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OBAMACARE'S IMPACT ON JOBS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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OBAMACARE'S IMPACT ON JOBS

WEDNESDAY, MARCH 13, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:12 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Hall, Shimkus, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Upton (ex officio), Pallone, Dingell, Schakowsky, Green, Butterfield, Barrow, Christensen, Sarbanes, and Waxman (ex officio).

Staff Present: Gary Andres, Staff Director; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Paul Edattel, Professional Staff Member, Health; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Debbee Hancock, Press Secretary; Sydne Harwick, Staff Assistant; Robert Horne, Professional Staff Member, Health; Carly McWilliams, Legislative Clerk; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator, Admin/Human Resources; Alli Corr, Minority Policy Analyst; Amy Hall, Minority Senior Professional Staff Member; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; Karen Nelson, Minority Deputy Committee Staff Director For Health; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

In today's sluggish economy, with depressed wages and millions of Americans who simply cannot find work, the Federal Government should be encouraging businesses to grow and expand and hire more people. We should be incentivizing good jobs that provide the opportunity for advancement and increased wages. As a result of Obamacare, however, we are doing exactly the opposite. And those who are hurt the most by the law are the most vulnerable: Low-wage young Americans in the retail and service industries.

Obamacare has multiple detrimental effects on American workers. It contains perverse incentives for employers to, one, not hire new employees; two, convert full-time employees to part-time status or only hire part-time workers; and, three, drop coverage they currently provide to employees. Additionally, the new taxes and

fees created by the law make it even harder for employers to compete in our current economy.

First, Obamacare requires that employers with 50 or more full-time equivalent employees provide Federally-approved health coverage or face a tax penalty of $2,000 for every employee beyond the 30th. If a business cannot afford to provide government-approved health insurance, making the decision to hire that 50thworker triggers the $2,000 penalty on the previous 20 employees as well. In many cases, employers have concluded that they simply cannot afford the cost of that 50th employee, effectively capping their growth and ensuring that fewer jobs exist for the millions of Americans who are unemployed or underemployed.

This is not theoretical. According to the January 2013 Report on Economic Activity published by the Federal Reserve, "Employers in several districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff."

Secondly, Obamacare is causing employers to convert full-time employees to part-time status and/or to hire only part-time worker employees, because the law defines anyone working 30 hours a week or more as full time, thus counting against the 50 FTE threshold. We are already seeing employers reducing hours of current employees so as not to trigger the employer mandate and resulting fine. And this trend disproportionately affects low-wage Americans in the restaurant, hotel, retail and service industries. Last month, The Wall Street Journal reported on a phenomenon known as part-time job sharing in the fast food industry. Here fast food chains such as the McDonald's, Burger King, or Wendy's will effectively share employees. An employee will work part-time in one restaurant, and then go work part-time in another. Both employers benefit—Obamacare does not require them to provide health insurance for part-time workers—but the employee suffers. He or she now has two part-time jobs, and yet still does not qualify for employer-sponsored insurance.

The Federal Reserve report confirms this trend. The report states that in Fed District 7, Chicago, some employers, "Are also beginning to limit hours for part-time workers to less than 30 hours in order to avoid the 30-hour"—that is the full-time employee status—"rule related to the Affordable Care Act."

Thirdly, those Americans blessed with a full-time job may lose their employer benefits. Many large employers have concluded that paying the $2,000 fine is still cheaper than providing health coverage. In some cases, large employers have found that they could save hundreds of millions of dollars or even billions of dollars by dropping coverage and paying the fine.

These devastating consequences of Obamacare are already being seen today. And as the law goes into effect in 2014, we will only get worse in future years. I look forward to hearing from our witnesses today exactly what the effects of Obamacare will be on jobs and the workforce.

And my time is up, so at this time, I will conclude and recognize the ranking member of the Subcommittee on Health, Mr. Pallone, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

In today's sluggish economy, with depressed wages, and millions of Americans who simply cannot find work, the federal government should be encouraging businesses to grow and expand and hire more people.

We should be incentivizing good jobs that provide the opportunity for advancement and increased wages.

As a result of Obamacare, however, we are doing exactly the opposite. And those who are hurt the most by the law are the most vulnerable—low-wage, young Americans in the retail and service industries.

Obamacare has multiple, detrimental effects on American workers. It contains perverse incentives for employers to: (1) not hire new employees, (2) convert full-time employees to part-time status or only hire part-time workers, and (3) drop coverage they currently provide to employees. Additionally, the new taxes and fees created by the law make it even harder for employers to compete in our current economy.

First, Obamacare requires that employers with 50 or more full-time equivalent (FTE) employees provide federally-approved health coverage or face a tax penalty of $2,000 for every employee beyond the 30th.

If a business cannot afford to provide government-approved health insurance, making the decision to hire that 50th worker triggers the $2,000 penalty on the previous 20 employees, as well.

In many cases, employers have concluded that they simply cannot afford the cost of that 50th employee, effectively capping their growth and ensuring that fewer jobs exist for the millions of Americans who are unemployed or under-employed.

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According to the January 2013 report on Economic Activity published by the Federal Reserve, "[E]mployers in several Districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff."

Second, Obamacare is causing employers to convert full-time employees to part-time status and/or to only hire part-time employees, because the law defines anyone working 30 hours a week or more as "full-time," thus counting against the 50 FTE threshold.

We are already seeing employers reducing hours of current employees so as not to trigger the employer mandate and resulting fine. And, this trend disproportionally affects low-wage Americans in the restaurant, hotel, retail, and service industries.

Last month, the Wall Street Journal reported on a phenomenon known as "part-time job sharing" in the fast food industry.

Here, fast food chains such as McDonald's, Burger King, or Wendy's will effectively "share" employees. An employee will work part-time at one restaurant and then go and work part-time at another.

Both employers benefit—Obamacare does not require them to provide health insurance for part-time workers.

But the employee suffers—he or she now has two part-time jobs and yet still does not qualify for employer-sponsored insurance.

The Federal Reserve report confirms this trend. The report states that in Fed District VII, Chicago, some employers "are also beginning to limit hours for part-time workers to less than 30 hours in order to avoid the 30-hour (full-time employee status) rule related to the Affordable Care Act."

Third, those Americans blessed with a full-time job may lose their employer benefits. Many large employers have concluded that paying the $2,000 fine is still cheaper than providing health coverage.

In some cases, large employers have found that they could save hundreds of millions or even billions of dollars by dropping coverage and paying the fine.

These devastating consequences of Obamacare are already being seen today, and, as the law goes into effect in 2014, will only get worse in future years.

I look forward to hearing from our witnesses exactly what the effects of Obamacare will be on jobs and the workforce.

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts. Critics of the Affordable Care Act have frequently claimed that the law would have a

negative impact on jobs and the overall health of the U.S. economy. But these claims have not been borne out by the facts. Simply put, health reform is contributing to lower health care costs which benefits families and employers by helping free up capital for saving, investing and hiring. Overall, national health spending is growing at a lower rate than it has in decades. The latest job numbers released last week showed that over 6 million private sector jobs were created since we passed the Affordable Care Act, and 750,000 of those jobs are in the health care sector.

