HEARING ON THE INDIVIDUAL AND EMPLOYER MANDATES IN THE DEMOCRATS' HEALTH CARE LAW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MARCH 29, 2012

Serial 112–HL09

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
78–672 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

DAVE CAMP, Michigan, *Chairman*

WALLY HERGER, California
SAM JOHNSON, Texas
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
PATRICK J. TIBERI, Ohio
GEOFF DAVIS, Kentucky
DAVID G. REICHERT, Washington
CHARLES W. BOUSTANY, JR., Louisiana
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
AARON SCHOCK, Illinois
LYNN JENKINS, Kansas
ERIK PAULSEN, Minnesota
KENNY MARCHANT, Texas
RICK BERG, North Dakota
DIANE BLACK, Tennessee
TOM REED, New York

SANDER M. LEVIN, Michigan
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
JIM MCDERMOTT, Washington
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
RON KIND, Wisconsin
BILL PASCRELL, JR., New Jersey
SHELLEY BERKLEY, Nevada
JOSEPH CROWLEY, New York

Jennifer Safavian, *Staff Director*
Janice Mays, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

WALLY HERGER, California, *Chairman*

SAM JOHNSON, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
DAVID G. REICHERT, Washington
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida

FORTNEY PETE STARK, California
MIKE THOMPSON, California
RON KIND, Wisconsin
EARL BLUMENAUER, Oregon
BILL PASCRELL, JR., New Jersey

CONTENTS

HEARING ON THE INDIVIDUAL AND EMPLOYER MANDATES IN THE DEMOCRATS' HEALTH CARE LAW

THURSDAY, MARCH 29, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 9:05 a.m., in Room 1100, Longworth House Office Building, the Honorable Wally Herger [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on the Individual and Employer Mandates in the Democrats' Health Care Law

March 29, 2012

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to explore the constitutional concerns raised by the individual mandate and economic problems caused by the employer mandate which were created in the Democrats' health care law. **The hearing will take place on Thursday, March 29, 2012, in 1100 Longworth House Office Building, beginning at 9:00 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

The "Affordable Care Act" (P.L. 111–148 and 111–152) imposes two highly coercive federal mandates on both individuals and employers. Beginning in 2014, the Federal Government will mandate that nearly every American purchase government-approved health insurance or pay a penalty. The United States Supreme Court will soon hear arguments in the days before the hearing about whether such a requirement is constitutional. Also, beginning in 2014, the Federal Government will mandate that many employers provide government-prescribed health insurance or pay a fine. Economists and employer groups have expressed concerns that the added costs associated with the employer mandate will impede their ability to hire and retain workers and result in lower wages. In announcing the hearing, Chairman Herger stated, **"The majority of Americans remain opposed to the Democrats' health care law, and an even larger number of Americans believe the individual mandate is a violation of their constitutional rights. The public remains concerned about the impact the law will have on their lives and with good reason. At its core, the Democrats' risky experiment relies on a federal mandate, forcing Americans to purchase a product—even if they can't afford it—or pay a fine. Furthermore, the law's new mandates and regulations are standing in the way of job creation at a time when unemployment remains high and our economy desperately needs more jobs. Although the courts are actively engaged, this hearing will allow for an open and candid discussion in Congress, where the law was passed, but where it did not receive the debate and dialogue that these issues deserve."**

FOCUS OF THE HEARING:

The hearing will focus on the constitutional questions surrounding the individual mandate and the economic impact of the employer mandate.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you

would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, April 12, 2012**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman HERGER. The subcommittee will come to order. I want to apologize for Ranking Member Stark, who has been caught in traffic so we will move ahead. Without objection, his opening statement will be made part of the record.

[The prepared statement of The Honorable Pete Stark follows:]

The Honorable Pete Stark, Statement for the Record

Chairman Herger,

Thank you for holding this hearing today; though, I must say that it seems to be a bit after the fact. The Supreme Court spent the last three days considering the constitutionality of ObamaCare with all of America watching the media circus that surrounded it. Today's hearing won't affect that outcome at all. And I might point out that – while I look forward to the discussion -- the Committee already had a hearing on the economic effects of the employer mandate in January, 2011. Nothing has changed on that front since the provisions in question are still not in effect.

Having spent three hours at the Supreme Court on Tuesday listening to the debate about the constitutionality of the individual mandate, I must also admit that I'm not sure how anxious I am to hear it all again. But, here we are.

I was disappointed in the press advisory announcing this hearing. It is fine to label a bill in Congress as a "Democratic" bill or a "Republican" bill. But, once those bills become law, they don't belong to one party. Whether folks like it or not, health reform is America's law, not the "Democrats' Law," as the Ways and Means Press Advisory labeled it.

It is a law that is already benefitting tens of millions of Americans. Just this week, I heard from a constituent of mine, Marilyn, who contacted me via Facebook to say that she's grateful that her 24-year-old daughter is able to be covered on her insurance plan. For her, and the millions like her, it is simply the law, it is protecting her families' health, and she is grateful.

I'd also note that Democrats don't hold the patent on an individual mandate. Many leading Republican elected officials and policy experts -- ranging from Newt Gingrich to Mitt Romney to the Heritage Foundation's Stuart Butler have all advocated an individual responsibility requirement for the purchase of health insurance. In fact, it is rooted in Republican ideology of "personal responsibility." Why is it fair to have free-riders in the system who impose costs on all of the rest of us? New found Republican opposition to this concept at times makes it seem as though we have all fallen down the rabbit hole. The simple reality is that you can't guarantee affordable, quality health insurance in the private health care marketplace without an individual responsibility requirement.

The second panel of this hearing deals with the potential effect of the employer mandate.

The facts counter Republican claims about the employer responsibility requirements. . Employer sponsored insurance will remain a strong source of coverage under the Affordable Care Act with many analysts from a variety of think tanks and government sources projecting minimal changes in the number of people who will have employer coverage under the ACA. I ask for unanimous consent to submit for the record studies from the Congressional Budget Office, CMS Office of the Actuary, RAND, Lewin, and Urban Institute, all of which project minimal changes in employer coverage under the ACA. Let's remember that the employer mandate only applies to companies with 50 or more full-time employees. The data show that in our purely voluntary health insurance system today, virtually all – 94 percent -- of employers at this size already offer coverage to their workers. Thus, the mandate doesn't negatively affect them. Instead, it levels the playing field among employers by making sure that each pay their share of health care costs for their workers. From an employee perspective, the ACA enables workers to make employment choices based on the job they are offered, not the health benefits that are attached to it, thus freeing workers from job lock and promoting entrepreneurism and job satisfaction.

In closing, I'd note that we're pleased to have Neil Siegel, a professor of law at Duke University and Stephen LaMontagne of Georgetown Cupcake with us today. Georgetown Cupcakes is a relatively new, but quickly growing, business in this cupcake-crazed world. They provide coverage to their workers and are not afraid of the ACA and its implications. I look forward to their comments about how ObamaCare will affect them.

With that, I yield back my time.

Chairman HERGER. We are here today at the actual end of an extraordinary week in the history of the Democrats' health care overhaul. Last Friday marked the 2-year anniversary of the law and for 3 days this week the Supreme Court considered its constitutionality. Today, the subcommittee will examine two mandates at the center of the law.

Beginning in 2014, the individual mandate will require Americans to buy government approved health insurance even if they can't afford it, or else pay a penalty. This mandate fundamentally changes the relationship between the individual and the Federal Government, and for the first time in history requires individuals to purchase a private product and enter into a private contract. Not surprisingly, the individual mandate is the subject of one of the most important and closely watched Supreme Court cases in modern times. The individual mandate is also deeply unpopular with the American people. A constitutionally suspect mandate that is opposed by the public is not a very stable cornerstone of a health reform plan, and yet, and yet, the administration claims it is essential.

The individual mandate is unprecedented, unlimited, unnecessary, and dangerous. Never before has Congress required individuals to purchase a private product. If Congress has the power to compel commerce, then its power becomes virtually unlimited. Indeed, the Obama administration has not put forward any limiting principle.

Finally, the individual mandate creates a Federal policy of police power, a power reserved in the Constitution for the States. This is dangerous because our dual system of sovereignty is essential to protecting individual liberty.

Our first panel will examine the constitutionality of the individual mandate. Not everyone was able to secure a seat to hear oral arguments at the Supreme Court this week, but it is important that the public as well as Members of Congress understand the constitutional questions raised by this coercive mandate. We have a distinguished panel of attorneys, each of whom have authored or coauthored influential amicus briefs in this historic case.

The second panel will discuss the economic problems created by the employer mandate. I can sum up those problems in one word. Jobs. The employer mandate places additional cost burdens on employers, which is the last thing job creators need during these tough economic times, and it would discourage the hiring of additional workers. In a recent U.S. Chamber of Commerce survey, over 1,300 small business executives found that 74 percent say the recent health care law makes it harder for their business to hire more employees. Given how long we have suffered with high unemployment, the employer mandate makes absolutely no sense.

In addition, the employer mandate will force employers to scale back their existing workforce, particularly workers at the lower end of the wage scale. Equally troubling, the mandate encourages employers to eliminate the health insurance they offer to their employees because the penalty associated with not offering coverage is far cheaper than the costs associated with offering and maintaining health insurance coverage.

In summary, the cornerstones of the Democrats' health care law are crumbling under the weight of scrutiny. The entire law needs to be repealed and replaced with real constitutional reforms that reduce the price of health insurance.

Before I recognize the minority for the purpose of an opening statement, I ask unanimous consent that all members' written statements be included in the record. Without objection, so ordered.

I now recognize the gentleman from New Jersey for opening statements.

Mr. PASCRELL. Just very briefly, Mr. Chairman. Let's make it clear before we start today that we are already paying, for the members of this committee who are here and who are not here, we are already paying for those folks who do not have insurance. Let's make the record clear on it. Let's not have confusion on that issue. And I think we do a disservice to the subject as well as to the American people to in any way infer or conclude that if we sustain the system that we are trying to move away from, that this will keep money in our pockets. We are going to continue to pay for those people who do not have insurance. There is no other way to pay the bills. And so I think that needs to be made very clear.

And I would like to know, you know, you talk about frivolous lawsuits, let's talk about what will be accomplished from this hearing. I am trying to think about that, think into the future. What is going to be accomplished in this hearing as we await the June decision from the Supreme Court?

And thirdly, when we say we need more constitutional reforms for health care, and if as many of the folks on your side of the aisle, in all due respect, reject the health care act, then what are you suggesting in its place? I would like to hear that before the end of the day. What are the constitutional reforms that you think are necessary in order to bring about a change to a system which both of us admit is not sustainable, which exists now? Then what do you suggest? And I would like those to be codified and sent to all the members, and then maybe we can have a debate on what you folks have been talking about. And I frankly don't know what you have been talking about, because I don't know that any of those constitutional reforms that you recommend have been put on the record.

Many of the people on your side, Mr. Chairman, have picked out certain parts of the health care act and said that these aren't so bad. We certainly wouldn't vote against this. We wouldn't vote against that. But I don't know what you stand for yourself. And I think we need to know that before we get into this discussion, or perhaps the members of the panel would suggest that we should continue to sustain the old system that we are trying to get away from. I don't know what they think. And I know one thing, that we are paying for those people who are uninsured.

Now, first, we have got to find out how many people are uninsured. Then we have to find out how much we have been paying, and we can calculate that. Right, Dr. Price, we can calculate that. How much the folks——

Mr. PRICE. Will the gentleman yield?

Mr. PASCRELL. Sure.

Mr. PRICE. The fact of the matter is, many of us have put forward positive solutions. H.R. 3000 is the comprehensive one, Empowering Patients First Act, that we put forward. And I would just like to correct the gentleman, that the gentleman says we are already paying for those that aren't covered. In fact, what happens is that the people providing the care eat the cost for it. So the doctors and the hospitals are eating the cost. There is no more cost shifting, and so the gentleman is inaccurate.

Mr. PASCRELL. Can I take back my time? That is off the wall, and you know it, Dr. Price. You know, you know who is paying these bills. It is no different than when Walmart, which part-timed its whole workforce, who paid—the question is, who paid for those folks that had to go and seek medical attention, be in the hospital, go to a doctor? The answer: You. You paid, and I paid. That is the only answer. When you say well, the insurance company.

Mr. PRICE. Will the gentleman yield——

Mr. PASCRELL. Which insurance? They don't have insurance.

Sure.

Mr. PRICE. Let me just ask you, please. When you are home over the next 2 weeks, please go visit a physician's office who sees patients.

Mr. PASCRELL. I do it all the time.

Mr. PRICE. Ask them how much bad debt they are unable to collect and that they are not being compensated for that care. Just ask them, that is all I ask you.

Mr. PASCRELL. Reclaiming my time, I am very aware of the physicians in this country, and you being one yourself, I would appreciate that fact that you are trying to protect your profession in a professional way. I have no problems with what you just said. But we know why the debt is accumulated, when people aren't paying their bills. And why aren't people paying their bills, Dr. Price?

Mr. PRICE. You want me to respond?

Mr. PASCRELL. Sure.

Mr. PRICE. I am happy to respond. I think it is because of the taxation of this society, the regulation, the regulatory burden and oppression that this administration puts on them so that we can't have a dynamic economy, and the lawsuit abuse that exists out there is astounding, astounding.

Mr. PASCRELL. Reclaiming my time. I know you have accused this administration of everything but thunderstorms, and you will get to that some day, I am sure.

Chairman HERGER. The gentleman's time is expired.

Mr. PASCRELL. May I just finish my sentence? Thank you. Thank you, Mr. Chairman. But we are paying, my grandfather, may he rest in peace, said we pay. The average person pays, and they don't even know it.

Chairman HERGER. The gentleman's time is expired. We will hear from four witnesses on our first panel. Carrie Severino, General Counsel, Judicial Crisis Network; Steven Bradbury, Attorney with Dechert LLP; Joseph Henchman, Vice President of Legal Projects, Tax Foundation; and Neil S. Siegel, Professor of Law and Political Science, Duke University School of Law.

You will each have 5 minutes to present your oral testimony. Your entire written statement will be made part of the record. Ms. Severino, you are now recognized for 5 minutes.

STATEMENT OF CARRIE SEVERINO, CHIEF COUNSEL, POLICY DIRECTOR, JUDICIAL CRISIS NETWORK

Ms. SEVERINO. Thank you, Mr. Chairman, Members of the committee. If men were angels no government would be necessary. We have all heard the famous quote from James Madison in Federalist 51, but rarely do we hear the rest of the quote even though it is absolutely crucial. "If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: You must first enable the government to control the governed; and in the next place oblige it to control itself."

I submit that the Patient Protection Affordable Care Act embodies precisely the type of uncontrolled government power that Madison and the founders recognized as a fundamental threat to our liberties. Having just fought in and won a revolution against a despotic central government, the framers of our Constitution were not about to tolerate the least slide back to tyranny. So they divided government power among three branches and were careful

to limit Congress' legislative authority to a specific list of powers and no more.

Congress explicitly invoked its power under the Commerce Clause as its authority for the health care law and its individual mandate in particular. It was wrong for three reasons:

First, the individual mandate goes against 200 years of history and precedent. In every Supreme Court affirmation of Federal power under the Commerce Clause, from regulating home-grown wheat to home-grown marijuana, you can always avoid government impositions by simply not participating in the regulated activity in the first place. But with the health care law, you are automatically subject to regulations simply, as Justice Breyer noted, by virtue of being born.

Now, if the Federal Government has always had such a direct and unavoidable power over its citizens, it would have surely exercised it long ago and for emergencies far more pressing than health reform, such as during the Great Depression or World War II, but it did not. And that lack of historical support is strike one for the individual mandate.

Strike two for the mandate is the fact that compelling individuals to buy a product is a far different thing from regulating an existing market. This is why the administration struggles mightily to blur this distinction by, for example, complaining that people who choose not to buy health insurance now can nevertheless be regulated now because they are likely to consume health care services sometime in the future.

But there is a constitutional difference between actual and potential participation because after all we are potential participants in every single market that we consciously choose to avoid, where still bystanders forced into the health insurance market now will have only one legal exit, and that is moving to another country.

The third problem with the administration's argument is that it lacks any limiting principle. The Supreme Court has repeatedly said that the Federal Government's power must have a stopping point because the structural limits on our government are central guarantees of individual liberty. The learning principle relied on by the administration really just boils down to a claim that health care is different. But the market for health insurance, or even health care is not unique. There are many other products in life like food, clothing, and shelter that every American must purchase now or some day and are just as, if not more, necessary to human happiness than health care. As Justice Kennedy noted Tuesday, the government is calling this unique today, but it will just call something else unique tomorrow. And if the Federal Government can force Americans to purchase insurance to lower National health care costs, there is nothing stopping it from issuing the broccoli mandates or compelled gym memberships in the name of lowering health care costs.

But let's presume the administration is right and health care is somehow unique. That still isn't a limiting principle, but an invitation for government to label any grand scheme it wants to impose on Americans as unique, simply because it is grand. At that point the theoretical limit on the power of government will be the power of one's imagination.

I think the administration recognizes these weaknesses in its argument, and it has hedged its bets by emphasizing the Necessary and Proper Clause in its most recent Supreme Court brief. But the Necessary and Proper Clause is not a freestanding grant of power. It merely gives Congress the authority for carrying into execution its other enumerated powers. The administration argues that the individual mandate necessarily flows from the need to cover the massive costs that will be imposed on insurers by other parts of the health care law. But that is simply not carrying into execution those provisions. It is avoiding the negative consequences of the same provisions. Otherwise, it would mean that the greater the harm caused by a piece of legislation, the more power Congress could claim as necessary to fix the self-created harms. This is the epitome of bootstrapping.

As Members of Congress, you bear an independent responsibility to ensure that the Legislative Branch stays within its constitutionally enumerated powers. To once again summon Madison: Because government is not made up of angels, limits on governmental power are absolutely crucial. Because the individual mandate shatters these limits, it should be deemed unconstitutional by you and the Supreme Court.

Thank you.

[The prepared statement of Ms. Severino follows:]

***TESTIMONY EMBARGOED UNTIL 9:00 AM
THURSDAY, MARCH 29, 2012***

Testimony of

Carrie Severino

Chief Counsel and Policy Director

Judicial Crisis Network

Before the

House Committee on Ways and Means

Hearing on the

Individual and Employer Mandates

in the Democrats' Health Care Law

March 24, 2012

Thank you Mr. Chairman and members of the committee,

"If men were angels, no government would be necessary."

We've all heard this famous quote from James Madison in Federalist 51, but rarely do we hear the rest of the quote even though it is absolutely crucial.

> If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself.

I submit that the Patient Protection and Affordable Care Act is precisely the type of uncontrolled exercise of government power that Madison and the founders recognized as a fundamental threat to our liberties.

Having just fought and won a revolution against a despotic central government, the framers of our Constitution were not about to tolerate the least slide back to tyranny. So they divided government power among three branches and they were particularly careful to limit the legislative authority to a specific list of powers and no more.

In its findings accompanying the PPACA, Congress exclusively and explicitly invoked its power to "regulate Commerce … among the several States" as its purported constitutional authority for the Individual Mandate.

It was wrong for three major reasons.

First, the administration's expansive interpretation goes against two hundred years of history and all Supreme Court precedent.

As both the Congressional Research Service and the Congressional Budget Office have observed, the PPACA is entirely without precedent insofar as it mandates individuals to enter a stream of commerce. The fact that, over the course of two centuries, Congress never used this purported power to compel purchases,

suggests that Congress never has understood itself to have this power in the first place. For example, at the height of World War II, the federal government did not compel Americans to buy war bonds, even when our national survival was at stake.

The administration's go-to case, in fact, came out of the World War II era, but involved a much more modest claim of federal power than does the PPACA. In the 1942 case of *Wickard v. Filburn* the Court articulated a very broad rule allowing Congress to regulate even intrastate activity if that activity, in the aggregate, exerted a "substantial economic effect" on the interstate economy. But in *Wickard* the question was whether a commercial farmer growing wheat to feed his livestock could still be regulated under the laws that capped his production of wheat for sale. Whether one agrees or disagrees with that decision, Filburn at least had the ability to avoid falling under those regulations simply by getting out of the wheat production business altogether.

The administration's other go-to case, *Gonzales v. Raich*, has a similar problem. There, the government was regulating the interstate marijuana market, and swept in home-grown medical marijuana as part of its broader criminalization efforts. But the plaintiffs in that case were at least engaging in an activity that can be regulated, indeed, rendered illegal, and they could have left the marijuana market in the same way that Filburn could have left the wheat market.

In the case of the PPACA, individuals engaged in *no activity whatsoever* are subject to the Individual Mandate and have no way to avoid the compulsion to enter the health insurance market. A more apt analogy to the regulation in *Wickard* would be a "Wheat Mandate" that forced every American to buy a government-prescribed amount of wheat or pay a penalty. This would be a more effective means of raising wheat prices than the regulation at issue in *Wickard*. It also would share the features the government relies upon to defend the mandate. The vast majority of Americans participate in the wheat market in some form just as the vast majority of Americans participate in the health insurance market. Gains to farmers from

boosting wheat prices under a wheat mandate could be used to offset their costs in fulfilling a moral obligation to provide food for the hungry, just as the increased revenues to insurance companies from forcing more people to buy insurance are designed to offset insurers' losses by being required to offer insurance at otherwise unsustainably-low prices.

If the federal government had the power to compel individuals to purchase products, it would not have resorted to so many roundabout methods to support industries and inflate the prices of certain products as it has done repeatedly over the last century. Historically Congress has induced purchases through tax incentives or by conditioning other government benefits on purchases. If the administration's position is correct in this case, these workarounds were clumsy and inefficient solutions to a problem Congress could have more easily solved by directly compelling purchases. Instead of instituting a complicated and expensive government bailout of General Motors, Congress could simply have required Americans to purchase GM cars as a form of patriotic duty. Instead of offering incentives like Cash for Clunkers or tax credits for energy-efficient home improvements, Congress could have required individuals owning non-energy-efficient vehicles or homes to exchange or upgrade them.

If the government truly had this simple and direct way of achieving its goals, it would have exercised it long ago, and for emergencies far more pressing than health care reform.

A second error of the administration's expansive reading of the Commerce Clause is that compelling commerce simply isn't the same as regulating commerce.

Even under the Supreme Court's broadest reading of the Commerce Clause, no law and no case has yet attempted to compel individuals to enter a market under the guise of "regulating" that market.

Dictionaries from the Framers' era clearly define the term "regulate" in terms that do not include compelling activity, just as dictionaries of today. Rather, they all refer to the object of regulation as a preexisting – not potential – activity. As a result, government's broad interpretation of the Commerce Clause just doesn't make linguistic sense.

In fact, PPACA's individual mandate is just that: a mandate, a command, not a "regulation" in any sense of the word. To hold otherwise is to stretch the language of the Commerce Clause beyond the breaking point.

This is why the administration struggles mightily to elide the distinction between regulating activity and compelling activity. It intentionally blurs, for example, the critical difference between individuals who are actual participants in the health insurance market and those who are merely potential participants.

The administration likewise blurs the distinction between the market for health insurance and the much broader market for health care itself. It argues that because most Americans are or will be part of the market for health *care*, all Americans can be forced to buy health *insurance* that would cover such care. This approximation may be "good enough for government work," but it is not "good enough" for the Constitution.

There are numerous other markets in which most Americans participate and which carry the same or greater moral obligations that accompany the provision of health care. Although individuals all may need food, clothing, and shelter, the government cannot simply mandate that Americans purchase even these necessities.

The third problem with the administration's expansive interpretation of the Commerce Clause is that it lacks any limiting principle.

The Supreme Court's Commerce Clause jurisprudence has emphasized that government's power must have a stopping point to be constitutional, precisely because the Court recognizes the structural limits on our government as the preeminent constitutional guarantee of individual liberty.

The limiting principle relied upon by the administration seems to boil down to a claim that "health care is just different." But, as I have explained, the market for health insurance – or even health care – is not unique. And even if it were, expanding the Commerce Clause so dramatically in that market alone is hardly a limiting principle. It is an appeal to ad-hoc and arbitrary rule making.

If the federal government can force Americans to purchase health insurance to lower national health care costs, there is no reason it cannot require other purchases to lower those costs as well. We have all heard talk of "broccoli mandates" and compelled gym memberships and, while these sound extreme, there is nothing stopping Congress from passing such a law on the administration's view of the Commerce Clause. The best it can do is to say that politics would never allow such laws to be passed. While this may be true for the moment, political moods are notoriously fickle, which is why the Framers chose a system of enumerated and divided powers as the primary means of checking the coercive force of the government, notwithstanding what 51% of the electorate may say at any given moment.

But if, contrary to the Framers' vision, the administration's position is adopted by the Supreme Court, the only limit on the power of government will be the power of imagination.

Given the weaknesses of its Commerce Clause arguments, the administration has hedged its bets by emphasizing the Necessary and Proper Clause in its most recent briefs.

Because the administration's Commerce Clause arguments have received mixed reviews from the lower and intermediate courts, it has dedicated significant space in recent briefing to an alternative argument in support of PPACA. It argues that the Individual Mandate is a "necessary and proper" corollary of overall health care reform. In so doing, the administration makes a string of stunning concessions about the harms that core provisions that PPACA, standing alone, would impose. The administration acknowledges that, if deprived of the overwhelming firepower of the Individual Mandate, PPACA would "create a spiral of higher costs and reduced coverage because individuals can wait to enroll until they are sick."[1] The administration further warns that the PPACA in the absence of the Individual Mandate, would likely "lead to a death spiral of individual insurance."[2] The Mandate, therefore, is necessary and proper to executing the PPACA, according to the administration.

But the Necessary and Proper Clause is not a free-standing or roving grant of power. It merely gives Congress the authority "[t]o make all Laws which shall be necessary and proper *for carrying into Execution*" its other enumerated powers. (emphasis added.) For example, Congress has the power to lay and collect taxes. In order to execute that power, it also needs the authority to hire people to collect those taxes in the form of the IRS, to construct a building to house tax collectors, to print and distribute tax forms, etc.

But the government power under the Necessary and Proper Clause, like the Commerce Clause, must have a limit to be constitutional. The key limit surpassed in this case is that this Clause can only authorize laws that are necessary to the *execution* of the other powers. The Mandate, quite simply, does not execute or implement any other enumerated power and therefore cannot be used as a basis for the PPACA's constitutionality.

---

[1] Petrs. Br. at 18.
[2] Petrs. Br. at 30.

Although the Mandate may preserve a health insurance industry that – by the administration's own admission – would otherwise be destroyed by the PPACA's core provisions, the Mandate does not *carry into execution* those provisions, it *averts the harmful consequences* of these constitutionally legitimate provisions.

The theory here runs into a limiting-principle problem worse than that associated with the Commerce Clause. Under the administration's analysis, Congress would be free to act whenever it believes a legitimate statute carries harmful policy implications with it. By extension, the more damaging a statute's provisions, the more power Congress has to pass essential or necessary "fixes" that would otherwise be unconstitutional. This is the epitome of boot-strapping. Indeed, it is not unlike a plaintiff in a case arguing for standing based on the costs-incurred in bringing the lawsuit.

Further the administration's position actually incentivizes poorly-conceived and sloppily-drafted statutes because the greater the harm caused by a piece of legislation, the more power Congress could claim in order to fix the self-created harms.

As Members of Congress, you have taken an oath to uphold the Constitution of the United States. You thus bear an independent responsibility to ensure that the Legislative Branch stays within its constitutionally enumerated powers. To once again summon Madison, because government is not made up of angels, external and internal controls on government power are absolutely crucial. Because PPACA's Mandate removes several fundamental restraints on government power, it should be deemed unconstitutional by both you and the Supreme Court.

Chairman HERGER. Thank you. Mr. Bradbury, you are recognized for 5 minutes.

STATEMENT OF STEVEN G. BRADBURY, PARTNER, DECHERT LLP

Mr. BRADBURY. Chairman Herger, Ranking Member Stark, and distinguished Members of the Subcommittee, it is an honor to appear before you today. I would like to focus on the economic realities behind the individual mandate as laid out in an amicus brief we filed in the Supreme Court on behalf of 215 leading economists. Justice Alito alluded to our brief when he made the following points to the Solicitor General at oral argument this past Tuesday.

Justice Alito noted that the Congressional Budget Office estimates that the average premium for a single health insurance policy in 2016 will be around $5,800 per year. He then observed,

based on calculations presented in our amicus brief, which were derived from public HHS survey data, that the typical young, healthy individual who is the real target of the individual insurance mandate, incurs on average only $854 in annual health care costs. That is less than one-seventh of the medical costs incurred by the average American per year, a number frequently cited by those defending the mandate.

Indeed, just focusing on emergency room costs the average annual emergency room costs for the young and healthy are only $56. Highlighting this dramatic difference between the insurance premium a young, healthy individual can be expected to pay in complying with the mandate and the relatively modest health care costs that that same individual can be expected to incur, Justice Alito pointed out the obvious: "What this mandate is really doing is not requiring the people who are subject to it to pay for the services that they are going to consume. It is requiring them to subsidize services that will be received by somebody else."

The very same point was driven home by the Washington Post in its editorial earlier this week supporting the mandate. The Post was very candid when it wrote, "Insurance companies would be unable to offer affordable coverage to those with preexisting conditions unless they also were guaranteed enrollment of the young and healthy customers who are less likely to consume health care services."

These economic realities show that the individual mandate has almost nothing to do with cost shifting in health care markets, since the people primarily targeted by the mandate, those who can afford health insurance but who voluntarily choose not to purchase it because they reasonably expect the cost of insurance to outweigh their foreseeable medical costs, account for only a small fraction of the $43 billion of uncompensated costs identified by the Solicitor General.

Instead, the mandate was actually enacted not to stop cost shifting, but to compel millions of Americans to pay more for health insurance than they receive in benefits as a means to subsidize the insurance companies, and thereby to mitigate the steep rise in insurance premiums that would otherwise be caused by the guaranteed issue and community rating requirements created by the Affordable Care Act itself.

The Act prevents health insurers from making the basic actuarial decisions made in every other insurance market. Insurers may no longer withhold health insurance from those with preexisting conditions or price insurance premiums to match customer's known actuarial risks. By requiring health insurers to cover the sick and set premiums based on average costs, these Federal requirements would dramatically increase health care premiums for all insured Americans unless Congress at the same time forces the young and healthy with relatively little need for comprehensive health insurance to enter the market on terms that are economically disadvantageous.

Whether or not these regulatory requirements are good policy, what is clear as a constitutional matter is that Congress is not regulating how health care consumption is financed, as the Solicitor General has put it, but rather is compelling the voluntarily unin-

sured to purchase insurance at disadvantageous prices as a quid pro quo to compensate for the enormous costs imposed by the law's regulatory burden. The economic data proved the point and they belie any claim that the mandate is constitutional on the ground that it regulates economic conduct with a substantial effect on interstate commerce.

The mandate is not a regulation of commerce. It is a forced subsidy meant to ameliorate the costs of Congress' own regulatory policies.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bradbury follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012

Testimony of Steven G. Bradbury

Before the

House Ways and Means Committee
Subcommittee on Health

Hearing on:

The Constitutionality of the Individual Mandate in the Affordable Care Act

March 29, 2012

Chairman Herger, Ranking Member Stark, and distinguished Members of the Subcommittee, it is an honor to appear before you today to discuss the constitutional issues raised by the individual mandate in the Affordable Care Act.

I participated in preparing an amicus brief for the Supreme Court on behalf of a large number of economists addressing the economic realities behind the individual mandate. Our brief offered a counterpoint to the economic justifications cited by the Solicitor General in support of the Government's Commerce Clause defense of the mandate, and I want to share with the Subcommittee today the highlights of the points we set out for the Court in our brief.

Introduction and Summary

In defending the constitutionality of the individual insurance mandate, the Solicitor General argues that the mandate is necessary to address the asserted effects on interstate commerce caused by the shifting of medical costs from the millions of Americans who voluntarily decide not to participate in the health insurance market—Americans who, by definition, tend to be younger, healthier, and less

poor—onto those who do purchase insurance. As an estimate of this cost-shifting problem, the Solicitor General cites a figure of $43 billion, which is identified as the total yearly amount of uncompensated medical costs attributable to all uninsured persons in the United States. *See* SG Br. at 2, 8, 19.

The "cost-shifting" justification for the individual mandate, however, does not withstand scrutiny. In reality, the individual mandate has almost nothing to do with cost-shifting in healthcare markets since the people primarily targeted by the mandate (those who can afford health insurance but who voluntarily choose not to purchase it because they reasonably expect the cost of insurance to outweigh their foreseeable medical costs) account for only a small fraction of the $43 billion of uncompensated costs identified by the Solicitor General. While the *amici* supporting the Government emphasize the approximately $6,300 in medical costs incurred by *the average* American per year, the Government provides no analysis of the costs actually paid by those subject to the mandate. In fact, the undisputed data show that the young, healthy, and uninsured, who are the real targets of the mandate, on average incur annual healthcare costs that are less than one-seventh of that figure.

Consistent with that reality, and as expressly stated in the ACA's findings, the mandate was actually enacted not to stop cost-shifting, but to compel millions of Americans to pay more for health insurance than they receive in benefits in order to subsidize both the voluntarily insured and the insurers, and thereby to mitigate the steep rise in insurance premiums that would otherwise be caused by the ACA itself. The data belie the Government's claim that the individual mandate is constitutional on the ground that it "regulates economic conduct with a substantial effect on interstate commerce." SG Br. at 18, 33.

The real purpose of the mandate is what the Solicitor General calls its "second" function—namely, maintaining "the viability of the Act's guaranteed-issue and community-rating provisions." SG Br. at 18. The ACA prevents health insurers from making the basic actuarial decisions that they make in every other insurance market. Insurers may no longer withhold health insurance from those with preexisting conditions or price insurance premiums to match applicants' known actuarial risks. By requiring health insurers to cover the sick and to set premiums based on average costs, these federal requirements would dramatically increase healthcare premiums for all insured Americans, unless Congress at the same time forces the young and healthy with relatively little need for comprehensive health insurance to enter the market on terms that are economically disadvantageous.

Whether or not these requirements are good policy, what is clear as a constitutional matter is that Congress is exercising federal power not to regulate "how health care consumption is financed," SG Gov't Br. at 17, but to compel the voluntarily uninsured to purchase insurance at disadvantageous prices, as a quid pro quo for health insurers and other existing market participants to compensate them for the deleterious effect of the ACA's costly regulatory requirements.

An Economic Analysis of the Individual Mandate

A. Individuals Who Voluntarily Forgo the Purchase of Health Insurance Do Not Impose a Significant Financial Burden on the Healthcare System.

As a central argument in his defense of the individual mandate under the Commerce Clause and the Necessary and Proper Clause, the Solicitor General contends that the mandate is justified because "the uninsured as a class" impose $43 billion on the rest of the economy. SG Br. at 19. But this claim is unfounded. In fact, only a small fraction of the uninsured—and therefore only a fraction of the costs of uncompensated care—are the targets of the mandate.

The individual mandate targets people who could but who *choose* not to purchase health insurance and who will not otherwise be covered by Medicaid or Medicare. These people tend to be younger and healthier.[1] These Americans make the rational economic decision to pay for their relatively modest healthcare expenditures out of pocket, rather than purchasing insurance. Indeed, if they needed health insurance at all, they would require only the relatively inexpensive insurance that is limited to covering catastrophic care, a type of insurance now foreclosed by the ACA.[2]

---

[1] *See* Jack Hadley et al., *Covering the Uninsured in 2008*, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation 60 (Aug. 2008), *available at* http://kff.org/uninsured/upload/7809.pdf.

[2] Under the ACA, insurers may offer catastrophic coverage plans to those under 30 and other individuals who qualify for certain exemptions under the Act, but such "catastrophic" plans are very different from the plans in the market today that are aimed only at large, truly unexpected expenses: They must still provide "essential health benefits" coverage, as defined under the Act, after a certain threshold has been met, and must also provide for "at least three primary care visits." 42 U.S.C. § 18022(e).

The economic data do not support the conclusion that the younger and healthier Americans targeted by the mandate pass the cost of their medical care on to others in a manner that increases the costs of health insurance for the rest of us. In fact, those who voluntarily decide to forgo insurance coverage actually tend to *overcompensate* the market for their own care relative to other consumers of healthcare services, because they generally pay their medical bills and they are not able to obtain care at the discounted prices negotiated by insurance providers.[3] Accordingly, the individual mandate cannot be justified as a solution to the alleged cost-shifting problem.

