir. We surveyed our clients about this time last year regarding the—their concern about the bill, its additional costs, its additional administrative burdens, and the cost attendant to that. A full 80 percent of our clients responded, and about half of our clients responded to the survey, which was remarkable—said they were either concerned or very concerned about the additional costs, administrative burdens imposed upon them by the health care reform law.

The bottom line is this: There is a tension created by the law between the finance offices in these companies who are looking at what they are currently spending on health insurance—$6,000, $8,000, $10,000, $11,000 per employee per year—and the human resource managers who feel they need to offer benefits to attract and retain talent. Ultimately, in challenging economic times the CFO wins that argument and if the business' survival depends on jettisoning health insurance they will do it.

And what this construct does, by offering extraordinarily generous federal subsidies to individuals to buy insurance in these insurance exchanges if they cannot get it from an employer, and it invites employers, in these challenging times, to exit that marketplace and allow their employees to migrate into the health insurance exchanges. Our fear—and I think our clients, many of them view—is that that will simply have to happen. They simply cannot continue to sustain these costs and without relief in that regard—they would love to do it, but without relief in that regard ultimately they will send their employees into the health insurance exchanges where they will draw federal money to buy coverage.

Mr. WALBERG. Yes, okay. Thank you.

Mr. Streitberger, maybe I am drawn to ask you questions because it is getting near lunch time and Red Robin is an interest at this point. But you mentioned that over the last 3 years, in your testimony, health care costs per employee have risen over 6 percent.

Mr. STREITBERGER. Yes, sir.

Mr. WALBERG. And that it is—that is before the full implementation of PPAC. If the president's health care mandate continues to force your prices to rise rapidly how will you limit the number of jobs Red Robin can create, and might you be forced to shift to a

model where some of your workers' hours would be reduced, minimized, your company's exposure to the employer penalties?

Mr. STREITBERGER. Well, those are all things that we are going to—that we are currently considering in how to deal with 2014. And yes, we would have to look at limiting hours that team members work, you know, to keep them below that because the cost is a—will spiral upwards when this kicks in.

We do the best that we can, as I mentioned earlier. We are self-insured. We pay the bills for our team members, which helps keep all our premiums as well as their premiums down. And with the lack of competition out there this is going to continue.

Now, ours increased 6 percent over the last 3 years, and a lot of that was in plan design and a lot of it with the fortune of having low claims history of our current population. So that 6 percent includes last year, which we were at zero. We kept our premiums flat.

Mr. WALBERG. So it could have been worse.

Mr. STREITBERGER. This was not health care legislation; this was just plan design and a little luck with low claims. But we can't count on that every year. Again, we want to keep affordable and robust health insurance, health coverage for our team members so that we can continue to grow and—but with these small margins the more we invest in things such as this, the slower we would be forced to grow, and then having to also entertain looking at limited hours.

Mr. WALBERG. Thank you.

And, Mr. Chairman, I think the old saw that said the best way to have health insurance is to have a job. This is going directly opposite in promoting health care at the expense of jobs, which ultimately does away with health care, as well.

Thank you.

Chairman ROE. I thank the gentleman for yielding.

I would now like to take this opportunity to thank our witnesses for taking your valuable time, and preparing your testimony, and coming to Washington and testifying. It has been very enlightening.

I will now recognize the ranking member for closing comments.

Mr. ANDREWS. Thank you.

I also would like to thank each of you for the time and preparation, and the inconvenience you suffered. I know one of our witnesses is going to go open another store in the state of Washington. I wish her well.

And I hope—Mr. Streitberger, you are opening a lot of stores. New Jersey is open to you.

I do want to express to the chairman my extreme disappointment that in scheduling this hearing and having a premier hamburger restaurant, premier cupcake vendor, that neither were asked to bring samples, evidently, for the members of the committee, and I want to express and register my extreme disappointment in that—that disappointment.

Mr. FENSHOLT. I will second that, Mr——

[Laughter.]

Mr. ANDREWS. The premise of much of the argument against the Affordable Care Act is that it is a job-killing health care law. Since

the president signed the law private sector employers in this country have added over 4 million new jobs.

I think that there is a political dispute about the law; I think it is one we ought to have in the election. But I think the facts are clear that the argument that this is a job-destroying health care law is not borne out by the evidence. Matter of fact, the opposite is borne out by the evidence.

But I look at this through the prism of personal experiences that some of you help us to edify this morning—all of you really have. On Tuesday morning—you want to talk about controlling cost—a woman went to a doctor to see how her diabetes was being managed. She had a stroke in 2005, mildly has been managing her blood sugar through exercise and diet, and as just great news about her blood sugar, and about her blood pressure, and about her blood tests, which all came back looking like she is doing very well.