Now, today I expect my colleagues to attempt to make the case that Congress must eliminate the employer mandate. Of course, they advocate that we should repeal the health care reform and, you know, their budget, which I understand they are voting on right now in the Budget Committee, would once again repeal the Affordable Care Act.

So, you know, they are honing in on the employer mandate as just part of their overall effort to kill the Affordable Care Act. But I strongly believe that these efforts to repeal not only employer mandate, but the whole bill are misguided. Most American workers already get their insurance through their employers. In fact, almost all, 93 percent of businesses with 50 to 199 employees already offer coverage. The Affordable Care Act purposely didn't change that, despite claims that it is a Federal takeover of health insurance. And in a private employer-based system aimed at getting at many Americans covered as possible, which is the main goal of health reform, it is important that all but the smallest businesses share the costs. And that is why every small business with fewer than 50 employees is completely exempt from the laws and employer responsibility provisions.

Now, it is no secret that medical care accounts for 18 percent of the U.S. Gross domestic product, and it is taking up at least as much of the mind share of plenty of American entrepreneurs and business owners. So what the Affordable Care Act attempts to do is increase access to the millions of uninsured Americans while slowing the growth of health care.

Now, I feel like we have had this discussion so many times, I don't know how, 50, 100. We will have it again on the floor with the budget this week. Unfortunately, it is still misunderstood that the rate at which health care costs have risen hang on the fact that so many have gone without insurance. Those uninsured don't go uncared for if they get sick, but, instead, they use the emergency room or simply go to the hospital and don't pay. And these billions in uncompensated care get passed along to the health care consumers, including large and small employers who offer insurance in the form of higher premiums. So by covering more people, we eliminate the need to cover this uncompensated care.

Now, I advocated and pushed forward the Affordable Care Act because I strongly believed that as health care costs were skyrocketing, American families and businesses simply couldn't continue to bear that weight. Business owners know that if current trends continue, health care spending will double in less than 10 years. For those American businesses and for the economy, defending the status quo just simply wasn't an option. And I know a lot of businesses are unsure, Mr. Chairman, of the law and some are

fearful that will cause an inability for the business to grow. But I believe that the mandate helps put smaller businesses on a more competitive footing with large firms, and it evens the playing field for those businesses that already provide health coverage but are forced to compete with companies that don't.

So, Mr. Chairman, let me just close by saying above all else, I believe that most employers want to be part of the solution and once they begin to comply, I am confident they will begin to understand the overall advantages to offering health benefits. Republican efforts to discredit the law and misinform the public can't obscure the fact that more and more Americans are benefiting from the provisions of the Affordable Care Act. I just don't understand. We continue to have hearings about either repealing the bill outright, which is what the Republican budget is discussing, you know, the Republicans are discussing in the Budget Committee right now, or repealing parts of it or cutting back on the funding.

The fact of the matter is the Affordable Care Act is a good bill. And the more their efforts are cut back on funding it, not implementing it, the more Americans will suffer. So I hope this is the last hearing we have on why the Affordable Care Act is, in the Republicans' opinion, not a good idea. But I guess that is wishful thinking on my part. I yield back.

Mr. PITTS. That is wishful thinking. On Friday we have one on premium increases that will further discuss the impact of the new law on premiums.

With that, the chair now recognizes the chairman of the full committee, Mr. Upton, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman. You know, millions of Americans are still struggling to find jobs, and is this committee's main priority to get them back to work. Today we are going to examine the Affordable Care Act's impact on the economy and jobs. And, fortunately, based on testimony that we are going to hear today, it is clear that the law is hurting our Nation's economy, and those Americans are trying to find work—particularly with those Americans who are trying to find work and make ends meet. Just this past week, the Federal Reserve released a report that painted a pretty grim picture of how the law is going to affect our economy. According to the Fed's own analysis, the law is leading employers to delay and minimize new hires.

Uncertainty stemming from the health care law is a leading concern for American businesses, large and small. One major provision causing much of the uncertainty is, of course, the law's employer mandate. Starting next year, employers with 50 or more full-time workers will be forced to provide Washington-approved health care coverage or pay a tax penalty. As we are going to hear from our expert witnesses today, this requirement is going to hurt part-time workers looking for more hours and Americans still looking for a job. As a result of the health care law, employers with 49 workers must now weigh whether hiring an additional worker is really worth the $40,000 tax penalty imposed by the IRS if they are unable to provide Washington-approved health care coverage.

At a time when our unemployment rate is still much too high, the Affordable Care Act is making it harder for our nation's employers to hire new workers. The new law is, in essence, penalizing job creation. For employers who decide that they are still going to want to offer health care coverage, the law is going to make it even more expensive. Last week our committee released a report highlighting over 30 studies that analyzed the new law's impact on health care premiums. One survey found that small group premiums could increase as much as 200 percent for employers with younger workforces. A specific provision causing premium increases is the $165 billion in new taxes on plans, medical devices, and drugs that are going to go passed onto consumers.

In addition, the Affordable Care Act includes price controls, regulations, and mandates that are going to lead to huge premium spikes. In my home state of Michigan, some folks will see their premiums go up as much as 35 to 65 percent. These statistics are not just projections on a sheet of paper, they have significant consequences as millions of American workers will see lower wages and less take-home pay because of the new law. Let's hope that we can work together to see what we can do to get these things down. I yield the balance of my time to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Millions of Americans are still struggling to find jobs, and it is the committee's main priority to get them back to work. Today, we will examine the Affordable Care Act's impact on the economy and jobs. Unfortunately, based on testimony we will hear today, it is clear that the law is hurting our nation's economy and those Americans trying to find work and make ends meet.

Just this past week, the Federal Reserve released a report that painted a grim picture of how the law will affect our economy. According to the Fed's own analysis, the law is leading employers to delay and minimize new hires.

Uncertainty stemming from the health care law is a leading concern for American businesses large and small. One major provision causing much of this uncertainty is the law's employer mandate. Starting in 2014, employers with 50 or more full-time workers will be forced to provide Washington-approved health coverage or pay a tax penalty. As we will hear from our expert witnesses today, this requirement will hurt part-time workers looking for more hours and Americans still looking for a job.

As a result of the health care law, employers with 49 workers must now weigh whether hiring an additional worker is worth the $40,000 tax penalty imposed by the IRS if they are unable to provide Washington-approved health care coverage. At a time when our unemployment rate is still much too high, the Affordable Care Act is making it harder for our nation's employers to hire new workers. The new law is essentially penalizing job creation.

For employers who decide that they still want to offer health insurance coverage, the law will make it more expensive. Last week, our committee released a report highlighting over 30 studies that analyzed the new law's impact on health care premiums. One survey found that small group premiums could increase as much as 200 percent for employers with younger workforces.

A specific provision causing premium increases is the $165 billion in new taxes on plans, medical devices, and drugs that will be passed on to consumers. In addition, the Affordable Care Act includes price controls, regulations, and mandates that will also lead to huge premium spikes. In my home state of Michigan, some folks will see their premiums go up between 35 to 65 percent.