The Solicitor General's $43 billion figure comes from analyses of healthcare costs contained in the Department of Health and Human Service's Medical Expenditures Panel Survey ("MEPS") dataset,[4] which is made up of data from "large-scale surveys of families and individuals, their medical providers, and employers," and is the most complete source of data on healthcare expenditures in the United States.[5] To put this figure in perspective, it is worth pointing out that the total value of the healthcare market in 2008 was roughly *$2.4 trillion*.[6] As the Congressional Budget Office ("CBO") has stated, "the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance."[7] Thus, the $43 billion in total uncompensated care represents less than 1.8 percent of the overall market.

Even that 1.8 percent, however, is quite misleading because it represents *the totality* of uncompensated care attributable to the uninsured in the healthcare system, not the costs specifically associated with those who are *voluntarily* uninsured and either not exempt from the mandate or not likely to become insured as a result of *other* provisions of the ACA. Indeed, the MEPS data reveal that the actual por-

---

[3] Jonathan Gruber & David Rodriguez, *How Much Uncompensated Care Do Doctors Provide?*, 26 J. Health Econ. 1151, 1159-61 (Dec. 2007).

[4] *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 1, 2 (2009), http:// familiesusa2.org/assets/pdfs/ hidden-health-tax.pdf (other pages of this source cited by Gov't Br. at 7, 8).

[5] Medical Expenditure Panel Survey ("MEPS"), U.S. Dep't of Health & Human Servs., http:// www.meps.ahrq. gov/mepsweb (last visited Feb. 12, 2012).

[6] Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure Projections 2010-2020, at Table 1 (2011), *available at* https://www.cms.gov/NationalHealthExpendData/ downloads/proj2010.pdf.

[7] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 13 (Nov. 30, 2009), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf (hereinafter *Premiums*).

tion of uncompensated care attributable to those targeted by the individual mandate is much smaller, and in fact constitutes less than one-half of one percent of the overall market for health care.

This reality is demonstrated when we subtract from the $43 billion figure the uncompensated costs attributable to the various categories of individuals who are not targeted by the individual mandate, as follows:

- *Medicaid recipients.* An estimated $18.0 billion of the $43 billion reflects care rendered to cost-shifters who are now newly eligible for Medicaid based on the ACA's expansion of Medicaid to all individuals and households whose income is at or below 133 percent of the poverty line;[8]

- *Illegal immigrants.* Of the remaining $25 billion, roughly $1.3 billion is attributable to uncompensated care provided to illegal aliens, who are expressly excluded from the mandate;[9] and

- *Those with preexisting conditions.* From the remaining $23.7 billion, an additional $7.7 billion must be subtracted for uncompensated care rendered to non-Medicaid-eligible, non-illegal immigrant individuals who would purchase health insurance, but whose preexisting conditions prevented them from doing so; under the ACA, they will be guaranteed coverage and so will no longer be uninsured.[10]

- *Those who will opt to pay the penalty rather than purchase insurance.* From the remaining $16 billion, another $3.2 billion should be subtracted to account for those younger, healthier Americans covered by

---

[8] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Most or all of those with income at or below 133 percent of the poverty line will also be exempt from the penalty that is tied to mandate, though not the mandate itself, under the exemption for those "who cannot afford coverage," 26 U.S.C. § 5000A(e)(1), and/or the exemption for those who do not file a tax return. *See* 26 U.S.C. § 5000A(e)(2).

[9] 26 U.S.C. § 5000A(d)(3) ("[i]ndividuals not lawfully present" not included in those subject to the mandate).

[10] 42 U.S.C. § 300gg-3. While it is possible that some with chronic conditions might fail to purchase insurance, it is reasonable to assume that given the guaranteed issue and community rating provisions, an overwhelming number of those individuals will make the economically rational choice to do so, since their healthcare costs would be expected to exceed the community-rated premiums.

> the mandate who can afford to purchase insurance but are expected to opt to pay the tax penalty instead. The CBO projects that approximately four million Americans will opt to pay the penalty.[11] Based on CBO estimates that 90 percent of those who pay the penalty will have incomes over the poverty line and 75 percent will have incomes more than twice the poverty line, we can estimate that roughly 80 percent of those who pay the penalty are likely to fall within the group targeted by the mandate.[12]

Taking these adjustments into account, we see that the *maximum* share of uncompensated care attributable to the mandate's target class would be at most approximately $12.8 billion, a much smaller number than the $43 billion cited by the Government.[13] Indeed, the true number is almost certainly significantly lower, because even without the mandate, there are other healthcare coverage subsidies provided under the ACA that are intended to and can be expected to induce many of those who are currently uninsured to choose to become insured in the future.

Accordingly, the voluntarily uninsured, who choose to pay their own relatively modest healthcare costs out of pocket, plainly cannot be described as free-riders who impose significant uncompensated costs on others. The actual amount of cost-shifting fairly attributable to the class of uninsured who are targeted by the mandate is, in truth, only a small fraction of the $43 billion in total uncompensated costs cited by Congress, and only a drop in the bucket of national healthcare costs. For these reasons, the purported cost-shifting rationale offered by the Solicitor General cannot reasonably justify the legislative decision to enact the mandate.

---

[11] CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* (Apr. 22, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11355/Individual_Mandate_Penalties-04-22.pdf.

[12] *Id.* at 2.

[13] This analysis is consistent with a recent study of California's healthcare system, which concluded that "[c]ost shifting from the uninsured is minimal" and is far outweighed by cost shifting attributable to patients covered by government insurance programs. Daniel P. Kessler, *Cost Shifting in California Hospitals: What Is the Effect on Private Payers?*, California Foundation for Commerce and Education 1 (June 6, 2007), *available at* http://www.cornerstone.com/files/CaseStudy/9bc04cf2-dd57-4f1d-ab3c-e5e0d5e7c96e/Presentation/CaseStudyFile/4796ca54-3a8a-4676-a61c-4c4b9f5a5272/Kessler_CFCE_ Cost_Shift_Study%206-6-07.pdf.

Apart from invoking the $43 billion figure, the Solicitor General also contends that the voluntarily uninsured must receive uncompensated care because participation in the market is "essentially universal," SG Br. at 35, and frequently expensive, *see id.* at 8, 19. The economist *amici* supporting the Government claim that the "average person" in 2007 used $6,305 in "personal health care services," which is "over 10 percent of the median family's income." Econ. Br. at 8. The Solicitor General also emphasizes how such costs render the payment of medical bills without insurance so difficult that the mandate can be seen as a necessary means to protect consumers. *See* SG Br. at 8, 12.

But statistics designed to show that the "average" person consumes a substantial amount of health care reveal little or nothing about the healthcare costs of those people specifically targeted by the mandate. The Government and its *amici* confuse a particular subset of healthcare consumers—the young, healthy, and voluntarily uninsured—with the overall market.

The mandate is not targeted at the "average" American in the healthcare market. It is meant to address adverse selection, and it is directed at younger, healthier individuals who, in the absence of such a mandate, would make an economically rational choice to forgo health insurance. *See* SG Br. at 29 n.6; 42 U.S.C. § 18091(a)(2)(I) ("[I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.").

As might be expected, the targeted subset consumes only a fraction of the national average in healthcare services per year. In fact, in 2010, the young, healthy, and voluntarily uninsured consumed, on average, only $854 in healthcare services, approximately 14 percent of the claimed "average" healthcare expenditure. That figure, moreover, constitutes less than 1.1 percent of an average family's yearly income based on the most recent available data, a far cry from the 10 percent costs of the "average" American cited by the Government's *amici*. *See* Econ. Br. at 8.[14] Thus, with regard to the specific class of persons targeted by the mandate, the Solicitor General's argument that these Americans' health care is too expensive to afford

[14] In 2007, the average household earned roughly $84,000. *See* Brian K. Bucks et al., *Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances*, Federal Reserve Bulletin, Feb. 2009, A5, *available at* http://www.federalreserve.gov/pubs/ bulletin/2009/pdf/scf09.pdf.

is simply not borne out by the data.

The Government's *amici* rely on the same flawed reasoning in arguing that because federal law requires emergency stabilization care, the voluntarily uninsured are an inherent cause of uncompensated care. *See* Econ. Br. at 13. Once again, the data show that the young and healthy who are the targets of the mandate consume *only $56* per year on average in *total* emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to, and paid by, patients) and the more routine care provided in emergency rooms. The data thus provide no evidence that the voluntarily uninsured are, as a class, receiving significant amounts of uncompensated care such that one could rationally justify the individual mandate as a solution to this purported cost-shifting problem.

The Government's economist *amici* argue that even if the average costs to the young, healthy, and uninsured are small, the expenses for such persons who do incur costs may be higher. *See* Econ. Br. at 9 (citing, for instance, $7,933 as the average in-hospital cost for a normal live birth and tens of thousands of dollars as the cost of treating ailments like colorectal cancer, pancreatic cancer, and heart attacks). Those numbers are surely larger than the average per capita cost. But the Government's *amici* provide no information about how many uninsured people actually *experience* such health events, or how many fail to pay those costs. Moreover, such an argument points toward requiring insurance for catastrophic costs, not for routine healthcare expenditures.[15]

B. The True Purpose of the Individual Mandate is To Subsidize the Higher Costs of Insurance Created by the ACA Itself.

The conclusion that the individual mandate will have little impact on reducing the costs of uncompensated care goes a long way toward exposing the real purpose of the mandate, which is to force millions of individuals into the health insurance market in order to subsidize the higher regulatory costs that the ACA itself will impose on private insurers. *See* 42 U.S.C. §§ 18091(a)(2)(C), 18091(a)(2)(I) (explaining that the mandate forces "healthy individuals" into the market as "new consumers" to reduce premiums). The Solicitor General forthrightly acknowledges that

---

[15] Even if the average healthcare costs of the uninsured population that is healthy, over 133 percent of the poverty line, and not an undocumented alien were considered (*i.e.*, not limited to the young), that sum would be $1,652, barely one-quarter of the $6,305 figure cited by the Government and its *amici*.

the individual mandate "is key to the viability of the Act's guaranteed-issue and community-rating provisions." SG Br. at 18.[16]

In the name of expanding coverage, Congress prohibited insurers from making the basic pricing decisions that they otherwise would make as rational economic actors. The ACA requires insurers to provide health coverage to those with preexisting conditions. *See* 42 U.S.C. §§ 300gg-1(a), 300gg-3(a). More significantly, insurers may not price health insurance based on the actuarial risks posed by a class of applicants, but must employ "community-rated" premiums—*i.e.*, premiums based on the average costs of the insurance pool. *See id.* § 300gg.

The ACA's prohibition on traditional means of pricing the insurance pool disrupts the market function of rating insurance premiums based on the probabilities of unexpected medical conditions. By doing so, the ACA effectively converts private health insurance into a government-mandated entitlement, which insurers must provide regardless of individual characteristics. By forcing health insurers to cover those with expensive medical conditions and to set premiums based on average costs, the ACA would cause health insurance premiums for everyone to rise dramatically. The CBO has estimated that before other offsetting reductions, including those due to the cross-subsidies provided by the individual mandate, the ACA's insurance reforms would cause costs for health insurance in the individual market to rise 27 to 30 percent over current levels in 2016.[17]

Congress thus imposed the individual mandate to subsidize private health insurers and lower the premiums for other insureds by compelling individuals, no matter how young and healthy, to pay for health insurance they do not want at premium levels that significantly exceed the value of the healthcare benefits they are likely to receive under the insurance. By forcing these individuals to engage in economically disadvantageous transactions, Congress sought to compensate for the regulatory costs imposed on insurers and to mitigate somewhat the sharp rise in health insurance premiums otherwise caused by the ACA.

---

[16] That the ACA was never grounded in an attempt to curb cost-shifting is likewise strikingly clear in Congress's half-hearted commitment to compel compliance. The penalty tied to the mandate is modest enough that many "free riders" would rationally choose to pay it rather than purchase insurance, and the ACA liberally excuses individuals from the penalty. *See* 26 U.S.C. § 5000A.

[17] CBO, *Premiums* at 6.

The CBO estimates that the individual mandate will have the effect of reducing premiums for those currently insured by a total amount between $28 and $39 billion in 2016 alone.[18] In other words, those targeted by the mandate will be forced to purchase health insurance at elevated premiums for the sole purpose of subsidizing the premiums of those who voluntarily enter the private health insurance market. Such a subsidy obviously has no correlation to any putative cost-shifting and everything to do with making more palatable the rise in health insurance costs that will result from the dramatic new regulatory requirements imposed by the ACA.

Thus, those subject to the mandate have not contributed materially to the cost-shifting problem identified by the Government. Instead, using the individual mandate as a subsidy, Congress hopes to compensate for the market-distorting effects of its own policy choices. Whatever one might say about such a course as a policy matter, the constitutional implications of permitting such bootstrapping as a valid regulation of interstate commerce are sweeping and unprecedented.

* * *

Thank you, Mr. Chairman. That concludes my testimony, and I would be happy to answer questions.

---

[18] CBO, *Premiums* at 5, 6; CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/ doc11379/Eliminate_ Individual_Mandate_06_16.pdf.

Chairman HERGER. Thank you very much, Mr. Bradbury. Mr. Henchman is recognized for 5 minutes.

STATEMENT OF JOSEPH D. HENCHMAN, VICE PRESIDENT, LEGAL PROJECTS, TAX FOUNDATION

Mr. HENCHMAN. Mr. Chairman, Ranking Member, Members of the subcommittee. Thank you for the opportunity to speak to you today about the Tax Foundation's perspective on whether the health care law's individual mandate is within Congress' power to levy and collect—lay and collect taxes granted by Article 1, Section 8 of the Constitution. Since our founding as an organization in

1937, we have advanced the ideas of simpler, more sensible tax policy with reliable research and principled analysis of tax issues at all levels of government. The government's primary argument, in this case to sustain the individual mandate, is that under the Commerce Clause it has the power to regulate interstate commerce, and that is a subject of much of the discussion in the briefs and of the court.

But the government secondarily argues that the mandate is an exercise of Congress' power to levy taxes because it is projected to raise revenue. We authored our brief in the case because we are very concerned by this argument and by the reasoning associated with it. One of the primary goals of our legal program at the Tax Foundation is to keep vibrant an understanding of the differences between taxes, fees, and penalties. Taxes are exactions imposed for the primary purpose of raising revenue for general spending. Penalties are exactions imposed for the primary purpose of punishing for an unlawful or undesirable act.

Now, we argue in our brief that the evidence shows that this is a penalty here. Everyone says that the primary purpose of the individual mandate is not for the revenue it is going to generate, but to discourage behavior. The statute calls it a penalty 12 times. It calls it a tax zero times. JCT calls it a penalty 24 times, and they include it under their regulatory provisions, not under their revenue provisions. The IRS cannot use liens and levies to enforce the mandate the way they can with taxes. The President told all of us when the bill was being considered that he absolutely rejects the notion that it is a tax. And the Justices this week seem very critical of the government's attempts to persuade them otherwise.

Now, you may ask why this matters. I assure you, it is not just some obsession of the Tax Foundation but has a real impact in the real world. There is three reasons why it is very important to keep a distinction between taxes and penalties. First, there are countless laws at the Federal level and in every State that treat taxes with some level of heightened scrutiny that is not given to other laws, including fees and penalties. Some examples: The Federal law that says you can't challenge a tax until it is collected, so the governments can have the revenue they need to operate; tax uniformity requirements, which exist in every State; tax super majority requirements, which exist in 16 States; voter approval thresholds; multiple reading requirements, and so on. If these provisions are to do what they are meant to do, you have to be able to tell the difference between taxes and non-taxes.

Second, the definition I outlined is not something we conjured up at the Tax Foundation. It is widely used and relied upon by courts across this country. Our brief lists five pages of cases from nearly every court in the land that has adopted this definition. And in fact, we have identified only four States that have departed from it. If the administration in this case were successful in getting the Supreme Court to adopt a completely new definition based on whether a revenue is raised, then that jeopardizes all of those taxpayer protections I mentioned and jeopardizes the ability of State and local governments to collect fees and fines they depend on.

Third, it goes to the very heart of the conception of how we pay for government. Taxes are the things we pay so that there will be

services for everybody. As Professor Randy Barnett put it this week, they are your duty in return for what government does to protect you and everyone else, and to equate that to a requirement to do business with a private company is to say that those are the same thing. That is very disturbing.

Now I am a good lawyer so this is the part where I say, if you disagree with me on everything I have said so far, try this: If it is a tax, it is not one that is permissible. Article 1, Section 8 of the Constitution says that direct taxes must be apportioned by State population. Now, although the founders disagreed on precisely what a direct tax was in a case about tax on carriages, they did agree that a tax directly levied on an individual is a direct tax. Alexander Hamilton, not one usually suspicious of big government, called this provision that prohibits direct taxes unapportioned by population, the thing that would ensure that the government could not tax in an abusive way.

So for all of these reasons, we think it is important that a meaningful distinction between tax and penalty is vital to give operation to all of those Federal and State provisions relating to tax policy, and we are hoping that the Supreme Court will agree with us.

Thank you.

[The prepared statement of Mr. Henchman follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:00 AM
THURSDAY, MARCH 29, 2012***

TAX FOUNDATION

National Press Building
529 14th Street, N.W., Suite 420
Washington, DC 20045
TEL 202.464.6200
www.TaxFoundation.org

Constitutional Questions Surrounding the Health Care Law's Individual Mandate: Beyond Congress's Power to Tax

By Joseph Henchman
Vice President, Legal & State Projects
Tax Foundation

Hearing Before the Committee on Ways & Means, Health Subcommittee,
U.S. House of Representatives

March 29, 2012

Mr. Chairman, Mr. Ranking Member, and members of the Committee:

Thank you for the opportunity to speak with you today about the Tax Foundation's perspective on whether the health care law's individual mandate is within Congress's power to lay and collect Taxes, granted by Article I, Section 8 of the Constitution. Since our founding in 1937, the Tax Foundation has advanced the ideas of simpler, more sensible tax policy with reliable research and principled analysis of tax issues at all levels of government.

As you know, the federal government is a government of limited and defined powers, so for the health care law's individual mandate to be valid, some grant of power in the Constitution must be found to sustain it. While the government and most of the other briefs in the case focus on Congress's power to regulate interstate commerce as the most relevant provision, the government has secondarily relied on Congress's power to tax. We authored our brief in the case to refute the government's mischaracterization of the individual mandate as a tax, to explain why the definition they propose is unworkable, and to warn that an adverse ruling on this point jeopardizes important taxpayer protections and well-defined case law in nearly every state.

A Tax is an Exaction Imposed for the Primary Purpose of Raising Revenue for Government Spending

I want to take a brief moment to explain why this is so important. While some may equate a tax as any government action that results in costs, monetary or non-monetary, the general public and

the courts have been careful to distinguish between different forms of government-collected exactions. Long-standing American suspicion of taxes, which dates from colonial times, has led to numerous federal and state restrictions specific only to taxes, such as the federal Anti-Injunction Act, tax supermajority requirements in 16 states, tax uniformity requirements in nearly every state, and voter approval thresholds. For these taxpayer protections to mean anything, a workable definition of "tax" is required.

Federal and state courts have risen to meet that need, articulating a definition that is widely accepted today. First, what matters is how the tax operates and not necessarily what it was labeled by policymakers who passed it. Otherwise, creative labeling (for which there is great political incentive) would nullify any restrictions. Second, look at what entity imposes the assessment, upon whom it is imposed, and how the revenue is used. Taking all that together, the definition that has emerged is that a tax is an exaction imposed for the primary purpose of raising revenue for general spending. This is in contrast to a fee, which is an exaction imposed for the primary purpose of recovering from the payor the cost of providing a particular service to the payor, and in contrast to a penalty, which is an exaction imposed for the primary purpose of punishment for an unlawful act.

We at the Tax Foundation work extensively on this issue, and our brief spends 5 pages listing case after case from federal and state courts that use this definition. (*See Appendix.*) Taxes are enacted primarily to raise revenue for general spending, penalties are enacted primarily to punish.

The Individual Mandate's Charge is a Penalty and Not a Tax Because Its Primary Purpose is Not to Raise Revenue but to Penalize

Applying that definition here, the individual mandate is not a tax because its primary purpose is to punish, not to raise revenue. The most common reason cited for its purpose is to regulate so-called "free riders" who use health care services but do not bear the cost. President Obama said to ABC News in 2009 that he "absolutely reject[s] the notion" that the individual mandate is a tax. The bill itself refers to the mandate as a "requirement to maintain minimum essential coverage," a "shared responsibility payment," and a "penalty." 26 U.S.C. § 5000A *et seq.* In fact, the law refers to it as a "penalty" twelve times and as a "tax" zero times. *See id.* The mandate also does not share the same enforcement provisions as taxes, with the IRS denied the use of liens or levies to enforce the provision. See 26 U.S.C. § 5000A(g)(2).

The Joint Committee on Taxation, which produced the technical explanation of the bill, refers to it as a tax in its subheading, but all of its other references evidence JCT's judgment that the mandate is not a tax. See Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, in Combination with the "Patient Protection and Affordable Care Act"* at 31 (Mar. 21, 2010), http://www.jct.gov/publications.html?func=startdown&id=3673. Aside from the reference in the subheading, the JCT never again refers to the mandate as a "tax" and instead invariably refers to it as a "penalty," doing so 24 times in its technical explanation of how the provision operates. *See id.* at 31-34. The explanation also falls under the policy and regulatory provisions of the Act, not under the "Revenue Provisions" heading. *See id.* at i-ii. JCT also left the mandate out of its revenue projections, where it estimated the financial impact of all provisions of the bill related to

raising revenue. See Joint Committee on Taxation, *Estimated Revenue Effects of the Amendment in the Nature of a Substitute to H.R. 4872, The "Reconciliation Act of 2010," As Amended, In Combination With the Revenue Effects of H.R. 3590, The "Patient Protection And Affordable Care Act ('PPACA')," As Passed by the Senate, And Scheduled For Consideration By The House Committee On Rules On March 20, 2010*, at 1-3 (Mar. 20, 2010), http://www.jct.gov/publications.html?func=startdown&id=3672.

Our brief also lists Supreme Court cases that emphasize a firm distinction between taxes and penalties. *See, e.g.*, *United States v. Reorganized CF & I Fabricators of Utah, Inc.*, 518 U.S. 213, 224 (1996), quoting *La Franca*, 282 U.S. at 572 ("[A] 'penalty,' as the word is here used, is an exaction imposed by statute as punishment for an unlawful act."); *Dep't of Rev. of Montana v. Kurth Ranch*, 511 U.S. 767, 779-80 (1994) ("[W]hereas fines, penalties, and forfeitures are readily characterized as sanctions, taxes are typically different because they are usually motivated by revenue-raising, rather than punitive, purposes."); *Bailey v. Drexel Furniture Co.*, 259 U.S. 20, 38 (1922) ("Taxes are occasionally imposed in the discretion of the Legislature on proper subjects with the primary motive of obtaining revenue from them and with the incidental motive of discouraging them by making their continuance onerous. They do not lose their character as taxes because of the incidental motive. But there comes a time in the extension of the penalizing features of the so-called tax when it loses its character as such and becomes a mere penalty, with the characteristics of regulation and punishment.").

While incidental revenue may be generated, the undeniable purpose of the individual mandate is to punish, discourage, and reduce illegal behavior, as a penalty and not a tax.

If the Mandate is a Tax, It Would Be an Unconstitutional Capitation Tax Unapportioned by State Population

In asserting that the individual mandate is permissible under the Taxing Power, the Government does not address the fact that if this were true, this tax would be a capitation tax unapportioned by state population, in direct violation of the constitutional requirement that "No capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken." U.S. CONST. art. I, § 9, cl. 4. A direct tax is only permissible if it is apportioned among the states in proportion to population, or levied on incomes. *See* U.S. CONST. amend. XVI; *Eisner v. Macomber*, 252 U.S. 189, 206 (1920) ("A proper regard for its genesis, as well as its very clear language, requires also that this amendment shall not be extended by loose construction, so as to repeal or modify, except as applied to income, those provisions of the Constitution that require an apportionment according to population for direct taxes upon property, real and personal. This limitation still has an appropriate and important function, and is not to be overridden by Congress or disregarded by the courts.").

The prohibition of unapportioned direct taxes exists for a strong purpose. Alexander Hamilton, conceding that a federal government with unlimited taxing power invited tyranny, explained that "[t]he proportion of these taxes is not to be left to the discretion of the national Legislature but is to be determined by the numbers of each State as described in the second section of the first article." THE FEDERALIST NO. 36, 226, 229-30 (1788). Hamilton characterized the provision as a compromise that ensured that the federal government could have recourse to direct taxation if

needed, but not in a way that could invite abuse or partiality. *See id.* George Mason, who felt that the provision was not sufficiently restrictive on government direct taxation, nevertheless described it correctly as meaning "that the quantity to be raised of each state, should be in proportion to their numbers in the manner therein directed." GEORGE MASON, VIRGINIA RATIFYING CONVENTION PAPERS 3:1087 (June 17, 1788).

Assuming *arguendo* that the Government's characterization of the mandate as a tax is correct, it would operate as a levy on individuals and not their incomes. The mandate penalty in 2016, for example, is imposed either in the amount of $695 per uninsured adult, or at the rate of 2.5 percent of the uninsured taxpayer's income in excess of the filing threshold (in 2010, $9,350), whichever is greater. *See* 26 U.S.C. § 5000A(c). Although the latter calculation could conceivably be considered a tax on income, the former direct amount cannot be. If it is a tax, it is a capitation tax, levied directly on the individual. Because its collection is not apportioned according to state population, its operation would violate U.S. CONST. art. I, § 9, cl. 4.

Conclusion

A meaningful distinction between "tax" and "penalty" is vital to give operation to numerous federal and state provisions relating to tax policy. If the U.S. Supreme Court held that a tax is any government collection of revenue, then government revenue collection efforts across the country would be imperiled, as many revenue sources are not subjected to the heightened restrictions that "taxes" are. To collect fees or impose criminal fines, states for the first time would see these charges subjected to supermajority, multiple reading, and other requirements. While some states may choose to extend such procedural requirements to non-tax revenue sources, this should be done explicitly through the legislative process, not by announcing a new definition of "tax" not comprehended at the time these provisions were adopted.

It is for these reasons that we requested that the Court find that the individual mandate exceeds Congress's Taxing Power under the U.S. Constitution.

Appendix: Federal and State Case Law Imperiled by a Ruling That the Individual Mandate is a Tax

- *United States v. State of New York*, 315 U.S. 510, 515-16 (1942) ("But a tax for purposes of [the Bankruptcy Code] includes any pecuniary burden laid upon individuals or property for the purpose of supporting the government, by whatever name it may be called.") (internal citations omitted);
- *United States v. La Franca*, 282 U.S. 568, 572 (1931) ("A 'tax' is an enforced contribution to provide for the support of government; a 'penalty,' as the word is here used, is an exaction imposed by statute as punishment for an unlawful act.").
- *San Juan Cellular Tel. Co. v. Pub. Serv. Comm'n of Puerto Rico*, 967 F.2d 683, 685 (1st Cir. 1992) (finding that a tax is thus an exaction imposed by the government, on the public, for the purpose of raising revenue which is then spent on general (not particular) public purposes; a charge not imposed by government, or a charge collected from those receiving particularized benefits, or a charge collected for primary purpose other than raising revenue, is not a tax.)
- *Valero Terrestrial Corp. v. Caffrey*, 205 F.3d 130, 134 (4th Cir. 2000) (applying *San Juan Cellular* to determine if a charge "qualifies" as a tax);
- *Neinast v. Texas*, 217 F.3d 275, 278 (5th Cir. 2000) (applying *San Juan Cellular*);
- *Hedgepeth v. Tennessee*, 215 F.3d 608, 612 (6th Cir. 2000) (describing *San Juan Cellular* as the "leading decision" used for "the definition of the term 'tax'");
- *RTC Commercial Assets Trust 1995-NP3-1 v. Phoenix Bond & Indem. Co.*, 169 F.3d 448, 457 (7th Cir. 1999) ("Penalties stand on a different footing. States do not assess penalties for the purpose of raising revenue. . . .");
- *Chicago & Nw. Transp. Co. v. Webster County Bd. of Supervisors*, 71 F.3d 265, 267 (8th Cir. 1995) ("A government levy is a tax if it raises revenue to spend for the general public welfare.");
- *Bidart Bros. v. California Apple Comm'n*, 73 F.3d 925, 931 (9th Cir. 1996) (applying *San Juan Cellular* test to "determin[e] whether an assessment is a tax");
- *Hill v. Kemp*, 478 F.3d 1236, 1244 (10th Cir. 2007) (finding that a tax's "primary purpose . . . is revenue rather than regulation");
- *Seven-Sky v. Holder*, 661 F.3d 1, 8 (D.C. Cir. 2011) ("It is well established that Congress used the term 'tax' in the Tax Injunction Act to mean assessments made for the purpose of raising revenues, not regulatory 'penalties' intended to encourage compliance with a law.");
- *Rural Tel. Coal. v. F.C.C.*, 838 F.2d 1307, 1314 (D.C. Cir. 1988) ("[A] regulation is a tax only when its primary purpose judged in legal context is raising revenue.");
- *Lightwave Tech., LLC v. Escambia County*, 804 So.2d 176, 178 (Ala. 2001) (finding that a charge "designed to generate revenue" for general spending is a tax);
- *May v. McNally*, 55 P.3d 768, 773-74 (Ariz. 2002) (adopting *San Juan Cellular*);
- *City of North Little Rock v. Graham*, 647 S.W.2d 452, 453 (Ark. 1983) (finding that a tax "is a means of raising revenue to pay additional money for services already in effect");
- *Sinclair Paint Co. v. State Bd. of Equalization*, 937 P.2d 1350, 1354 (Cal. 1997) ("In general, taxes are imposed for revenue purposes, rather than in return for a special benefit conferred or privilege granted.");

- *Zelinger v. City & County of Denver*, 724 P.2d 1356, 1358 (Colo. 1986) ("A hallmark of such taxes is that they are intended to raise revenue to defray the general expenses of the taxing entity.");
- *Stuart v. Am. Sec. Bank*, 494 A.2d 1333, 1337 (D.C. 1985) (describing taxes as "for the purpose of raising revenue");
- *Gunby v. Yates*, 102 S.E.2d 548, 550 (Ga. 1958) ("A tax is an enforced contribution exacted pursuant to legislative authority for the purpose of raising revenue to be used for public or governmental purposes . . . .");
- *State v. Medeiros*, 973 P.2d 736, 742 (Haw. 1999) (holding that a tax does not apply to direct beneficiaries of a service, does not directly defray the costs of a particular service, or is not necessarily proportionate to the benefit received);
- *BHA Inv., Inc. v. State*, 63 P.3d 474, 479 (Idaho 2003) ("[T]axes are solely for the purpose of raising revenue.");
- *Crocker v. Finley*, 459 N.E.2d 1346, 1350 (Ill. 1984) ("[A] charge having no relation to the services rendered, assessed to provide general revenue rather than compensation, is a tax.");
- *Ennis v. State Highway Comm'n*, 108 N.E.2d 687, 693 (Ind. 1952) ("Taxes are levied for the support of government . . . .");
- *City of Hawarden v. US W. Commc'ns, Inc.*, 590 N.W.2d 504, 507 (Iowa 1999) (holding that an exaction intended to raise revenue is a tax);
- *Citizens' Util. Ratepayer Bd. v. State Corp. Comm'n*, 956 P.2d 685, 708 (Kan. 1998) ("The primary purpose of a tax is to raise money, not regulation.");
- *Krumpelman v. Louisville & Jefferson County Metro. Sewer Dist.*, 314 S.W.2d 557, 561 (Ky. 1958) ("[T]axes are generally held to be a rate or duty levied each year for purposes of general revenue . . . .");
- *Audubon Ins. Co. v. Bernard*, 434 So.2d 1072, 1074 (La. 1983) (holding that "revenue is the primary purpose" of a tax);
- *Bd. of Overseers of the Bar v. Lee*, 422 A.2d 998, 1004 (Me. 1990) ("[T]axes are primarily intended to raise revenue . . . .");
- *Workmen's Comp. Comm'n v. Prop. & Cas. Ins. Guar. Corp.*, 570 A.2d 323, 325 (Md. 1990) (finding that taxes "are intended to raise revenue for public purposes");
- *Emerson Coll. v. City of Boston*, 462 N.E.2d 1098, 1105 (Mass. 1984) (finding that a charge "collected not to raise revenues" but for another purpose is not a tax);
- *Bolt v. City of Lansing*, 587 N.W.2d 264, 269 (Mich. 1998) (holding that a charge with "a revenue-raising purpose" is a tax);
- *County Joe, Inc. v. City of Eagan*, 560 N.W.2d 681, 686 (Minn. 1997) (holding that a charge "expressly intended to raise revenue" is a tax);
- *Leggett v. Missouri State Life Ins. Co.*, 342 S.W.2d 833, 875 (Mo. 1961) (finding that a charge is not a tax unless "the object of [it] is to raise revenue to be paid into the general fund of the government to defray customary governmental expenditures");
- *Monarch Mining Co. v. State Highway Comm'n*, 270 P.2d 738, 740 (Mont. 1954) ("Taxes are levied for the support of government, and their amount is regulated by its necessities.");
- *Douglas County Contractors Ass'n v. Douglas County*, 929 P.2d 253, 257 (Nev. 1996) (holding that a charge with the "true purpose . . . to raise revenue" is a tax);

- *Horner v. Governor*, 951 A.2d 180, 183 (N.H. 2008) (finding that a tax must be "intended to raise additional revenue" not "solely to support a governmental regulatory activity made necessary by the actions of those who are required to pay the charge");
- *Resolution Trust Corp. v. Lanzaro*, 658 A.2d 282, 290 (N.J. 1995) (finding that a tax "is intended primarily to raise revenue"); *Scott v. Donnelly*, 133 N.W.2d 418, 423 (N.D. 1965) ("If the primary purpose is revenue, it is a tax; on the other hand, if the primary purpose is regulation, it is not a tax.");
- *Olustee Co-op Ass'n v. Oklahoma Wheat Utilization Research and Market Dev. Comm'n*, 391 P.2d 216, 218 (Okl. 1964) (citing definition of tax in part including purpose "to provide public revenue");
- *Woodward v. City of Philadelphia*, 3 A.2d 167, 170 (Pa. 1938) ("[T]axes are defined to be burdens or charges imposed by the legislative power upon persons or property to raise money for public purposes, and to defray the necessary expenses of government.");
- *State v. Foster*, 46 A. 833, 835-36 (R.I. 1900) ("If the imposition of such a condition has for its primary object the regulation of the business, trade, or calling to which it applies, its exercise is properly referable to the police power; but if the main object is the obtaining of revenue, it is properly referable to the taxing power.");
- *Brown v. County of Horry*, 417 S.E.2d 565, 568 (S.C. 1992) (citing with approval the standard that "a tax is an enforced contribution to provide for the support of government . . . .");
- *Valandra v. Viedt*, 259 N.W.2d 510, 512 (S.D. 1977) ("[T]axes are imposed for the purpose of general revenue . . . .");
- *Memphis Retail Liquor Dealers' Ass'n v. City of Memphis*, 547 S.W.2d 244, 245-46 (Tenn. 1977) ("If the imposition is primarily for the purpose of raising revenue, it is a tax . . . .");
- *Hurt v. Cooper*, 110 S.W.2d 896, 899 (Tex. 1937) (finding that a tax is a charge with the "primary purpose" of "raising of revenue");
- *V-1 Oil Co. v. Utah State Tax Comm'n*, 942 P.2d 906, 911 (Utah 1996), *vacated on other grounds*, 942 P.2d 915 (Utah 1997) ("Generally speaking, a tax raises revenue for general governmental purposes . . . .");
- *Marshall v. Northern Virginia Transp. Authority*, 657 S.E.2d 71, 77-78 (Va. 2008) ("We consistently have held that when the primary purpose of an enactment is to raise revenue, the enactment will be considered a tax, regardless of the name attached to the act.");
- *City of Spokane v. Spokane Police Guild*, 553 P.2d 1316, 1319 (Wash. 1976) ("[I]f the primary purpose of legislation is regulation rather than raising revenue, the legislation cannot be classified as a tax even if a burden or charge is imposed.");
- *City of Huntington v. Bacon*, 473 S.E.2d 743, 752 (W.Va. 1996) ("The primary purpose of a tax is to obtain revenue for the government . . . .");
- *State v. Jackman*, 211 N.W.2d 480, 485 (Wis. 1973) ("A tax is one whose primary purpose is to obtain revenue . . . .")

Other Support:

- 4 Cooley, *The Law of Taxation*, ch. 29 § 1784 (4th ed. 1924) ("If revenue is the primary purpose and regulation is merely incidental the imposition is a tax; while if regulation is the primary purpose the mere fact that incidentally a revenue is also obtained does not make the imposition a tax . . . .");

- BLACK'S LAW DICTIONARY 1214 (9th ed. 2009) (defining tax as "[a] charge, usu. monetary, imposed by the government on persons, entities, transactions, or property to yield public revenue.").