She is a Medicare recipient, and I will tell you, I am especially glad that the prospect she will have another stroke or heart attack are lower because she is my wife's mom. And she swims every day, and she counts every carb that she eats, and she takes care of herself.

And we didn't pass a law that said she had to do that. Believe me, I can't pass any laws in my household that would affect anyone, as far as I can tell. But she made a really good personal choice, and she has got a higher quality of life, and she is costing the federal Treasury less. We have got to figure out a way to increase that behavior in any way we can.

On Sunday I encountered a constituent. She and her husband were music directors for a local Catholic church and the church has suffered a downturn in the collection plate because a lot of the parishioners are out of work, so the church had to cut back and make the two music directors part time instead of full time.

They both lost their health insurance because they were part time; the diocese couldn't afford to cover them anymore. And the husband, who is six-five and 250 pounds, his pulse was down to, like, 41, and my physician friends would understand that there was something going on there. So he goes to a local emergency room, they look at him, and they say, "You have got a serious problem. You probably need some heart surgery." And they were uninsured.

Now, happily, there is an institution in our area called the Deborah Heart and Lung Center that is like the Shriners concept, that they will see anyone and take care of them whether or not they can pay their bill. And they were lucky enough to live near a facility like that.

The man had a pacemaker put in a few months ago and he is alive today. I don't think he would be alive today were it not for the fortuitous event that that hospital was accessible to him.

That should not happen. These are hardworking, taxpaying, mortgage-paying citizens who, through no fault of their own, found themselves in a position where they were facing financial ruin, and worse than that, loss of life because of lack of health insurance.

That should not happen in this country. And I think that this law should stay in effect because it will prevent that from happening in this country.

And then the final thing that I saw this weekend that is a very good thing is that on Monday morning I was at Memorial Day breakfast at one of my American Legion posts and a friend of mine there is an electrical contractor. And last year when I saw him he was worried because he had one job left after the one he was working on.

He now has a 4-month backlog of electrical contracting jobs waiting for him throughout the rest of the summer and into the fall. Now, he is not indicative of every employer in America. He is certainly not, you know, a statistically significant sample. It is one guy.

But we have talked about the health insurance bill. He has about four or five employees. You know what he has to do under the bill? Nothing. Nothing. Because for the truly small businesses in the country there are no obligations imposed on them because of the understanding of what that costs.

I would like Mr. Streitberger's company to open 5,000 more stores. And I understand we have got to do something to control health care costs to make that a realistic and affordable goal. And for everyone here I would like to see them grow and be more successful and more prosperous.

I understand the intensity of the political argument about this. Boy, do I understand it. We all lived through it the last couple years.

But these are not issues that should be decided by ideological jihad; they should be decided by careful reasoning of people that want to solve these problems. I think we can do that together. I think we should build on this law—fix its deficiencies, build on its successes, and put our country in a different and better place. And I am confident that we can work together and do that.

I thank you for participating in a meaningful discussion that helps us do that, each of you. Thank you.

Chairman ROE. I thank the gentleman for yielding.

And I will finish by saying after 31 years of the practice of medicine I never saw a Republican or a Democrat heart attack in my life. I never delivered a Republican or a Democrat baby in my life, and I have delivered lots of them. And I never operated on a Republican or Democrat cancer. It is a people problem, and unfortunately, this health care law was passed on a partisan basis.

And I agree with the ranking member that we should work together in a bipartisan way to solve this, because if not it will never be accepted by the American people. Cost is a big issue because if you can't afford to buy it then you can't have it. I mean, it is that simple.

The only way I see that you can do this is to either go to a consumer-driven system or to a single-payer system where care is rationed. I mean, otherwise we are not—nobody is going to be able to afford health insurance, even the wealthiest is not, among us.

And the second thing that the ranking member brought up—Mr. Andrews brought up—which is coverage. There is no question there is a gap in coverage. I saw it every day in my practice, where there were people who worked hard every day and couldn't get affordable health care coverage. We have to address that in this country.

To clear the record up, there is a law called EMTALA that was passed, I think, in 1986, where if you show up in an emergency room, whether you are legally here in this country, illegally, whether you can pay or not pay, we give you care in this country. And I am not saying that is the best way to do it but it is done.

And I feel an obligation when someone—I am required and would do it. When a patient shows up without a doctor if I am on call I am going to take care of that patient in the emergency room.