These statistics are not just projections on a sheet of paper. They have significant consequences as millions of American workers will see lower wages and less take home pay because of the law.

My hope is that the president and Congress can work together to avert the real harm the law is having on employers and workers across this nation before it is too late. I would like to thank the witnesses for their time and expertise today.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for yielding. I thank the chairman of the subcommittee for calling this hearing.

We have all heard, of course, that provisions of the Affordable Care Act are not going to take place until January 2014. But, honestly, employers and companies are already feeling the effects of this disastrous law. The affordability—patient protection afford—accountability—I can't even say it; "affordability" doesn't belong in the title. But it has a direct and indirect effect on employers and employees. Individuals who will not only be affected directly by new taxes, but also indirectly as employers are forced to lower wages and decrease hiring in order to compensate for the new taxes that employers face. The law includes a tax intended to encourage employers to provide health insurance to their employees. Instead of encouraging growth, this tax creates a disincentive for employers to grow their workforce.

Not only does the law tax employers more if they hire additional employees, but the law gives employers an outlet, a safety valve, to drop coverage for their employees by providing premium subsidies to individuals in the exchanges.

At a time this country is beginning to find relief from the severe recession and its high unemployment, now is not the time to discourage economic growth. Instead of expanding coverage and lowering costs, the President's health care law has pushed greater costs onto the backs of consumers, forcing those who are not responsible to bear the effects of higher costs.

Mr. Chairman, I just can't help but observe this past weekend when I sat down with my accountant with a shoe box full of receipts to do any income taxes, he pointed out to me on the W-2 form a new line which has not existed before in which the employer's contribution to an employee's health insurance now appears. That begs the question, why is that there? At some point, that line is going to be taxed. Right now, it is there as sort of an innocent bystander. But, trust me, the IRS will not sit still long before that is added to the tax burden, which only increases the cost of delivering care in this country.

Thank the chairman for the recognition. I yield back my time.

Mr. PITTS. Chair thanks the gentleman. And now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. Today's hearing is entitled "Obamacare and Jobs." It is a topic that has been the focus of an endless stream of campaign ads, press releases, and talking points ever since the passage of the Affordable Care Act in 2010. Given this topic's prominence in the Republican echo chamber, and this subcommittee's hearings on it in the last Congress, it is understandable if members experience some deja vu during today's hearing.

We will hear some dire predictions that we have been hearing for 3 years about this supposedly nefarious piece of legislation. And just as before, these claims will be what every independent fact checker has called them: Whoppers, false, and political gamesmanship. Since the passage of the Affordable Care Act, we have added 6 million private sector jobs. That is 3 years of continuous job growth.

Throughout this period of growth, businesses have known what reforms look like. They have had time to plan and to account for new rules and consumer protections. And despite the dire warnings about this job-killing law and the troubling statements some businesses have made in anonymous surveys, we have seen steady job growth and we have seen health costs rise at historically low levels.

Republicans expect us to believe all of this is happening in spite of health reform rather than because of it. And that is their right, to say it, but it is not credible. I hope the Republicans will heed Speaker Boehner's advice to accept health reform as the law of the land. I hope that they will start looking at the empirical evidence rather than the Tea Party rhetoric.

Democratic witness today, Dr. Linda Blumberg, has looked at the empirical evidence. She, like the Congressional Budget Office, or I should say the nonpartisan Congressional Budget Office, has crunched the numbers and determined that the Affordable Care Act does not raise costs on employers, will not cause job losses, and will not lead to a decline in employer sponsored health coverage. But I fear that the reason we are here today is not to discuss what is really in the Affordable Care Act or to have a good-faith discussion about ways to improve upon it in the future, or to make sure that it succeeds.

Rather, the goal is to amplify the voices of a small minority who believe that the discriminatory, dysfunctional system we have had before was working fine. My Republican friends think that we should double down on the same deregulatory approach to health insurance that led to ever higher costs, tens of millions of more uninsured, and did nothing to control health care costs.

I don't believe that is the way forward. Because of health reform, insurers will no longer be able to exclude consumers from coverage based on preexisting conditions or gouge them for 40-percent profit margins or charge them premiums 10 times as high as their neighbors because of a preexisting condition, their age, their gender, or for any other reason.

Because of health reforms, small businesses are able to get tax credits to help pay for coverage, and they will be able to pool their purchasing power, like bigger businesses, to keep their costs low and decrease the risks that one sick employee will dramatically raise their costs. Because of health reform, workers will have the security of knowing that they can get quality affordable coverage, even if they change jobs, or they employer doesn't offer it.

Because of health reform, businesses will have a healthier, more productive workforce. These are real steps forward. It is interesting to take note of the Republican budget that was just presented to the world yesterday. You know what they did? They took all the savings in the Affordable Care Act that they complained about and kept them. But they took all the benefits of the Affordable Care Act

and repealed them. That is what they would like to do to this country. I think that we ought to note that as we have this hearing, which is just for politics, just as their budget is just for politics. But it is the same politics that was rejected by the American people in the last election. Accept the Supreme Court decision, accept the election results, work together as Americans to make sure that we can successfully cover all Americans for health insurers and not see them treated so poorly as we have had in the health care system over all the time up to the present. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman.

We have one panel today. And I will introduce them at this time. Three witnesses. Ms. Diana Furchtgott-Roth, Senior Fellow to the Manhattan Institute. Dr. Linda Blumberg, Senior Fellow at the Urban Institute. And Mr. Tom Boucher, owner and CEO of Great New Hampshire Restaurants, Inc. He is testifying on behalf of the National Restaurant Association.

You will each be given 5 minutes to summarize your testimony. Your written testimony will be entered into the record.

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

STATEMENTS OF DIANA FURCHTGOTT-ROTH, SENIOR FELLOW, MANHATTAN INSTITUTE; TOM BOUCHER, OWNER AND CHIEF EXECUTIVE OFFICER, GREAT NEW HAMPSHIRE RESTAURANTS, INC., TESTIFYING ON BEHALF OF THE NATIONAL RESTAURANT ASSOCIATION; AND LINDA J. BLUMBERG, SENIOR FELLOW, THE URBAN INSTITUTE

STATEMENT OF DIANA FURCHTGOTT-ROTH

Ms. FURCHTGOTT-ROTH. Thank you very much. Thank you very much for inviting me to testify today.

As we have heard, the Affordable Care Act is going to raise the cost of employment when fully implemented. Companies with 50 or more workers will be required to offer a generous health insurance package. The penalty raises significantly the cost of employing full-time workers, especially low-skilled workers, because the penalty is a higher proportion of their compensation than for highly paid workers.

So the $2,000 penalty amounts to 10.9 percent of average annual earnings in the food and beverage industry and 9.3 percent in retail trade. This is in addition to the employers' cost of Social Security and Medicare. So whereas economic models might show that the cost does not have an effect on the overall amount of hiring, it does have effect on specific parts of the employment spectrum, namely, low-skilled workers. To look at the effects of the requirements to offer health insurance, I suggest to the honorable members of the committee the following thought experiment. What if employers were required to pay the cost of food, clothing, or housing for their employees? These are admittedly far more important than health insurance. Well, they would hire with employees with more skills, they would reduce the cash wage to compensate. This is what we are going to see in the same scale for employees with the Affordable Care Act.