Contrary Case Law:

- *Apocada v. Wilson*, 525 P.2d 876, 884-85 (N.M. 1974) (holding that a charge that raises revenue beyond costs is not a tax);
- *Heatherly v. State*, 678 S.E.2d 656, 657 (N.C. 2009) (dividing equally on the question of definition of tax);
- *State ex. rel. Petroleum Underground Storage Tank Release Comp. Bd. v. Withrow*, 579 N.E.2d 705, 710 (Ohio 1991) ("It is not possible to come up with a single test that will correctly distinguish a tax from a fee in all situations where the words 'tax' and 'fee' arise.");
- *Auto. Club of Oregon v. State*, 840 P.2d 674, 678 (Or. 1992) (describing "tax" as any revenue collected by government, separate from "assessment").

ABOUT THE TAX FOUNDATION

The Tax Foundation is a non-partisan, non-profit research organization founded in 1937 to make information about government finance more understandable and accessible to the general public. Based in Washington, D.C., our analysis is guided by the principles of sound tax policy: simplicity, neutrality, transparency, and stability.

ABOUT THE CENTER FOR LEGAL REFORM AT THE TAX FOUNDATION

The Tax Foundation's Center for Legal Reform educates the legal community and the general public about economics and principled tax policy. Our research efforts focus on the scope of taxing authority, the definition of tax, economic incidence, and taxpayer protections.

Chairman HERGER. Thank you. Mr. Siegel is recognized.

STATEMENT OF NEIL S. SIEGEL, PROFESSOR OF LAW AND POLITICAL SCIENCE, DUKE UNIVERSITY SCHOOL OF LAW

Mr. SIEGEL. Chairman Herger, Ranking Member Stark, and Members of the Committee. Good morning. I am honored to be here. For three independently sufficient reasons, the minimum coverage provision is within the scope of Congress' enumerated powers in Article 1, Section 8 of U.S. Constitution.

First, the Necessary and Proper Clause gives Congress the power to pass laws that are necessary and proper to carry into execution Congress' other enumerated powers. All sides in the Affordable Care Act litigation agree that the Commerce Clause gives Congress broad authority to guarantee access to health insurance by requiring insurance companies to offer coverage to Americans with preexisting conditions.

Under well-established law, the minimum coverage provision is necessary and proper to carrying into execution this undeniably valid regulation of insurers. The question in the Supreme Court's words is simply whether the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power, guaranteeing access to health insurance is a legitimate end for constitutional purposes, and the minimum coverage provision is reasonably adapted to the attainment of that end. Without the provision there would be a perverse incentive for people to wait until they are sick to obtain health insurance. This adverse selection problem would substantially undermine and indeed threaten to unravel insurance markets.

Second, the minimum coverage provision is justified by the Commerce Clause standing alone. A Federal law is valid under the commerce power if it regulates economic conduct that substantially affects interstate commerce. The minimum coverage provision passes this test because it regulates how people pay for or do not pay for the health care they unavoidably consume and cannot be denied at a time they cannot predict, at a cost potentially so high that others may have to bear it. Cost shifting is undeniably an economic problem and its aggregate effects on interstate commerce are substantial.

Third, the minimum coverage provision is also justified by Congress' tax power. Although Congress called the ACA's required payment for noninsurance a penalty, labels do not determine whether an exaction is a tax for constitutional purposes. As the Supreme Court has held since the 1930s, what matters constitutionally is whether a required payment to the IRS is "productive of revenue" and "operates as a tax." The Congressional Budget Office estimates that 4 million Americans each year will choose to make the shared responsibility payment instead of obtaining coverage. The CBO further predicts that the required payment provision in the Act will produce $54 billion in Federal revenue from 2015 to 2022. Because the ACA's required payment for noninsurance will operate as a tax, it is a tax for purposes of the tax power.

Opponents of the minimum coverage provision insist that if the provision is upheld, then Federal power is limitless. That charge is incorrect. The minimum coverage provision respects five significant limits on Federal power.

First, the provision addresses genuinely economic problems, not merely social problems that do not involve markets.

Second, these problems are interstate in scope. Collective action failures at the State level, interstate externalities impede the ability of the State to guarantee access to health insurance by acting on their own.

Third, the provision does not violate any individual constitutional right, including the right to bodily integrity, which would clearly be violated by mandates to consume certain vegetables or to exercise a certain amount each week.

Fourth, unlike other purchase mandates, such as for food, clothing, and shelter, the provision combats the unraveling of a market that Congress has clear authority to regulate. In light of the adverse selection problem that I just mentioned, upholding the provision does not mean Congress can issue whatever purchase mandates it wants. Rather, a decision upholding the provision could hold narrowly that Congress may issue a purchase mandate when, but only when, such a mandate is needed to prevent the unraveling of a market that Congress is already regulating in undeniably constitutional ways.

Fifth, the provision respects limits on the tax power. The difference between a constitutional tax and an unconstitutional penalty is the difference between the minimum coverage provision and a required payment of $10,000 that increases with each month that an individual remains uninsured. Unlike the minimum coverage provision, that exaction would raise little or no revenue because it would be highly coercive.

For these reasons, Congress should conclude that the minimum coverage provision is within the scope of Congress' enumerated powers, and the Supreme Court should decline the invitation to issue what would without exaggeration be the most consequential invalidation of a Federal law on federalism grounds since the constitutional crisis of the Great Depression and the New Deal.

Thank you.

[The prepared statement of Mr. Siegel follows:]

*****TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012*****

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Hearing
Prepared Statement of
Neil S. Siegel
March 29, 2011
Washington, DC

Chairman Herger, Ranking Member Stark, and Members of the Subcommittee:

The Patient Protection and Affordable Care Act (ACA)[1] requires most lawful residents of the United States to either maintain a certain level of health insurance coverage (the minimum coverage provision) or pay a certain amount of money each year (the shared responsibility payment). The ACA labels this required payment a "penalty."[2] For three independently sufficient reasons, the minimum coverage provision is within the scope of Congress's enumerated powers in Article I, Section 8 of the United States Constitution. The provision is justified by (1) the Necessary and Proper Clause, U.S. CONST. art. I, § 8, cl. 18; (2) the Commerce Clause, art. I, § 8, cl. 3; and (3) the Taxing Clause, art. I, § 8, cl. 1.

First, the Necessary and Proper Clause gives Congress the power to pass laws that are necessary and proper to carrying into execution Congress's other enumerated powers. It is common ground on all sides of the ACA litigation that the Commerce Clause gives Congress broad authority to regulate insurance. *See* United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944). It is thus also undisputed in the litigation that Congress has the constitutional authority to guarantee access to health insurance in the ACA by prohibiting

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified primarily in scattered sections of 42 U.S.C.).
[2] ACA, Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (to be codified at 26 U.S.C. § 5000A).

insurance companies from denying coverage based on preexisting conditions, canceling insurance absent fraud, charging higher premiums based on medical history, and imposing lifetime limits on benefits. 42 U.S.C.A. § 300gg, 300gg-1(a), 300gg-3(a), 300gg-11, 300gg-12.

Under well-established law, the minimum coverage provision is necessary and proper to carrying into execution these undeniably valid regulations of insurance companies. "[T]he relevant inquiry is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power.'" United States v. Comstock, 130 S. Ct. 1949, 1957 (2010) (quoting Gonzales v. Raich, 545 U.S. 1, 37 (2005) (Scalia, J., concurring in judgment) (quoting United States v. Darby, 312 U.S. 100, 121 (1941)). And as Justice Scalia has stressed, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (quoting United States v. Wrightwood Dairy Co., 315 U.S. 110, 118–19 (1942)).

Guaranteeing access to health insurance is a legitimate end, and the minimum coverage provision is reasonably adapted to the attainment of that end. Without the minimum coverage provision, there would be a perverse incentive for people to wait until they are sick to obtain health insurance. This is known as an "adverse selection" problem, and it would substantially undermine insurance markets. *See, e.g.*, Neil S. Siegel, *Free Riding on Benevolence: Collective Action Federalism and the Minimum Coverage Provision*, 75 L. & CONTEMP. PROBS., no. 3 (forthcoming April 2012) (documenting and analyzing the adverse selection problem).

Indeed, in light of this adverse selection problem, the minimum coverage provision may be essential to Congress's legitimate end of guaranteeing access. Regardless of the degree of necessity, however, when Congress is pursuing constitutional ends, courts have long been highly deferential in assessing Congress's choice of means. *See* McCulloch v. Maryland, 17 U.S. (4

Wheat.) 316 (1819); Thomas More Law Ctr. v. Obama, 651 F.3d 529, 564 (6th Cir. 2011) (Sutton, J., concurring in part and delivering the opinion of the court in part) ("The courts do not apply strict scrutiny to commerce clause legislation and require only an 'appropriate' or 'reasonable' 'fit' between means and ends.") (quoting *Comstock*, 130 S. Ct. at 1956–57 (2010)).

Second, the minimum coverage provision is justified by the Commerce Clause standing alone. A federal law is constitutionally valid under the commerce power if it regulates economic subject matter that substantially affects interstate commerce. *See, e.g.*, United States v. Morrison, 529 U.S. 598, 613 (2000); United States v. Lopez, 514 U.S. 549, 567 (1995). The minimum coverage provision regulates economic conduct that substantially affects interstate commerce because it regulates how people pay for—or do not pay for—the health care they inevitably consume. In passing the ACA, Congress determined that the "cost of providing uncompensated care to the uninsured was $43,000,000,000" in 2008 alone. 42 U.S.C.A. § 18091(a)(2)(F) (West 2011). Congress further found that "health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year." *Id.* Cost-shifting is undeniably an economic problem, and its aggregate effects on interstate commerce are substantial.

Third, the minimum coverage provision is also justified by Congress's tax power. Although Congress called the ACA's required payment for non-insurance a "penalty," the Supreme Court has never held that mere labels determine whether something is a tax for constitutional purposes. Congress does not lose a power that it has by calling it a power that it lacks, just as Congress does not gain a power that it lacks by calling it a power that is has. As Judge Kavanaugh concluded, "[T]he fact that an exaction is not labeled a tax does not vitiate Congress's power under the Taxing Clause." Seven-Sky v. Holder, --- F.3d ---, 2011 WL

5378319, at *48 n.37 (D.C. Cir. 2011) (Kavanaugh, J., dissenting as to jurisdiction and not deciding the merits) (citing *License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1867)).

What matters constitutionally is not how Congress labels a required payment to the Internal Revenue Service but whether it "is productive of some revenue" and "operates as a tax." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see, e.g.*, *United States v. Kahriger*, 345 U.S. 22, 31, 28 (1953) (noting that the exaction "produces revenue"). The Congressional Budget Office (CBO) estimates that four million people each year will choose to make the shared responsibility payment instead of obtaining coverage. CBO, Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act (Revised April 30, 2010), at 1, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/individual_mandate_penalties-04-30.pdf. The CBO further predicts that the required payment provision will produce $54 billion in federal revenue from 2015 to 2022. CBO, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March 2012), at 11, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. Thus the ACA's required payment for non-insurance will operate as a tax. It is therefore a tax for purposes of Congress's tax power. *See* generally Robert D. Cooter & Neil S. Siegel, *Not the Power to Destroy: A Theory of the Tax Power for a Court that Limits the Commerce Power*, 99 VA. L. REV. (forthcoming 2013) (analyzing the characteristics of taxes and penalties).[3]

Opponents of the minimum coverage provision insist that if the provision is upheld, then federal commerce power is constitutionally limitless. That is incorrect. Upholding the minimum coverage provision does not imply limitless federal power to issue any and all mandates. On the

[3] This conclusion does not imply that the federal tax Anti-Injunction Act (TAIA), 26 U.S.C. § 7421(a), bars the current challenges to the minimum coverage provision. *See* Michael C. Dorf & Neil S. Siegel, *"Early-Bird Special" Indeed!: Why the Tax Anti-Injunction Act Permits the Present Challenges to the Minimum Coverage Provision*, 121 YALE L.J. ONLINE 389 (2012), http://yalelawjournal.org/2012/01/19/ dorf&siegel.html.

contrary, the minimum coverage provision respects three significant limits on the commerce power. First, the provision addresses economic problems. Second, these problems are interstate in scope. And third, the provision does not violate any individual rights.

In a country with unrestricted interstate travel and mobile participants in health care and insurance markets, individual states are not well situated to force insurers to cover people with preexisting conditions. With different regulations in different states, insurers can move to states that do not impose such a requirement. Moreover, individuals may decline better job opportunities in states that do not guarantee access to health insurance because they cannot afford to lose their insurance. *See* Siegel, *Free Riding on Benevolence*, *supra* (documenting the phenomena of insurer exodus and "job lock").

In addition, in a society committed to providing stabilizing care to the uninsured in an emergency, states are not well situated to combat $40-50 billion in cost shifting each year from the uninsured to others. When uninsured individuals obtain care without paying, providers raise their prices and insurance companies raise the premiums that individuals and families must pay. Because many of these insurance companies operate in multiple states, this cost shifting can disrespect state boundaries. The overall capital reserves of insurance companies constitute a larger pool that undergirds all their market segments. Thus, just as market investments can hurt the overall financial health of insurers, so can poor loss ratios in one state hurt the ability of insurers to remain in more marginal markets in other states. Poor loss ratios in a particular state may stretch the overall reserves of insurance companies, which in turn may affect their ability to operate in other states. *See* Siegel, *Free Riding on Benevolence*, *supra*.

In addition, residents of one state may travel interstate in order to obtain needed medical care. *See id.* (citing examples involving Tennessee, Mississippi, and Arkansas; Maryland, the

District of Columbia, and Virginia; Pennsylvania and West Virginia; and Washington, Alaska, Montana, and Idaho). And at any moment in time, millions of Americans may require medical care while present in a state other than their state of residence. The phenomenon of cross-state hospital use means that cost shifting is an interstate problem, not an intrastate problem.

These are all large economic problems. They require collective action that only the federal government can take and that Article I, Section 8 grants Congress the authority to take. *See* Seven-Sky v. Holder, 661 F.3d 1, 20 (D.C. Cir. 2011) (majority opinion of Silberman, J.) ("The right to be free from federal regulation is not absolute, and yields to the imperative that Congress be free to forge national solutions to national problems, no matter how local -- or seemingly passive -- their individual origins."); Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115 (2010) (interpreting Section 8 in light of the collective action problems that the nation faced under the Articles of Confederation, when Congress lacked the power to tax, regulate interstate commerce, and raise a military by regulating individual behavior instead of requisitioning the states).

While upholding the minimum coverage provision would respect longstanding constitutional limits on congressional power, invalidating the provision would create new and indefensible limits on congressional power. Striking down the provision would also establish a potentially unlimited judicial power to invalidate federal statutes based on political preference.

For example, opponents of the minimum coverage provision argue that Congress may not use its commerce power to regulate "inactivity." If the courts were to adopt this novel proposal to limit federal power, Congress would be powerless to mandate vaccination in the face of a public health emergency, such as a deadly flu pandemic spreading like wildfire around the

country. *Cf.* 42 U.S.C. § 264(a) (2006) (authorizing the Secretary of Health and Human Services to make and enforce regulations necessary "to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession"). Given interstate mobility, Americans would be at the mercy of any state that refused to mandate vaccination.

National security, too, could be jeopardized if the asserted prohibition on regulating "inactivity" gained general support. Wisely, the Founding generation declined to impose such an arbitrary limit on the scope of federal power. Thus the Militia Act of 1792 required "every free able-bodied white male citizen" between the ages of 18 and 45 to obtain at his own expense "a good musket or firelock, a sufficient bayonet and belt, two spare flints, and a knapsack, a pouch, with a box therein, to contain not less than twenty four cartridges." 1 Stat. 271.

Opponents of the minimum coverage provision also argue that the Necessary and Proper Clause does not justify it because the provision does not help to carry into execution the ACA provisions that guarantee access to health insurance. Rather, opponents argue, the provision counteracts the perverse incentive these provisions create to wait until one is sick to get insured. On this view, Congress may never use the Necessary and Proper Clause to ameliorate a problem that is partially of Congress's own creation.

This proposed limit on federal power ignores *McCulloch* and *Comstock* and threatens to read the Necessary and Proper Clause out of the Constitution. Congress may prevent terrorist attacks on military bases even though Congress created the bases that face possible attack. Congress may prevent mail theft even though it created the Postal Service that risks being robbed. Likewise, Congress may ameliorate problems associated with rights to access health insurance even though Congress created those access rights in the first place.

In sum, the minimum coverage provision is within the scope of Congress's enumerated powers in three, independently sufficient ways. The Necessary and Proper Clause, the Commerce Clause, and the Taxing Clause each support the provision. Opponents of the provision are right that examining its constitutionality involves fundamental questions of constitutional limits, but not in the way they insist. While the provision respects important limits on Congress's authority, there are no defensible limits on the limits that opponents would create to invalidate the provision. This absence of limits on judicial interference with Acts of Congress demonstrates why the Supreme Court should uphold the minimum coverage provision. Striking it down would amount to the most consequential invalidation of a federal law on federalism grounds since the constitutional crisis of the Great Depression and the New Deal.

Chairman HERGER. Thank you.

Mr. Bradbury, in his ruling, the 11th Circuit Court decisions wrote that, quote: "Not only have prior congressional actions not asserted the power now claimed, they contain some indication of precisely the opposite assumption. Instead of requiring action, Congress has sought to encourage it."

Can you give some examples of how Congress has encouraged action, but not required it?

Mr. BRADBURY. Yes, Mr. Chairman. There are many, many examples through history. The case of the wheat case, Wickard *v.* Filburn, that was a restriction on supply in order to prop up or promote the price of wheat to protect the farming communities. It would have been much more potent and direct if Congress believed it had the power to require every family in America to buy two loaves of bread a week. Increasing demand in the market would have been a more direct way to prop up the price.

More recently, the Cash for Clunkers program. That is an incentive to try to get people to turn in older, polluting cars in order to buy newer, more energy-efficient vehicles. Rather than a direct mandate that people do it, it was a cash incentive.

So there are many, many examples like that throughout history.

Chairman HERGER. Thank you.

Ms. Severino, I want to read a quote from the 11th Circuit Court decision ruling the individual mandate unconstitutional and get your reaction to it. "The government's position amounts to an argument that the mere fact of an individual's existence substantially affects interstate commerce, and therefore Congress may regulate them at every point of their life. This theory affords no limiting principles in which to confine Congress' enumerated power."

As troubling as the individual mandate is, it seems the court is saying even worse things could happen in the future. What does the court mean by no limiting principles to confine Congress' power?

Ms. SEVERINO. What the court is looking for is some way to say where the Commerce Clause ends, because if it doesn't have a limit then none of the constitutional limits on Congress are effective because the Congress could effectively regulate anything via the Commerce Clause power.

To address some of the arguments against a limiting principle that was just brought up, this is clearly a regulation that violates all of these limits. If this is regulating something that is economic and not just social, he would say, but any social activity you engage in also has an effect on the economy, and I would say additionally on the interstate economy in a world that is not just nationalized but globalized. There is also the claims there are no individual rights violated doesn't answer the question about the Commerce Clause. We need limits not just from the Bill of Rights, but also on the Commerce Clause itself. And to allow Congress to regulate to any degree a market that is already regulating, well, I would submit that there are very few markets left that Congress doesn't have some degree of regulation on, so that also is not a limiting principle.

I think the Supreme Court, even more so than the courts of appeals recognizes that they are the final backstop to ensure these limits on the constitutional powers of Congress, and so they are going to be very concerned as they consider this case to make sure that their argument, their final analysis affords such a limit.

Chairman HERGER. Thank you.

Mr. Henchman, throughout this debate over the health care law, we have seen the President and his Cabinet offer very inconsistent

answers to the fairly straightforward question of whether the unpopular coercive penalty imposed on people who do not comply with the individual mandate is a tax. President Obama has denied that it is a tax. Secretary Sebelius told this committee that it "operates as a tax, but is not a tax, per se." They argue in one part of the case it is not a tax, and in the individual mandate part they argue it is a tax.

Is this just politics, or does it matter whether the individual mandate is considered a tax versus a penalty?

Mr. HENCHMAN. Excellent question, Mr. Chairman, and it shows that we have more work to do at the Tax Foundation in explaining what a tax is to the American people. But ultimately, I think it is driven by legal strategy. The government feels that they might have a better case under the taxing power if they can't make the Interstate Commerce Clause argument, and that is why they have heavily relied on it.

And indeed this came up on Monday. Justice Alito asked the Solicitor General, today you are arguing that the penalty of the tax for purposes of the Anti-Injunction Act and tomorrow you are going to be back and argue that it is a tax for purposes of the Constitution. And he asked whether the court has ever held that something is a tax for purposes of the taxing power and is not a tax for the Anti-Injunction Act, and they haven't. That has never happened. It is unprecedented.

You know, speaking as a person who works at the Tax Foundation, I have to say that a tax is the same thing. If it is a tax under the Anti-Injunction Act, it is a tax under the Constitution, and it is a tax in the popular conception. It is splitting hairs to try to define differences between those things. We are very reliant on the view held, not only by us, but also by nearly every court in the land that a tax is not just something that generates revenue, but has the purpose of generating revenue.

Professor Siegel's point that anything that generates revenue is a tax, the Oregon Supreme Court agrees with him, but that is about it. Everybody else disagrees with him, so that view is outside the mainstream.

Chairman HERGER. Thank you. Mr. Stark is now recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman. Thank the witnesses for their efforts today. Ms. Severino, I just wanted to correct some of your testimony. You say that the only recourse to avoid the mandate would be to leave the country. First, you could pay the penalty and remain uninsured. And secondly, I am not sure there is any country in the world which does not have uninsured coverage and requiring the citizens to pay for it. So it would be interesting to know what country you might have in mind.

Professor Siegel, you highlight the severe limitations that would be put on the Federal Government if the Supreme Court were to decide that the individual mandate in the health reform law was unconstitutional.

Could you expand on that concern and list some of the actions by the Federal Government that you think might be impinged, and what that might mean to us?

Mr. SIEGEL. Yes, I would be happy to. I think this is a case about limits. It is not just a case about limits for the Federal Government. It is a case about limits for those who want to undermine the powers of this Congress. What are the limits on the limits that the opponents of the Affordable Care Act want to impose on the Congress of the United States as an institution?

So, for example, the argument is that Congress may not regulate so-called inactivity under the Commerce Clause. Think about the potential implications of this limit. Imagine a very real possibility, a public health emergency, a flu pandemic spreading around the country like wildfire. There is no doubt in my mind that this Congress would have the power under those very limited circumstances to quarantine, pursuant to the Federal Quarantine Authority, to impose mandatory vaccination to prevent widespread deaths. If Congress doesn't have the power then every American is at the mercy of a single State that doesn't mandate vaccinations.

Do we really want to decide for now for all time that no matter how grave the circumstances, Congress can't mandate certain action under the commerce power. Think about the Necessary and Proper Clause, and take seriously the bootstrapping objection. The objection is that Congress under the Necessary and Proper Clause can't take action to help alleviate a problem that is partially of its own creation. That rewrites the Necessary and Proper Clause out of the Constitution. The Necessary and Proper Clause is explicit textural authority for bootstrapping. It gives Congress the power to take actions that would otherwise be outside of the scope of its other enumerated powers. If you take it seriously, it means that Congress may not criminalize terrorist attacks on military bases because the problem wouldn't exist if Congress hadn't first created the bases and created the targets. It means Congress can't prohibit mail robbery because there would be no mail to rob if Congress hadn't established a post office. And one could go on and on.

Just like in medicine, sometimes in law, interventions have both socially beneficial consequences and unavoidable side effects. And the Constitution gives this institution the power to address both.

Mr. STARK. Yield back.

Chairman HERGER. Thank you. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. This is an interesting conversation, you know. You talk about post offices, but we don't need them. Fed Ex can do a better job and has admitted they can. The post office is way in debt. You know, I listened to the Solicitor General Tuesday. You sound just like him. The only difference is you are not drinking water about every two sentences. And I couldn't believe what he was saying; neither can I believe what you are saying.

Ms. Severino, the 11th Circuit stated: "Few powers if any could be more attractive to the Congress in compelling the purchase of certain products. Yet, if we focus on the modern era when congressional power under the Commerce Clause has been at its height, still Congress has not asserted its authority. Even in the face of a Great Depression, a world war, Cold War, recessions, oil shocks, inflation and unemployment, Congress never sought to require the purchase of wheat or war bonds, force a higher savings rate or

greater consumption of American goods, or require every American to purchase a more fuel-efficient vehicle.''

Is the 11th Circuit correct? Is the individual mandate unprecedented, and are there any other examples that Congress requires the purchase of a commercial product, even in times of crisis?

Ms. SEVERINO. No, you are correct, Mr. Congressman. There is no other example of this, and this is something that the Congressional Research Service and the Congressional Budget Office, both nonpartisan organizations, have found, that this is the first time the government has claimed this type of expansive power. So to say that this is just like everything else is, I think, more a matter of legal spin than actual effect. The fact of the matter is the government hasn't taken this step before.

Now, some will claim that there is a very broad commerce power, and therefore it should be stretched one step further to encompass this, this authority. But the fact of the matter is that is not something that has ever been upheld under the Commerce Clause power before because it simply hasn't been tried before.

Mr. JOHNSON. Just an obstruction of freedom to America, isn't it?

Ms. SEVERINO. Yes, sir.

Mr. JOHNSON. Ms. Severino, the 11th Court decision ruling also stated: ''Americans have historically been subject only to a limited set of personal mandates, serving on juries, registering for the draft, filing tax returns, and responding to the census. These mandates are in the nature of duties owed to the government attendant to citizenship and contain clear foundations in the constitutional text.''

What is the difference between these kind of mandates and the Obamacare individual mandate?

Ms. SEVERINO. Well, those mandates are found on other provisions in the Article 1 powers to the legislature. So for example, the draft being related directly to the power to raise an army. This is very different from the Commerce Clause power which allows the power to regulate something. Regulate does not mean to mandate it into existence. You can raise an army by mandating that people join the Army. You cannot regulate commerce by mandating that people enter into commerce. So there is a fundamental difference in the way these powers are conceived by the government. And I think that is why, as I said before, this has never been claimed as a power before.

And finally, I think this goes back as well to the limiting principle. Because commerce is so broad and basically can cover every aspect of our life, you could say that brushing our teeth or not in the morning affects Congress because it is going to affect your market for dental care, et cetera. Everything Americans do can affect commerce down the line in some way. We can't claim that every aspect of American life is just going to be governed by any of these other powers. So there is no limiting principle because of the breadth of commerce itself.

Mr. JOHNSON. Yeah, we can't hide behind that clause. The Constitution needs to mean something to all of us. Of the people, by the people, for the people.

Thank you, Mr. Chairman.

Ms. SEVERINO. Thank you, Congressman.

Chairman HERGER. Thank you.

Mr. Pascrell is recognized.

Mr. PASCRELL. Mr. Chairman, the key purpose of individual responsibility requirement within the Affordable Care Act—by the way, Ms. Severino, before I continue, would you answer this question, please, if you can, yes or no? Does government have any specific responsibility to the indigent as far as health care is concerned? Yes or no.

Ms. SEVERINO. Do you mean Federal Government or State?

Mr. PASCRELL. The Federal Government. I am sorry.

Ms. SEVERINO. I don't believe the Federal Government has a specific responsibility in that matter, but the State government does.

Mr. PASCRELL. And if it did, where would that responsibility be edified, within the Constitution?

Ms. SEVERINO. If the Federal Government had such a responsibility?

Mr. PASCRELL. Yes.

Ms. SEVERINO. I believe it would be embodied in the Constitution.

Mr. PASCRELL. Thank you. I think that its presence keeps a lot of free riders who can afford to purchase health insurance from forcing everyone else to ultimately pay for their health care expenses. You need the mandate in order for things like a ban on preexisting conditions to work. And the mandate we will see whether it is constitutional or not. There is no such thing as inaction in the health care market. You are going to use the system eventually whether you like it or not. And we provide care for you even if you don't have insurance. There is precedent for this, and I believe it should be upheld.

I think it is important to remember that the individual mandate was a bipartisan idea. That doesn't make it right. That doesn't make it constitutional, but it was bipartisan.

It is interesting that only when the Democrats enacting comprehensive health reform that all of a sudden the other side became opposed to the idea of individual responsibility. I mean, you can chronologically check this out. You may differ with that chronology.

In 1991 Mark Pauly, are you familiar, the panel, with Mark Pauly? Any of you?

He is a scholar at the American Enterprise Institute. He developed an individual mandate for then President George H.W. Bush. I have a copy of one of his articles here. And I ask for a unanimous consent to submit into the record a Health Affairs article authored by Mr. Mark Pauly on the individual mandate. Mr. Chairman?

Chairman HERGER. Without objection.

[The article follows, The Honorable Bill Pascrell:]

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133.

MAKING A CASE FOR EMPLOYER-ENFORCED INDIVIDUAL MANDATES

by Mark V. Pauly

Prologue: *The Clinton administration's approach to ensuring universal health insurance coverage has triggered a chorus of complaints from a variety of quarters. Among those critics who take exception to the administration's approach are economists such as Mark Pauly, who argue that there is a better way to deal with financing coverage for currently uninsured workers. In this paper Pauly argues that a special form of an individual mandate for insurance coverage will achieve the same policy objective but raise fewer employer hackles, be less unfair and distortive, help voters know what they are selecting, and assure an equal level of coverage with no more administrative hassle. As President Clinton articulated in a speech before the National Governors' Association in the summer of 1993, Americans need to realize that "health care is not something paid for by the tooth fairy, that we should all be acutely aware of the cost each of us imposes on it." Puuly's proposal for an employer-enforced individual mandate ensures that "the best way to make people aware of the cost of the care they receive is to have them pay for it individually." Pauly holds a doctorate in economics from the University of Virginia. Among his peers, he is considered one of the nation's finest technical economists. Pauly is the Bendheim Professor of Economics at the University of Pennsylvania and chair of its Health Care Systems Department. He is also director of research at the Leonard Davis Institute at Penn. Pauly is a member of the National Academy of Sciences' Institute of Medicine and is the lead author of a widely discussed paper published in the Spring 1991 issue of Health Affairs, entitled "A Plan for 'Responsible National Health Insurance'."*

22 HEALTH AFFAIRS | Spring (II) 1994

Abstract: An employer-enforced individual mandate has some substantial advantages over the mixed employer and individual mandate embodied in the Clinton administration's proposed health plan. Economic reasoning strongly suggests that almost all of the cost of an employer mandate will fall on workers and that in any case the incidence of an individual mandate is the same as that of an employer mandate. However, an individual mandate is easier for voters to understand, avoids administrative complexities and inequities, and eliminates the chance of adverse employment effects of mandated employer coverage.

One of the most politically troublesome features of President Bill Clinton's proposed health reform plan is its requirement for mandatory contributions by all employers toward the health insurance coverage of their employees and families. The primary rationale consistently offered by analysts and advocates alike for this feature is that it is the conventional (or "American") way of paying for insurance. Indeed it is, for the great majority of the working population. However, it is equally instructive that this method of choosing and financing coverage has not been chosen by a small but growing minority within the work force. When the job does not bring insurance coverage with it, some workers obtain it in other ways, either through a working spouse or through individual purchase of insurance, and some go without coverage, at least for a time. Employers that do not offer coverage have been most strongly opposed to the proposed Clinton plan, which would make their voluntary behavior illegal. In forbidding anyone from taking a job that does not carry health insurance as a fringe benefit, the plan constrains employers and workers alike.

Nevertheless, there are strong social reasons for arranging institutional structures so that all of the population has at least some health insurance. The most fundamental reason is that insurance may be important in inducing people to purchase medical services that are effective for their health and that other citizens are not willing to see them go without.[1] This same altruistic motivation has led to the construction of arrangements that make services available, even if imperfectly and at the last minute, to sick people who seek them in hospital emergency rooms, but with the cost of these services left to be financed by the "shifting" of costs to the hospital's paying customers. This patchwork arrangement obviously is less satisfactory than the assumption that all citizens have appropriate insurance coverage.

In an attempt to defuse the opposition by noninsuring employers to an employer mandate, the Clinton plan contains a complex pattern of subsidies-a pattern that itself is likely to distort behavior, cause political turmoil, and have a substantial budgetary cost to the government. Is there a better way to deal with the financing of coverage for currently uninsured workers, one that raises fewer employer hackles, is less unfair and distortive, helps voters know what they are choosing, and assures an equal level of coverage with no more administrative hassle? In this paper I argue that a

special form of an individual mandate for insurance coverage will achieve these objectives. If anything will frustrate the attempt, at long last, to assure universal coverage, or lead to postponement of the effective date to an indefinite future, it is the opposition to an employer mandate. Finding a preferable alternative thus takes on special urgency.

Why An Individual Mandate?

The broad rationale for an individual mandate is based on several key facts or premises. The first key fact is that, in any economy, the cost of a good such as health insurance must ultimately be paid by individuals as individuals. Corporations, employers, and governments are often legal persons, but in economic terms they simply represent other individuals, such as stockholders, taxpayers, and owners. Since mandates to pay for something, like the taxes they are, ultimately must fall on individuals, it will at a minimum be necessary to identify who those individuals are in order to evaluate a mandate, and ultimately to consider the desirability of taxing them. The second key fact, as already noted, is that a mandate is a tax. It is an earmarked payment, but it is a compulsory payment for public purposes, a tax by any other name. The third observation is more a premise than a fact: It seems desirable, for rational political decision making, for citizens to be aware of what taxes they are paying to obtain benefits. That is, good political decision making is assisted, as President Clinton noted in his speech introducing the Health Security Act in September 1993, by avoiding the mistaken view that the government can provide benefits for which no one must pay; by implication, the best system is one in which it is easy to see the connection between what one pays and what the public benefits are. The best system is one in which the financing is politically transparent.

In addition to the idea that a good financing mechanism is one in which voters can easily judge who is paying what for what, we usually assume that we have some efficiency and equity objectives in mind. There is a precise economic definition of *efficiency*, but for the present I simply use the concept to mean the absence of distortions in production or consumption arrangements. There is no generally accepted complete definition of *equity*, but there is usually consensus that equity implies that people of equal means should pay the same amount for the same public service ("horizontal equity," in the textbooks) and that people with more total income or wealth should pay more (or at least no less) for a given public benefit ("vertical equity").

All of these observations point in the direction of a main theme of this paper: that direct, explicit taxes to pay for health insurance are to be preferred to indirect, implicit taxes such as an employer mandate. Direct

taxes are easier for citizens to understand, easier to tailor to the income or wealth levels of individual citizens, and generally less distortive than indirect taxes, which are confusing, inequitable horizontally and vertically, and often causes of inefficiency.

Probably the most general direct tax available to real-world government is the personal income tax, with the value-added tax a close second. For this discussion, however, I assume that health insurance benefits are to be financed by a new earmarked mandated payment, which will be neither a simple surcharge on current income taxes nor an earmarked value-added tax. Indeed, since the great majority of Americans under age sixty-five already obtain and pay for private insurance in connection with their employment, there is some virtue in disrupting existing arrangements as little as possible, as long as transparency, equity, and efficiency can be preserved.

Employer Mandates, Individual Mandates, And Blended Systems

A full employer mandate would be an arrangement in which the employer is required to pay the full health insurance premium for every worker. Japan's system comes closest to an employer mandate. A full individual mandate is an arrangement in which each individual or family is required to obtain and pay for insurance coverage that meets a minimum benefit standard in some fashion. As described in our "Responsible National Health Insurance" proposal, such a mandate does not require that the insurance be purchased individually, or that individuals have the right to require their employers or fellow workers to permit them to do so.[2]

The Clinton reform plan is a system that blends individual and employer mandates. For the self-employed, it is a full individual mandate. For the employed, it combines an employer mandate to pay part of the premium with an individual mandate to pay the remaining part, and provides income-related subsidies for each part.

What's the difference? The general theoretical conclusion from economics is that there is likely to be very little difference, in the long run, between an individual mandate and an employer mandate. There are actually two propositions here. One that is almost always true but does permit exception is the following: The cost of an employer mandate ultimately will fall almost entirely on worker wages. The other, always true, is that wherever the cost of a mandate falls, it will be the same regardless of whether the mandate falls on employer or employee. I use a numerical example or scenario (in the spirit of the Clinton documents) to illustrate why these propositions hold and where differences, if any, are likely to arise.

Imagine a flower shop (called the "Flower Shoppe") with ten employees,

each of whom earns $25,000 per year. The employees are identical in both productivity and expected medical expenses. The firm initially offers no health insurance as a fringe benefit and pays no portion of any health insurance premium. Tax effects on total compensation are ignored. All of the employees are single, and the average premium in the locality for the coverage mandated under the Clinton plan would be $2,000 per year for singles. The employer's 80 percent share of this premium would thus be $1,600, or 6.4 percent of the average wage, so no subsidy would be paid to this firm under the Clinton plan's cap of 7.9 percent.