Physicians, and nurses, and health care people do it every single day across this country and don't ask anything for it. The problem is it leaves the burden on the hospital to figure out how to pay for the bills—how to pay the bills, I should say.

I held a hearing in Evansville, Indiana about a year ago—a subcommittee hearing, and a small business person who was an IHOP owner was there—something you would, Mr. Streitberger, you would be familiar with. He had 800 employees in his 12 stores and he made about $3,000 per employee—netted about that per employee, which he said was, in that business, pretty good, and he thought was very good.

Since he had over 50 employees, if he provided what the government said he had to provide, the essential benefits package, which we don't know what it is yet and how much it is going to cost, then it would cost him—he would be upside-down about $7,000 per employee. He calculated—his H.R. people did. If he paid the penalty he made no profit, made no money at all. So what is he supposed to do?

Can he raise prices, as you pointed up? He can't do that. We have to work through this.

Another issue that we did hear—a small issue, but very much a big issue for me as a practitioner—is having someone with a flexible spending account, which should be getting you out of the most expensive part of health care, away from the doctor, away from the system, lets you make those health care decisions yourself and then purchase it with your own money, now you are requiring someone to see me to get a prescription for Nyquil. I mean, it is crazy when you see that. It makes no sense whatsoever.

You are forcing that person into a higher cost or you are forcing that person to make a phone call that day to the doctor, wait until it is called in, and add more bureaucracy and mandates to me with no payment for it at all, just more work to do.

There is a much simpler way to do it. One of the simplest transactions on this planet is a patient coming to see me as a physician, me providing a service, and them going out with whatever I do that day. And that is where consumer-driven care gets the insurance companies out of it, and you insure yourself for catastrophic problems—not for a headache or not for a cold but for catastrophic things. And it is the only way I can see we can actually get the health care costs under control.

And I think you can do it for our Medicaid population. I think they respond exactly—there are folks and some of the best shoppers in the world are people who are at lower income. They have to be. So they make, probably, better decisions than people that have more disposable income.

I think this has been a great hearing. I certainly appreciate all of your testimony, appreciate your being here.

With no further comments, this meeting is adjourned.

[Additional submission of Chairman Roe follows:]

TAX CHANGES	
2010	• **New Tax Credit for Limited Number of Small Businesses:** Maximum credit of 35% of employers insurance premiums is only available to those with fewer than 10 employees with wages of under $25 k per employee. Credit completely phased-out for firms with more than 25 employees and wages above $50 k. • **Tanning Tax:** 10% tax on indoor UV tanning
2011	• **HSA/FSA:** Prevent HSA and FSA Owners from Using Funds for Over-the-Counter Medicine (Raises $5 B) • **New Drug Tax:** New Tax on Brand-name Drugs (Raises $27 B) • **W-2 Forms:** Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual W-2 Form.
2013	• **Medicare Payroll Tax:** Increases the Medicare Payroll Tax by 0.9% to 3.8% for those with earned income above $200 k / $250 k joint (Raises $86.8 B) • **New Investment Tax:** Impose New Tax on Investment Income of 3.8% for with income above $200 k / $250 k joint (Raises $123.4 B) • **New Medical Device Tax:** New 2.3% Tax on Non-Retail Medical Devices (Raises $20 B) • **FSA Limits:** Limit Contributions to Flexible Spending Accounts (FSAs) to $2,500 (Raises $13 B) • **Eliminate Deduction for Employer Expenses for Medicare Drug Subsidies** (Raises $4.5 B) • **Medical Expense Deduction:** Raise the Threshold for Deducting Medical Expenses From 7.5% to 10% (Raises $15.2 B)
2014	• **New Individual Mandate Begins:** Individual must purchase insurance or face tax penalties, once fully-phased-in, of up to $695 or 2.5% of income (whichever is greater). • **New Employer Mandate Begins:** Employers with more than 50 employees who do not offer insurance or who offer coverage but their employees receive a federal insurance subsidy to pay a penalty of up to $2,000 per employee for each employee over 30 employees. • **New Insurance Subsidies Available:** For individual or families above the Medicaid eligibility cutoff, but below 400% of poverty (currently $88,200 for a family of four) who are not offered or eligible for other insurance coverage, a tax credit is available to purchase insurance through the new government exchanges. • **New Annual Tax on Health Insurance Providers** (Raises $60 B)
2018	• **New "Cadillac" Tax:** 40% Excise tax on High-Cost ("Cadillac") Insurance Plans (Raises $32 B)

Courtesy of the Office of the Republican Whip Eric Cantor March 25, 2010

[Whereupon, at 11:51 am., the subcommittee was adjourned.]

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