So I heard today from the honorable members that the Affordable Care Act doesn't raise costs and they don't see where it raised costs. Well, here's why it does. First of all, it requires an overly generous plan, a plan offered in the exchange has to have no copayments for routine care, mandatory drug abuse coverage, mandatory mental health coverage. And low-cost plans, catastrophic health plans, where you are just insured against routine—where you are just insured against large expenditures, such as falling off your bicycle in traffic or catching cancer or having a heart attack, those kinds of plans are not allowed. But those kinds of plans are less expensive than the other plans.

Another reason it raises costs is the structure of guaranteed issue. Under the Supreme Court decision, you could pay a tax and legally not get health insurance. Tax is $95 the first year, 2014; about $350 the second year; 690 the third year. That is much smaller than the cost of buying health insurance. So anyone who is young and healthy is going to just legally pay the tax, not get health insurance. So the pool of sick people who are insured is going to get sicker and sicker. So we are going to get that more sick people in the pool of insured. That is going to raise costs. These people who are uninsured who pay the tax are then going to go to emergency rooms. So people will still be going to emergency rooms. There is also a large loophole in the bill that is again going to require people to go to emergency rooms. If you get affordable care under the act, if your employer offers you affordable care, you are required to take it. So say you are married, you have a family, your employer offers you affordable health care. But he is only required to offer you affordable care for a single person, not for a family. You are required to take that. So you have a wife and three children, and you are low income. The wife and three children cannot get subsidies on the exchanges. They are not required to be insured by the employer either. So these people, the families of individuals who are insured by the employer are going to be going to the emergency rooms because they won't qualify for subsidies.

What we have here in the bill is a bill that gives people an incentive to hire high-skilled workers. Because if you hire a high-skilled worker and you pay them, say, average wage above $50,000 a year or so, you take the cost of the health care plan out of their wage, they get a lower cash wage. So as an employer, you are left basically where you are before. But low-skilled workers, you are incentivized to hire part-time, under 30 hours a week. If you are a small business, you are incentivized not to grow more than 50 workers because then you get a penalty. You are incentivized to hire capital for labor, as we see these self-scanning machines in drug stores, and we see that people who take money when you go out of parking lots are no longer there, you just put your credit card in the machine.

So the economy might do fine, as Dr. Blumberg is going to say. But low-skilled workers are going to lose out. And the costs of health care in the United States are going to rise because of the incentives that I just described. Thank you very much for giving me the opportunity to testify, and I would be glad to answer any questions afterwards.

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

Effects of the Affordable Care Act on Jobs

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Senior Fellow, Manhattan Institute

Testimony before the Subcommittee on Health of the House Energy and Commerce Committee

March 13, 2013

Effects of the Affordable Care Act on Jobs

Chairman Pitts, members of the Committee, I am honored to be invited to testify before you today on the effects of the Affordable Care Act on jobs. 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 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. I am the author of a study entitled *The Effects of the Patient Protection and Affordable Care Act on the Franchise Industry*.

High unemployment tops of the list of concerns for Americans. In early March, the Labor Department announced that the February unemployment rate declined to 7.7 percent. That was good news, but the Department also announced that the labor force participation rate declined to 63.5 percent, equivalent to levels in September 1981. The civilian labor force declined by 130,000. Many workers left the labor force because they have not been able to find jobs.

It is normal in a recovery for the labor force participation rate to rise, not decline, as people move back into the labor force. This recovery, however, has been accompanied

by a shrinking workforce. Including discouraged and underemployed workers, the Labor Department's measure of unemployment is 14.3 percent.[1]

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 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.

To look at the effects of the requirement to offer health insurance, I suggest to the honorable Members of the Committee the following thought experiment. What if employers were required to provide food, clothing or housing—admittedly far more important than health insurance? Firms would hire fewer employees. They would hire

[1] Bureau of Labor Statistics, "The Employment Situation—February 2013," March 8, 2013, http://bls.gov/news.release/pdf/empsit.pdf.

employees with more skills. They would reduce the cash wage to compensate for the amount they had to spend on food, clothing, and housing.

The same is happening in a smaller scale with the requirement to provide a certain level of health insurance or pay a fine. 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 11.2 percent. Teens face an unemployment rate of 25.1 percent. The rate for African American teens is even higher, at 43.1 percent.[2]

Another group that is disproportionately affected is younger workers. Of the 1.4 million adults who found jobs over the past year, over 1 million are over 55 years old, and

[2] Bureau of Labor Statistics, ibid.

336,000 are between ages 25 and 55—even though the 25 to 55 group is over 50 percent larger than the 55 and older group. 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.[3] 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

[3] PricewaterhouseCoopers (PwC), February 2011, *The Economic Impact of Franchised Businesses: Volume III, Results for 2007*, February 2011, http://www.buildingopportunity.com/download/National%20Views.pdf.

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 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.

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 11.2 percent, nearly 3 times as high as rates for college graduates, and well above the national average of 7.7 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 10.9 percent of average annual earnings in the food and beverage industry and 9.3 percent in retail trade.[4] 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 February over 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

[4] Bureau of Labor Statistics, Current Employment Statistics, March 8, 2013, http://www.bls.gov/web/empsit/ceseeb8b.htm.

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 government estimates.

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.

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.

The $2,000 and $3,000 per worker tax payments are the most visible taxes under the new health care law, but they are not the only taxes. The U.S. Government Accountability Office has published a list of 47 different tax provisions in the new law. This list is reproduced in Table 4.

Despite the broad new array of taxes, the Act is structured so as to give the Internal Revenue Service limited enforcement to collect the tax, so that most individuals will be able to avoid paying individual penalties altogether. This will leave the burden of the tax to be paid by employers.

In a June 25, 2012 article in *Tax Notes,* law professors Jordon Barry of the University of San Diego School of Law and Bryan Camp of the Texas Tech University School of Law describe precisely how the Act limits the collection of the tax penalties by the Internal Revenue Service.

Under Section 5000A, the Act does not allow the IRS to use prosecution or criminal penalties to collect the health insurance tax penalty. Further, the IRS is not allowed to place a levy on a person's property, or file a notice of lien to collect the tax. This is completely at odds with other methods of collecting federal taxes, Barry and Camp explain.

The IRS could collect the tax penalty if taxpayers were entitled to a refund of overpaid federal income taxes. The agency could then subtract the health insurance penalty from the refund. But if taxpayers underpaid their income taxes, and were not entitled to a refund, collection would be most difficult.