The Flower Shoppe plans to give 10 percent raises in 1994 ($2,500). It has chosen this amount for two reasons: (1) It expects increasing productivity to cause output per worker to rise by at least $2,500 per worker, and (2) it expects to have to pay such a raise in its locality to remain competitive in the local labor market. Thus, it can afford to pay the raise and still increase profits, it would reduce those profits if it laid off any workers, and it has to pay the raise to retain its workers.

What will happen if the firm is mandated under the Clinton plan to pay $1,600 for health insurance for each employee and each employee is individually mandated to pay $400, with the coverage to be obtained from the local health alliance? Assume initially that the imposition of the mandate does not change the dollar amount of the increase in compensation that the firm can and must offer; it stays at $2,500. The answer is obvious: The firm will use part of that increase in compensation to pay the mandated health insurance premium, pay the remaining $900 as a raise next year, but expect workers to take $400 of the raise to pay for their share of the health insurance premium. Compared to the previous year, each worker ends up with a health insurance policy and $500 more in cash.

There are two key ideas in this scenario. First, given the assumption that the size of the increase in total compensation is fixed, the full incidence of the employer and employee mandate falls on workers, in the sense that the total premium reduces income spendable on other things by an equal dollar amount. Second, as is obvious, each worker's final position with respect to wages and fringes is exactly identical under this "employer mandate" to what it would be had there been an individual mandate requiring each worker to buy his or her own $2,000 insurance policy; individual mandates and employer mandates are identical.

There is thus no difference in economic effects between the two kinds of mandates. The only potential difference is in the perceptions employers and employees may have as to who is paying what. In the individual mandate all payrnents for insurance are made after the paycheck amount is calculated, whereas under the employer mandate 80 percent of the premium is deducted or withheld before the amount is calculated. Of course, if

the employer informs the worker what the total cost of the compensation package is, the difference is only a matter of accounting. However, the failure, under an employer mandate, to inform workers explicitly about the total payment for insurance and the total amount of compensation may lead workers to perceive things differently.

What determines the level of total compensation? It is obvious that the key to the result that employees pay for mandated coverage is the assumption that neither the imposition nor the locus of an insurance mandate changes the total compensation the employer is going to offer. Any differential effects of mandates therefore must require this assumption to fail to hold. When might this happen, or when might employers and workers believe that it happens?

To avoid making economists look like complete fools, let us deal with a scenario in which the cost of an employer mandate will fall on profits rather than on wages. Suppose that the employer mandate was imposed only on the Flower Shoppe, not on any other employer in town. Then offering constant total compensation will not permit the firm to continue to attract its current complement of employees; they will leave for similar firms that offer the old level of cash wages and no health insurance. If it was the firm's profit-maximizing strategy not to offer health insurance, it must have been the case that, at least for this set of potential employees, cash compensation was preferred to the amount of health insurance it could buy. Were that not the case, the firm could have increased its profits by offering health insurance in lieu of wages. If the Flower Shoppe alone is then compelled to offer health insurance by a mandate, its compensation package will not be as attractive as those of its competitors. Either it will hire fewer workers, or it will have to pay them more in total-enough to compensate for the difference between the cost of health insurance and its value. Either way, at least some of the cost of the mandate will fall on the firm's profits (and some on workers' wages).

Even in this case, however, there would be no difference between an employer mandate and an individual mandate. Suppose workers at just this one firm were required to buy health insurance out of their wages (an individual mandate). The effect would be the same as that of an employer mandate: Working at that firm would be less attractive relative to alternatives, and profits would fall.

Universal coverage requires a universal mandate, so this "one-firm" case is not really relevant. It may, however, be what many employers are thinking of when they say that they cannot "afford" a mandate. They are implicitly assuming that other employers' compensation offerings to workers will stay the same.

Would a universal mandate be expected to change the total compensa-

tion the firm can and will offer? One possible (although not probable) case is that offering health insurance might improve employees' health, and thus their productivity. This would allow the owner to afford higher compensation, and all could gain from the mandate. This scenario seems unlikely, however, for two reasons. First, for middle-class workers, with a few debatable exceptions, there is little evidence that more generous insurance coverage improves health. Second, if coverage were health-improving and employees knew this, it would have paid for employers to offer it-contrary to the initial assumption. One might invoke employee ignorance as an excuse, but it seems a weak one. In general, it seems unlikely that offering insurance would change what employees are worth to the firm.

The other possibility, somewhat more likely, is that a universal mandate (of either type) will change what employees must be offered to stay with the firm. One possibility is that the combination of universal mandate and health alliance may lower the cost of insurance, perhaps enough to make it worth the lost wages to workers. However, it seems unlikely that there will be such a net reduction in insurance costs.

The other, more complex case is one in which workers with lower demands for insurance specialize in certain jobs or products. This would occur if the taste for insurance were correlated to some extent with the skills needed for certain jobs. One simple basis for correlation would be if the demand for insurance were sensitive to total income or wages, and certain jobs or products used workers at different wage or skill levels. Low-skill, low-wage workers who produce certain products then would be more attracted by cash-rich, fringe benefit-poor compensation packages.

In this case, some of the cost of the mandate could fall on owners, if their capital were more tightly tied to a specific product or service than the skills of workers were. Take two extremes. At one extreme, workers must work, and they have a skill that can only be used to produce a particular product, but the capital they work with can easily be converted to other uses. It is obvious that the return to capital cannot be reduced by the mandate, but the wages of these workers could be. At the other extreme, the owner's capital is tied up in a particular product, but workers could be nearly as productive doing lots of other things, including working in industries where coverage is the norm. Then these specific workers would not bear the cost of the mandate, but capital owners would. Even here costs ultimately would fall on workers in general.[3]

The key insight, however, is that whatever happens in this more complex case, the result would be the same whether the mandate is on employer or employee. Consider the case in which capital is linked to certain products, and instead of assuming that employers were obliged to pay for coverage, imagine that workers were required to do so. This would make working

in that industry less attractive, profits would fall, and workers would leave until they were as well off in that job as in competing jobs. The punchline is that however complex the final incidence of a mandate (relative to some initial situation in which some firms did not provide coverage through the workplace), that pattern will be the same if the mandate is initially placed on the worker or on the employer. This goes back to the earlier point: It does not matter whether the check to pay for coverage is deducted before or after the compensation amount is accounted.

All of these analyses imply that in the long run wages will fall by the amount of the employer cost of the additional coverage. This type of analysis is at the heart of the conclusion by Clinton administration economists that there will be at worst minor unemployment effects of an employer mandate. That is, to reach their conclusion they had to assume that the incidence of an employer mandate is on workers. For all but minimum-wage workers-for whom there can still be problems-mandates will affect wages, not employment. In and of itself, this does not necessarily mean that mandates do no harm to workers; it only means that mandates reduce workers' wage levels rather than their chances of keeping their jobs.

Some modem macroeconomic theories of involuntary unemployment sometimes attribute money-wage rigidity to a kind of myopia in employer and worker perception: Employers and employees do not adjust money wages as soon as unemployment starts to develop because they do not know what is happening in the labor market as a whole.[4] However, it is precisely the same myopia that would lead an employer to lay off workers because the employer could not "afford,, the mandate: The employer does not know for sure that the mandate, imposed on competitors in the labor market, will permit wages to be cut. To be sure, even if all employers are myopic and fire people, eventually the increase in unemployment will put downward pressure on market-level money wages. "In the long run" wages must fall-even if employers are thick-headed. But in the process there can be some transitional unemployment.

Will an individual mandate cause employers to drop payment for coverage? Now we consider an alternative scenario. Imagine that Posie Palace is a florist identical in all respects to the Flower Shoppe except that Posie Palace now pays 80 percent of a health insurance premium and therefore pays $1,600 toward health insurance but pays $1,600 less in money wages. All employees opt to pay the remaining 20 percent, so all are initially covered. This firm would be unaffected by an employer mandate. What about an individual mandate? The answer to this question may depend to some extent on the form the individual mandate takes. The simplest and, in my view, the best form for such a mandate is one that simply requires that each citizen obtain coverage somehow, that treats all

payments for the employee's insurance as part of taxable income, but that does not or need not specify how that coverage must be obtained. Thus, the workers at Posie Palace can be in compliance with the law by continuing their current behavior.

But might the employer in the Posie Palace imagine that after the passage of an individual mandate it would be good business to stop or reduce the amount paid for insurance before compensation is calculated, the "employer payment?" As President Clinton asked in his speech to the National Governors' Association conference last summer, "If you impose an individual mandate, what is to stop every other employer in America from just dumping [insurance for] his employees or her employees, to have a sweeping and extremely dislocating set of–chain of events start?" From the viewpoint of workers, if the employer stops "paying" for insurance and does not change money wages, this would be equivalent to reducing their net compensation, since they would have to make up the lost employer payment. Unless (contrary to assumption) the employer was overpaying in the first place, such a reduction in employer payment cannot increase profits. After all, the initial level of employer contribution was voluntary, chosen with an eye to conditions in the labor market. If Posie Palace cut the employer payment, working at the Flower Shoppe would become a better alternative.

Thus, there is no direct impact of an individual mandate that would make the employer want to change things. If anything, an individual mandate should greatly increase the likelihood that employers will make opportunities for coverage available. For one thing, for employers that now choose to offer group coverage, an individual mandate offers them no reason to stop doing so. An individual mandate certainly does not require that individuals purchase their insurance individually; it only requires that they obtain coverage, and for the great majority of American workers, the cheapest way for them to obtain the coverage they will be required to have is to continue with their current employment-related group insurance. In addition, for those employees who do not now obtain coverage through the workplace, the obligation that they get coverage somehow will surely lead many of them to bargain with their employers for employer assistance in arranging group coverage in return for reductions in employee wages, if the group of workers and employers decide that they want to have a minimum participation and incentive for levels of participation. In short, far from triggering a spiral of employers discontinuing opportunities for employment-related coverage, the effect of an individual mandate should be to greatly increase the prevalence of such opportunities.

Would the availability of tax credits to employees cause the employer to cease offering coverage? If the credits take the fixed-dollar form we de-

scribed in our "Responsible National Health Insurance" proposal, the answer is "no," since the size of the credit does not depend on whether the premium is paid as an "employee payment" or an "employer payment." In the bill introduced by Sen. John Chafee (R-RI), such a possibility would arise, since that bill ties the credit to the size of the "employee payment"– it fails to recognize that "employer payments" reduce the money available to employees to spend on other things fully as much as so-called employee payments do.

Could there be indirect effects? The advantage of offering a fringe benefit to workers in this firm will be eroded when all of its competitors in the labor market are forced to do the same thing and offer the same package. However, it still will be disadvantageous to the firm to require employee pay ment, unless employees fail to notice what is going on.

How can an individual mandate be enforced? It might, at first thought, appear more difficult to enforce an individual mandate than an employer one-there are many more employees than there are employers, and what does the government do if an employee neglects to obtain coverage on his or her own? The easiest way to think of an answer to this question is to note that the individual mandate is a tax-in effect, it requires each citizen to pay a tax, which is used to finance health insurance.[5] Thus, it seems natural to use the same mechanisms to enforce collection of this tax as for other taxes imposed on employees. The way the individual income tax and the employee's share of the payroll tax are collected is via mandatory withholding by the employer, with any overpayment or underpayment adjusted for at tax return time. The same mechanism would appear to be feasible for the insurance tax. The employer would be required to ascertain whether or not the employee had obtained insurance (including as a member of an employment-related group) and, if not, to withhold from the employee's wages enough to pay for insurance from a government-contracted or government-run insurer of last resort.

What is being proposed here is really a hybrid, in which the employer is used as the first-line tax collector, but in which the payer is clearly identified to be the employee. The task of collecting such premiums (and adjusting them for family composition, plan chosen, or income) is no more difficult (and no easier) than is the task of collecting income taxes through wage or income withholding. For higher-wage persons, who file income tax returns, the administrative cost of adding one additional tax or surcharge (or check box) to form 1040, and requiring insurance status to be recorded on the withholding tax statement (form W-4) that must be filed for every worker, would appear to be minimal. For lower-income workers for whom subsidies would be paid, voluntary cooperation would be enhanced by the desire to obtain the subsidy, and the credit that would pay the subsidy need

be no more difficult to administer than (and could even be merged with) the earned income credit. Finally, persons already receiving welfare payments could have their credit incorporated with their other government payment.

While there will be some additional administrative complexity added to the current system, it is not obvious that combining an individual mandate with a system of tax credits is any more administratively complex than the Clinton proposal. That proposal imposes a new tax on a new base and requires a new definition of what is a "firm" and what is an "employee." In addition, the Clinton plan already requires a partial individual-mandated payment, subsidized based on an individual's income, so it is already going to be incurring the administrative cost of an individual mandate.

Advantages Of The Individual Mandate

One advantage of an individual mandate relates to the previous discussion: An individual mandate can be much more precisely targeted, and therefore be both fairer and more efficient, than an employer mandate. Presumably, for example, we desire to subsidize the health insurance purchase of low-income families, not low-wage individuals or families. Although wages are correlated with income, there can be low-wage earners in high-income families, or well-off low-wage families that get nonwage income. In addition, there certainly can be low-wage and low-income workers in firms with high average wages. An individual mandate allows the credit or subsidy to a person to depend only on their circumstances, not where they work, and so can avoid the serious distortions of firm organization inherent in the Clinton approach.[6]

A new employer mandate may not result immediately in lower employee wages. Long-term labor contracts, myopia on the part of employers, and general uncertainty may cause money wages to fail to fall immediately for formerly uninsured workers. If this happens, a likely response of employers will be to lay off workers, since they will now be too expensive to continue to hire in such numbers. The key issue here is whether employment can be adjusted more rapidly than money wages. As noted above, increased unemployment eventually will put downward pressure on money wages, so even employer misperceptions will not be a bar to adjustment. But most policymakers probably would agree that adjusting to a mandate through unemployment is more painful than adjusting to it though lower money wages (though obviously neither is painless). An individual mandate for payment will avoid the necessity of adjusting posted or cash money wages and therefore will be able to avoid this painful period of transition.

In addition, workers now earning near the minimum wage are not able to

reduce their money wages, so some of them will have to be fired. Estimates of the employment effects of the Clinton employer mandate have been politically controversial, ranging from slight job gains to losses in excess of four million. The virtue of an individual mandate is that it neatly avoids this controversy, since money wages will not have to adjust to an individual mandate, nor will it cause the minimum wage law to be violated.

Still a third advantage of an individual mandate is that it does not base insurance premiums on public subsidies, employment status, or wage levels. Problems associated with part-time workers, two-worker families, or independent contractors simply will not arise.

The final advantage of an individual mandate over an employer mandate is better political decision making. It surely is safe to say that there is no general agreement among policymakers, lobbyists, or ordinary citizens about who pays the cost of an employer mandate. I assert that good decisions in a democracy occur when citizens find it easy to understand both the extra taxes and the extra benefits they will get from government action. (I reject the School of Machiavelli approach, which holds that it is sometimes necessary for wise politicians to deceive the electorate for its own good.) An individual mandate is much more straightforward in terms of its intelligibility-under an individual mandate, what you pay is what you pay. On the grounds of political transparency, then, such a tax is to be preferred.

To be sure, one of the dangers of informing the electorate in a democracy is that, given the set of political institutions (constitution) under which decisions are made, they may not choose what one prefers. They might prefer no health reform to a health reform they must pay for under an individual mandate. They might prefer a set of tax credits either more or less progressive than the Clinton plan and different from what one prefers. But that is the hard lesson of democracy.

From Employer Mandate To Employer-Enforced Individual Mandate

For better or worse, the Clinton plan already takes choice about health insurance coverage away from employers and transfers it to health alliances. The employer plays only the role of financier. Economic theory says that the employer plays that role as that of a tax collector in disguise, only to be unmasked in the long-run denouement, in which it becomes apparent to all the players that the employees paid for their health insurance themselves. While mistaken identity can be comic, and while politics can generate a comedy of its own, good social decision making would seem to require more honesty and transparency. Extending the individual mandate already imposed on nonwage earners (and 20 percent imposed on wage earners) to all

citizens under age sixty-five would have some substantial advantages and would be relatively easy to implement. Moreover, an individual mandate seems much more in the spirit of a number of other important points President Clinton made in his speech to the governors. For instance, he talked about the need to prevent people from being "free riders still riding the system." An enforced individual mandate prevents free riding. He also spoke eloquently about the need for Americans to realize "that health care is not something paid for by the tooth fairy, that we should all be acutely aware of the cost each of us imposes on it." There seems to be little reason to doubt that the best way to make people aware of the cost of the care they receive is to have them pay for it individually.

In short, the individual mandate approach seems much more consistent with the president's overall objectives than the employer mandate approach his advisers currently seem to favor. Most of the other desirable health reforms-transfers to help high-risk people, purchasing cooperatives to lower the administrative cost of insurance for small groups, and curtailment of tax incentives for overly lavish coverage-can easily, perhaps more easily, be combined with an individual mandate system than with an employer mandate system.

NOTES

1. M.V. Pauly, *Medical care at Public Expense* (New York: Praeger Publishers, 1971).
2. M.V. Pauly et al., "A Plan for 'Responsible National Health Insurance'," *Health Affairs* (Spring 1991): 5-25.
3. P.M. Danzon, "Mandated Employment-Based Health Insurance Incidence and Efficiency Effects" (Unpublished working paper, Department of Health Care Systems, The Wharton School, University of Pennsylvania, November 1989).
4. See, for example, R.G. Ehrenberg and R.S. Smith, *Modern Labor Economics* (Glenview, Ill.: Scott Foresman and Co,, 1982), 480-483.
5. M.V. Pauly, *Responsible National Health Insurance* (Washington: AEI Press, 1992).
6. M.V. Pauly, "The Clinton Plan: What Happened to the Tough Choices?" *Health Affairs* (Spring I 1994): 147-160.

Mr. PASCRELL. Thank you. I agree with Mr. Pauly: "Making sure everyone pays their fair share is essential to controlling health costs. The CBO estimates that if individual responsibility is repealed, premiums in the individual market will see an increase of 15 to 20 percent as compared to current law." That is what CBO said. That is not what the Democrats said; that is not what the Republicans said; that is not what the President said; that is what CBO said.

Affordable Care Act is about keeping down costs and reducing the number of uninsured Americans. When it comes to health care, we are all in this together. I like to say that. I like to say that.

Dr. Siegel, Professor Siegel, on Tuesday Justice Kennedy noted the unique nature of the health insurance market. He said, and I quote, "but I think it is true that if most questions in life are matters of degree in the insurance and health care world, both markets," two markets we are talking about, "the young person who was uninsured is uniquely approximately very close to affecting the rates of insurance in the course of providing medical care in a way that is not true in other industries." That is my concern in this case.

He comments to the lack of inaction of the health care market. Professor Siegel, can you please discuss the idea of inaction in the health care act in the market?

Chairman HERGER. Regrettably, the gentleman's time has expired, but if you could respond in writing we would appreciate it.

Mr. PASCRELL. Seriously?

Mr. SIEGEL. I think you are identifying a key part of——

Chairman HERGER. Again, the time is expired. If you could respond in writing, please.

Mr. SIEGEL. Oh, I am sorry, sir. I didn't hear you.

Mr. PASCRELL. Can he give a response? Come on, Mr. Chairman.

Chairman HERGER. Well, 5 minutes is what each of us is allowed. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. A quick question, Mr. Bradbury. In your testimony you say Mr. Siegel argues that if the individual mandate is unconstitutional, then the Federal Government could not respond to a flu epidemic by mandating vaccinations. How would you respond to that?

Mr. BRADBURY. I actually don't accept that. I don't agree with that. In the hypothetical, the mandating of flu vaccinations would not be mandating commercial transactions. Yes, he is positing a very extreme situation, where there is a national or a multi-state regional pandemic that is a major threat to health and the economy, that falls within the definition of a national security problem. The Federal Government may respond to national security problems. We have biosecurity planning for pandemics.

Actually, the way it would usually happen, of course, is the States would mandate vaccinations. The Federal role under existing statutes would be to support the States by ensuring the supply of vaccine, by assisting in maintaining quarantines, by assisting States in closing borders. But in the most extreme hypothetical case where the State's ability to respond is completely broken down, it becomes almost like an insurrection situation. The Federal Government certainly has authority to respond to protect national security in a situation like that.

I think it is very different.

Mr. REICHERT. Thank you. Mr. Henchman, I want to go back to your discussion about taxes and the question the chairman had posed a little bit earlier in the discussion. So the individual mandate must maintain a minimum essential coverage, but there are some exceptions to those. I am a former sheriff, and of course one of the exceptions is individuals who are in prison. And I am going to get right back to that. The penalties here for individuals, they begin at $95, and they go to $325, and then it goes to $695, and

then it is indexed to CPI. There is also some penalties attached to the employer mandate. Is that not correct?

Mr. HENCHMAN. Right. I believe the next panel is talking about that aspect, but yes.

Mr. REICHERT. But just along the line of taxes, it is $2,000, I think, if they don't supply enough insurance. It is $3,000 if it is unaffordable insurance, and my question is, this is all about freedom, really. I mean, the burden on businesses and then the individual mandates, and I know this might be outside of your scope a little bit, but I think it is good for those out there who might be watching us today to think about what happens if the individual can't pay the penalty? Do you know?

Mr. HENCHMAN. Right. Well, it is certainly not about revenue, and for this I will agree with Congressman Pascrell who started and talked about why we have this mandate. And he gave a very good reason. The reason he did not give is revenue. And that is not the reason why this mandate was adopted. It was adopted for some other purpose, some other primary purpose than to generate a bunch of revenue.

Mr. REICHERT. Well, I know in my previous profession again that I spent 33 years at, if somebody has a fine that they haven't paid——

Mr. HENCHMAN. Right.

Mr. REICHERT [continuing]. The next step is jail. So, is that in the plan? Do you know? Does anyone on the panel know?

Mr. HENCHMAN. Well, how it is structured, as you laid out is, let's take 2016 for instance. The mandate is kind of fully phased in at that point. People have a choice of either paying $695, or 2.5 percent of their income. That is whichever is higher above the filing threshold——

Mr. REICHERT. Right.

Mr. HENCHMAN [continuing]. Or getting insurance. The IRS is not permitted to use levies and garnishment the way they can with other tax obligations.

Mr. REICHERT. Right.

Mr. HENCHMAN. But it remains to be seen precisely how this will be enforced.

Mr. REICHERT. Right, so let me just, because my yellow light has gone on here. So we play this out. The fines are added up. They get greater and greater. The person doesn't buy their insurance. And according to one of the exceptions here, if you go to jail you have health care. I know that because when we had the Kane County Jail in Seattle, if you got arrested we supplied health care. So I guess if you don't pay your fine and you go to jail, you can get health care.

Mr. HENCHMAN. It remains to be seen how the IRS is going to enforce it. If they put it on the tax form, I should note the tax form has a perjury statement. If you say I have insurance and I don't owe this, you would be committing perjury.

Chairman HERGER. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman.

Mr. Chairman, no fault of the witnesses who are here today trying to do a good job testifying, and out of respect for you, too, but

I view this hearing as just a colossal waste of time for this committee.

First of all, the Judiciary Committee, not the Health Subcommittee of the Ways and Means, has jurisdiction over constitutional law issues. And, secondly, unless you have been living under a rock this week, the United States Supreme Court is taking this very issue up to make a determination later this summer. So if you wanted to have a constructive hearing today, Mr. Chairman, we should have panel after panel of experts talking about how are we going to explain to the 39,000 children in western Wisconsin with a preexisting condition that your effort to overturn or repeal the Affordable Care Act will leave them without adequate health insurance in their lives. Or the fact that 15,000 small business owners in western Wisconsin who qualify today for a tax credit for the health care that they are providing their employees today won't have that tax credit any longer. Or 9,000 seniors who are falling into the donut hole this year, receiving a 50 percent price discount, why they are going to have to pay all of that out of pocket again because of the repeal or overturning of the Affordable Care Act. Or how are we going to explain to citizens throughout the Nation that their insurance companies can once again drop them from coverage when they do get sick or injured, a policy of rescission which now is prohibited under the Affordable Care Act. Or reinstate lifetime limits on health insurance policies.

So if you want to do something constructive in the Health Subcommittee of Ways and Means, we should be having panel after panel talking about what plan B is, what the alternative is to the Affordable Care Act, and the explanation we can give our citizens if the Affordable Care Act is overturned or if you are successful in repealing it.

Or how are we going to address the 50 million Americans who are uninsured today because of the health care system?

That is what we should be doing today, is talking about alternatives and plan B's. And my good friend, Mr. Price, said they do have some ideas. Let's get that out. Let us have a discussion about it. This Member of Congress is interested in one thing: making sure that every American in the country has access to affordable and quality health care. There may be other ways of doing it, but just by repealing this law sets us back to the status quo. And having this hearing on the constitutional law issues that the Supreme Court is determining themselves, doing their job this week, is in my view a colossal waste of time.

But I will play along here with what time I have remaining.

Mr. Henchman, I think it is astounding that time after time you are saying that whether you call this a penalty or tax, the purpose behind the penalty wasn't for us to raise revenue to help pay for the Affordable Care Act. As a member of the Ways and Means Committee, that is exactly what we were trying to do under the penalty, is to raise revenue, because one of the prerequisites to passing this bill that President Obama was demanding, and all of us agreed, by the way, who supported it, was that this bill had to be paid for. And in fact, it was. And under the Congressional Budget Office's analysis, not only was it paid for, but it will reduce the budget deficit by $1.2 trillion over the next 20 years.

So again, if you decide to repeal this and go back to the status quo, that blows another hole in our budget because this legislation would reduce it by $1.2 trillion based on the nonpartisan budget watchdog called the Congressional Budget Office. So, yes, this was the purpose behind it, as a member of the Ways and Means Committee, was to raise revenue.

Mr. Siegel, let me ask you because I found it interesting listening to the Supreme Court questioning on Tuesday, Justice Kennedy asking the Solicitor General, and maybe I missed something, but it sounded like he was creating a whole new standard of Supreme Court review under the Affordable Care Act.

Justice Kennedy to the Solicitor General: Assume for a moment, you may disagree, but assume for a moment that this is unprecedented. This is a step beyond what our cases have allowed, the affirmative duty to act to go into commerce. If that is so, do you not have a heavy burden of justification?

And he went on in that line of questioning and again said to the Solicitor General: Do you not have a heavy burden of justification to show authorization under the Constitution?

I thought it was a reasonable basis standard of the court. Am I missing something here? Is Justice Kennedy trying to establish a much higher burden of proof?

Mr. SIEGEL. And if I had been arguing the case, I would answer it in the alternative. I would say: Justice Kennedy, you yourself just said in that colloquy there is a presumption of constitutionality. Congress gets a presumption of constitutionality as a coordinate branch of government, and that is what Madison is talking about in Federalist 51. He is not talking about judicial review, let alone aggressive judicial review. The presumption of constitutionality is how the law has always been. So if you impose a special justification now, you are moving the goalpost.

Mr. KIND. Professor, really the crux of the individual mandate, why requiring it, is because those who choose not to participate in the health insurance market is driving up the cost for everyone else who is; isn't that the reason, the basis, under the Commerce Clause, for the individual mandate?

Mr. SIEGEL. I think that is the basis under the Commerce Clause. And I think there is also the adverse selection problem under the Necessary and Proper Clause. All of the people in Wisconsin you just talked about, they fall into the nongroup market. And if they don't qualify for Medicaid or Medicare, and if they don't have employer-based insurance, then if they get sick and they don't have a job they and their families are in serious trouble.

Guaranteed issue combats that problem, and the minimum coverage provision combats the adverse selection problem that a company is guaranteed issue in the absence of a mandate.

Mr. KIND. Thank you.

Mr. JOHNSON. [Presiding.] The gentleman's time has expired.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman. I want to agree with Mr. Kind on one thing: the status quo is unacceptable. There is no doubt about it. We would simply suggest that the bill that has been adopted, the law that has been adopted moves us in absolutely the

wrong direction, not for doctors but for patients. And it is patients that we ought to be concerned about.

Mr. Siegel, you mentioned that you didn't know where the limits of Congress were. Well, I would suggest to you that the limits of Congress are well defined in the Constitution and the Bill of Rights, and the 10th Amendment that you are very familiar with, but it is important to remind ourselves, says that the powers not delegated to the United States by the Constitution nor prohibited by it to the States are reserved for the States respectively, or to the people. It is pretty clear what Congress' limits are. It is our contention that this bill/law has gone beyond the limitations of the constitutional provisions.

I want to talk about the consequences of the individual mandate. Mr. Kind was concerned that we are talking more about the law here in the Health Subcommittee of the Ways and Means Committee, and I want to talk about, as a physician, to kind of parse out exactly what the consequences of the individual mandate are.

Mr. Siegel, you know that there are 10 categories of essential benefits that are defined in the law. One of those, for example, is the ambulatory patient services. What are the minimum benefits required in this law for ambulatory patient services?

Mr. SIEGEL. I don't know the answer to that question.

Mr. PRICE. Who decides?

Mr. SIEGEL. I think the Congress of the United States in the first instance decides, or as delegated to a relevant agency pursuant to Congress' authority to delegate.

Mr. PRICE. And the law has delegated that to the Secretary of Health and Human Services?

Mr. SIEGEL. Right. Under a doctrine that has existed for 70–80 years.

Mr. PRICE. So the Secretary of Health and Human Services is going to decide what is allowed to be ambulatory patient services, outpatient services for the country.

Another category is maternity care. Is it correct that the Secretary of Health and Human Services is going to decide what is allowed for maternity care in this country; correct?

Mr. SIEGEL. I would be happy to answer questions about whether that is constitutionally problematic.

Mr. PRICE. Do you believe that it is constitutional for the Secretary of Health and Human Services to decide what the maternity services are covered under this bill?

Mr. SIEGEL. The only possible objection I can see is a nondelegation doctrine law. This objection has not existed in constitutional law.

Mr. PRICE. Accept my premise that the law provides that that definition is ceded to the Secretary of Health and Human Services. What if the Secretary of Health and Human Services said that midwifery weren't allowed in the minimum benefits package, would that be constitutional?

Mr. SIEGEL. Tell me what the constitutional objection would be?

Mr. PRICE. My question to you is would that be constitutional? In your opinion, would the Secretary of Health and Human Services under the current law as adopted by this Congress and signed

by the President be allowed to define that midwifery is not included under maternity services?

Mr. SIEGEL. I would need to know a lot more about what the basis for the decision was, and whether there was a basis and reason under the nondelegation doctrine.

Mr. PRICE. The fact of the matter is that the Secretary of Health and Human Services, through the power that the legislative branch has given the executive branch, is now allowed to decide what is included in all of those services, which is our concern. And that is that patients are no longer the ones that are going to be allowed to decide what kind of health coverage that they are able to select; it is the Federal Government. That is our concern. That is the fundamental basis of the concern.

Ms. Severino, I noticed that you were coming out of your bootstraps, no pun intended, when Mr. Siegel commented on your argument about bootstrapping. And I wish you would expand on what that means to real people and why it is such an important issue in this area.

Ms. SEVERINO. Yes. I think it is kind of shocking that the Necessary and Proper Clause is the constitutional textual basis for bootstrapping because it is also part of limited powers. Our framers assumed the government was given limited powers, not unlimited powers. They weren't worried that we don't have not limits on the limits that we are going to impede on government power, they were worried about keeping government small and tethering it to its appropriate jobs.

The Necessary and Proper Clause is supposed to carry into execution other powers. So to build a military base, it is clearly carrying into execution being able to raise an army or maintain a navy. Building post offices and criminalizing attacks on post offices and robbers is clearly carrying into execution the ability to have an efficient and effective mail service.

Nothing about the individual mandate carries into execution the other provisions of the law. It doesn't carry into execution allowing guaranteed issue. You can have guaranteed issue without the individual mandate. Many States do. It doesn't carry into execution community rating. Again, other States have done this, and you can do it without the individual mandate.

Now, what Congress found was when you do those without the individual mandate, they have negative consequences. But that is not the same thing as carrying into execution something. Having negative consequences, we are creating a law. Or even that we have created a law that says emergency rooms have to provide coverage for certain individuals under certain circumstances. That, while individual emergency rooms may want to do such a thing out of moral obligations, creating that requirement also creates a problem of cost shifting. Creating a problem does not then open wide the constitutional door for any solution Congress wants to create.

Mr. JOHNSON. The time of the gentleman has expired.

Doctor, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Siegel, there is a tale of two States, Washington State and Massachusetts. Washington State in 1993 passed a comprehensive health care bill which had mandates in it and guaranteed issue,

and all of the things that are in the Massachusetts law, essentially. Different format but basically the same.

They then, in Washington State, in court lost the mandate. The mandate was taken out, but they were left with the basic guaranteed issue. In 1995, a woman coming in said I want insurance. She bought insurance. She had the baby, she canceled it; 1996 she came in, bought insurance, had the baby, and canceled it. They spent $1,000 on premiums and Primera, Blue Cross/Blue Shield spent $8,000. Primera lost $120 million in Washington State until they pulled out their individual coverage and we had no individual coverage in the State of Washington for a period of time until the State legislature repealed the guaranteed issue.

Now, what I want to ask you: What other way can you control costs? Because clearly, you have to have both guaranteed issue. If you have guaranteed issue, that is preexisting conditions are out of the way, you must have universal coverage so you have a big enough pool to spread the cost. Otherwise the sick come in, do exactly what this woman did.

I would like to enter into the record and ask unanimous consent, an article from the Seattle Times dated March 28.

Chairman HERGER. Without objection.

[The article follows, The Honorable Jim McDermott:]

The Seattle Times
Local News

Thursday, March 29, 2012 - Page updated at 11:30 p.m.

Why Washington state's health reform faltered after loss of mandates

By Carol M. Ostrom
Seattle Times health reporter

As the U.S. Supreme Court tackles the question of whether individuals can be required to buy health insurance — a key provision in the federal health-care overhaul — some in Washington state are battling a strong sense of déjà vu mixed with dread.

They remember 1993, when state lawmakers passed a comprehensive state law aimed at insuring everyone and spreading the health-care expenses of the sickest throughout a large pool of policyholders.

But the law, which relied on both mandates and incentives, was soon dismembered, leaving only popular provisions, such as prohibiting insurers from denying coverage to sick people or making them wait many months for coverage.

Without any leverage to bring healthy people onto insurance rolls, insurers, left with the priciest patients, began a financial death spiral.

Ultimately, companies pulled out of the individual market and almost no one in Washington could buy an individual policy for any price.

For those involved, the lessons learned remain sharp as a scalpel.

"It's the same thing we're very likely to face if the Supreme Court blows a hole in the current law," warns Randy Revelle, a former King County executive who was heavily involved in the state effort nearly two decades ago.

Unlike the debate going on in the high court, the lessons here don't involve constitutional questions. They're all about the realities of the health-insurance market and politics.

At the top of the list:

Lesson 1: Good intentions, no matter how popular, can backfire — big time.

Lesson 2: A machine doesn't work so well if you remove parts.

Lesson 3: Buy-in from both political parties and strong public support are needed to maintain enough momentum to sustain complex reforms through potential changes in administration.

The '94 "death spiral"

In an amicus brief in the Supreme Court case, Gov. Chris Gregoire and other governors referred to the "death spiral" in Washington's individual-insurance market that began in 1994.

The 1993 law, passed when Democrats controlled both houses and the governor's seat, was then the most ambitious overhaul effort in the nation.

The delicate balancing act ended when Republicans, who objected to what they saw as heavy-handed government control of the health industry, swept into power in both houses.

By the time the new Legislature finished, the only parts of the law that survived were the "consumer-friendly" pieces, championed by then-Insurance Commissioner Deborah Senn, a Democrat.

"We kept some of the insurance reforms in law, because they were very popular, but we didn't keep the market reforms," says Pam MacEwan, who was a member of the Health Services Commission charged with implementing the law and is now a Group Health Cooperative executive. "It was a big problem."

That's primarily because there was nothing left in the law to push or entice people to buy insurance when they were healthy, which would have spread costs more broadly.

What happened next is starkly summarized in a 1995 letter sent to Premera Blue Cross by a woman in Eastern Washington.

A few months before she gave birth that year, the woman bought an individual policy from Premera. As soon as the insurer paid her hospital expenses, the woman canceled the policy, telling Premera "we will do business with you again when we are pregnant."

True to her word, in 1996, she bought insurance, Premera said, once again canceling after the insurer paid for the delivery of her next child.

Altogether, she paid in $1,807 in premiums. Premera paid out $7,024.68 in medical bills.

You don't have to be a business genius to recognize the problem with those numbers when multiplied by thousands of customers.

Claims went up. Premiums rose. Pretty soon only sick people thought insurance was worth the cost. Premiums rose even more.

Healthy people, like the Eastern Washington woman, waited until they needed insurance to buy it. At the time, Gov. Gary Locke likened it to buying fire insurance after your house is on fire.

State breaks the logjam

Before deciding in 1998 not to sell any more individual policies in the state, Premera lost $120 million in today's dollars, says company spokesman Eric Earling. By mid-1999, the state's other two big insurers, Regence BlueShield and Group Health, stopped selling individual policies.

In 1999, with the individual health-insurance market essentially dead, Locke began crafting a compromise. Signed into law in the spring of 2000, it was a bitter pill for some, but it got the market back into action.

In exchange for coming back into the market, insurers could charge whatever they wanted, bypassing the rate review normally done by the insurance commissioner's office. They could also force patients to wait nine months to be covered, and exclude the most expensive patients.

To deal with those patients, the state revived its high-risk pool. Insurers, who would help subsidize the pool, would be allowed to reject 8 percent of applicants, who could then buy coverage through the pool — if they could afford it.

At the time, Sen. Alex Deccio, a Republican from Yakima, summed it up neatly: "We are in a private-enterprise system."

"Have" vs. "have-not"

Washington's insurance experience, some worry, could be repeated on a much larger scale, should the Supreme Court find the mandate unconstitutional.

Insurers, in an amicus brief to the court, argue that if the mandate is removed they should be allowed to exclude people and set prices based on health — now barred in the federal plan.

Others argue that the mandate, with its relatively weak financial penalty for those who don't buy insurance, isn't necessary for the federal health overhaul to proceed.

They calculate that many young, low-income uninsured would buy policies without a mandate, since the federal overhaul dangles attractively low premiums for the young and subsidizes those with low incomes.

State Sen. Karen Keiser, D-Kent, who chairs the Senate's health-care committee and a group of lawmakers exploring alternatives, says if the federal mandate is overturned, each state would be left to choose options ranging from doing nothing to legislating ways to bring as many people as possible into a health-insurance pool.

"Of course, that would mean that our country would be made of 'have' states and 'have-not' states, making the health disparities even worse, which is pretty awful," Keiser said in an email.

Washington Insurance Commissioner Mike Kreidler says 85 percent of state residents, who now have group coverage, wouldn't be directly affected by the federal mandate.

But, he adds, the typical Washington family's yearly insurance bill includes about $1,000 to cover costs for the uninsured, which his office calculates have reached about $1 billion a year in the state. The state hospital association says charges for charity care and bad debt by patients may amount to as much as $2 billion.

Kreidler's office has estimated that under the federal plan, the vast majority of the approximately 1 million uninsured would qualify for Medicaid or subsidies.

Revelle, now policy leader for the Washington State Hospital Association, says the state's struggle to improve health coverage was illuminating.

"A fundamental lesson we learned in the process — and that unfortunately was not learned in the federal process — is that health care is so big, so complex, so passionate, that it has got to have bipartisan support," Revelle said.

It also needs widespread public support to last through the years it takes to impose changes on an entrenched industry.

And that's difficult, he says, not only because of health care's complexity, but because people do not agree on fundamental values.

"It's very hard to look out five or 10 years," Revelle says. "But we should constantly be thinking: Where do we need to be five to 10 years from now?"

Mr. MCDERMOTT. Give me the other ways that you can control costs? If the Supreme Court is thinking if we don't go this private sector route through the health insurance industry, what other way will we have in this committee to do it?

Mr. SIEGEL. I think the most prominent alternative that would both be effective in controlling costs, would also be substantially more coercive. I think everyone in the ACA litigation agrees that Medicare for all, a single payer, a government takeover, would be constitutional. It would be within the scope of the tax power. You would have to undo a lot of preexisting law in order for that to be unconstitutional.

I think the Affordable Care Act alternative of guaranteed issue and a minimum coverage provision, the intent there is to respect

concerns about liberty and choice to a greater extent than the single payer would by giving people options, alternatives about the insurance that they want, not just having the government provide it.

So I think that would be an effective, clearly constitutional way to do it. The Affordable Care Act alternative is a way to preserve private markets.

Mr. MCDERMOTT. So it is really preserving the private sector in the health care issue?

Mr. SIEGEL. And that is why I think during the 1990s the minimum coverage provision was very prominent in conservative economic and political thought. It was an alternative to the single payer. It was an alternative to the employer mandate. People agreed or disagreed as a policy matter. No one made a Federal constitutional case out of it. And I think this speaks directly to the question of why is it that Congress hasn't done this before.

So one theory that has been put on the table is that we all knew from the founding that this was unconstitutional, and then something happened. There was some kind of collective amnesia, where the Affordable Care Act was being debated and now something that had always been known to be unconstitutional was suddenly thought constitutional by one of the two major parties. In fact, I don't think that is a likely explanation. I think the likely explanation is no one thought of this being a real constitutional problem before this debate. In fact, more conservative thinkers thought it might even be advisable as a policy matter. But even if they didn't, they didn't think it was unconstitutional.

Mr. MCDERMOTT. Do you think the individual mandate came from the Heritage Institute?

Mr. SIEGEL. It was Heritage. It was AEI. It was conservative economists. It was Republicans in the Senate. At one point it was Newt Gingrich. At another point it was Mitt Romney. I believe Bob Dole for a while. Again, there was a robust debate about the policy merits; just like there could be a robust debate about whether we ought to have a post office.

Mr. MCDERMOTT. I want to get one other thing on the record.

Dr. Price suggested that Secretary Sebelius sits down there and picks and chooses whatever she wants. As I understand the law, there is a committee at the Institute of Medicine that makes recommendations to her, so she is not without recommendations when she makes her decisions; is that correct?

Mr. SIEGEL. In truth, I do not know.

Mr. MCDERMOTT. Okay. Well, that is the way that I read the law and the fact is that Congress can come in and change. So the idea that she is the czar is really kind of a myth, really.

Mr. SIEGEL. I think it is another issue about which we can have a policy disagreement.

Chairman HERGER. [Presiding.] The time of the gentleman has expired.

Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Mr. Bradbury, your testimony and the briefs you have written in this case have done an excellent job of explaining the purpose of the individual mandate. The Democrats' health care law has many provisions that make it more expensive, in effect, for insurance

companies to offer health care. The law increases taxes on insurance. There are numerous other taxes, mandate benefit packages full of bells and whistles, and there are many new regulations on insurance companies. So to compensate the insurance companies, Congress creates millions of new customers by forcing individuals to buy their product, a very restricted product given all of the regulations that have come through. So the individual mandate is really in effect about making insurance companies whole.

What is the difference between that and Congress forcing car companies to make electric cars and compensating them by mandating that Americans buy electric cars?

Mr. BRADBURY. I really think fundamentally as a matter of economics there is not a difference. There has been a lot of talk about insurance is different or unique or health insurance is unique. But insurance is just a way, an overt mechanism, for spreading risk across a larger base of participating individuals. Well, that is true in any industry. The more people buy electric cars, the lower the price of each unit produced. If Congress imposes very strict and onerous requirements on car companies, saying they can only produce electric cars or super-efficient vehicles and the cost of those vehicles per unit is much, much higher than the average American is interested in paying, then under this theory Congress could turn around and require that every American family that can afford it must buy an electric vehicle and that would drive the unit cost down because supply would increase and production costs would go down on a unit basis. It is really no different, as a matter of economics, from what is being argued here.

Mr. BOUSTANY. It really struck me, and I was at the Supreme Court on Tuesday and listened to the 2 hours of argument. There was a discussion about insurance as a financing mechanism for health care. But yet in listening to much of the discussion, it was a very narrow type of discussion because it was almost as if there was only one way to do this. For instance, in health care law, we know there are significant restrictions on health savings accounts which I as a physician believe health savings accounts are a good way to help individuals finance their health care needs. It promotes personal responsibility. It promotes a more informed consumer of health services. And knowing that health care, I don't call it a right or a privilege, I think it is a personal responsibility, and so things that we can do to promote that type of ownership of your own health care destiny are really important. So in this narrow view that I alluded to just a moment ago, it is interesting that you have government creating a very restricted, very regulated, even more so than now, marketplace, with the minimum benefits package, restrictions across the board, in effect narrowing choices for families, for individuals, for businesses, narrowing it down and recognizing, in doing so, you are forcing everybody like through a funnel into a one-size-fits-all process, a more expensive process even by the Congressional Budget Office's own estimates. And so what happens, the individual mandate. I think you have highlighted that fairly well.

Would anyone like to comment?

Mr. BRADBURY. I would say obviously one alternative economically would be to open up the options for Congress to free the mar-

kets on an interstate basis from restrictions on what kinds of insurance can be offered. For example, from one State to another. To actually increase or make it almost unlimited what kinds of policies could be offered, and then there would be many, many choices from bare bones policies to Cadillac policies and people could pick and choose. I am not saying that would cover everybody in every instance. Preexisting conditions may always be a tough issue because that is not insurance when you are actually buying a policy that covers something you already have.

Mr. BOUSTANY. It is sick care.

Mr. BRADBURY. It is like an annuity. It is not an insurance policy, it is an entitlement. So there will be those costs. But over time as there are more options in the markets, then more people will have mix-and-match policies they can choose that are economically advantageous for them and get the coverage that they need, and government can take care, State governments can take care of the residual folks who can't get the coverage.

Mr. BOUSTANY. So create a real market for all of us. And for those who have defined needs with very definable and problematic health considerations, it is not an insurance issue because insurance is bought to deal with risk. Once you are sick, you are sick. Now there needs to be a way to finance that separately.

Thank you. I yield back.

Chairman HERGER. Again, I want to thank our witnesses for your testimony, and at this time I would like to invite our second panel to step forward. While they do, I will introduce them in the interest of time.

To better understand the impacts of the employer mandate, we will hear from Diane Furchtgott-Roth, Senior Fellow, Manhattan Institute of Policy Research; Sylvester Schieber, Independent Consultant; Tom Shaw, President, Barton Mutual Insurance Company; and Stephen LaMontagne, President and CEO Georgetown Cupcake.

Ms. Furchtgott-Roth, you are recognized for 5 minutes.

STATEMENT OF DIANE FURCHTGOTT-ROTH, SENIOR FELLOW, MANHATTAN INSTITUTE FOR POLICY RESEARCH

Ms. FURCHTGOTT-ROTH. Thank you very much, Mr. Chairman, for inviting me to speak here today on this very important subject of how the Affordable Health Care Act affects employment. It was interesting listening to the preceding discussion. The views seem to be from some members that because health care was essential and because everyone might need it at some time, it was the role of the government to mandate it and employers to provide it.

Well, there are many essential services—food, clothing, housing—but we don't ask employers to provide them. If we feel that low-income people need these services, food for example, we give them foot stamps. Housing, we give them housing vouchers. We don't ask employers to have a minimum provision of food. We don't require them to provide breakfast or lunch or snacks to their employees.

And it is the same with health insurance. We don't ask employers to provide life insurance, auto insurance, other kinds of insur-

ance. I agree that people should have access to health insurance. I don't agree that employers have to be the ones who provide it. Why? It creates a great disincentive for hiring.

One reason we have such a high unemployment rate, over 8 percent for more than 3 years in a row, well after the end of the recession, is because there is a big cliff moving from 49 to 50 workers. If a employer moves from 49 to 50 workers, he has to pay $40,000 a year in penalties. That is because the first 30 workers are exempt. But moving from 49 to 50, you take off 30, you multiply it by $2,000, you get $40,000 a year, and that is a big disincentive to hiring. It especially hurts low-skilled workers. $2,000 is 12 percent of the average earnings in the food and beverage industry, which is an industry where people often get their first jobs. I myself had my first job scooping ice cream in Baskin-Robbins. This also hurts franchise businesses, and I think this was probably not the intention of Congress. If you have four Dunkin' Donuts or four Baskin-Robbins and they each have 15 workers, they are subject to the penalty because in all, the franchise would have 60 workers in all. This means that these franchise businesses are competing against smaller, nonfranchise businesses. So if there is a Baskin-Robbins that is part of a franchise and it is across the street from a Joe's Diner, for example, the Baskin-Robbins would have to pay the $2,000 per worker per year in penalty. Joe's Diner wouldn't, and this would be very hard on the franchise businesses.

There are many franchise establishments. They are responsible for about $468 billion of GDP. They create 9 million jobs. They employ many low wage, entry-level workers, as well as higher paid workers. And our unemployment rate for low skilled workers is about 14 percent right now. Our teenage unemployment rate is 25 percent. Our African American teen unemployment rate is even higher. This is not something that we want employers to have to do because it reduces employment and it slows GDP growth.

In the previous panel, there was a discussion of what to do about the health care problem. We need to take it away from the employer. Any premium should be tax deductible so that private markets develop. You never hear anyone saying I am losing my job. I am going to lose my auto insurance. I won't be able to drive.

There are many bills that suggest how to go. One of the best is Congressman Price's Empowering Patients First Act, which would mean that a worker would have portable health insurance. His employer could pay part of it and then if he moves jobs, changes jobs, his next employer could pay part of the same kind of insurance, just like an IRA or a 401(k) plan. If that individual wanted, he could buy health insurance outside of his employer also, and that is what we need to move to. We know how insurance markets work. We have made them work with auto insurance, life insurance, and home insurance, and we should make them work also for health insurance. We can do this. We know how to do it without penalizing employment, without penalizing workers, and especially without penalizing low skilled workers, the most vulnerable among us who need a job.

Thank you very much.

[The prepared statement of Ms. Furchtgott-Roth follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012

Disincentive Effects of the PPACA on Job Creation

Diana Furchtgott-Roth
Senior Fellow, Manhattan Institute

Testimony before the Health Care Subcommittee of the House Committee on Ways and Means

March 29, 2012
Disincentive Effects of the PPACA on Job Creation

Chairman Herger, members of the Committee, I am honored to be invited to testify before you today on the effects of the Patient Protection and Affordable Care Act on the franchise industry. The Act has employment effects on millions of Americans, and I thank you for holding this hearing.

I am a senior fellow at the Manhattan Institute. From 2005 through September 2011 I was a senior fellow at the Hudson Institute, where I authored a study entitled *The Effects of the Patient Protection and Affordable Care Act on the Franchise Industry*. From 2003 until April 2005 I was chief economist at the U.S. Department of Labor. From 2001 until 2002 I served at the Council of Economic Advisers as chief of staff. I have served as Deputy Executive Secretary of the Domestic Policy Council under President George H.W. Bush and as an economist on the staff of President Reagan's Council of Economic Advisers.

High unemployment rates are at the top of the list of concerns for American workers. In early March, the Labor Department announced that the unemployment rate held steady at 8.3 percent. The rate has remained above 8 percent for over three years.

Even though an 8.3 percent rate of unemployment is high, it masks a broader employment problem in the workforce. Including discouraged and underemployed workers, the Labor Department's measure of unemployment is 14.9 percent. And many workers have left the labor force because they have not been able to find jobs. The labor force participation rate has declined from 66 percent in January 2009 to 63.9 percent today—a rate that is about equal to the early 1980s.

Could it be that the $2,000 per worker penalty in the new health care law, effective 2014 and levied on employers who do not provide the right kind of health insurance, is discouraging hiring?

The Patient Protection and Affordable Care Act of 2010 will raise the cost of employment when fully implemented in 2014. Companies with 50 or more workers will be required to offer a generous health insurance package, with no lifetime caps and no copayments for routine visits, or pay an annual penalty of $2,000 for each full-time worker.

This penalty raises significantly the cost of employing full-time workers, especially low-skill workers, because the penalty is a higher proportion of their compensation than for high-skill workers, and employers cannot take the penalty out of employee compensation packages.

Employers are not blind. They see these penalties coming, and they are adjusting their workforce accordingly.

The evidence that employers are economizing on workers is all around us. More supermarkets and drug stores have self-scanning machines at checkout. Large

department stores have price-scanning machines scattered around the stores, so that shoppers can check prices without asking a clerk. Food trucks line the streets in New York and Washington, D.C., enabling restaurants to sell their food without waiters. These workforce adjustments are just one reason that employment growth has been slower than usual during this economic "recovery."

Hardest hit are workers with fewer jobs skills. The unemployment rate for adult workers with less than a high school diploma is 12.9 percent. Teens face an unemployment rate of 23.8 percent. The rate for African American teens is even higher, at 34.7 percent.

Another group that is disproportionately affected is younger workers. Of the 2 million adults who found jobs over the past year, 1.7 million are over 55 years old, and 300,000 are between 25 and 55—even though the 25 to 55 group is three times the size of those 55 and older. Younger workers have far fewer employment opportunities, which affects their lifetime expected earnings.

Suppose that a firm with 49 employees does not provide health benefits. Hiring one more worker will trigger an annual penalty of $2,000 per worker multiplied by the entire workforce, after subtracting the statutory exemption for the first 30 workers. In this case the penalty would be $40,000, or $2,000 times 20 (50 minus 30). Indeed, a firm in this situation might have a strong incentive not to hire a 50th worker, or to pay him off the books, thereby violating the law.

In addition, if an employer offers insurance, but an employee qualifies for subsidies under the new health care exchanges because the insurance premium exceeds 9.5 percent of his income, his employer must pay $3,000 per worker. This combination of penalties gives businesses a powerful incentive to downsize, replace full-time employees with part-timers, and contract out work to other firms or individuals. For example, a restaurant might outsource some of its food preparation versus paying employees to make it on-site.

What has been rarely discussed is that the franchise industry will be particularly hard-hit because the new law will make it harder for small businesses with 50 or more employees to compete with those with fewer than 50 employees.

Franchisors and franchisees, who often own groups of small businesses, such as stores, restaurants, hotels, and service businesses, will be at a comparative disadvantage relative to other businesses with fewer locations and fewer employees. This will occur when a franchisor or franchisee employs 50 or more persons at several locations and finds itself competing against independent establishments with fewer than 50.

An estimated 828,000 franchise establishments in the U.S. accounted for more than $468 billion of GDP and more than 9 million jobs, based on PricewaterhouseCoopers' report

of 2007 Census data.[1] When factoring the indirect effects, these franchise businesses accounted for more than $1.2 trillion of GDP—or nearly 10 percent of total non-farm GDP. Of franchise businesses, an estimated 77 percent were franchisee-owned and 23 percent were franchisor-owned.

Franchise businesses can be organized in many ways. In some cases the franchisor, or parent company, will own and operate some locations while franchising others. In other cases, a franchisee will own a single location or "unit." In a third set of cases, a franchisee will own multiple locations, referred to as a "multi-unit franchisee." More than half of all franchise establishments are owned by multi-unit franchisees. In the cases where the franchisor and the franchisee own and operate multiple locations, these firms are treated as one company for penalty and health care purposes.

The new health care law would put many franchise businesses at a disadvantage relative to non-franchise competitors by driving up their operating costs. Many of these businesses would be subject to the $2,000 health care penalty if they do not provide health insurance. The multi-unit franchisees will have a particularly difficult time operating in this uneven business environment.

Suppose a multi-unit franchisee owns four establishments with 15 full-time employees each. Under the new health care law, this multi-unit franchisee will be treated as a single firm with 60 full-time employees, and the employer will be required by law to provide healthcare benefits for all employees or pay a fine of $2,000 per full-time employee per year.

However, if these four establishments were owned and operated separately, they would be exempt from the requirement of providing healthcare benefits. Further, if these four separately-owned businesses choose to offer health insurance, they would in some cases be entitled to a penalty credit.

When the employer mandates are phased in 2014, many franchise businesses will be motivated to reduce the number of locations and move workers from full-time to part-time status. This will reduce employment still further and curtail the country's economic growth. More than 3.2 million full-time employees in franchise businesses may be affected.

Industries that have traditionally offered the greatest opportunities to entry-level workers—leisure and hospitality, restaurant—will be particularly hard-hit by the new law. Many of these employers do not now offer health insurance to all of their employees, and employ large percentages of entry-level workers, whose cost of hiring will increase significantly.

---

[1] PricewaterhouseCoopers (PwC), February 2011 (b), The Economic Impact of Franchised Businesses: Volume III, Results for 2007, February 2011.

The franchise industry has offered an entry point to low-skill workers, who have some of the highest unemployment rates in America. Adults without high school diplomas face an unemployment rate of 12.9 percent, more than 3 times as high as rates for college graduates, and well above the national average of 8.3 percent.

Under the new law, for each block of 30 weekly hours of part-time work by one or more employees a business is deemed to have one full time equivalent employee. The penalty for full-time employees is $2,000 per worker after the first 30 employees.

Businesses with fewer than 50 employees will have an advantage. If they do not hire too many workers - another government-induced disincentive for hiring in this weak labor market - and stay within the 49-person limit, these firms will not have to provide health insurance and will have a cost advantage over the others. Such businesses will be able to compete advantageously against businesses with multiple locations and 50 or more employees.

The $2,000 penalty will amount to 12 percent of average annual earnings in the food and beverage industry and 8 percent in retail trade. This is a cost in addition to the employer's share of Social Security and Medicare taxes (7.65 percent, equal to what the employee pays), as well as workers' compensation and unemployment insurance.

When the government requires firms to offer benefits, employers will generally prefer to hire part-time workers, who will not be subject to the penalty. Even though the Act counts part-time workers by aggregating their hours to determine the size of a firm, part-time workers are not subject to the $2,000 penalty. Hence, there will be fewer opportunities open for full-time work. Many workers who prefer to work full-time will have an even harder time finding jobs.

In August 8.8 million people were working part-time because they could not find full-time jobs. The new health care law would exacerbate this problem.

In addition to hiring more part-time workers, firms will have an added incentive to become more automated, or machinery-intensive—and employ fewer workers. Fast food restaurants could ship in more precooked food and reheat it, rather than cook it on the premises. Something analogous is already gaining momentum in industries such as DVD rental, where manual labor at retail outlets is being replaced by customer-activated DVD checkout. Supermarkets, drugstores and large-chain hardware stores also are introducing do-it-yourself customer checkout.

Some employers will be allowed to keep existing plans, a term known as "grandfathering." However, restrictions on "grandfathering" could force up to 80 percent of small businesses to drop their current health insurance plans within three

years and either replace them with more expensive new plans or go without insurance altogether and pay the penalty, according to the government estimates.[2]

The restaurant industry, which represents 23 percent of franchise businesses by number and 50 percent of franchise business employment, provides an example of how firms with seasonal, part-time employees, competitive environments, and low profit margins will face new challenges in connection with the provision of health insurance. Some restaurant owners are likely to drop existing coverage that no longer meets the requirements of the Act. Several restaurants received waivers from the Department of Health and Human Services in 2011, but these waivers will not continue into 2014, once the Act is fully phased in. Many restaurants will be penalized because their low-wage workers will choose to get subsidized coverage on the state exchanges.

The disincentive in the Act to hire additional workers is illustrated in Table 1. If a business does not offer health insurance, then, beginning 2014, it will be subject to a penalty if it employs more than 49 workers in all its establishments. For 49 workers, the penalty is 0. For 50 workers, the penalty is $40,000; for 75 workers, it is $90,000; and for 150 workers, the penalty is $240,000. Each time a business adds another employee, the penalty rises.

On the other hand, as is shown in Table 2, businesses can reduce costs by hiring part-time workers instead of full-time workers. A firm with 85,000 full-time workers and 7,000 part-time workers that does not offer health insurance would pay a penalty of $170 million. By keeping the number of hours worked the same, and gradually reducing full-time workers and increasing part-time workers, until the firm reaches 17,000 full-time workers and 92,000 part-time workers, the penalty is reduced to $34 million. If the firm abandons full-time workers altogether, admittedly an unlikely option, but useful for illustration, the penalty is reduced to zero.

Some businesses, single-unit franchisees and others, could minimize cost by increasing part-time hourly workers, reducing the number of full-time workers, and dropping employer-provided health insurance. Even if businesses choose to offer health insurance to their full-time employees, the Act gives them an incentive to employ more part-time hourly workers than full-time workers in an effort to maximize penalty benefits. If Congress leaves these incentives in place, the reduction in full-time employment would be costly to the economy.

---

[2] U.S. Department of the Treasury, U.S. Department of Labor, U.S. Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," *Federal Register*, Vol. 75, No. 116, Thursday, June 17, 2010.

Table 3, with data taken from the International Franchise Association Educational Foundation, shows the costs of the new health care law to the multi-unit franchise business. Multi-unit franchisees would face more than $3.5 billion in penalties—penalties that could be reduced if firms switched from full-time to part-time workers. Costs would be highest in the quick service restaurant industry, with total penalties of more than $1.6 billion. More than 1.7 million full-time jobs are at risk in multi-unit franchisee businesses, with 820,000 jobs in the quick service industry.

With employment growth slowing and unemployment high, it is worth examining the effects of penalties on employment under the new health care law. America cannot afford these negative effects on employment.

Thanks for inviting me to testify today. I would be glad to answer any questions.

Chairman HERGER. Thank you very much.
Mr. Schieber, you are recognized for 5 minutes.

STATEMENT OF SYLVESTER J. SCHIEBER, CONSULTANT, COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Mr. SCHIEBER. Thank you, Mr. Chairman and members of the Committee. I appreciate the opportunity to testify today regarding some research that I have been working on recently. My prepared remarks summarize that work. The research that I have been doing with Dr. Steven Nyce shows that many workers have failed to get ahead in recent years, largely due to growing health care costs.

Health reform has the potential to increase the demand for health care services and could exacerbate an already bad situation with adverse consequences for workers' economic prospects.

Under ACA, many employers will be required to provide workers with health insurance or pay a penalty for not doing so. This will impose a significant fixed cost component into compensation. If employers cannot make offsetting adjustments to other compensation components, some workers will be unable to maintain their jobs. The most vulnerable workers, as we just heard, are those at the bottom end of the earning spectrum.

Table 3 of my remarks shows the average share of increasing compensation required to finance health benefits over each of the past 3 decades for full-time, full-year workers at 10 different earnings levels. Averages include those who did not receive health benefits from their own employers. Declining coverage, concentrated among lower waged workers, has mitigated some of the crowding out effect shown in the table. But workers who lost employer provided health insurance had to spend more out of pocket for their health care needs, a classic example of damned if you do or damned if you don't.

Table 4 shows how benefit costs have risen relative to wages between 1980 and 2009 for workers actually enrolled in their employer health benefit plans. These costs have grown faster for the lowest paid workers than in Table 3. For example, benefit costs relative to wages for the second decile, these are people at the 20th percentile, were twice those for workers in the ninth decile in 1980, and three times more than in 2009. The lowest earners are most damaged by high health inflation.

Peter Orszag and Ezekiel Emanuel, two of the architects of the Affordable Care Act, have estimated that health reform will have little affect on national health expenditures between now and 2030. Richard Foster, the Chief Actuary at CMS, suggests that health reform will provide little relief to the cost trajectory of employer-sponsored health benefit plans in coming years. That means that current inflation rates are going to persist.

A full-time worker in the second earnings decile in 2009 earned somewhere around $25,000 in total compensation. If his or her productivity goes up at the rate of growth that the Social Security actuaries estimate, by 2019 this worker will be earning around $36,600 in total compensation. But if current health inflation persists, nearly 75 percent of that gain will have been consumed by rising health benefit costs. If the worker has family coverage, the cost of health benefits will grow to consume more than his or her added productivity improvement.

In 1980, employer contributions for health benefit plans were only 3.8 percent of total compensation paid to workers. By 2010, they had risen to 9 percent. Excessive health inflation now applies to a much larger base than it did 20 or 30 years ago. For workers and plans, the cost issues are much worse than the average for all workers. For those in the second earnings decile taking coverage, the cost of health benefits rose from just under 10 percent of their pay in 1980 to 31 percent of their pay in 2009, so nearly a third of pay is being paid out of their compensation for health benefits.

This ugly arithmetic suggests that employers cannot offer many workers both health benefits and growing wages and hope to remain competitive in a global economy. The mandate to provide health insurance coverage may be an admirable goal, but has a potential to limit employability of lower wage workers.

Some analysts believe that most employers will stay in the game of offering health benefits even under these circumstances. Our analysis, however, suggests that many employers may eliminate their plans and let workers fend for themselves in the new exchanges because the economics of employing them simply doesn't work at current cost and inflation rate.

At the margin, shifting an ever-larger share of low earners into publicly subsidized health insurance programs might seem desirable, but we cannot avoid the reality of a national health care marketplace and the costs with it. Shifting health costs from employer compensation packages to a mix of public subsidies and worker contributions will not reduce health care expenditures unless we bring medical inflation under control. If health reform is not expected to bend this cost curve, then I have to ask: Who is going to pay this bill?

Thank you very much.

[The prepared statement of Mr. Schieber follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012

Testimony of Sylvester J. Schieber, Ph.D.
Independent Consultant

Committee on Ways and Means, Health Subcommittee
Hearing on the Individual and Employer Mandates

March 29, 2012

Mr. Chairman and Members of the Committee, I appreciate the opportunity to testify today regarding some research that Dr. Steven A. Nyce of Towers Watson, the human resources consulting firm, and I have developed recently. We undertook this work at the request of the Council for Affordable Health Coverage, an organization comprised of associations, employers and individuals concerned about the cost of health coverage here in the United States.

Summary

Most Americans are painfully aware that their health care premiums are rising faster than other necessities of life. Many also know that their earnings are growing slowly or not at all, despite apparent increases in worker productivity. Both of these problems have been widely reported, but are seldom linked even though they are directly connected. Workers' inability to get ahead in recent years is largely attributable to growing health care costs. The analysis that Dr. Nyce and I have developed suggests that if we do not get health inflation under control, the situation will get progressively worse. Because health reform has the potential to increase the demand for health care services, it could exacerbate an already bad situation and have significant adverse consequences for workers' job and income prospects.

Employers compensate workers with cash wages, by paying a share of the payroll tax to support Social Security and Medicare, and by sponsoring and financing a substantial share of the costs of employee benefit plans. A large share of the cost of benefits for many employers is tied to the cost of sponsoring health benefit plans. Health benefit plan costs are unique among the elements of compensation paid to workers in that they are more a fixed cost than the others. The cost an employer incurs in providing health insurance to a $25,000 a year worker is essentially the same as that for providing health insurance to one earning $150,000 per year. Because of that, the health benefit component of compensation is a much larger share of the remuneration

paid to lower earners than to higher ones. Because health inflation has driven employers' health benefit costs much more rapidly than worker productivity in recent years, these benefits are eroding what is paid to workers in cash. For a worker earning around $25,000 today, the average health benefit financed by employers is roughly one-third of their pay. If this worker's contribution to a firm increases by $300 this year because of improved productivity but employer's the cost of providing health insurance increases by $450, then there is no money left to increase the amount going into the pay envelop. If some other aspect of compensation cannot be reduced, there is the potential that this worker is no longer economically viable for employment in the firm.

Under the 2010 Affordable Care Act, many employers will be required to provide workers with health insurance or to pay a penalty for not doing so. This means that the extremely important fixed-cost component of compensation will be imposed on these employers. The analysis that follows strongly suggests that the outcome will be that the problem of slow growing earnings levels will be considerably exacerbated in the future. If employers have little flexibility in making offsetting adjustments to other elements of the compensation package, it will mean some workers will find it increasingly difficult to find and keep jobs. The most vulnerable to these risk exposures are the workers at the bottom of the earnings distribution. The cost of health care, however, has gotten so high that this risk is spilling up the economic ladder more quickly than most people realize. Richard Foster, the chief actuary at the Centers for Medicare and Medicaid Services, has estimated that the Affordable Care Act will increase total health care expenditures relative to prior law by 0.9 percent of GDP by 2019.[1] We have to

[1] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act," as Amended (April 22, 2010), Table 5, found at: http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.

consider that there is some significant risk that health reform will increase the rate at which inflation is eroding workers' economic advancement opportunities.

Background

According to data developed by the Office of the Actuary at the Social Security Administration, workers across the U.S. economy were rewarded 66 percent of their output per hour as compensation in 1950. In 1970, they were rewarded at 67 percent of their output per hour. In 1990, the reward rate was 64 percent of their product per hour and in 2008, it was 64 percent.[2] Economists generally consider compensation to include both the cash paid to workers for their contributions in the workplace and also the benefits that employers finance in accordance with the legal requirements to make payroll tax contributions and the financing of health, retirement and other benefits provided to workers.

While total compensation paid to workers has remained a relatively constant share of total economic productivity in the United States over the period since the end of World War II, the structure of compensation has changed steadily and considerably over the period as shown in Table 1. In 1950, nearly 95 cents of every dollar of compensation was in the pay envelop. By 2010, only 80 percent of compensation was paid in cash. The "other benefits" component of Table 1 is almost completely attributable to employer contributions for their health benefit and retirement programs.

The information in Table 1 only hints at the important dynamics that have been playing out in recent decades. In order to dig deeper, we looked at what has been happening to full-time, full-year workers at various points in the earnings spectrum over the decades of the 1980s,

[2] Unpublished data from the Office of the Actuary, Social Security Administration based on data derived from the U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts* and the U.S. Department of Labor, Bureau of Labor Statistics, *Current Employment Statistics*.

1990s, and the first decade of the new millennium. When we developed the analysis, we only had data through 2009. We hope to update the analysis in the next couple of months to include 2010. We do not believe the story will change to any significant degree in adding another year.

Table 1: Shares of Compensation Paid in Designated Forms for Selected Years

	1950	1970	1990	2010
Cash pay	94.8%	89.4%	82.4%	80.1%
Employer contributions for				
Payroll taxes	2.2	3.9	6.2	6.0
Other benefits	3.0	6.8	11.4	13.9

Source: Developed from the U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts.*

Figure 1 shows the compound annual growth rates in inflation-adjusted average hourly pay rates across 10 comparably-sized pay groups—we call them deciles—from 1980 to 1990, 1990 to 2000, and 2000 to 2009 for full-time, full-year workers.[3] Splitting the workforce in this fashion allows us to assess how compensation and its various components grew or failed to do so at various points in the earnings spectrum and over time.[4] The results in Figure 1 make it clear that different segments of the workforce have had considerably different experiences in recent decades. Figure 1 helps to explain why some people feel they are being left behind.

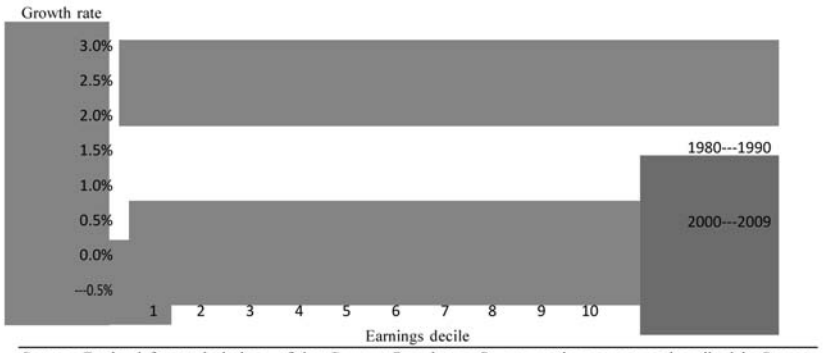
During the 1980s, there was negative wage growth for low earners, modest but flat growth across the middle-income segments and progressively higher growth across the top 30 percent of the distribution. This was a decade that started with a hard recession and the

[3] The first 9 deciles include 10 percent of the total workers being analyzed each year. The top decile includes only 9 percent of the workers because the Census Bureau does not release the income data for people in their *Current Population Survey* with incomes above a certain level. We needed the reported income data to estimate total compensation and the shares being spent on the non-wage components.

[4] The data in Table 1 run through 2010 but at the time we developed the analysis, the *Current Population Survey* data from the Census Bureau only gave us earnings data through 2009. That is the reason Figure 1 and subsequent figures only go through 2009.

elimination of many manufacturing jobs. During the decade, there was a realignment of economic activity as global competition intensified. This was the period when virtually all analyses of the pay and income dispersion phenomenon agree that the growth in rewards was disproportionately concentrated toward the upper end of the earnings spectrum. In the 1990s there was significant wage growth across all earnings categories—but wages still grew considerably more at the top income levels. During this period, many middle and upper-level managers in private firms were included in pay-for-performance plans and, with rapid economic growth during the mid to late-1990s, earners at the top of the distribution did disproportionately well. The rate of growth in pay clearly fell back during the 2000s and was not as flat across the earnings distribution as during the 1990s.