Barry and Camp conclude, "The restrictions placed on the IRS's ability to collect the tax penalty make it unlikely the IRS can effectively enforce the individual mandate....Thus, many taxpayers who neglect or refuse to pay the tax penalty could structure their

affairs in such a way as to avoid being subject to legal consequences of any sort for years to come, if ever."[5]

Although individuals will be able to avoid paying the tax, employers will not. Increased hiring costs will cause them to reduce hiring by substituting skilled for unskilled employees in some cases, and machines for employees in others. Placing a tax on hiring will only further reduce the growth of employment.

[5] Barry, Jordan M. and Bryan Camp, *Is the Individual Mandate Really Mandatory?* Tax Notes, Vol. 135, p. 1633, June 25, 2012.

Table 1: Disincentives for Growth

	Avg. Annual Wage
Full-time Employees	$40,000

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Full-Time Employees	49	50	75	100	150
2014 Penalty	$0	$40,000	$90,000	$140,000	$240,000
Change in Cost per Employee (2014)	$0	$800	$1,200	$1,400	$1,600
Percent Cost Increase Per Employee (2014)	0.0%	2.0%	3.0%	3.5%	4.0%

Source: Author calculations based on new health care law.

Note: Scenario 1 assumes that there are no part-time employees and therefore the employer mandate does not apply.

Table 2: Cost Savings from Moving Workers from Full-time to Part-time

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6
Full-time Employees	85,000	68,000	51,000	34,000	17,000	0
Part-time Hourly Employees	7,000	28,250	49,500	70,750	92,000	113,250
2014 Employer Mandate Penalty	$169,940,000	$135,940,000	$101,940,000	$67,940,000	$33,940,000	0
Change in Total Cost (2014)	$169,940,000	-$113,593,500	-$397,135,500	-$680,653,000	-$964,231,000	- $1,247,679,750
Percent Change in Cost per Employee	6.64%	-8.66%	-22.67%	-35.55%	-47.42%	-58.40%
Assumed Cost Per Labor Hour (2011)	$19.60	$19.60	$19.60	$19.60	$19.60	$19.60
Cost Per Labor Hour (2014)	$20.91	$18.73	$16.56	$14.39	$12.21	$10.04

Source: Author calculations based on new health care law.

Note: The calculation is full-time employees minus the exempted 30 full-time employees, and then multiplied by the $2,000 employer mandate penalty.

Table 3: Estimated Effect of Healthcare Reform on Multi-Unit Franchise Businesses

Business Category	Jobs	Establishments	Employer Mandate Penalty	Full-time Jobs at risk
Quick service restaurants	1,174,957	62,404	$1,631,664,898	820,057
Table/Full Service restaurant	350,648	12,467	$557,958,133	279,746
Business services	306,658	49,474	$228,654,370	113,692
Lodging	318,159	11,976	$501,453,723	250,048
Personal services	294,945	66,584	$166,025,405	90,595
Retail food	159,901	19,961	$129,928,679	65,043
Real Estate	189,104	48,429	$102,037,036	52,421
Retail products and services	150,626	40,618	$80,171,475	40,025
Commercial and residential services	124,603	35,004	$65,120,442	32,619
Automotive	72,398	13,453	$42,741,404	21,360
All Multi-Unit Franchisees	3,141,999	360,371	$3,505,755,565	1,765,607

Source: U.S. Bureau of the Census, 2007 Economic Census; International Franchise Association, member data; and author calculations.

Table 4: Tax Provisions in the Affordable Care Act

	Legislation section	Internal Revenue Code (IRC) section	Provision description	Internal Revenue Service's (IRS) role	Effective date
1	1001		Prohibits group health plans from discriminating in favor of highly compensated individuals.	Issued notice inviting public comment on application to group health plans.	9/23/2010
2	1102		Establishes a temporary reinsurance program to provide reimbursement for a portion of the cost of providing health insurance coverage to early retirees.	Ensure payments received for submission of claims for health coverage to early retirees are not included in the gross income of the employment-based plan.	3/23/2010 Until 1/1/2014
3	1104		Imposes a penalty on health plans identified in an annual Department of Health and Human Services (HHS) penalty fee report, which is to be collected by the Financial Management Service after notice by the Department of the Treasury (Treasury).	Draft guidance or regulations, according to IRS.	3/23/2010
4	1311		Requires state exchanges to send to Treasury a list of the individuals exempt from having minimum essential coverage, those eligible for the premium assistance tax credit, and those who notified the exchange of change in employer or who ceased coverage of a qualified health plan.	Coordinate with HHS on drafting guidance or regulations, according to IRS.	3/23/2010

5	1322	501(c)(29)	Provides tax exemption for nonprofit health insurance companies receiving federal start-up grants or loans to provide insurance to individuals and small groups.	Ensure tax exemption for certain nonprofit health insurers receiving loans or grants under the Consumer Operated and Oriented Plan as established by HHS to provide insurance in the individual and small-group market.	3/23/2010
6	1341		Provides tax exemption for entities providing reinsurance for individual policies during first 3 years of state exchanges.	Ensure tax exemption for entities providing reinsurance for individual health insurance policies during the first 3 years of state exchanges.	3/23/2010
7	1401	36B	Provides premium assistance refundable tax credits for applicable taxpayers who purchase insurance through a state exchange, paid directly to the insurance plans monthly or to individuals who pay out-of-pocket at the end of the taxable year.	Prescribe regulations governing the reconciliation of advance payment amounts with authorized credits and where taxpayer's filing status differs from what was used to determine credit eligibility.	01/01/2014
8	1402		Provides a cost-sharing subsidy for applicable taxpayers to reduce annual out-of-pocket deductibles.	Prescribe regulations with the Secretary of HHS on calculating family size and household income.	3/23/2010
9	1411	36B	Outlines the procedures for determining eligibility for exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.	Verify household income and family size for purposes of eligibility for the tax credit and cost-sharing reduction.	3/23/2010

10	1412	36B	Allows advance determinations and payment of premium tax credits and cost-sharing reductions.	Make advance tax credit payments directly to issuer of a qualified plan on a monthly basis. Collect information from exchanges on individuals' participation, including the plan purchased and amounts advanced.	3/23/2010
11	1414	6103	Authorizes IRS to disclose certain taxpayer information to HHS for purposes of determining eligibility for premium tax credit, cost-sharing subsidy, or state programs including Medicaid, including (1) taxpayer identity; (2) the filing status of such taxpayer; (3) the modified adjusted gross income of taxpayer, spouse, or dependents; and (4) tax year of information.	Disclose certain taxpayer information to HHS officers, employees, and contractors on any taxpayer whose income is relevant to determining their eligibility for the premium tax credit, cost-sharing subsidy, Medicaid, state Children's Health Insurance Program, or a basic state health program established under PPACA.	3/23/2010
12	1421	45R	Provides nonrefundable tax credits for qualified small employers (no more than 25 full-time equivalents (FTE) with annual wages averaging no more than $50,000) for contributions made on behalf of its employees for premiums for qualified health plans.	Administer tax credit for small employers who contribute to health insurance premiums for their employees.	1/1/2010