Figure 1: Compound Annual Growth Rates of Inflation-Adjusted Hourly Pay for Full-Time, Full-Year Workers by Earnings Decile and for Selected Periods

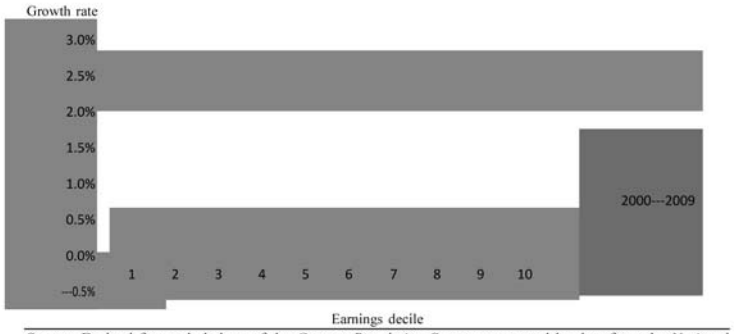


Source: Derived from tabulations of the *Current Population Survey*, various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

Figure 1 helps to explain why some segments of the workforce feel they are not doing as well as others but is incomplete. In Figure 2, employer costs for retirement plans, including

employers' plans and social insurance benefits, as well as for employers' health plans are added to cash pay. While wage growth in the 2000s fell short of that achieved during the 1990s, there was more compensation growth across most of the earnings spectrum in the early 2000s than in either of the prior two decades. Figure 2 suggests that workers across the earnings spectrum have benefited from added productivity in recent years at least in terms of what employers are paying them in reward for their work contributions. Those in the eighth earnings decile and above did somewhat better than those at lower levels, but generally workers did much better than the cash-only perspective suggests. If workers in middle and lower earnings levels feel they are not partaking of the rewards for their work contributions, given the results in Figure 2, it suggests they either do not understand the value of contributions made to benefit programs or simply do not value the benefits being provided by employers in relation to the cost of these programs.

Figure 2: Compound Annual Growth Rates of Inflation-Adjusted Hourly Compensation for Full-Time, Full-Year Workers by Earnings Decile and for Selected Periods



Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

One explanation for why workers might not appreciate the value of the contributions that employers are making to their benefit programs is that most of employers' contributions for payroll taxes and employee benefit programs are out of the line of sight of workers. Some employers give workers total compensation statements each year delineating the cost of benefits being provided but even that is not the same as providing a regular paystub with deductions indicating the costs of benefits. Without the line of sight, workers have little clue about the costs involved and thee effect on take-home pay. They may appreciate even less how their positioning in the earnings distribution affects the relative costs of benefits that employers are providing.

Payroll taxes and employer contributions tend to be a relatively comparable share of wages for workers across the bottom eight or nine earnings deciles and trail off somewhat at very high earnings levels because of the cap on earnings for the Social Security payroll tax and income-tax limits on what can be contributed to retirement plans for the highly compensated. Health insurance provided by employers tends to have a different cost structure across the earnings spectrum than other significant benefits. Consider, for example, where an employer is providing health insurance costing $10,000 per worker on average, of which only $2,500 is covered by direct employee contributions and the remaining $7,500 is a compensation cost that applies to each worker regardless of pay level. For the worker earning $20,000 per year, this benefit equals 37.5 percent of cash wages but for the $200,000 worker, it is only 3.75 percent of wages. If employers' health insurance costs are growing faster than workers' productivity, which they have been doing for the last several decades, and this is eroding wages, it will naturally have a much larger effect on low earners than high ones because health benefits make up so much more of lower earners' total compensation. Because of that, health benefits have the potential to make certain workers uneconomical in some cases.

When benefit costs grow more rapidly than the compensation budget, wage growth is reduced. The growing share of compensation diverted to benefits, shown in Table 2, explains some of the public consternation about what has been happening to disposable earnings. The sluggish growth in disposable income has been attributed to a variety of causes, including changing reward structures in the corporate world and tax policy as the focus of many commentaries. Those factors may have played some role in developments, but growing benefit costs were likely a much larger reason for the unsatisfactory results many people have had at the pay window in recent years. The underlying factors that have affected the non-wage components of compensation over the past three decades have not played themselves out, so these forces will have a continuing role in the future rewards picture.

Table 2: Share of Compensation Gains Provided in the Form of More Expensive Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods*

Earnings decile	1980-1990*	1990-2000	2000-2009
1	100.0%	30.4%	35.2%
2	100.0%	23.1%	47.7%
3	90.8%	25.0%	52.3%
4	54.1%	21.3%	60.8%
5	63.9%	17.8%	55.7%
6	43.0%	18.8%	55.3%
7	48.6%	12.4%	54.8%
8	36.8%	9.6%	50.3%
9	29.7%	7.8%	45.0%
10	21.4%	6.8%	37.7%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

*Total benefit cost increases in the 1980s for the first and second earnings decile exceeded 100 percent of compensation growth. In both cases, benefit costs increased significantly, but total compensation growth was in the negligible first decile and negative in the second.

Health Care Inflation and Workers' Pay

In the 1980s, increases in payroll tax rates arose as the 1977 and 1983 Social Security Amendments dealing with the financing problems of that era took effect. By the 1990s, those were relatively absorbed. Employer contributions for their retirement plans actually declined as a percentage of compensation over the 1980s and 1990s partly in response to regulatory changes but also because of the bullish financial market results we enjoyed in that period. In the early years of this century, employers have had to make significantly higher contributions to retirement plans and that is retarding wage growth. In every decade though, growing health costs have been a major factor in slowing the growth of dollars in the pay envelop.

Table 3 shows the share of increasing compensation that has been diverted to increased employer contributions for health benefit programs over each of the past three decades. Note that the share of compensation that was diverted to health benefits includes all full-time, full-year workers at each earnings level, including those who did not receive health benefits from their own employers.

For the workers actually covered by their own employers' health benefit plans, the implications were even more severe than the table suggests. Declining coverage, which has tended to be concentrated among lower-wage workers, actually mitigated some of the "crowding out" effect shown in Table 3 in recent years. But workers who lost employer-provided health insurance had to spend more out of pocket for their own health care consumption. It is a classic case of "damned if you do and damned if you don't."

Keep in mind that the primary purpose of this analysis was to explain how health care cost inflation undercuts the general rewards for broad groups of the workforce. However, rising health costs also affect employers' hiring decisions. In considering whether to keep or add a

worker, employers focus on the narrow question of what that worker will cost compared to the value he or she will bring to the organization. In economic terms, the marginal costs of workers in the various earnings deciles who actually take health insurance are quite different from the average costs of all workers in the deciles.

Table 3: Share of Compensation Gains Provided in the Form of More Expensive Health Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods*

Earnings decile	1980-1990*	1990-2000	2000-2009
1	100.0%	26.8%	23.6%
2	100.0%	20.8%	30.4%
3	100.0%	23.6%	30.1%
4	57.2%	21.0%	36.5%
5	74.4%	19.8%	28.9%
6	45.2%	22.5%	26.7%
7	55.5%	15.5%	25.8%
8	38.7%	12.1%	20.1%
9	21.4%	9.1%	15.0%
10	12.1%	2.9%	9.1%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

*Health benefit cost increases in the 1980s for the bottom three earnings deciles exceeded 100 percent of compensation growth.

As noted earlier, health insurance provided by employers tends to have a different cost structure across the earnings spectrum than other significant benefits. Health insurance benefits taken by the clerical person earning $8 per hour in a company creates a cost roughly equivalent to the benefit provided to a worker earning 10 or 20 times that amount or more. In this regard, employers' health benefits costs tend to be much more in the nature of fixed costs for the workers who participate in such plans. Because of that, health benefits have the potential to make certain workers uneconomical in some cases.

Table 4 shows how health benefit costs have risen relative to wages between 1980 and 2009 for workers who actually enrolled in the health benefit plans offered by their employers. In 1980, employers' costs for such workers were in single digits relative to wages for all decile groups except the lowest, with the median enrolled employee costing about six percent of pay. Over the next three decades, those costs have grown more than threefold relative to wages, reaching more than a third of individuals' wages among the lowest decile groups. In fact, for the lowest decile group, health costs have nearly eclipsed half of employees' take-home pay in 2009. What's more, these costs have been growing at a much faster pace for the lowest-paid workers, highlighting the greater impact of compounding on the lower-pay groups. For example, health benefit costs relative to wages for the second decile were twice those for workers in the ninth decile in 1980 and three times more by 2009. In short, the escalating cost of health care benefits may price low-wage workers out of labor markets.

Table 4: Health Benefit Costs as a Share of Wages for Full-Time, Full-Year Workers Receiving Health Care Benefits through Their Employer

	1980	1990	2000	2009
1	15.4%	30.9%	38.1%	49.5%
2	9.5%	18.7%	22.9%	30.9%
3	8.0%	15.3%	18.6%	25.5%
4	7.2%	13.3%	16.0%	22.3%
5	6.3%	11.6%	14.0%	19.4%
6	5.8%	9.9%	12.1%	16.8%
7	5.4%	9.2%	10.8%	14.8%
8	4.9%	8.2%	9.2%	12.5%
9	4.3%	6.9%	7.8%	10.2%
10	3.2%	4.9%	4.7%	6.3%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

The Past as Prologue

The future growth of compensation components that siphon rewards out of workers' paychecks will depend on a variety of factors. If the employer-based pension and retirement savings programs continue to operate at current levels, contributions to the systems should moderate considerably in the next four or five years once remaining unfunded pension liabilities are covered by added contributions required under the Pension Protection Act of 2006. What happens to the payroll tax will depend on how Social Security and Medicare financing shortfalls are addressed. If most of the underfinancing in these programs is addressed through higher tax rates, the adjustments of our retirement systems will make a further claim of workers compensation and dampen earnings growth. If much of the financing shortfall is addressed by increasing earnings subject to taxation, the effects will be concentrated at higher earnings levels. What happens to the payroll tax in coming years will be extremely important, but the real wild card in this deck is what happens to health costs. The implications will likely be quite significant.

The reason health care is such a wild card in the compensation and employment outlook is because no one really knows what the implications of health reform will be on health costs over the next decade or two. The last time the federal government intruded on the health financing system by introducing a major new national program was in the mid-1960s when Medicare was implemented. There was not much to go on then either in terms of estimating what costs would be under the program. In the decade prior to the adoption of the Medicare Part A (Hospital Insurance [HI]) program, hospital costs had been rising about three percentage points faster per year than covered wages.[5] The Advisory Council on Social Security Financing

[5] Robert J. Myers, actuary to the Committee on Ways and Means, "Actuarial cost estimates and summary of provisions of the Old-Age, Survivors and Disability Insurance Systems as modified by the Social Security Amendments of 1965 and actuarial cost estimates and summary of provisions of the Hospital Insurance and

met during 1963 and 1964 to consider these trends and determine what assumption to use in projecting the new HI program costs. The advisory council proposed assumptions for the initial projections: Hospital costs would rise 2.7 percent more than wages over the first five years of the program's operations, then trend down to the wage growth rate over the next five years and for all subsequent years.[6] As it turned out, over the first quarter century of the Medicare HI program's operations, the average covered wage subject to the payroll tax grew at an average compound rate of 6.2 percent per year, while average daily hospital costs rose at a compound rate of 11.9 percent per year. Over the last 10 years of that period—when it was "conservatively" assumed that hospital costs would grow at the same rate as wages—the growth rate in daily hospital costs was outpacing wage growth by 4.5 percentage points per year.[7]

A second major variable in determining actual HI cost rates was the hospital utilization rate. Estimated utilization rates were based on the 1957 Survey of Beneficiaries conducted by the Social Security Administration.[8] In making the projections, Robert Myers argued that utilization rates were most likely to conform to a "low-cost estimate," at least during the early years of the program, "to give recognition to the possibility of success of current efforts for progressive patient care, for reductions in hospitalization costs resulting from development of outpatient hospital diagnostic facilities and for progressive cost-reducing trends in medical practice."[9] In the final cost projections, the Ways and Means Committee of the House of

---

Supplementary Medical Insurance Systems as established by such act" (Committee on Ways and Means, House of Representatives, 89th Congress, First Session, July 1965).

[6] Ibid. p. 28.

[7] Average wages were calculated from the Average Wage Index series developed by the Office of the Actuary, Social Security Administration; average daily hospital charges and reimbursement rates were taken from the *Social Security Bulletin Annual Statistical Supplement, 1976,* p. 178, *Social Security Bulletin Annual Statistical Supplement, 1981*, p. 209, and *Social Security Bulletin Annual Statistical Supplement, 1993*, p. 311.

[8] Robert J. Myers, "Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965," Actuarial Study No. 59 (U.S. Department of Health, Education and Welfare, Social Security Administration, Division of the Actuary, January 1965), p. 7.

[9] Ibid, p. 8.

Representatives had Myers use higher utilization rates than those used for his original estimates. The increase in the early-year utilization assumption was about 20 percent under the more conservative assumptions. The use of the high-cost utilization rates in later years was considered a safety factor. As the program was implemented, over the first 17 years or so, utilization levels consistently ran some 20 percent higher than even the more conservative Ways and Means Committee assumptions. The estimates that had been repeatedly characterized as "conservative" turned out to be excessively optimistic.

In addition to higher than expected inflation and greater than expected utilization of services, the expanding protections offered through HI became a third contributing factor in cost inflation. In 1972, all those who had received disability benefits for 24 consecutive months under the Social Security Disability Insurance Program or the Railroad Retirement Program became eligible for coverage. At the same time, HI benefits were also made available to those younger than 65 with end-stage renal disease who were insured under Social Security or receiving an SSDI benefit. By 1975, the number of days of HI-covered care provided to this new group was approaching 10 percent of the elderly caseload. By 1983, the disabled and end-stage renal covered days of care under the HI program were 16 percent of the elderly caseload.

The underestimated costs for Medicare's HI program were not simply additive—they compounded each other. If reality had lived down to expectations, the cost of the HI program in 1990 would have been less than half of what it was. Health cost inflation stretched well beyond the financing of Medicare. It also affected the cost of health insurance benefits that employers were providing to workers.

It is interesting to juxtapose the expectations on the costs of implementing the Affordable Care Act with those that prevailed by prominent policymakers and analysts involved in the

development and implementation of Medicare several decades ago. Peter Orszag, former director of the Office of Management and Budget and a major architect of the Affordable Care Act, and Ezekiel Emanuel, special advisor to the White House and OMB during its development, have predicted that under the new law, total health expenditures in the United States in 2030 will be only 0.50 percent less as a share of GDP than under prior law.[10] Against a pre-reform estimate by the Congressional Budget Office that health care spending would rise from around 17.5 percent of GDP in 2009 to 29 percent of GDP in 2030,[11] an anticipated saving of 0.5 percent of GDP does not suggest substantial relief from excessive medical cost inflation.

Not everyone agrees with the assessment that the Affordable Care Act will operate as its architects suggest it will if fully implemented. Richard Foster, the chief actuary at the Centers for Medicare and Medicaid Services, estimated that the Affordable Care Act would actually increase total health care expenditures by 0.9 percent of GDP by 2019.[12] Tracking through Foster's analysis in the memo that includes the estimate that health expenditures will expand over the remainder of this decade under health reform, he estimated that expenditures under employer-sponsored health plans would climb from $847.0 billion in 2010 and $1,387.3 billion in 2019. Foster's projections of expenditures under employer-sponsored private health insurance suggests that the cost of health benefits in 2019 would be 3.7 percent lower under the reform measure than prior law.[13] Before concluding that this might be a sliver of sunshine in this story, we need to keep in mind that the base projection was that there would be 64 percent growth in employer plan costs so CMS projects that will fall to only 60 percent. Furthermore, even the

---

[10] Peter R. Orszag and Ezekiel J. Emanuel, "Health Care Reform and Cost Control," *New England Journal of Medicine* (June 16, 2010), found at: http://healthpolicyandreform.nejm.org/?p=3564.

[11] Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (2007), p. 13, found at: http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

[12] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act," as Amended (April 22, 2010), Table 5, found at: http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.

[13] Ibid.

actuaries at CMS believe there will be a slight decline in the number of workers covered under employer-sponsored health benefits by 2019.[14] In other words, if the CMS actuaries' estimates are correct, health reform will provide virtually no relief to the cost pressures that were expected under current law for those receiving benefits under these plans.

So what does this outlook and evidence and evidence supporting it suggest for our future? Major policy changes that expand insurance coverage of large segments of the population and that change financing incentives, payment mechanisms and the like will almost certainly affect health care pricing and utilization patterns. We ignore at our peril the possibility that the new health reform law will turn out to have a set of unanticipated costs similar to Medicare, especially when we consider that the new law's major proponents and architects admit we will have to re-engineer the delivery system to create the sort of cost savings they anticipate. Since health care insurance financing is such an important element of the compensation package the majority of workers receive, health reform will likely continue to play a central role in determining workers' employment and wage outcomes.

Looking Ahead

Employers' rising health costs can be offset by cutting other parts of the total compensation package. But workers' cash pay tends to be sticky downward—meaning that it is difficult to reduce pay without causing disruptions among their workforces that most employers try to avoid. If employers are forced to absorb health cost increases that exceed the added productivity that workers bring to the table, they will stop hiring.

No one knows for certain what the implications of the Affordable Care Act, might be for U.S. workers in terms of their future health costs—or even how they will acquire their health

[14] Ibid., based on a data from Table 5 of the analysis.

insurance coverage in the coming years. Our analysis makes clear, however, that, if we cannot bring excessive health care inflation under control, wages will continue to stagnate, and low-wage workers will find it harder to find work. We must recognize the possible risk that we could exacerbate an already troubling situation.

A full-time worker in the second earnings decile in 2009 earned around $25,000 in total compensation on average. If his or her productivity goes up by the rate of growth Social Security actuaries estimate, by 2019 this worker will be earning around $36,600 in total compensation. But here's the rub: nearly 75 percent of the gain will have been consumed by rising health benefit costs. If the worker has family coverage, the cost of health benefits will grow to consume more than his or her added productivity improvement over the period.

Let's assume that future health costs grow at the rate they have been growing since 2000. In keeping with assumptions by the Congressional Budget Office and the Obama Administration that employers will not cut back their coverage under health reform, let's further assume that current health insurance coverage and take-up rates persist. Table 5 projects the results: Health benefits will cut even more deeply into compensation than over the past couple of decades. If employer-provided health insurance coverage expands because of the mandates under health reform, or if inflation rises because of added demand for services or any other reason, the outcome could be even worse than Table 5 suggests. The reason for this conclusion is that we are now starting from a much larger base of health costs under these benefit plans than we had 20 or 30 years ago. In 1980, employer contributions for health benefit plans were only 3.8 percent of total compensation paid to workers. By 2010, they had risen to 9.0 percent. Excessive health inflation that we have been experiencing and may well experience in the future now applies to a much larger share of compensation than it has in the past.

Table 5: Share of Compensation Gains Provided in the Form of More Expensive Health Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods Where Health Cost Inflation Persists at Current Rates and Coverage and Take-Up Rates Remain at Current Levels

Earnings decile	Projection periods		
	2009 to 2015	2015 to 2030	2009 to 2030
All	24.9%	35.0%	32.4%
1	39.1%	54.9%	50.9%
2	38.4%	54.0%	50.1%
3	38.5%	54.2%	50.2%
4	38.3%	53.9%	49.9%
5	35.1%	49.3%	45.7%
6	33.1%	46.6%	43.2%
7	29.9%	42.0%	38.9%
8	26.2%	36.9%	34.2%
9	21.8%	30.7%	28.5%
10	13.9%	19.5%	18.0%

Source: Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

For workers participating in their employer plans, the cost issues are much worse than the averages for all workers suggest. For those in their employers' health benefit plans in 1980, the employers' costs of providing them health benefits was equivalent to 7 percent of their wages but this rose to 21 percent in 2009. For workers in the second decile with coverage, the cost of health benefits being taken rose from just under 10 percent of their pay in 1980 to 31 percent in 2009. The implications of excessive health inflation become stark for such workers.

Consider the case of a worker whose productivity warrants a compensation level of $30,000 per year. Ignoring the effects of potential increases in payroll taxes to address Social Security and Medicare funding issues and other unanticipated factors, assume that this worker is receiving $10,000 in the form of health benefits because he or she has family coverage under the

employer's plan. If this worker's productivity increases 1.5 percent next year, it would warrant an increase of $450 in compensation. If health benefit costs go up by 4.5 percent next year, then all of this worker's productivity reward would be scalped off to cover the higher health benefit costs. Among workers with health insurance coverage, the cost of these benefits has been increasing about 3 percentage points faster per year in recent years than productivity improvement rates.

This ugly arithmetic suggests that employers cannot offer such workers both health benefits and growing wages, and hope to remain competitive in a global economy. The employer mandate to provide health insurance coverage may be an admirable goal from the sole perspective of getting more people health insurance but it has the potential to create a straightjacket for employers continuing to offer health benefits in regard to being able to economically afford to hire lower-wage workers. The only safety valve that employers with predominantly lower-wage workers may have is simply to abandon offering health insurance because the federal subsidies for workers who acquire insurance in exchanges under the Affordable Care Act rather than from their employers could dramatically change the economics of health care. While some policy analysts believe that most employers will stay in the game of offering health benefits to their workers, the analysis presented here leads me to conclude that many employers, particularly in low-wage industries, will likely eliminate their plans and let workers fend for themselves in the new exchanges because the economics employing low earners simply doesn't work at current cost and inflation levels.

At the margin, shifting an ever larger share of low earners into publicly subsidized health care insurance programs might seem desirable but we cannot avoid the reality of a national health care marketplace. The mere shifting of health insurance costs -- from employers'

compensation packages to a mix of public subsidy and workers' contributions out of their disposable wages -- will not reduce national health care spending unless we bring medical inflation under control. If health reform is not expected to bend down the curve of health cost growth, who is going to pay the bill?

20

Chairman HERGER. Thank you.
Mr. Shaw is recognized for 5 minutes.

STATEMENT OF THOMAS J. SHAW, PRESIDENT, BARTON MUTUAL INSURANCE COMPANY

Mr. SHAW. Good morning, and thank you, Chairman Herger and Ranking Member Stark, and members of the Ways and Means Sub-

committee on Health, for the opportunity to testify today on the important topic of the employer mandate and the impact it will have on our business.

Barton Mutual Insurance Company, located in Liberal, Missouri, is a single-state property casualty insurer. Our company was founded in 1894 to provide fire insurance to farmers in our county. We now provide insurance products for a wide variety of risks, including commercial risks. We employ 58 people full time and have furnished health insurance for decades. I have been employed as the CEO since 1986.

As health insurance costs rose, we adjusted accordingly and explored different options. First we raised deductibles. We examined self-insurance and purchasing reinsurance but determined that was unfeasible. When high deductible health plans were created, we jumped at the opportunity to place our employees in control of directing their medical care consumption. The practice of putting money in their HSAs, the health savings accounts, led them to seek out more affordable prescriptions and carefully plan and manage their doctors' visits. Within 60 days, the anecdotal evidence of savings buzzed around our office. Our employees enjoy the coverage and responsibility and believe it makes them better consumers of health care.

Our annual costs today are about $7,394 per employee. We do not have a very healthy group. Last year, our costs increased by 7.3 percent. If we continue to incur the same increase, 7.3 percent a year, when mandated coverage takes effect in 2014, our costs will be approximately $8,513 per employee. Costs and premiums continue to rise since the passage of the law with no relief in sight. In addition to the mandated coverage, there is the essential health benefits package and a tax on fully insured health plans that will increase the cost of insurance. Further, the lengthy regulatory process makes planning and forecasting costs even more difficult.

The Patient Protection and Affordable Care Act promised lower costs and expanded coverage for all. We were told we could keep our current plan. Instead, the employer mandate forces employers with 50 or more full-time employees to provide expensive government-prescribed health insurance or pay a fine. We have witnessed higher costs and it is nearly a given we will drop our group HDHD plan and pay the $2,000 penalty per employee. The incentives are lined up in a manner that makes it nearly impossible to maintain coverage.

This law does not fix any problems for small businesses of our size, those employers above the 50 full-time employee threshold, and the law makes it extremely unattractive for a smaller business to grow above the threshold. Although the savings from dropping would allow us to increase payroll to some extent, cost pressures on all fronts will lead us to hold those savings to tamp down overhead in what is a mature, competitive industry. The full savings will not go completely into taxable wages. We strive to meet market rates for salaries today, and savings garnered in any area of operations will go toward maintaining a viable business. We need to look for savings wherever we can find them.

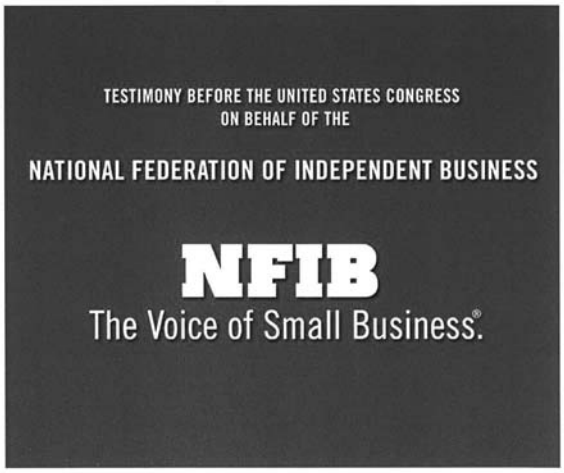
The new law is not helping my business. We worked for decades to provide good coverage for our employees and continue to work

on doing so. However, there is little incentive to continue to provide coverage. For employers, there will be fewer choices of insurance products and self insurance underwriting will essentially be eliminated. Consumers will have fewer choices to make, which means decisions will be made from the top down. This is exactly the opposite of increasing choices and flexibility that could help small businesses continue to provide affordable coverage.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Shaw follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:00 AM
THURSDAY, MARCH 29, 2012***



Testimony of Thomas J. Shaw, Barton Mutual Insurance Company

U.S. House Committee on Ways and Means
Subcommittee on Health

"Individual and Employer Mandates in the Democrats'
Health Care Law"

March 29, 2012

Good morning and thank you Chairman Herger, Ranking Member Stark, and Members of the Ways and Means Subcommittee on Health for the opportunity to testify today on the important topic of the employer mandate and the impact it will have on our business. Barton Mutual Insurance Company, located in Liberal, Missouri, is a single state property-casualty insurer (non-auto). Our company was founded in 1894 to provide fire insurance to farmers in our county. We now provide insurance products for a wide variety of risks including commercial. We employ 58 people full-time and have furnished health insurance for decades. I have been employed as the CEO since 1986.

As health insurance costs rose, we adjusted accordingly and explored different options. First, we raised deductibles. We examined self-insurance and purchasing re-insurance, but determined this was unfeasible. When High Deductible Health Plans (H.D.H.P) were created, we jumped at the opportunity to place our employees in control of directing their medical care consumption. The practice of our putting money into their health savings account (H.S.A.) led them to seek out more affordable prescriptions, and carefully plan and manage doctor visits. Within 60 days, the anecdotal evidence of savings buzzed around the office. Our employees enjoy the coverage and responsibility, and believe it makes them better consumers of health care.

We partner with our employees in managing this financing. For the first time, this year, Barton pays 95% of the employee's cost. In the past we had always paid 100%. The employee may purchase family coverage, or they can waive coverage and elect to go to a spouse's plan and we will contribute 50% of their spouse's deductible via health reimbursement account (H.R.A.). The employee deductible is $2,500 and Barton contributes $1,250 to the H.S.A.

Our annual costs today are $7,394 per employee. Last year, our costs increased by 7.3% (73.9% in increased costs since 2008). If we continue to incur the same increase, 7.3% per year, when mandated coverage takes effect in 2014, our costs will be $8,513 per employee. Costs and premiums continue to rise since the passage of the law with no relief in sight. In addition to the mandated coverage, there is the essential health benefits

package and a tax on fully insured health plans that will increase the cost of insurance. Further, the lengthy regulatory process makes planning and forecasting costs even more difficult.

The Patient Protection and Affordable Care Act (P.P.A.C.A.) promised lower costs and expanded coverage for all. Instead, the employer mandate forces employers with 50 or more full-time equivalent employees to provide expensive, "qualified" health insurance or pay an annual $2,000 fine per employee (minus the first 30 employees). We have witnessed higher costs and it's nearly a given we will drop our group H.D.H.P. and pay the per employee penalty. The incentives are lined up in a manner that makes it nearly impossible to maintain coverage. This law does not fix any problems for small businesses of our size – those employers just above the 50 full-time employee threshold, and the law makes it extremely unattractive for a smaller business to grow above the threshold.

Though the savings from dropping coverage would allow us to increase payroll to some extent, cost pressures on all fronts will lead us to hold those savings to tamp down overhead in what is a mature competitive industry. The full savings will not go completely into taxable wages. We strive to meet market rates for salaries today, and savings garnered in any area of operations will go toward remaining a viable business. We need to look for savings wherever we can find them.

The new law is not helping my business. We worked for decades to provide good coverage to our employees and continue to work on doing so annually. However, there is little incentive to continue to provide coverage. For employers, there will be fewer choices of insurance products since health insurance underwriting will essentially be eliminated. Consumers will have fewer choices to make, which means decisions will be made top-down. This is exactly the opposite of increasing choices and flexibility that could help small businesses like ours continue to provide affordable coverage.

Chairman HERGER. Thank you.
Mr. LaMontagne, you are recognized.

STATEMENT OF STEPHEN LAMONTAGNE, PRESIDENT AND CEO, GEORGETOWN CUPCAKE, INC.

Mr. LAMONTAGNE. Mr. Chairman, Ranking Member Stark, and Members of the Committee, thank you for the invitation to appear before you today to discuss the implications of the Affordable Care Act on small and large employers.

My remarks represent the views of Georgetown Cupcake and its owners. They are not necessarily representative of the views of the small business community as a whole. We are not economists. We are not constitutional scholars. We are business people, and my hope is that we can provide some insight into how some businesses

think about health benefits as a component of employee compensation.

Georgetown Cupcake was founded in 2008 by my wife Sophie and her sister Katherine and over the course of the past 4 years, in a challenging economic climate, we have grown from one location to now three locations, in Washington, D.C., Bethesda, Maryland, and most recently New York City. We have launched a national shipping operation, and have two other planned locations coming online this year in Boston and Los Angeles.

Also during this time, we have grown from a staff of two to a staff of well over 350 employees, including about 100 full-time employees. So all this to say in a very short time we have experienced every stage in the maturation process of a business, from being a start-up to a small business to now a growing business that is continuing to evolve and innovate.

As business owners, we strive to be a world class employer. And in a highly competitive environment, we believe it is necessary to offer a well rounded compensation package that includes competitive wages and salaries, paid vacation and sick leave, opportunities for growth within the company, a positive organizational culture, and affordable health insurance coverage. We believe that health insurance coverage is a necessary component of a well rounded compensation package not only because it enables us to attract and retain the very best employees, not only because it helps us to remain competitive, but also because we believe it is the right thing to do.

We offer our staff, our full-time employees, a menu of coverage options through a major national insurance provider and pay 75 percent of the monthly premium. Nearly all of our full-time employees have enrolled in Georgetown Cupcake's plan or are covered by the plans of their spouses or parents. Of the employees who have enrolled in our plan, nearly all have chosen coverage that features in network services, a zero deductible, free well childcare, free physical examinations, mammograms, cancer screenings and other procedures, low copays for doctor's visits, free emergency room care and inpatient hospital services with no maximum lifetime benefit. We are proud to be able to extend this comprehensive coverage to our employees. And as a result, many of our full-time employees have been with the company since inception.

Under certain provisions of the Affordable Care Act that come into effect in 2014, large employers, defined as those with over 50 full-time employees, or full-time equivalents, we are counted in that group, face potential penalties if they fail to provide affordable health insurance coverage to their full-time staff. Some studies have asserted that large employers will elect to drop health insurance coverage altogether because in certain cases the cost of the penalties may be less than the cost of providing coverage. I believe that these studies make oversimplified assumptions about the decision making processes of small and large businesses. In our case, we will continue to provide an option for our employees to obtain access to affordable, high-quality care even if it results in modest additional cost to us.

Time will tell what the true impact of the Affordable Care Act will be on total enrollment in employer-sponsored health insurance

plans. We certainly applaud the intent of the legislation to reduce the overall number of uninsured Americans and to lower the cost of health care without sacrificing quality of care, and we believe that all of the options on the table are worth considering, including health insurance exchanges designed to give consumers more educated choices about their own coverage. Yet it is difficult to predict how quickly these exchanges will be created, how effectively they will be administered, how transparent they will be to consumers, and how quickly consumers might transition to them. In theory, if they can alleviate upward pressure on the cost of insurance premiums while ensuring the same access to care and quality of care, and if employers are allowed to participate, then I think they could be a win/win for all involved. However, we will have to wait and see how this and other aspects of the legislation are implemented before being able to fully assess the costs and benefits relative to existing options for employer-sponsored coverage.

In summary, we believe that being a world class employer means providing an option for affordable health insurance coverage for your staff. We support the goal of reducing the number of uninsured Americans, and we believe that employer-sponsored coverage has been and will continue to be one important component of a multi-pronged strategy to address what is a multi-dimensional challenge of expanding coverage while controlling costs. Above all we believe that most employers, including and especially Georgetown Cupcake, want to do the right thing and want to be part of the solution, whatever that may be.

Thank you.

[The prepared statement of Mr. LaMontagne follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012

Mr. Chairman, Members of the Committee,

It is an honor to appear before you today to discuss the implications of the Affordable Care Act on small and large employers. Although my remarks represent the views of Georgetown Cupcake and its owners, and should therefore not be misinterpreted as the views of the business community as a whole, my hope is that they will provide some insight into how some businesses think about health benefits as a component of employee compensation.

Georgetown Cupcake was founded by my wife, Sophie, and her sister, Katherine, over four years ago, and first opened its doors to the public on Valentine's Day 2008. Over the course of the past four years, and during the most challenging economic climate of our generation, Georgetown Cupcake has grown from one location, to now three retail locations including our flagship in Georgetown, a second location in Bethesda, MD, and most recently a third location in the SoHo neighborhood of New York City. In addition, we launched our nationwide shipping operation in 2010 and new locations are planned in Boston and Los Angeles in the spring and fall of 2012. During this time, we have also grown from a staff of two, to a staff of now well over 350 employees, including over 100 full time employees. We have experienced every stage in the maturation process of a business, from being a start-up, to a small business, to now a growing business that continues to evolve and innovate.

As business owners, we strive to be a world-class employer. In a highly competitive environment, it is therefore necessary to offer a well-rounded compensation package that includes competitive wages and salaries, paid vacation and sick leave, opportunities for merit-based bonuses and promotions, an organizational culture based on positive values, and affordable health insurance coverage. We believe that affordable health insurance is a NECESSARY component of a well-rounded compensation package; not only does it enable us to attract and retain the best employees; not only does it help us to remain competitive, but also it is the right thing to do.

Georgetown Cupcake offers its full time employees a menu of coverage options through a major national insurance provider and pays 75% of the monthly premiums. Nearly all of our full time employees have enrolled in Georgetown Cupcake's plan or are covered by the plans of their spouses or parents. Of the employees who have enrolled in Georgetown Cupcake's plan, nearly all have chosen coverage that features, for in-network services, a zero deductible; free well-child care, physical examinations, mammograms, and cancer screenings; low co-pays for doctor's visits; free emergency care and inpatient hospital services; and no maximum lifetime benefit. Vision benefits are also available. We are proud to be able to extend such comprehensive benefits to our employees, and as a result many of our full-time employees have been with the company for several years.

Under certain provisions of the Affordable Care Act that come into effect in 2014, large employers, defined as those with more than 50 full time and full time equivalent employees, face potential penalties if they fail to provide affordable health insurance coverage to full time staff. Some studies assert that large employers will elect to drop health insurance coverage altogether because, in certain cases, the cost of the penalties may be less than the cost of providing insurance. These studies make over-simplified assumptions about the decision making processes of small and large businesses. In the case of Georgetown Cupcake, we will continue to provide an option for our employees to obtain access to affordable, high quality care, even if it results in modest additional cost.

The true impact of the Affordable Care Act on total enrollment in employer-sponsored health insurance plans is, at best, uncertain. We applaud the intent of the legislation, to reduce the overall number of uninsured Americans and to lower the cost of healthcare without sacrificing quality of care. All of the options on the table are worth considering, including health insurance exchanges designed to help consumers make educated choices about their own coverage. Yet, it is difficult to predict how quickly insurance exchanges will be created, how effectively they will

be administered, how transparent they will be to consumers, and how quickly consumers might transition to them. In theory, if health insurance exchanges can alleviate upward pressure on the cost of insurance premiums while ensuring the same access to care and quality of care, and if employers are allowed to participate, then they would constitute a win-win for all involved. However, businesses will have to wait and see how this and other aspects of the legislation are implemented before being able to fully assess the costs and benefits relative to existing options for employer-sponsored coverage.

In summary, Georgetown Cupcake believes that being a world class employer means providing an option for affordable health insurance. We support the goal of reducing the number of uninsured Americans and believe that employer-sponsored coverage has been, and will continue to be, one important component of a multi-pronged strategy to address the multi-dimensional challenge of expanding coverage while controlling costs. Above all, we believe that most employers, especially Georgetown Cupcake, want to be part of the solution, whatever that may be.

Thank you, and I look forward to your questions.

Chairman HERGER. Thank you.

Ms. Furchtgott-Roth, the Democrats' health care law mandates that if you are an employer with at least 50 full-time equivalent employees, you must pay for government prescribed health care or pay a $2,000 per employee fine. Can you give some reasons why some employers today might not believe they can afford to offer health care to their employees?

Ms. FURCHTGOTT-ROTH. Health care is going to be more expensive because of the qualified benefit plan. Plans such as catastrophic health care where you can have a health savings account to pay for routine expenditures, and then have health care to cover major expenditures such as getting cancer or falling off your bicycle in traffic, those won't be allowed anymore because they don't meet with the qualified benefit plan.

So employers of low-wage workers are going to find that it adds a lot to compensation. They are going to substitute with other kinds of capital. We already see this happening in CVS with self-scanning checkout counters, and other supermarkets. We see many food trucks, for example, around the streets. This saves them the cost of wages for services because people line up to purchase the food. I have seen several cupcake trucks. I don't know if it is

Georgetown Cupcake. There are many of these cupcake trucks, also.

So the incentive will be not to provide health care for low-wage workers, to, in fact, drop these low-wage workers altogether because of the penalty. For higher wage workers, the employer can take it out of the salary and so we would expect to see a lower take-home wage and paying the penalty. But the burden is going to fall on low wage, low skilled workers.

Chairman HERGER. Thank you. Republicans on this committee have long warned that the employer mandate will encourage employers to drop the current health insurance plan people have and like, is simple math. If an employer is currently paying more for health care coverage for its employees than it would pay in mandate penalties, it has an incentive to drop coverage to both save money and remain competitive. In fact, the nonpartisan Congressional Budget Office predicts that 3 to 5 million Americans will lose their current employer-sponsored health insurance.

Mr. Shaw, I read in your testimony that you have already made these calculations. How much do you expect your company to save by dropping health insurance coverage in 2014?

Mr. SHAW. That is difficult to say since we don't know what the mandated cost for the group insurance is going to be. But if our situation is any indication, where we are not a very healthy group, we are paying $8,500 per employee now, it is going to be a lot cheaper to pay the $2,000 penalty plus the lower wage penalty that comes along with it. The math is so simple, why would we continue the group health. We know our employees can be taken care of because the government says they have to buy it at this point. They are going to find a way through the exchanges to get health insurance. The employer does not need to be in the middle of all of that and, with the extra expense, pay the penalty.

Chairman HERGER. So does the difference between the $2,000 and the $8,500 you are paying per employee, multiplying that out, would be the difference, particularly in a competitive market?

Mr. SHAW. Approximately $300,000, I think. That wouldn't all be savings because I am sure we would do adjustments to payroll or somehow to make up some difference for the employee to go out and get their own health insurance. We would try to make those adjustments. But not fully, I don't anticipate.

Chairman HERGER. So the ObamaCare actually encourages employers to drop health insurance?

Mr. SHAW. It looks that way to me.

Chairman HERGER. Mr. Schieber, you make the point that as a practical matter, employers cannot hire or retain workers whose total compensation rises faster than their productivity. You estimated that if workers enrolled in mandated employer health plans, the rise in employer premiums would absorb more than 100 percent of the productivity gained for the bottom quarter of wage earners between now and 2030. You add "the likely result will be fewer jobs or lower pay." Who is likely to be the most impacted by this loss of jobs, management or entry level workers?

Mr. SCHIEBER.Well, it is going to be the entry level workers. If you think about somebody who is earning $20,000 or $25,000 a year, and their productivity is going up a little over 1 percent a

year, that is what the Social Security actuaries estimate is the average in the economy, next year their added contribution to companies is around $250. If they have family coverage, if they are covered under this plan we just heard about, $8,000, $9,000, and the cost of that is going up about 5 percent a year because of this excessive health inflation, well, the cost of providing them health insurance then is going up at $500 a year, but they are only bringing in an added $250 to the table to pay for that. So the problem is that we live in a market-based economy. These companies have to cover the cost of their workers or they go out of business. And so, you know, sometimes they call economics the dismal science, and probably for a reason, but it does try to pay attention to the laws of arithmetic, not just the laws that Congress introduces.

Chairman HERGER. Thank you. Mr. Stark is recognized.

Mr. STARK. Thank you, Mr. Chairman. I thank the panel.

Mr. LaMontagne, the critics of the Affordable Care Act have suggested that the increased cost of compensation by providing health care would impose a financial burden to employers and force them to cut staff and wages and stop giving pay raises. I presume that if you are in the franchise business, it doesn't make any difference. If you have got a Burger King here and you have one two blocks away and the minimum wage goes up, neither Burger King store has an advantage, right? They each raise the price of a hamburger to cover it or swallow it if they choose. But competitively when you are making a standard product it doesn't make a lot of difference. You may not like it, but it doesn't.

Would employers have to cut staff and wages if there was an increase in compensation costs? What would be your first reaction? Stop putting frosting on your doughnuts?

Mr. LAMONTAGNE. I can only speak for our business.

Mr. STARK. You are the only person running a business, so I have to take your word for it.

Mr. LAMONTAGNE. If there were an increase in compensation, either directly through an increase in the Federal or State minimum wage, or indirectly through an increase in the cost of total compensation to an employee, including health insurance coverage, in our case we would not reduce staffing levels because we staff based on the level of people that we need to run our operation smoothly. If we had to take people out, the cost to us in terms of inefficiency and loss of operational smoothness, if you will, would be greater than the savings that you would realize just by cutting one or two or three staff.

Mr. STARK. Would your tendency be for small increases or decreases in your, "production" to either cut back hours for everybody a few hours or go to overtime if you had to go the other way rather than hire and train new workers every time there was a minor change in your production?

Mr. LAMONTAGNE. I think Mr. Shaw made a great point, which is businesses face cost creep from all sides, not just labor costs, not just health insurance costs, but from every direction. We look at our budgets as a whole, and we have to make decisions on how to streamline looking at them as a whole.

Again, in our case, we would not cut hours or shift to more of a part-time labor force because we are a growing business and we

are investing in our employees because we want to promote people from within so that they can grow with the company. And you don't send a message to your staff that you want them to grow with you by transitioning to an all part-time work force.

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

Chairman HERGER. Thank you. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. And thank you for your testimony today. In almost every health care hearing and Ways and Means hearing on health care, I have mentioned a list of things that have sort of been coming to light as we discuss this health care law further. And one of the things that the previous Speaker, Nancy Pelosi, said is we have got to pass this bill first to find out what is in it. And of course, that is what we are doing right now. We are finding out what is in it. And some of these things are very harmful to small businesses.

We discovered that the 1099 requirement was very harmful to small businesses. The Democrats and Republicans together finally agreed with that, and it was repealed. The CLASS Act has been repealed. We discovered that we don't have the money to implement that plan. And Mr. Shaw, you mentioned in your testimony that you were frustrated because the promise was you could keep your health care if you liked to keep your health care, but I am not sure if you knew that the President himself said at an event that I happened to be at that when he was asked the question about whether or not this promise was really included in the law, he said, well, there might have been some language snuck into the health care law that runs contrary to that premise. So I wonder what else runs contrary to a promise, promises that were made about this bill, and we are finding out more and more and more what is running contrary.

So I am interested in a couple of things here. So Mr. Schieber, with the employer mandate, would revenues of a business increase with the employer mandate?

Mr. SCHIEBER. The revenues of some health care providers might increase because there could be substantially increased demand for health care services. I don't know why Walmart's revenues would increase or IBM's revenues would increase.

Mr. REICHERT. Will the employer mandate improve a business' profit margin?

Mr. SCHIEBER. Well, it depends a little bit. We just heard here, there might be a situation arise, and I actually believe there might be a lot of them, where companies go through a calculation where they can put some of their cost to the government. And so they could conceivably become more efficient, but that means that the government is going to face a higher cost than maybe are being anticipated for this bill.

Mr. REICHERT. Where will businesses then find the money, though, to provide this health care coverage if there is additional cost, and they have this threat of $2,000 penalty and there is a $3,000 penalty if the health care offered is unaffordable.

Mr. SCHIEBER. Well, the fact of the matter is that employers do evaluate whether or not workers are covering the cost that it takes to hire them. And if you paid attention to what has been

going on in our economy in recent years, if you go to a grocery store today or you go to almost any kind of retail outlet today, they have now got these automated checkout lines where you scan your own stuff. What they are trying to do is they are trying to save money on labor costs, because those workers are no longer bringing in additional revenue that is recovering their costs. They are trying to get more efficient because we are operating in an extremely competitive world. If you go into any office building in almost any city this year that is being cleaned in the evening, it used to be that part of the staff of the company that operated that office cleaned that building. That is no longer the case. That has all been subbed out because those people are getting much lower pay. They are getting much lower benefits than the people that actually work in the office. There is a variety of ways that this takes effect. And I believe that the high unemployment rate that is concentrated in people without skills, people just coming out of school, people without training, people at very low wages is partly because some of these overburdened costs, or actually underburdened, you can't see them. Most people don't see them, but they are there and when you are doing your budget you have to cover them.

Mr. REICHERT. Right.

Mr. SCHIEBER. And I think that is why we have got a lot of the persistent unemployment rate at the lower end today that we do.

Mr. REICHERT. I appreciate your answer, and thank you for your time, and I yield back.

Chairman HERGER. Thank you. The gentleman from Washington is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Mr. LaMontagne, it may be just my experience, but we also have a cupcake company in Washington in Seattle, Cupcake Royale. The woman who runs it has been back here and testified, and testified before committees in Congress. We also have a woman named Molly Moon. She runs a little ice cream operation. They give health care benefits to all of their people, just like the women who started your company give health care benefits to their people. Now, I think that must be because they think that there is some inherent value in it, that it is the right thing to do. And what I find difficult is to listen to the CEO of an insurance company say, well, if I could pay a penalty and pay less, I would throw my employees off the plan and put them into the exchange. And I would like to hear your own thinking about whether you would go to your employees in the cupcake company and say, it is cheaper for us, so we are not going to cover you anymore. Go down to the exchange and buy your insurance, and we will pay the penalty.

Now, tell me how you think about that. Because I think this is a straw man that is put up here. We can't keep our coverage. What it means is that the management of companies will take it away from their employees by saying we are not going to pay any more, and it is not that there is anything in the law that says it can't be done. So I would like to hear you talk about how you think about your employees and whether you would rather involve yourself in their coverage or send them down the street to the exchange.

Mr. LAMONTAGNE. As I mentioned previously, we believe that in the system that we have now health insurance coverage is a necessary component of a well-rounded compensation package. And it is something that as we grew from a small startup into a company that approached 30, 40, 50, full-time workers, our full-time staff asked us for it because it mattered to them. It is something that they wanted. And we thought that in order to make sure that we could keep them on board, again we are a growing company, we are making an investment in our staff. We want them to internalize our processes and procedures, and make a greater contribution in the future. We felt that it was necessary and certainly the right thing to do to add that to our total compensation package.

Mr. MCDERMOTT. Was there anything besides staff morale involved in that decision? I mean, did you make any other kind of—was there any other level of decision-making that went into that?

Mr. LAMONTAGNE. Certainly, staff morale and responsiveness was one element that went into the calculation. I think in a competitive environment, where other employers are offering health insurance as a part of their compensation packages, in order for us to remain competitive it is necessary to add that option as well. And also we personally believed that once we got to that stage in our growth, that it was the right thing to do to add coverage, and——

Mr. MCDERMOTT. Do you think you would have lost any of them if you did not respond to that request?

Mr. LAMONTAGNE. Yes, I think we would have.

Mr. MCDERMOTT. The best people.

Mr. LAMONTAGNE. And we would have lost some very good people.

Mr. MCDERMOTT. That is the experience of a lot of small businesses. My son did a startup in the high-tech industry, and he said, Dad, we had to give benefits or we couldn't recruit anybody to our company, because if we didn't have a benefit package people wouldn't come. So it seems to me if you want the best people you have to have a benefit package, right?

Mr. LAMONTAGNE. In the system that we have today, I believe that it is necessary, yes.

Mr. MCDERMOTT. Are you familiar with anything in Hawaii? I mean, Hawaii has the system where every employer who has a full-time employee has to give benefits, right? Do you know about that?

Mr. LAMONTAGNE. I am not familiar with the Hawaii——

Mr. MCDERMOTT. It is true. And the question I have is, for anybody on the panel is, why does it work in Hawaii and it doesn't work here? Why would it not work in the United States on the continent when it works out in the island? How do they do that? I mean, is Hawaii so depressed or they have no business, or what is going on?

Ms. FURCHTGOTT-ROTH. Well, I would be glad to answer that.

Mr. MCDERMOTT. Sure. I would like to hear you.

Ms. FURCHTGOTT-ROTH. So they take it out of the total well, it is part of the total compensation package. So the cost of health insurance comes at the expense of more take-home wages. So an

employer provides the compensation package. It consists of health insurance, vacation, sick leave, and also a cash wage.

Mr. MCDERMOTT. But no businesses are failing because of this, right?

Ms. FURCHTGOTT-ROTH. What they are doing is providing——

Mr. MCDERMOTT. Are businesses failing in Hawaii because they have to give health care?

Ms. FURCHTGOTT-ROTH. I do not know the answer to that, but I know they are providing a lower cash wage than they would have otherwise if they did not have to provide the health insurance.

Chairman HERGER. The gentleman's time is expired. Dr. Price is recognized.

Mr. PRICE. Thank you so much, and I want to thank the panel. This has been very interesting because I think that the unintended, or maybe intended consequences of this law, are significant, especially in the employer/employee relationship. Mr. LaMontagne, I want to applaud you for providing health coverage for our employees. We did in my practice when I was in the private sector. My understanding is you have three different options available for your employees, is that right?

Mr. LAMONTAGNE. Yes, that is correct.

Mr. PRICE. And what are those?

Mr. LAMONTAGNE. One is the option that I described in my statement which is the one that nearly all of our staff had enrolled in, which is a very comprehensive level of coverage for in-network services, and then, you know, small copays for out-of-network services. And then the second option is a slightly higher expense for out-of-network services, but generally the same level of coverage for in-network services.

Mr. PRICE. Right.

Mr. LAMONTAGNE. And then the third option that we had was one that involved health savings account option, which as it turns out was not one of the options that any of our staff selected. They opted for the most comprehensive coverage available.

Mr. PRICE. So the choices that you put in place for your employees, however, were the ones that you selected, not that somebody else selected?

Mr. LAMONTAGNE. I mean, these are choices that we met with a broker for the national insurance provider. We had a dialogue with our staff about what they were looking for, and——

Mr. PRICE. But you selected it.

Mr. LAMONTAGNE. Yes.

Mr. PRICE. And in 2014, the bill will stipulate that you have got to pick. You don't get to pick. In fact, you have got to comply with what Washington tells you to comply with. Do you think that is fair? What if it is not what you want?

Mr. LAMONTAGNE. I mean, in looking at the options that we have and how the legislation defines minimum essential coverage and affordable care, I think what we have available would satisfy those criteria.

Mr. PRICE. What if it doesn't? What if they dictate something else to you? Is that fair?

Mr. LAMONTAGNE. As long as we can provide coverage to our staff, and if employer-sponsored coverage is part of the system that will eventually, I think, lead to the outcomes that everyone hopes that we get, you know, we will look at all of the options that are available.

Mr. PRICE. Do you think it is fair that the Federal Government can say that a health savings account is not something that ought to be available to folks even though your employees didn't choose to select it? Do you think that is fair?

Mr. LAMONTAGNE. I think any action to limit options is one that I would not find—not find favor. I think——

Mr. PRICE. I think that is very wise. Ms. Roth, you mentioned that a catastrophic plan that I just talked about, sense, wouldn't be available. Why is that?

Ms. FURCHTGOTT-ROTH. Well, it wouldn't be allowed under the exchange. For this plan under the exchange you have to have a qualified benefit plan. That means no copayments for routine care, mandatory mental health, drug abuse. We found out last week free contraceptives, recently, all unlimited lifetime payments.

Mr. PRICE. So any high deductible catastrophic plan wouldn't qualify?

Ms. FURCHTGOTT-ROTH. Correct, because it doesn't have zero copayment for routine care.

Mr. PRICE. So if an American wanted a high deductible catastrophic plan, but was forced into an exchange they wouldn't be able to select the kind of coverage plan that they wanted, is that correct?

Ms. FURCHTGOTT-ROTH. That is correct and these health savings accounts with catastrophic health insurance have saved money. They have saved 11 percent to the State of Indiana, for example.

Mr. PRICE. Absolutely. I want to revisit Burger King. We talked a fair amount about Burger King, and I think it was Mr. Stark that said that one Burger King had to comply with the law and another Burger King had to comply. What about Joe's Burger Shop across from the Burger King that doesn't have 50 employees? What are the requirements? What are the competitive requirements on the Burger King because of Joe's Burger Shop and what are the consequences of that for the employees?

Ms. FURCHTGOTT-ROTH. Joe's Burger Shop would not have to pay the penalty that had 49 or fewer employees, and by the way the Burger Kings, if they laid off all of their full-time workers and replaced them with part-time workers they wouldn't have to pay the penalty either. So the incentive would be to lay off full-time workers, replace them with part-time workers. Or if you had a Burger King across the street from the Wendy's, if they shared workforces and the workforce was at half-time at Wendy's, half-time at Burger King, then the Burger King and Wendy's would be competitive with Joe's Burger. Otherwise Joe's Burger would always be able to undercut the Burger King and the Wendy's, and the incentive should not be like that.

Mr. PRICE. Exactly. So the perverse incentives in this bill actually harm the lower wage worker in this country.

Ms. FURCHTGOTT-ROTH. Yes, precisely. And there is another incentive that also harms the low wage worker. Firms only have to provide affordable coverage for a single worker. They don't have to provide affordable coverage for a family. But if the worker gets affordable coverage from his employer as a single, the rest of the family is not allowed to get subsidized health insurance on the exchange. They are in limbo. They are uncovered. They can purchase full-priced insurance on the exchange, but many of them would not be able to afford to do so.

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

Chairman HERGER. Thank you. Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman. I think Dr. Price raised a bunch of very important points that illustrate how disruptive this is all going to be. Mr. Schieber, your testimony highlighted a number of critical points and I think it is fairly well-established in your testimony, and in general terms, that the increasing cost of health care is hurting both businesses and workers. I think that is fairly well-established. And secondly, the problem of rising health care costs started before the passage of this health care law, yet those cost increases are continuing and we potentially will see some price shocks in the insurance market. That is what I am hearing from businesses, large and small, in my district and around the country.

So I guess the remaining question then becomes, does the Democrats' health care law make this fundamental problem better or worse? So I have a series of questions for you. Does imposing the employer mandate raise or lower the cost of health care for employers?

Mr. SCHIEBER.Well, it would raise the cost for any employer who is now required to cover a worker who is not covered. I mean, there has been some intimation here, I wouldn't want anybody to go away thinking that there is not an economic—there is not a relationship between what people are paid and whether or not they are now getting health insurance.

At the second decile in 2009, about 22 percent of full-time, full-year workers were actually receiving health insurance from their employer. At the fifth decile it was about 60 percent. At the eighth decile over 76 percent. There is an extremely strong economic relationship between payment. So at the bottom we are going to raise the pay of quite a lot of—the compensation costs of employing quite a lot of workers.

Mr. BOUSTANY. All right. So also does the taxing health insurance plans—there is a tax in this new law taxing health insurance plans, does that raise or lower the cost of providing health insurance?

Mr. SCHIEBER. It would raise the cost of providing health insurance.

Mr. BOUSTANY. Right. What about mandating an essential health benefits package? Would that raise or lower the cost?

Mr. SCHIEBER. If the package was richer than the package—even if you had been offering a package, if the new package is richer than the package you have been offering, it has got to cost more.

Mr. BOUSTANY. It will cost more. What about mandating employers to pay 60 percent of the actuarial value of the plan? Does that raise the cost?

Mr. SCHIEBER. Again, it depends a little bit on what they have been doing. But if they have been paying less than 60 percent, if it is a 50/50 plan, I pay half, you pay half, it would raise the cost of the plan.

Mr. BOUSTANY. Okay. So now we have talked about a number of provisions in the health law which, as you have stated, will raise costs for employers. And I think you eloquently stated earlier that a business faced with a fixed cost, paying a penalty, or the variable cost, which we already know is higher than the penalty, and rising, and perhaps going to rise by you know, 5, 6, 7 percent or more. We don't know, but we know it is rising. It is a pretty simple business decision, it seems to me, and it is one of the things I am hearing from a number of business owners around my district; fixed cost, lower; variable cost and rising. What do you do?

Mr. SCHIEBER. Well, I would assume this fixed cost will probably rise a bit over time. But it is not clear which one would rise faster, but if you—if your variable, what you characterize as the variable cost is higher than the fixed cost you are going to have to pay, you would probably pay the fixed cost.

Business people are rational economic beings. They try to make decisions based on the arithmetic of running their business, and they look at differential cost rates, and they make decisions based on that in terms of how they run their business.

Mr. BOUSTANY. And that same business person is going to want choices that would promote a competitive marketplace rather than simply a one-size-fits-all, this is it, take it or leave it, and accept the cost?

Mr. SCHIEBER. Well, if you look in the retail industry, for example, you would typically find a much different benefit package than you would find in a computer engineering firm where you are going to have extremely high-skill versus low-skill relatively mobile workers. You find significant difference. I worked in the benefits industry most of my career. I have worked with a lot of employers. There are definite differences, and when you look at those differences, you can understand them when you look at the economics of the business. These things vary by the economics of the businesses.

Mr. BOUSTANY. And so a business looking at this fixed cost versus variable cost, will likely say, I am sorry, we are not going to provide this benefit. We know you will get it in the exchange, and yet we are seeing multiple problems with the establishment of exchanges, which seem to be falling behind. So again, it gets back to the point of the major disruptions in coverage, on top of the fact that, I know we didn't discuss this in this hearing today, but we have significant shortages of physicians and nurses and specialists, which will further lead to disruptions in health care as we know it, and disruptions for the worse, not for the better.

Mr. SCHIEBER. You know, I don't think we can begin to anticipate all of the changes we might face. There is a section in my testimony about the implementation of Medicare in the mid-1960s. We thought prices were going to be relatively stable. We thought de-

mand would be relatively stable. With the introduction of Medicare, prices started rising very rapidly. Demand exceeded considerably what was originally anticipated. There were significant spillover effects to the employer market.

During the 1970s, when Medicare was really taking its full effect in the U.S. economy, employee-sponsored health benefit costs were going up 6.8 percent a year faster than compensation. So it can have spillover effect. So we can be introducing a whole variety of inflationary effects we haven't even begun to think of. And the people who have been costing this out have assumed, at best, that costs are going to be about the same as they were under the prior regime. So I think we have got some tremendous hidden risks here that we are really not talking about.

Mr. BOUSTANY. Thank you. I see my time is expired. Thank you, Mr. Chairman. I yield back.

Chairman HERGER. Thank you. Mr. Kind is recognized.

Mr. KIND. I appreciate the additional information, Mr. Chairman. I appreciate it.

Chairman HERGER. Well, with that, I would like to thank our witnesses and our panel for participating. I would like to respond to a comment that was made by my friend from Washington about Hawaii.

I am looking at an Associated Press article that indicates that since its passage 35 years ago the cost-conscious business owners, and it is talking about Hawaii, have found an easy way to avoid the law by hiring more part-time workers who aren't required to be covered. It goes on to say if it weren't for that law the medical benefits are one area we could look to cut because this is a recession. It hurts the business. You can't pass it on to customers in this economy.

And again, I would like to thank each of our witnesses.

Mr. LaMontagne, I am one of the few small business people on this committee. My heart really goes out to you and gratitude goes out to you for obviously the hard work that you have put into, and your family, to running your business. But as a small business person, and as I talk to people in my northern California district, there is a big difference between those businesses that might be blessed to have a large margin and those who are much more competitive, that the difference between $2,000 and $8,000 can make a difference whether they are in business or not.

But I want to thank you for running your business in such a way that you have that margin, and also for being generous enough and doing the right thing to continue with your employees. My concern is that you are more the exception than the rule.

It is apparent to me in this hearing from the testimony presented today that the Democrats' health care law is unconstitutional and will rob Americans of their current health plan and further hinder economic growth. That is why I will continue to call for a full repeal. The goal of health care reform should be to make health care coverage more affordable for all Americans, not to reengineer the contract between private citizens and their government.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that the witnesses respond in a timely manner.

With that, the Subcommittee is adjourned.
[Whereupon, at 11:25 a.m., the Subcommittee was adjourned.]
[Member Opening Statement follows:]

The Honorable Pete Stark

The Honorable Pete Stark, Statement for the Record

Chairman Herger,

Thank you for holding this hearing today; though, I must say that it seems to be a bit after the fact. The Supreme Court spent the last three days considering the constitutionality of ObamaCare with all of America watching the media circus that surrounded it. Today's hearing won't affect that outcome at all. And I might point out that – while I look forward to the discussion -- the Committee already had a hearing on the economic effects of the employer mandate in January, 2011. Nothing has changed on that front since the provisions in question are still not in effect.

Having spent three hours at the Supreme Court on Tuesday listening to the debate about the constitutionality of the individual mandate, I must also admit that I'm not sure how anxious I am to hear it all again. But, here we are.

I was disappointed in the press advisory announcing this hearing. It is fine to label a bill in Congress as a "Democratic" bill or a "Republican" bill. But, once those bills become law, they don't belong to one party. Whether folks like it or not, health reform is America's law, not the "Democrats' Law," as the Ways and Means Press Advisory labeled it.

It is a law that is already benefitting tens of millions of Americans. Just this week, I heard from a constituent of mine, Marilyn, who contacted me via Facebook to say that she's grateful that her 24-year-old daughter is able to be covered on her insurance plan. For her, and the millions like her, it is simply the law, it is protecting her families' health, and she is grateful.

I'd also note that Democrats don't hold the patent on an individual mandate. Many leading Republican elected officials and policy experts -- ranging from Newt Gingrich to Mitt Romney to the Heritage Foundation's Stuart Butler have all advocated an individual responsibility requirement for the purchase of health insurance. In fact, it is rooted in Republican ideology of "personal responsibility." Why is it fair to have free-riders in the system who impose costs on all of the rest of us? New found Republican opposition to this concept at times makes it seem as though we have all fallen down the rabbit hole. The simple reality is that you can't guarantee affordable, quality health insurance in the private health care marketplace without an individual responsibility requirement.

The second panel of this hearing deals with the potential effect of the employer mandate.

The facts counter Republican claims about the employer responsibility requirements. . Employer sponsored insurance will remain a strong source of coverage under the Affordable Care Act with many analysts from a variety of think tanks and government sources projecting minimal changes in the number of people who will have employer coverage under the ACA. I ask for unanimous consent to submit for the record studies from the Congressional Budget Office, CMS Office of the Actuary, RAND, Lewin, and Urban Institute, all of which project minimal changes in employer coverage under the ACA. Let's remember that the employer mandate only applies to companies with 50 or more full-time employees. The data show that in our purely voluntary health insurance system today, virtually all – 94 percent -- of employers at this size already offer coverage to their workers. Thus, the mandate doesn't negatively affect them. Instead, it levels the playing field among employers by making sure that each pay their share of health care costs for their workers. From an employee perspective, the ACA enables workers to make employment choices based on the job they are offered, not the health benefits that are attached to it, thus freeing workers from job lock and promoting entrepreneurism and job satisfaction.

In closing, I'd note that we're pleased to have Neil Siegel, a professor of law at Duke University and Stephen LaMontagne of Georgetown Cupcake with us today. Georgetown Cupcakes is a relatively new, but quickly growing, business in this cupcake-crazed world. They provide coverage to their workers and are not afraid of the ACA and its implications. I look forward to their comments about how ObamaCare will affect them.

With that, I yield back my time.

[Member Submissions for the Record follows:]

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
M V Pauly
Making a case for employer-enforced individual mandates
Health Affairs, 13, no.2 (1994):21-33

doi: 10.1377/hlthaff.13.2.21

MAKING A CASE FOR EMPLOYER-ENFORCED INDIVIDUAL MANDATES

by Mark V. Pauly

Prologue: *The Clinton administration's approach to ensuring universal health insurance coverage has triggered a chorus of complaints from a variety of quarters. Among those critics who take exception to the administration's approach are economists such as Mark Pauly, who argue that there is a better way to deal with financing coverage for currently uninsured workers. In this paper Pauly argues that a special form of an individual mandate for insurance coverage will achieve the same policy objective but raise fewer employer hackles, be less unfair and distortive, help voters know what they are selecting, and assure an equal level of coverage with no more administrative hassle. As President Clinton articulated in a speech before the National Governors' Association in the summer of 1993, Americans need to realize that "health care is not something paid for by the tooth fairy, that we should all be acutely aware of the cost each of us imposes on it." Puuly's proposal for an employer-enforced individual mandate ensures that "the best way to make people aware of the cost of the care they receive is to have them pay for it individually." Pauly holds a doctorate in economics from the University of Virginia. Among his peers, he is considered one of the nation's finest technical economists. Pauly is the Bendheim Professor of Economics at the University of Pennsylvania and chair of its Health Care Systems Department. He is also director of research at the Leonard Davis Institute at Penn. Pauly is a member of the National Academy of Sciences' Institute of Medicine and is the lead author of a widely discussed paper published in the Spring 1991 issue of Health Affairs, entitled "A Plan for 'Responsible National Health Insurance'."*

22 HEALTH AFFAIRS | Spring (II) 1994

Abstract: An employer-enforced individual mandate has some substantial advantages over the mixed employer and individual mandate embodied in the Clinton administration's proposed health plan. Economic reasoning strongly suggests that almost all of the cost of an employer mandate will fall on workers and that in any case the incidence of an individual mandate is the same as that of an employer mandate. However, an individual mandate is easier for voters to understand, avoids administrative complexities and inequities, and eliminates the chance of adverse employment effects of mandated employer coverage.

One of the most politically troublesome features of President Bill Clinton's proposed health reform plan is its requirement for mandatory contributions by all employers toward the health insurance coverage of their employees and families. The primary rationale consistently offered by analysts and advocates alike for this feature is that it is the conventional (or "American") way of paying for insurance. Indeed it is, for the great majority of the working population. However, it is equally instructive that this method of choosing and financing coverage has not been chosen by a small but growing minority within the work force. When the job does not bring insurance coverage with it, some workers obtain it in other ways, either through a working spouse or through individual purchase of insurance, and some go without coverage, at least for a time. Employers that do not offer coverage have been most strongly opposed to the proposed Clinton plan, which would make their voluntary behavior illegal. In forbidding anyone from taking a job that does not carry health insurance as a fringe benefit, the plan constrains employers and workers alike.

Nevertheless, there are strong social reasons for arranging institutional structures so that all of the population has at least some health insurance. The most fundamental reason is that insurance may be important in inducing people to purchase medical services that are effective for their health and that other citizens are not willing to see them go without.[1] This same altruistic motivation has led to the construction of arrangements that make services available, even if imperfectly and at the last minute, to sick people who seek them in hospital emergency rooms, but with the cost of these services left to be financed by the "shifting" of costs to the hospital's paying customers. This patchwork arrangement obviously is less satisfactory than the assumption that all citizens have appropriate insurance coverage.

In an attempt to defuse the opposition by noninsuring employers to an employer mandate, the Clinton plan contains a complex pattern of subsidies-a pattern that itself is likely to distort behavior, cause political turmoil, and have a substantial budgetary cost to the government. Is there a better way to deal with the financing of coverage for currently uninsured workers, one that raises fewer employer hackles, is less unfair and distortive, helps voters know what they are choosing, and assures an equal level of coverage with no more administrative hassle? In this paper I argue that a

special form of an individual mandate for insurance coverage will achieve these objectives. If anything will frustrate the attempt, at long last, to assure universal coverage, or lead to postponement of the effective date to an indefinite future, it is the opposition to an employer mandate. Finding a preferable alternative thus takes on special urgency.

Why An Individual Mandate?

The broad rationale for an individual mandate is based on several key facts or premises. The first key fact is that, in any economy, the cost of a good such as health insurance must ultimately be paid by individuals as individuals. Corporations, employers, and governments are often legal persons, but in economic terms they simply represent other individuals, such as stockholders, taxpayers, and owners. Since mandates to pay for something, like the taxes they are, ultimately must fall on individuals, it will at a minimum be necessary to identify who those individuals are in order to evaluate a mandate, and ultimately to consider the desirability of taxing them. The second key fact, as already noted, is that a mandate is a tax. It is an earmarked payment, but it is a compulsory payment for public purposes, a tax by any other name. The third observation is more a premise than a fact: It seems desirable, for rational political decision making, for citizens to be aware of what taxes they are paying to obtain benefits. That is, good political decision making is assisted, as President Clinton noted in his speech introducing the Health Security Act in September 1993, by avoiding the mistaken view that the government can provide benefits for which no one must pay; by implication, the best system is one in which it is easy to see the connection between what one pays and what the public benefits are. The best system is one in which the financing is politically transparent.

In addition to the idea that a good financing mechanism is one in which voters can easily judge who is paying what for what, we usually assume that we have some efficiency and equity objectives in mind. There is a precise economic definition of *efficiency,* but for the present I simply use the concept to mean the absence of distortions in production or consumption arrangements. There is no generally accepted complete definition of *equity,* but there is usually consensus that equity implies that people of equal means should pay the same amount for the same public service ("horizontal equity," in the textbooks) and that people with more total income or wealth should pay more (or at least no less) for a given public benefit ("vertical equity").

All of these observations point in the direction of a main theme of this paper: that direct, explicit taxes to pay for health insurance are to be preferred to indirect, implicit taxes such as an employer mandate. Direct

taxes are easier for citizens to understand, easier to tailor to the income or wealth levels of individual citizens, and generally less distortive than indirect taxes, which are confusing, inequitable horizontally and vertically, and often causes of inefficiency.

Probably the most general direct tax available to real-world government is the personal income tax, with the value-added tax a close second. For this discussion, however, I assume that health insurance benefits are to be financed by a new earmarked mandated payment, which will be neither a simple surcharge on current income taxes nor an earmarked value-added tax. Indeed, since the great majority of Americans under age sixty-five already obtain and pay for private insurance in connection with their employment, there is some virtue in disrupting existing arrangements as little as possible, as long as transparency, equity, and efficiency can be preserved.

Employer Mandates, Individual Mandates, And Blended Systems

A full employer mandate would be an arrangement in which the employer is required to pay the full health insurance premium for every worker. Japan's system comes closest to an employer mandate. A full individual mandate is an arrangement in which each individual or family is required to obtain and pay for insurance coverage that meets a minimum benefit standard in some fashion. As described in our "Responsible National Health Insurance" proposal, such a mandate does not require that the insurance be purchased individually, or that individuals have the right to require their employers or fellow workers to permit them to do so.[2]

The Clinton reform plan is a system that blends individual and employer mandates. For the self-employed, it is a full individual mandate. For the employed, it combines an employer mandate to pay part of the premium with an individual mandate to pay the remaining part, and provides income-related subsidies for each part.

What's the difference? The general theoretical conclusion from economics is that there is likely to be very little difference, in the long run, between an individual mandate and an employer mandate. There are actually two propositions here. One that is almost always true but does permit exception is the following: The cost of an employer mandate ultimately will fall almost entirely on worker wages. The other, always true, is that wherever the cost of a mandate falls, it will be the same regardless of whether the mandate falls on employer or employee. I use a numerical example or scenario (in the spirit of the Clinton documents) to illustrate why these propositions hold and where differences, if any, are likely to arise.

Imagine a flower shop (called the "Flower Shoppe") with ten employees,

each of whom earns $25,000 per year. The employees are identical in both productivity and expected medical expenses. The firm initially offers no health insurance as a fringe benefit and pays no portion of any health insurance premium. Tax effects on total compensation are ignored. All of the employees are single, and the average premium in the locality for the coverage mandated under the Clinton plan would be $2,000 per year for singles. The employer's 80 percent share of this premium would thus be $1,600, or 6.4 percent of the average wage, so no subsidy would be paid to this firm under the Clinton plan's cap of 7.9 percent.

The Flower Shoppe plans to give 10 percent raises in 1994 ($2,500). It has chosen this amount for two reasons: (1) It expects increasing productivity to cause output per worker to rise by at least $2,500 per worker, and (2) it expects to have to pay such a raise in its locality to remain competitive in the local labor market. Thus, it can afford to pay the raise and still increase profits, it would reduce those profits if it laid off any workers, and it has to pay the raise to retain its workers.