13	1501	5000A	Requires all U.S. citizens and legal residents and their dependents to maintain minimum essential insurance coverage unless exempted starting in 2014 and imposes a fine on those failing to maintain such coverage.	Collect penalties incurred by individuals who do not have minimum essential health insurance coverage, using limited collection methods including offsetting penalty amounts against refunds or credits.	1/1/2014
14	1502	6055, 6724(d)	Requires every person who provides minimum essential coverage to file an information return with the insured individuals and with IRS.	Prescribe the form and manner of the information return required to be filed by January 31 by all insurers, including employers that provided minimum essential health coverage to individuals in the preceding year. Apply penalties where an insurer does not file the information return. Notify individuals filing tax returns who do not have minimum essential health coverage that they can be penalized and provide information on the individual's state exchange.	1/1/2014

15	1513	4980H	Imposes a penalty on large employers (50+ FTEs) who (1) do not offer coverage for all of their full-time employees, offer unaffordable minimum essential coverage, or offer plans with high out-of-pocket costs and (2) have at least one full-time employee certified as having purchased health insurance through a state exchange and was eligible for a tax credit or subsidy.	Collect penalties assessed annually, monthly, or periodically and repay any penalty including interest where the premium credit or cost sharing is subsequently disallowed.	1/1/2014
16	1514	6056, 6724(d)	Requires information reporting of health insurance coverage information by large employers (subject to IRC 4980H) and certain other employers.	Prescribe the form of the information return to be filed by large employers and other employers offering minimum essential health coverage certifying that coverage was offered and providing information on the individuals covered, and impose penalties on those failing to submit returns.	1/1/2014
17	1515	125(f)(3)	Offers tax exclusion for reimbursement of premiums for small-group exchange-participating health plans offered by small employers to all full-time employees as part of a cafeteria plan.	Ensure tax exclusion for employers offering exchange-participating health plan in an employee cafeteria plan.	1/1/2014
18	1563	9815	Subjects new group health plans to certain Public Health Service Act requirements and imposes the excise tax on plans that fail to meet those requirements. (conforming amendment)	Impose the excise tax for failure to meet Public Health Service Act requirements on new group health plans under PPACA.	3/23/2010

19	3308	6103	Authorizes IRS to disclose certain taxpayer information to the Social Security Administration (SSA) regarding reduction in the subsidy for Medicare Part D for high-income beneficiaries. (conforming amendment)	Disclose certain taxpayer return information to SSA under IRC 6103.	3/23/2010
20	5605		Requires the independent institute partnering with the National Academy of Sciences (NAS) to implement a key national indicator system to be a nonprofit entity under section 501(c)(3).	Enable the independent private organization partnering with NAS to create the key national indicator system to be a nonprofit entity under IRC 501(c)(3).	3/23/2010
21	6301	4375, 4376, 4377, 9511	Imposes a fee through 2019 on specified health insurance policies and applicable self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund to be used for comparative effectiveness research.	Administer fee on insured and self-insured health plans equal to $2 per individual insured ($1 in plan years ending during fiscal year 2013) to be used by Patient-Centered Outcomes Research Trust Fund for comparative effectiveness research.	10/1/2012
22	9001	4980I	Imposes a 40 percent excise tax on high cost employer-sponsored health insurance coverage on the aggregate value of certain benefits that exceeds the threshold amount.	Administer excise tax on high-cost employer-sponsored health insurance coverage and impose penalties on employers, or the plan sponsor for multiemployer plans, for failure to properly calculate amount of the excess benefit subject to the tax.	1/1/2018
23	9002	6051	Requires employers to disclose the value of the employee's health insurance coverage sponsored by the employer on the annual Form W-2.	Administer change to W-2 reporting to include the value of employer-sponsored health coverage excluding any flexible health spending arrangements.	1/1/2011

24	9003	105, 106, 220, 223	Repeals the tax exclusion for over-the-counter medicines under a Health Flexible Spending Arrangement (FSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), or Archer Medical Savings Account (MSA), unless the medicine is prescribed by a physician.	Administer change to qualified expenses that can be reimbursed by a health FSA or HSA to include only prescription drugs and insulin.	1/1/2011
25	9004	220, 223	Increases tax on distributions from HSAs and Archer MSAs not used for medical expenses.	Administer increase to tax on distributions from HSAs and Archer MSAs that are not used for qualified medical expenditures.	1/1/2011
26	9005	125	Limits health FSAs under cafeteria plans to a maximum of $2,500 adjusted for inflation.	Administer reduction in health FSA amounts to a maximum of $2,500 adjusted for inflation.	1/1/2013
27	9007	501(c)(29), 4959, 6033	Imposes additional reporting requirements for charitable hospitals to qualify as tax-exempt under IRC 501(c)(3) and requires hospitals to conduct a community health needs assessment at least once every 3 years and to adopt a financial assistance policy and policy relating to emergency medical care.	Ensure compliance with additional requirements for charitable hospitals to qualify as 501(c)(3) organization, review community benefit activities at least once every 3 years, impose penalties for failing to conduct community needs assessment, issue guidance on what constitutes reasonable efforts to determine patient eligibility for financial assistance under the hospital's policy, and annually report to Congress on levels of charity care provided and costs of care incurred.	3/23/2010 Community assessment: 03/23/13

28	9008		Imposes a fee on each covered entity engaged in the business of manufacturing or importing branded prescription drugs.	Calculate the fee amount and collect fee on manufacturers of branded prescription drugs sold to Medicare Parts B and D; Medicaid; Department of Veterans Affairs (VA); TRICARE; or other Department of Defense or VA programs.	1/1/2011
29	9010		Imposes an annual fee on any entity that provides health insurance for any U.S. health risk with net premiums written during the calendar year that exceed $25 million.	Calculate and collect annual fee on certain health insurance providers and administer penalties for entities who fail to report the amount of their net premiums for the calendar year, or report inaccurately.	1/1/2014
30	9012	139A	Allows the deduction for retiree prescription drug expenses only after the deduction amount is reduced by the amount of the excludable subsidy payments received.	Ensure amount of deduction for retiree prescription drug expenses has been reduced by any subsidy payments received.	1/1/2013
31	9013	213	Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5 percent of Adjusted Gross Income (AGI) to 10 percent of AGI (unless taxpayer turns 65 during 2013-2016 and then threshold remains at 7.5 percent).	Ensure itemized deductions for unreimbursed medical expenses by taxpayers meet the 10 percent AGI threshold.	1/1/2013

32	9014	162	Denies the business expenses deductions for wage payments made to individuals for services performed for certain health insurance providers if the payment exceeds $500,000.	Ensure deductions for remuneration exceeding $500,000 are not allowed for certain insurance providers.	01/01/13: For services performed after 12/31/09
33	9015	1401, 3101, 3102	Imposes an additional Hospital Insurance (Medicare) Tax of 0.9 percent on wages over $200,000 for individuals and over $250,000 for couples filing jointly.	Collect additional Hospital Insurance Tax to remit to the hospital insurance trust fund.	1/1/2013
34	9016	833	Limits eligibility for deductions under section 833 (treatment of Blue Cross and Blue Shield) unless the organizations meet a medical loss ratio standard of at least 85 percent for the taxable year.	Issue guidance on determining medical loss ratio and ensure that proper deductions are allowed under IRC 833.	1/1/2010
35	9021	139D	Allows an exclusion from gross income for the value of specified Indian tribe health care benefits.	Ensure that the value of specified Indian tribe health care benefits is not included in gross income.	3/23/2010
36	9022	125	Allows small businesses to offer simple cafeteria plans—plans that increase employees' health benefit options without the nondiscrimination requirements of regular cafeteria plans.	Ensure compliance with requirements of "simple cafeteria plans" for small businesses.	1/1/2011

37	9023	48D	Establishes a 50 percent nonrefundable investment tax credit for qualified therapeutic discovery projects.	Award certifications with HHS for qualified investments and distribute the $1 billion provided for 2009 and 2010 as tax credits or grants.	1/1/2009
38	10108	139D	Requires employers to provide free choice vouchers to certain employees who contribute over 8 percent but less than 9.8 percent of their household income to the employer's insurance plan to be used by employees to purchase health insurance though the exchange.	Ensure that taxpayers receiving vouchers do not get the premium assistance tax credit or cost sharing subsidy and do not include the amount of the free choice voucher in calculating gross income, and allow employers to deduct cost of voucher as a business expense.	1/1/2014
39	10907	5000B	Imposes a tax on any indoor tanning service equal to 10 percent of amount paid for service.	Ensure tax is collected and remitted to IRS at time and in manner specified.	7/1/2010
40	10908	108(f)(4)	Excludes from gross income amounts received by a taxpayer under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.	Ensure that student loan repayments or forgiveness for certain health care professionals working in certain areas are excluded from gross income.	1/1/2009
41	10909	23, 137	Increases the maximum adoption tax credit and the maximum exclusion for employer-provided adoption assistance for 2010 and 2011 to $13,170 per eligible child.	Facilitate the expansion of the already established adoption credit and exclusion for the adoption assistance program.	1/1/2010

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010)					
42	1004	105, 162, 401, 501	Extends the exclusion from gross income for reimbursements for medical expenses under an employer-provided accident or health plan to employees' children under 27 years.	Ensure that taxpayers properly exclude (or deduct, in the case of self-employed taxpayers) amounts paid by employers for health insurance for employees' older children.	3/30/2010
43	1402	1411	Imposes an unearned income Medicare contribution tax of 3.8 percent on individuals, estates, and trusts on the lesser of net investment income or the excess of modified adjusted gross income (AGI + foreign earned income) over a threshold of $200,000 (individual) or $250,000 (joint).	Ensure collection of unearned income Medicare contribution tax on net investment income or modified adjusted income of certain individuals, trusts, or estates.	1/1/2013
44	1405	4191	Imposes a tax of 2.3 percent on the sale price of any taxable medical device on the manufacturer, producer, or importer.	Ensure payment by manufacturers, producers, or importers of a 2.3 percent sales tax on certain medical devices (does not include eyeglasses, contact lenses, hearing aids or other devices excluded by IRS).	1/1/2013

45	1408	40	Amends the cellulosic biofuel producer credit (nonrefundable tax credit of about $1.01 for each gallon of qualified fuel production of the producer) to exclude fuels with significant water, sediment, or ash content (such as black liquor).	Ensure that tax credits for cellulosic biofuel are not allowed for fuels with significant water, sediment, or ash content.	1/1/2010
46	1409	6662, 6662A, 6664, 6676, 7701	Clarifies and enhances the applications of the economic substance doctrine and imposes penalties for underpayments attributable to transaction lacking economic substance.	Impose penalties for underpayments, nondisclosed transactions, and erroneous claims for refund or credit relating to non-economic-substance transactions.	3/30/2010
47	1410	6655	Increases the required payment of corporate estimated tax due in the third quarter of 2014 by 15.75 percent for corporations with more than $1 billion in assets, and reduces the next payment due by the same amount.	Ensure payment of estimated taxes by certain corporations is increased for the filing in July, August, or September 2014.	3/30/2010

Source: GAO summary of PPACA and Reconciliation Act provisions affecting IRS.

Mr. PITTS. Chair thanks the gentlelady, and now recognizes Dr. Blumberg for 5 minutes for opening statement.

STATEMENT OF LINDA J. BLUMBERG

Ms. BLUMBERG. Mr. Chairman, Ranking Member Pallone, and members of the committee.

I appreciate the opportunity to testify before you today on the impact of the Affordable Care Act on American businesses and workers. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. My testimony draws on my own and my colleagues' analyses of the ACA, much of it relying on the Urban Institute's health insurance policy simulation model, a micro-simulation model that incorporates the best economic behavioral research to estimate individual and employer responses to the specific provisions of the law.

Our analysis shows that if the Affordable Care Act had been implemented in 2012, employer-sponsored coverage would have increased by over 4 million people. In small, midsized, and large firms alike, more workers and families would have had private health insurance. The largest relative coverage increase, about 6.3 percent, would have occurred among workers in small firms with 100 or fewer employees. The 2.7 percent increase in individuals covered by employer plans in total would have cost employers the equivalent of .0003 percent of total wages. For businesses in general, employer premium spending for per person insured would not be affected by the law, remaining constant at about $3,650. But for small employers, premium spending per person would decline by about 4 percent.

For small businesses with 100 or fewer workers, our analysis shows that on average, employers choosing to offer coverage would find average costs per person insured reduced by 7.3 percent, and spending for the group as a whole reduced by 1.4 percent. The reductions reflect efficiencies in the insurance market and tax credits that offset premium costs for the smallest employers with the lowest wage workers.

The law leaves the cost per person insured virtually unchanged for large businesses with more than 1,000 employees. These employers already cover the vast majority of their employees, will continue to do so, and will retain the flexibility to define their own benefits. Coverage increases, largely due to somewhat higher employee enrollment rates, would increase total spending by large businesses by about 4 percent. Only midsize businesses with 101 to 1,000 employees as a group experience an increase in costs per person insured reflecting penalties on as many as 5 percent of these employers who are not currently providing coverage to their workers.

Expanded enrollment, however, is the primary factor contributing to an increase in overall spending. Aggregate employer spending on health, taking into account the increase in the number of covered lives and new assessments, would increase by roughly 2 percent.

In short, contrary to concerns that the ACA will increase costs and reduce employer-sponsored coverage, the law will have a negligible impact on total employer-sponsored coverage and costs and

make small businesses, for whom coverage expands the most, financially better off. An increase in employer costs equal to a small fraction of a percent of total wages could simply not have large implications for the overall level of employment. Plus the increase in health care spending under reform will expand employment in the health sectors largely, if not completely offsetting any small employment effects in other sectors.

In addition, Lisa Dubay and colleagues, consistent with analysis by Kolstad and Kowalski, find that there is no evidence that the similar comprehensive reforms implemented in Massachusetts in 2006 had a negative effect on employment in that State. In fact, Dubay, et al., finding hold up, even when looking specifically at the most vulnerable employers, the smallest firms and those in the retail trade and accommodation and food service industries.