What will happen if the firm is mandated under the Clinton plan to pay $1,600 for health insurance for each employee and each employee is individually mandated to pay $400, with the coverage to be obtained from the local health alliance? Assume initially that the imposition of the mandate does not change the dollar amount of the increase in compensation that the firm can and must offer; it stays at $2,500. The answer is obvious: The firm will use part of that increase in compensation to pay the mandated health insurance premium, pay the remaining $900 as a raise next year, but expect workers to take $400 of the raise to pay for their share of the health insurance premium. Compared to the previous year, each worker ends up with a health insurance policy and $500 more in cash.

There are two key ideas in this scenario. First, given the assumption that the size of the increase in total compensation is fixed, the full incidence of the employer and employee mandate falls on workers, in the sense that the total premium reduces income spendable on other things by an equal dollar amount. Second, as is obvious, each worker's final position with respect to wages and fringes is exactly identical under this "employer mandate" to what it would be had there been an individual mandate requiring each worker to buy his or her own $2,000 insurance policy; individual mandates and employer mandates are identical.

There is thus no difference in economic effects between the two kinds of mandates. The only potential difference is in the perceptions employers and employees may have as to who is paying what. In the individual mandate all payrnents for insurance are made after the paycheck amount is calculated, whereas under the employer mandate 80 percent of the premium is deducted or withheld before the amount is calculated. Of course, if

the employer informs the worker what the total cost of the compensation package is, the difference is only a matter of accounting. However, the failure, under an employer mandate, to inform workers explicitly about the total payment for insurance and the total amount of compensation may lead workers to perceive things differently.

What determines the level of total compensation? It is obvious that the key to the result that employees pay for mandated coverage is the assumption that neither the imposition nor the locus of an insurance mandate changes the total compensation the employer is going to offer. Any differential effects of mandates therefore must require this assumption to fail to hold. When might this happen, or when might employers and workers believe that it happens?

To avoid making economists look like complete fools, let us deal with a scenario in which the cost of an employer mandate will fall on profits rather than on wages. Suppose that the employer mandate was imposed only on the Flower Shoppe, not on any other employer in town. Then offering constant total compensation will not permit the firm to continue to attract its current complement of employees; they will leave for similar firms that offer the old level of cash wages and no health insurance. If it was the firm's profit-maximizing strategy not to offer health insurance, it must have been the case that, at least for this set of potential employees, cash compensation was preferred to the amount of health insurance it could buy. Were that not the case, the firm could have increased its profits by offering health insurance in lieu of wages. If the Flower Shoppe alone is then compelled to offer health insurance by a mandate, its compensation package will not be as attractive as those of its competitors. Either it will hire fewer workers, or it will have to pay them more in total-enough to compensate for the difference between the cost of health insurance and its value. Either way, at least some of the cost of the mandate will fall on the firm's profits (and some on workers' wages).

Even in this case, however, there would be no difference between an employer mandate and an individual mandate. Suppose workers at just this one firm were required to buy health insurance out of their wages (an individual mandate). The effect would be the same as that of an employer mandate: Working at that firm would be less attractive relative to alternatives, and profits would fall.

Universal coverage requires a universal mandate, so this "one-firm" case is not really relevant. It may, however, be what many employers are thinking of when they say that they cannot "afford" a mandate. They are implicitly assuming that other employers' compensation offerings to workers will stay the same.

Would a universal mandate be expected to change the total compensa-

tion the firm can and will offer? One possible (although not probable) case is that offering health insurance might improve employees' health, and thus their productivity. This would allow the owner to afford higher compensation, and all could gain from the mandate. This scenario seems unlikely, however, for two reasons. First, for middle-class workers, with a few debatable exceptions, there is little evidence that more generous insurance coverage improves health. Second, if coverage were health-improving and employees knew this, it would have paid for employers to offer it-contrary to the initial assumption. One might invoke employee ignorance as an excuse, but it seems a weak one. In general, it seems unlikely that offering insurance would change what employees are worth to the firm.

The other possibility, somewhat more likely, is that a universal mandate (of either type) will change what employees must be offered to stay with the firm. One possibility is that the combination of universal mandate and health alliance may lower the cost of insurance, perhaps enough to make it worth the lost wages to workers. However, it seems unlikely that there will be such a net reduction in insurance costs.

The other, more complex case is one in which workers with lower demands for insurance specialize in certain jobs or products. This would occur if the taste for insurance were correlated to some extent with the skills needed for certain jobs. One simple basis for correlation would be if the demand for insurance were sensitive to total income or wages, and certain jobs or products used workers at different wage or skill levels. Low-skill, low-wage workers who produce certain products then would be more attracted by cash-rich, fringe benefit-poor compensation packages.

In this case, some of the cost of the mandate could fall on owners, if their capital were more tightly tied to a specific product or service than the skills of workers were. Take two extremes. At one extreme, workers must work, and they have a skill that can only be used to produce a particular product, but the capital they work with can easily be converted to other uses. It is obvious that the return to capital cannot be reduced by the mandate, but the wages of these workers could be. At the other extreme, the owner's capital is tied up in a particular product, but workers could be nearly as productive doing lots of other things, including working in industries where coverage is the norm. Then these specific workers would not bear the cost of the mandate, but capital owners would. Even here costs ultimately would fall on workers in general.[3]

The key insight, however, is that whatever happens in this more complex case, the result would be the same whether the mandate is on employer or employee. Consider the case in which capital is linked to certain products, and instead of assuming that employers were obliged to pay for coverage, imagine that workers were required to do so. This would make working

in that industry less attractive, profits would fall, and workers would leave until they were as well off in that job as in competing jobs. The punchline is that however complex the final incidence of a mandate (relative to some initial situation in which some firms did not provide coverage through the workplace), that pattern will be the same if the mandate is initially placed on the worker or on the employer. This goes back to the earlier point: It does not matter whether the check to pay for coverage is deducted before or after the compensation amount is accounted.

All of these analyses imply that in the long run wages will fall by the amount of the employer cost of the additional coverage. This type of analysis is at the heart of the conclusion by Clinton administration economists that there will be at worst minor unemployment effects of an employer mandate. That is, to reach their conclusion they had to assume that the incidence of an employer mandate is on workers. For all but minimum-wage workers-for whom there can still be problems-mandates will affect wages, not employment. In and of itself, this does not necessarily mean that mandates do no harm to workers; it only means that mandates reduce workers' wage levels rather than their chances of keeping their jobs.

Some modem macroeconomic theories of involuntary unemployment sometimes attribute money-wage rigidity to a kind of myopia in employer and worker perception: Employers and employees do not adjust money wages as soon as unemployment starts to develop because they do not know what is happening in the labor market as a whole.[4] However, it is precisely the same myopia that would lead an employer to lay off workers because the employer could not "afford,, the mandate: The employer does not know for sure that the mandate, imposed on competitors in the labor market, will permit wages to be cut. To be sure, even if all employers are myopic and fire people, eventually the increase in unemployment will put downward pressure on market-level money wages. "In the long run" wages must fall-even if employers are thick-headed. But in the process there can be some transitional unemployment.

Will an individual mandate cause employers to drop payment for coverage? Now we consider an alternative scenario. Imagine that Posie Palace is a florist identical in all respects to the Flower Shoppe except that Posie Palace now pays 80 percent of a health insurance premium and therefore pays $1,600 toward health insurance but pays $1,600 less in money wages. All employees opt to pay the remaining 20 percent, so all are initially covered. This firm would be unaffected by an employer mandate. What about an individual mandate? The answer to this question may depend to some extent on the form the individual mandate takes. The simplest and, in my view, the best form for such a mandate is one that simply requires that each citizen obtain coverage somehow, that treats all

payments for the employee's insurance as part of taxable income, but that does not or need not specify how that coverage must be obtained. Thus, the workers at Posie Palace can be in compliance with the law by continuing their current behavior.

But might the employer in the Posie Palace imagine that after the passage of an individual mandate it would be good business to stop or reduce the amount paid for insurance before compensation is calculated, the "employer payment?" As President Clinton asked in his speech to the National Governors' Association conference last summer, "If you impose an individual mandate, what is to stop every other employer in America from just dumping [insurance for] his employees or her employees, to have a sweeping and extremely dislocating set of–chain of events start?" From the viewpoint of workers, if the employer stops "paying" for insurance and does not change money wages, this would be equivalent to reducing their net compensation, since they would have to make up the lost employer payment. Unless (contrary to assumption) the employer was overpaying in the first place, such a reduction in employer payment cannot increase profits. After all, the initial level of employer contribution was voluntary, chosen with an eye to conditions in the labor market. If Posie Palace cut the employer payment, working at the Flower Shoppe would become a better alternative.

Thus, there is no direct impact of an individual mandate that would make the employer want to change things. If anything, an individual mandate should greatly increase the likelihood that employers will make opportunities for coverage available. For one thing, for employers that now choose to offer group coverage, an individual mandate offers them no reason to stop doing so. An individual mandate certainly does not require that individuals purchase their insurance individually; it only requires that they obtain coverage, and for the great majority of American workers, the cheapest way for them to obtain the coverage they will be required to have is to continue with their current employment-related group insurance. In addition, for those employees who do not now obtain coverage through the workplace, the obligation that they get coverage somehow will surely lead many of them to bargain with their employers for employer assistance in arranging group coverage in return for reductions in employee wages, if the group of workers and employers decide that they want to have a minimum participation and incentive for levels of participation. In short, far from triggering a spiral of employers discontinuing opportunities for employment-related coverage, the effect of an individual mandate should be to greatly increase the prevalence of such opportunities.

Would the availability of tax credits to employees cause the employer to cease offering coverage? If the credits take the fixed-dollar form we de-

scribed in our "Responsible National Health Insurance" proposal, the answer is "no," since the size of the credit does not depend on whether the premium is paid as an "employee payment" or an "employer payment." In the bill introduced by Sen. John Chafee (R-RI), such a possibility would arise, since that bill ties the credit to the size of the "employee payment"– it fails to recognize that "employer payments" reduce the money available to employees to spend on other things fully as much as so-called employee payments do.

Could there be indirect effects? The advantage of offering a fringe benefit to workers in this firm will be eroded when all of its competitors in the labor market are forced to do the same thing and offer the same package. However, it still will be disadvantageous to the firm to require employee pay ment, unless employees fail to notice what is going on.

How can an individual mandate be enforced? It might, at first thought, appear more difficult to enforce an individual mandate than an employer one-there are many more employees than there are employers, and what does the government do if an employee neglects to obtain coverage on his or her own? The easiest way to think of an answer to this question is to note that the individual mandate is a tax-in effect, it requires each citizen to pay a tax, which is used to finance health insurance.[5] Thus, it seems natural to use the same mechanisms to enforce collection of this tax as for other taxes imposed on employees. The way the individual income tax and the employee's share of the payroll tax are collected is via mandatory withholding by the employer, with any overpayment or underpayment adjusted for at tax return time. The same mechanism would appear to be feasible for the insurance tax. The employer would be required to ascertain whether or not the employee had obtained insurance (including as a member of an employment-related group) and, if not, to withhold from the employee's wages enough to pay for insurance from a government-contracted or government-run insurer of last resort.

What is being proposed here is really a hybrid, in which the employer is used as the first-line tax collector, but in which the payer is clearly identified to be the employee. The task of collecting such premiums (and adjusting them for family composition, plan chosen, or income) is no more difficult (and no easier) than is the task of collecting income taxes through wage or income withholding. For higher-wage persons, who file income tax returns, the administrative cost of adding one additional tax or surcharge (or check box) to form 1040, and requiring insurance status to be recorded on the withholding tax statement (form W-4) that must be filed for every worker, would appear to be minimal. For lower-income workers for whom subsidies would be paid, voluntary cooperation would be enhanced by the desire to obtain the subsidy, and the credit that would pay the subsidy need

be no more difficult to administer than (and could even be merged with) the earned income credit. Finally, persons already receiving welfare payments could have their credit incorporated with their other government payment.

While there will be some additional administrative complexity added to the current system, it is not obvious that combining an individual mandate with a system of tax credits is any more administratively complex than the Clinton proposal. That proposal imposes a new tax on a new base and requires a new definition of what is a "firm" and what is an "employee." In addition, the Clinton plan already requires a partial individual-mandated payment, subsidized based on an individual's income, so it is already going to be incurring the administrative cost of an individual mandate.

Advantages Of The Individual Mandate

One advantage of an individual mandate relates to the previous discussion: An individual mandate can be much more precisely targeted, and therefore be both fairer and more efficient, than an employer mandate. Presumably, for example, we desire to subsidize the health insurance purchase of low-income families, not low-wage individuals or families. Although wages are correlated with income, there can be low-wage earners in high-income families, or well-off low-wage families that get nonwage income. In addition, there certainly can be low-wage and low-income workers in firms with high average wages. An individual mandate allows the credit or subsidy to a person to depend only on their circumstances, not where they work, and so can avoid the serious distortions of firm organization inherent in the Clinton approach.[6]

A new employer mandate may not result immediately in lower employee wages. Long-term labor contracts, myopia on the part of employers, and general uncertainty may cause money wages to fail to fall immediately for formerly uninsured workers. If this happens, a likely response of employers will be to lay off workers, since they will now be too expensive to continue to hire in such numbers. The key issue here is whether employment can be adjusted more rapidly than money wages. As noted above, increased unemployment eventually will put downward pressure on money wages, so even employer misperceptions will not be a bar to adjustment. But most policymakers probably would agree that adjusting to a mandate through unemployment is more painful than adjusting to it though lower money wages (though obviously neither is painless). An individual mandate for payment will avoid the necessity of adjusting posted or cash money wages and therefore will be able to avoid this painful period of transition.

In addition, workers now earning near the minimum wage are not able to

reduce their money wages, so some of them will have to be fired. Estimates of the employment effects of the Clinton employer mandate have been politically controversial, ranging from slight job gains to losses in excess of four million. The virtue of an individual mandate is that it neatly avoids this controversy, since money wages will not have to adjust to an individual mandate, nor will it cause the minimum wage law to be violated.

Still a third advantage of an individual mandate is that it does not base insurance premiums on public subsidies, employment status, or wage levels. Problems associated with part-time workers, two-worker families, or independent contractors simply will not arise.

The final advantage of an individual mandate over an employer mandate is better political decision making. It surely is safe to say that there is no general agreement among policymakers, lobbyists, or ordinary citizens about who pays the cost of an employer mandate. I assert that good decisions in a democracy occur when citizens find it easy to understand both the extra taxes and the extra benefits they will get from government action. (I reject the School of Machiavelli approach, which holds that it is sometimes necessary for wise politicians to deceive the electorate for its own good.) An individual mandate is much more straightforward in terms of its intelligibility-under an individual mandate, what you pay is what you pay. On the grounds of political transparency, then, such a tax is to be preferred.

To be sure, one of the dangers of informing the electorate in a democracy is that, given the set of political institutions (constitution) under which decisions are made, they may not choose what one prefers. They might prefer no health reform to a health reform they must pay for under an individual mandate. They might prefer a set of tax credits either more or less progressive than the Clinton plan and different from what one prefers. But that is the hard lesson of democracy.

From Employer Mandate To Employer-Enforced Individual Mandate

For better or worse, the Clinton plan already takes choice about health insurance coverage away from employers and transfers it to health alliances. The employer plays only the role of financier. Economic theory says that the employer plays that role as that of a tax collector in disguise, only to be unmasked in the long-run denouement, in which it becomes apparent to all the players that the employees paid for their health insurance themselves. While mistaken identity can be comic, and while politics can generate a comedy of its own, good social decision making would seem to require more honesty and transparency. Extending the individual mandate already imposed on nonwage earners (and 20 percent imposed on wage earners) to all

citizens under age sixty-five would have some substantial advantages and would be relatively easy to implement. Moreover, an individual mandate seems much more in the spirit of a number of other important points President Clinton made in his speech to the governors. For instance, he talked about the need to prevent people from being "free riders still riding the system." An enforced individual mandate prevents free riding. He also spoke eloquently about the need for Americans to realize "that health care is not something paid for by the tooth fairy, that we should all be acutely aware of the cost each of us imposes on it." There seems to be little reason to doubt that the best way to make people aware of the cost of the care they receive is to have them pay for it individually.

In short, the individual mandate approach seems much more consistent with the president's overall objectives than the employer mandate approach his advisers currently seem to favor. Most of the other desirable health reforms-transfers to help high-risk people, purchasing cooperatives to lower the administrative cost of insurance for small groups, and curtailment of tax incentives for overly lavish coverage-can easily, perhaps more easily, be combined with an individual mandate system than with an employer mandate system.

NOTES

1. M.V. Pauly, *Medical care at Public Expense* (New York: Praeger Publishers, 1971).
2. M.V. Pauly et al., "A Plan for 'Responsible National Health Insurance'," *Health Affairs* (Spring 1991): 5-25.
3. P.M. Danzon, "Mandated Employment-Based Health Insurance Incidence and Efficiency Effects" (Unpublished working paper, Department of Health Care Systems, The Wharton School, University of Pennsylvania, November 1989).
4. See, for example, R.G. Ehrenberg and R.S. Smith, *Modern Labor Economics* (Glenview, Ill.: Scott Foresman and Co,, 1982), 480-483.
5. M.V. Pauly, *Responsible National Health Insurance* (Washington: AEI Press, 1992).
6. M.V. Pauly, "The Clinton Plan: What Happened to the Tough Choices?" *Health Affairs* (Spring I 1994): 147-160.

The Seattle Times
Local News

Thursday, March 29, 2012 - Page updated at 11:30 p.m.

Why Washington state's health reform faltered after loss of mandates

By Carol M. Ostrom
Seattle Times health reporter

As the U.S. Supreme Court tackles the question of whether individuals can be required to buy health insurance — a key provision in the federal health-care overhaul — some in Washington state are battling a strong sense of déjà vu mixed with dread.

They remember 1993, when state lawmakers passed a comprehensive state law aimed at insuring everyone and spreading the health-care expenses of the sickest throughout a large pool of policyholders.

But the law, which relied on both mandates and incentives, was soon dismembered, leaving only popular provisions, such as prohibiting insurers from denying coverage to sick people or making them wait many months for coverage.

Without any leverage to bring healthy people onto insurance rolls, insurers, left with the priciest patients, began a financial death spiral.

Ultimately, companies pulled out of the individual market and almost no one in Washington could buy an individual policy for any price.

For those involved, the lessons learned remain sharp as a scalpel.

"It's the same thing we're very likely to face if the Supreme Court blows a hole in the current law," warns Randy Revelle, a former King County executive who was heavily involved in the state effort nearly two decades ago.

Unlike the debate going on in the high court, the lessons here don't involve constitutional questions. They're all about the realities of the health-insurance market and politics.

At the top of the list:

Lesson 1: Good intentions, no matter how popular, can backfire — big time.

Lesson 2: A machine doesn't work so well if you remove parts.

Lesson 3: Buy-in from both political parties and strong public support are needed to maintain enough momentum to sustain complex reforms through potential changes in administration.

The '94 "death spiral"

In an amicus brief in the Supreme Court case, Gov. Chris Gregoire and other governors referred to the "death spiral" in Washington's individual-insurance market that began in 1994.

The 1993 law, passed when Democrats controlled both houses and the governor's seat, was then the most ambitious overhaul effort in the nation.

The delicate balancing act ended when Republicans, who objected to what they saw as heavy-handed government control of the health industry, swept into power in both houses.

By the time the new Legislature finished, the only parts of the law that survived were the "consumer-friendly" pieces, championed by then-Insurance Commissioner Deborah Senn, a Democrat.

"We kept some of the insurance reforms in law, because they were very popular, but we didn't keep the market reforms," says Pam MacEwan, who was a member of the Health Services Commission charged with implementing the law and is now a Group Health Cooperative executive. "It was a big problem."

That's primarily because there was nothing left in the law to push or entice people to buy insurance when they were healthy, which would have spread costs more broadly.

What happened next is starkly summarized in a 1995 letter sent to Premera Blue Cross by a woman in Eastern Washington.

A few months before she gave birth that year, the woman bought an individual policy from Premera. As soon as the insurer paid her hospital expenses, the woman canceled the policy, telling Premera "we will do business with you again when we are pregnant."

True to her word, in 1996, she bought insurance, Premera said, once again canceling after the insurer paid for the delivery of her next child.

Altogether, she paid in $1,807 in premiums. Premera paid out $7,024.68 in medical bills.

You don't have to be a business genius to recognize the problem with those numbers when multiplied by thousands of customers.

Claims went up. Premiums rose. Pretty soon only sick people thought insurance was worth the cost. Premiums rose even more.

Healthy people, like the Eastern Washington woman, waited until they needed insurance to buy it. At the time, Gov. Gary Locke likened it to buying fire insurance after your house is on fire.

State breaks the logjam

Before deciding in 1998 not to sell any more individual policies in the state, Premera lost $120 million in today's dollars, says company spokesman Eric Earling. By mid-1999, the state's other two big insurers, Regence BlueShield and Group Health, stopped selling individual policies.

In 1999, with the individual health-insurance market essentially dead, Locke began crafting a compromise. Signed into law in the spring of 2000, it was a bitter pill for some, but it got the market back into action.

In exchange for coming back into the market, insurers could charge whatever they wanted, bypassing the rate review normally done by the insurance commissioner's office. They could also force patients to wait nine months to be covered, and exclude the most expensive patients.

To deal with those patients, the state revived its high-risk pool. Insurers, who would help subsidize the pool, would be allowed to reject 8 percent of applicants, who could then buy coverage through the pool — if they could afford it.

At the time, Sen. Alex Deccio, a Republican from Yakima, summed it up neatly: "We are in a private-enterprise system."

"Have" vs. "have-not"

Washington's insurance experience, some worry, could be repeated on a much larger scale, should the Supreme Court find the mandate unconstitutional.

Insurers, in an amicus brief to the court, argue that if the mandate is removed they should be allowed to exclude people and set prices based on health — now barred in the federal plan.

Others argue that the mandate, with its relatively weak financial penalty for those who don't buy insurance, isn't necessary for the federal health overhaul to proceed.

They calculate that many young, low-income uninsured would buy policies without a mandate, since the federal overhaul dangles attractively low premiums for the young and subsidizes those with low incomes.

State Sen. Karen Keiser, D-Kent, who chairs the Senate's health-care committee and a group of lawmakers exploring alternatives, says if the federal mandate is overturned, each state would be left to choose options ranging from doing nothing to legislating ways to bring as many people as possible into a health-insurance pool.

"Of course, that would mean that our country would be made of 'have' states and 'have-not' states, making the health disparities even worse, which is pretty awful," Keiser said in an email.

Washington Insurance Commissioner Mike Kreidler says 85 percent of state residents, who now have group coverage, wouldn't be directly affected by the federal mandate.

But, he adds, the typical Washington family's yearly insurance bill includes about $1,000 to cover costs for the uninsured, which his office calculates have reached about $1 billion a year in the state. The state hospital association says charges for charity care and bad debt by patients may amount to as much as $2 billion.

Kreidler's office has estimated that under the federal plan, the vast majority of the approximately 1 million uninsured would qualify for Medicaid or subsidies.

Revelle, now policy leader for the Washington State Hospital Association, says the state's struggle to improve health coverage was illuminating.

"A fundamental lesson we learned in the process — and that unfortunately was not learned in the federal process — is that health care is so big, so complex, so passionate, that it has got to have bipartisan support," Revelle said.

It also needs widespread public support to last through the years it takes to impose changes on an entrenched industry.

And that's difficult, he says, not only because of health care's complexity, but because people do not agree on fundamental values.

"It's very hard to look out five or 10 years," Revelle says. "But we should constantly be thinking: Where do we need to be five to 10 years from now?"

[Public Submissions for the Record follows:]

Statement of the American Farm Bureau Federation

TO THE HOUSE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

REGARDING HEARING ON THE INDIVIDUAL AND EMPLOYER MANDATES IN THE DEMOCRATS' HEALTH CARE LAW

MARCH 29, 2012

600 Maryland Ave. SW | Suite 1000W | Washington, DC 20024 | p. 202.406.3600 | f. 202.406.3606 | www.fb.org

Farm Bureau appreciates the House Ways and Means Subcommittee on Health looking into the individual and employer mandates and their impact on America's small businesses.

The Patient Protection and Affordable Care Act (PPACA) penalizes farm and ranch businesses with 50 or more "full-time equivalent" employees if they do not provide government-prescribed health insurance, or if certain employees receive a tax credit and purchase insurance through the exchanges. Penalties also are imposed on individuals, including self-employed farmers and ranchers, who fail to purchase qualified health coverage.

Farm Bureau is opposed to mandates that require individuals to have health insurance and that require employers to provide it for their workers. Most farmers and ranchers are self-employed and buy health insurance for themselves and their workers through individual and small group markets. Coverage mandates accompanied by penalties for noncompliance will only make a difficult situation worse for people already unable to afford coverage.

The complex nature of the agricultural workforce is causing additional concern about the implementation of the employer mandate. Many agricultural operations may only have a few full-time employees but hire a considerable seasonal workforce to help with planting and/or harvesting. In general, Farm Bureau believes that the nature of agricultural work and agricultural employment is incompatible with many of the definitions and implementation plans that have been proposed and make mandates especially onerous for agricultural employers.

There is also uncertainty about whether or not affordable, short-term coverage will be available for temporary or seasonal agriculture workers, some of whom may be employed on multiple farms or ranches for just a few days for each operation. In cases where a seasonal or temporary worker has multiple employers, there are questions about who would be responsible to purchase health insurance and how coverage would be coordinated to avoid duplicate coverage and unnecessary expense.

Farm Bureau urges Congress to repeal insurance coverage mandates that require individuals to have health insurance and that require employers to provide it for their workers.

Center for Fiscal Equity, Statement

Comments for the Record
House Committee on Ways and Means
Subcommittee on Health
Hearing on the Individual and Employer Mandates
in the Democrats' Health Care Law
Thursday, March 29, 2012, 9:00 AM
by Michael G. Bindner
The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic.

The hearing advisory states that most people oppose the current law. While this is technically true, it is also true that a little less than half the opposition comes from progressives who wanted a stronger law in terms of government involvement. Additionally, those who oppose the law, in many cases, do not do so on its merits, which were mostly lifted from conservative think tanks and the Massachusetts experience, but because they see the law as a stepping stone to the kind of reform favored by the Democrats who oppose the law. Later in our comments, we will address how mandates under the law are inadequate to offset community rating and guaranteed acceptance procedures and the likely consequences of that. First, however, we will address some of the issues before the court regarding mandates.

Before even considering the constitutionality of mandates under the Commerce Clause, the Supreme Court will examine if the mandate penalty is actually a tax and if it is a tax, whether consideration of this issue is even ripe. The Center for Fiscal Equity has always believed that this penalty is, in fact, a tax, and that the Court will likely quickly rule that it is and that further consideration of its constitutionality must wait until the tax is collected, leaving all other issues in abeyance until that occurs – although, frankly, it would be an act of judicial malpractice to let clients go forward on a what would be a Quixotic quest against the taxing power to bring this up again.

That is the first hurdle and it is the out that the Court is looking for to avoid the complicated constitutional question. The second is that the dollars funding the public relations campaign against the law are not brought out because the don...ors object to the mandate, but because the non-wage income payroll taxes which will take effect soon are costing rich people money - especially since there are no offsets to paying them or passing the cost to customers - essentially turning these taxes into a VAT. Indeed, a VAT would be less objectionable than keeping these taxes in place, because the burden is more broadly shared, more visible and refundable at the border.

As an aside, the objection to using the threat of loss of federal funding to enforce Medicaid reforms is a long objection of so called "Federalists" (who are in truth, states rights supporters, which is something different) has never gained much traction, from using highway funding to enforce the 55 mile per hour speed limit to using the same funding to force a 21 year old drinking age. It is an unsophisticated objection. I made the same argument in Iowa Model legislature when in High School – contending that the clause prohibiting differing regulations of commerce or revenue applied. Any first year law student or historian will point out that this clause applies to international trade, not the regulation of interstate commerce or the use of intergovernmental funds. We suspect that the Court has likely allowed it to be argued to kill this argument once and for all. To expect either a radical rethinking of the Commerce Clause or intergovernmental funding requirements will occur at this time is the legal equivalent of believing in unicorns.

The opposition to reform is well funded and sophisticated. We believe it has nothing to do with mandates, the Commerce Clause or Medicaid funding. The real reason conservative major donors don't like the law is the funding mechanism for much of reform. Wealthy donors are writing checks because of provisions creating additional taxes on un-earned income that fix Medicare Part A funding and fund other health care reform, essentially turning the Hospital Insurance Tax into a Value Added Tax with an exemption on profits paid to the 98%. Fighting for repeal on this basis, however, would only be politically unpopular. Only judicial repeal would of the whole law stops this tax hike, although there is no justification for not severing this portion from the law, even if the mandate falls.

Note that whenever this tax applies to those whose holding operate in less than a perfectly competitive market, in other words to most commerce in 21st century America, the costs will likely be passed to the consumer and it would be more honest to simply enact a Value Added Tax or VAT-like Net Business Receipts Tax (which is proposed below).

We will now return to the question of the adequacy of mandates. The key issue for the future of health care consolidation is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the Affordable Care Act (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support, as proposed by Chairman Ryan, also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Resorting to single-payer catastrophic insurance with health savings accounts (another Republican proposal) would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related. For example, Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

If cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed. The ability to exercise market power, with a requirement that services provided in lieu of public services be superior, will improve the quality of patient care. To the extent that

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304
571-334-8771
fiscalequity@verizon.net

Hearing on the Individual and Employer Mandates in the Democrats' Health Care Law
Thursday, March 29, 2012, 9:00 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

Chamber of Commerce, Statement

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

RANDEL K. JOHNSON
SENIOR VICE PRESIDENT
LABOR, IMMIGRATION & EMPLOYEE BENEFITS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062
202/463-5448 · 202/463-3194 FAX

April 11, 2012

The Honorable Wally Herger
Chairman
House Committee on Ways and Means Subcommittee on Health
United States House of Representatives
Washington, DC 20510

Dear Chairman Herger:

The U.S. Chamber of Commerce ("Chamber") applauds your efforts to highlight the harmful economic impact that the employer mandate is having on our country now two years after the enactment of the Patient Protection and Affordable Care Act, despite the fact that the mandate will not become fully effective for another two years. Your hearing regarding the Individual and Employer Mandates in the Democrats' Health Care Law on March 29, 2012 importantly showcased the ongoing harm that the mandate is having on business, jobs and the economy. The Chamber continues to support the repeal of the employer mandate and agrees that the employer mandate is discouraging employers from hiring, a fact that our members have verified in survey after survey.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees. For small businesses struggling to remain open, the new health reform law (the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, collectively referred to as "PPACA") and its myriad of requirements impose yet another financial challenge. In addition to imposing new mandates, the law is forcing small businesses and individuals to navigate the new legal requirements with fewer resources and fewer choices.

The employer mandate discourages growth, investment and hiring.

The U.S. Chamber of Commerce conducted a survey at the end of March 2012 with very important findings.[1]

[1] http://www.freeenterprise.com/health-care/new-survey-results-show-unpopularity-health-care-law

- Over 85% of respondents indicated that they do not expect the law to reduce the cost of health care or slow the rate of increase.

- Over 65% of respondents are very concerned that their business will not be able to comply with the law's new mandates.

- Over 84% said that the health care law will hurt their business.

As you mentioned in your opening statement, the Chamber also conducted a small business study two months earlier in January of 2012, which similarly provided daunting responses.[2]

- Of over 1,300 small business executives surveyed, 74% believe the recent health care law is an impediment to job creation. It simply makes it harder for their business to hire more employees.

- The level of pessimism by employers is frighteningly high, with 85% saying the economy is "on the wrong track." Only one in six employers say they intend to hire new workers next year.

The Chamber couldn't agree with you more as to the detrimental effects that the employer mandate is having on our economy and businesses. Particularly in these difficult economic times, we need to focus on encouraging growth, investment, and job creation. Instead, as employers wait to see how the general statutory provisions contained in the law are interpreted and implemented through the regulatory process, small businesses are doing everything they can to remain below the 50 full-time employee equivalent threshold and remain exempt from the employer mandate. Given that small businesses make up more than 99.7% of all employers (according to the U.S. Small Business Administration), to improve the economy and get more Americans back to work, we must restore confidence in our small businesses.[3]

Beyond our own recent survey and study, reports from the Congressional Budget Office also forecast dire results. In a report released on March 15, 2012, as many as 20 million Americans could lose their employer-provided coverage because of the health reform law. Additionally, the benefits are expected to be less than previously expected. Compared to a year ago, the law is now anticipated to cover two million fewer people, after factoring in penalties paid by individuals and businesses that don't get or provide healthcare coverage. Under the CBO's most optimistic estimate, 11 million mostly lower wage workers would lose their employer coverage. About three million would choose to drop their coverage to go into the new subsidized health exchanges or be enrolled in Medicaid, while another nine million would gain employer-sponsored coverage, for a net total of five million people losing employer coverage in 2019.[4]

---

[2] http://www.uschambersmallbusinessnation.com/community/quarterly-survey-2
[3] http://web.sba.gov/faqs/faqIndexAll.cfm?areaid=24
[4] http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf

The U.S. Chamber of Commerce appreciates this opportunity to submit a statement for the record on such an important issue. We look forward to working with you to repeal the employer mandate and pass meaningful health reforms that truly build on the employer sponsored system rather than undermine it.

Sincerely,

Randel Johnson

CC: Members of the Committee on Ways and Means Subcommittee on Health

NFIB and Small Business Coalition for Affordable Healthcare, Statement

March 29, 2012

The Honorable Wally Herger, Chairman
U.S. House Ways and Means Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Pete Stark, Ranking Member
U.S. House Ways and Means Subcommittee on Health
1106 Longworth House Office Building
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark,

Representing the country's largest, oldest and most respected small business associations who have spent more than a decade working to improve access to and affordability of private health insurance, the Small Business Coalition for Affordable Healthcare (SBCAH) appreciates the Ways and Means Subcommittee on Health looking into the effect of individual and employer healthcare mandates on America's job creators.

In the Patient Protection and Affordable Care Act (PPACA), the employer mandate penalizes businesses with 50 or more "full-time equivalent" employees if they do not provide government-prescribed health insurance, or if certain employees receive a tax credit and purchase insurance through the Exchanges. Regulations promulgated to implement this mandate are further exacerbating the confusion among employers, increasing employer uncertainty as to the various ways to: classify and define employees; calculate the impact of the cumbersome requirement; and minimize the costs associated with compliance. This cumbersome burden will only increase costs for small business owners.

This onerous mandate will force employers to use their resources and savings to pay these penalties, at the expense of hiring employees, creating jobs, and expanding their businesses. It also establishes a powerful disincentive to hire more than 50 full-time equivalent employees. Thus, it punishes both employers and employees alike. While the employer will struggle with the cost of the penalties, the employees will suffer lower wages and possibly job loss. According to the Congressional Budget Office (CBO), the employer mandate and other harmful provisions in PPACA would cost the economy over 800,000 jobs. CBO also recently estimated the employer mandate could cause as few as three to five million and as many as 20 million individuals to lose their current employer sponsored insurance coverage. This hurts small businesses that generate two-thirds of the new jobs each year.

Further, this unprecedented mandate creates more uncertainty for the nation's job creators. These penalties are already discouraging employers from making immediate and long-term business decisions

during our nation's economic recovery. Particularly now, small businesses need certainty to allow them to plan for the future as well as flexibility in providing health insurance to their employees.

SBCAH supports H.R. 1744, The American Job Protection Act, which will provide employers desperately needed certainty by repealing the employer mandate. The mandate – although not effective until 2014 – is already stifling job creation and economic growth and is counter-productive to the goal of expanding access to affordable health insurance for small businesses.

Again, SBCAH appreciates the Ways and Means Subcommittee on Health looking into the effect of individual and employer healthcare mandates on America's job creators. We look forward to working with you on these issues in the future.

Sincerely,

American Bakers Association

American Council of Engineering Companies

American Farm Bureau Federation ®

American Foundry Society

American Rental Association

American Supply Association

Associated Builders and Contractors, Inc.

Automotive Aftermarket Industry Association

Bowling Proprietors' Association of America

Electronic Security Association

International Franchise Association

National Association for the Self-Employed

National Association of Home Builders

National Association of Manufacturers

National Association of Wholesaler-Distributors

National Club Association

National Federation of Independent Business

National Restaurant Association

National Retail Federation

National Roofing Contractors Association

North American Die Casting Association

NPES The Association for Suppliers of Printing, Publishing and Converting Technologies

The Professional Golfers Association of America

Service Station Dealers of America and Allied Trades

Small Business and Entrepreneurship Council

Specialty Equipment Market Association

Tire Industry Association

U.S. Chamber of Commerce

Western Growers Association

○