Most employers potentially facing additional costs do have counterbalancing effects that should largely offset these. First, the best empirical economic literature finds that most, if not all of the contributions that employers make to the cost of their health insurance, are passed back to workers over time in the form of lower wages than they would have had in the absence of health benefits. This will be the case whether the employers' costs come as premium contributions or assessments paid as a consequence of not offering coverage. Most workers will value having access to employer-sponsored insurance, and evidence shows that they are willing to trade off a portion of their wages to obtain those benefits. Second, employers of low-wage workers can benefit from the expansion of Medicaid eligibility, which will provide comprehensive, low, or no-cost coverage to the lowest income workers, with no penalty to the employers for their participation.

Third, more comprehensive information and easier price comparisons in the small group market could well lead to increased price competition, making employers and their workers more effective shoppers and pressuring plans to lower costs. Many State-based exchanges are already exploring defined contribution approaches for their small group exchanges in order to provide employees with plan choice, largely absent in small group today, while still providing employers the ability to limit their contributions to the costs of coverage. The bottom line is this is a very complicated set of interactions. But all of our research indicates that the total effects of the ACA on employers and employment will be quite small.

Thank you very much. And I am happy to answer any questions you might have.

[The prepared statement of Ms. Blumberg follows:]

The Implications of the Affordable Care Act for Employers

Statement of
Linda J. Blumberg, Ph.D.
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The Urban Institute
Health Policy Center

United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

March 13, 2013

Mr. Chairman, ranking member Pallone, and members of the committee, I appreciate the opportunity to testify before you today on the impact of the Affordable Care Act (ACA) on American businesses and workers. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. I am a senior fellow at the Urban Institute with more than two decades of experience analyzing the impact of policy on insurance coverage and costs. My testimony draws on my own and my colleagues' analyses of the ACA,[1] much of it relying on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM)—a microsimulation model that relies on the best economic behavioral research to estimate individual and employer responses to the specific provisions of the law.

Our analysis shows that, if the ACA had been fully implemented in 2012,

- Employer-sponsored coverage would have increased by over 4 million people. In small, mid-sized, and large firms alike, more workers and their families would have private health insurance.
- This 2.7 percent increase in individuals covered by employer plans costs employers the equivalent of .0003 percent of total wages.
- For businesses in general, employer premium spending per person insured would not be affected by the law, remaining constant at about $3,650. But for small employers, premium spending per person insured would decline by about 4 percent.
- Aggregate employer spending on health, taking into account the increase in the number of covered lives and new assessments, would increase by roughly 2 percent.

In short, contrary to concerns that the ACA will increase costs and reduce employer-sponsored coverage, the law will have a negligible impact on total employer-sponsored coverage and costs and makes small businesses—for whom coverage expands the most—financially better off.

What are ACA's requirements for employer-sponsored insurance coverage?

Few of the ACA's requirements affect all employers, regardless of size. Those that do are primarily provisions prohibiting or constraining current limits on health insurance coverage—like dollar limits on annual or lifetime benefits, rescissions of coverage, and waiting periods (or delays in the start of coverage) of more than 90 days. Additional provisions have been implemented to expand access to group (as well as nongroup) coverage—specifically by extending dependent coverage to adult children up to age 26, eliminating pre-existing condition exclusions for children, and requiring coverage of specified preventive services without cost sharing. Most of these have already been implemented without incident and without an impact on the share of people covered by employer-sponsored insurance (ESI).

The ACA does not require any employers to provide their workers coverage, and, for employers with more than 100 employees, the law establishes no requirements beyond those just mentioned if they choose to offer benefits. But beginning in 2013, employers with 50 or

[1] The results presented here are more fully developed in Linda J. Blumberg et al., "Implications for the Affordable Care Act for American Business," Urban Institute, October 2012, available at http://www.urban.org/publications/412675.html.

more employees will face penalties, whether or not they offer coverage, if at least one of their full-time employees receives a subsidy for the purchase of nongroup coverage in a health insurance exchange. In general, individuals are eligible for subsides if their incomes fall between 138 percent and 400 percent of the federal poverty level and if the employee's share of the lowest cost premium for individual coverage exceeds 9.5 percent of income or if, on average, the plan reimburses less than 60 percent of covered expenses—conditions designed to protect most employers offering coverage from facing any penalties.

The ACA exempts employers with fewer than 50 workers from any penalties associated with offering insurance coverage and, as of 2014, for a period of two years offers employers with 25 or fewer employees and average pay of $50,000 or less tax credits toward premiums for coverage if they choose to provide it. According to the IRS, the ACA offers 4 million businesses the opportunity to receive a substantial tax reduction.

Alongside the tax credits, for those small employers (defined as having 50 or fewer workers in 2014 and 2015, and 100 or fewer after 2015) who opt to provide coverage, the law will

- require coverage of "essential health benefits,"
- provide access to new insurance markets through "exchanges," and
- limit premium variation across firms to geographic area, age, and tobacco use.

Regulations issued by the Department of Health and Human Services leave it to states to define essential health benefits from a set of options, including each state's most enrolled small employer plans—therefore making the essential health benefits unlikely to impose new costs on small businesses. The impact of rating requirements will vary across states, based on each state's current rules and levels of coverage. In general, less healthy groups in the market will see premium savings. New markets or exchanges will reduce administrative costs for the smallest groups and will promote transparency and competition likely to benefit all small groups (as well as individuals in the nongroup market). The law's requirements for state and federal premium monitoring or rate review and minimum medical loss ratios will reinforce these market effects and help constrain premiums in markets less amenable to competition.

What impact will the ACA's requirements have on employer health insurance costs and coverage?

The Urban Institute's Health Insurance Policy Simulation Model allows us to simulate the impact of these ACA provisions on business costs and employer-sponsored coverage. HIPSM simulates the decisions of individuals and businesses in response to policy changes and estimates changes in coverage and spending by employers, individuals, and the government resulting from specific reforms. To assess the ACA's impact on cost and coverage, we simulated the main coverage provisions of the law, including, if applicable, penalties or tax credits, as if they had been fully implemented in 2012.

Our findings are as follows:

- Employer-sponsored coverage would have increased by 2.7 percent (from 151.5 to 155.6 million people) and employer spending by 2.2 percent (from $553.4 to $565.8

billion). The largest relative coverage increase (6.3 percent) would have occurred among workers in small firms with 100 or fewer employees.

- For small businesses with fewer than 50 workers, which are exempt from penalties and may be eligible for premium tax credits, along with other employers with 100 or fewer workers, the law reduces the costs of coverage in aggregate. Our analysis shows that, on average, these employers, if they choose to offer coverage, would find average costs per person insured reduced by 7.3 percent and spending for the group as a whole reduced by 1.4 percent. The reductions reflect efficiencies in the insurance market and tax credits that offset premium costs for the smallest employers with low-wage workers.

- The law leaves the cost per person insured virtually unchanged for large businesses (with more than 1,000 employees). Our analysis shows these employers already cover the vast majority of their employees, will continue to do so, and will retain the flexibility to define their own benefits. Coverage increases (largely due to somewhat higher employee enrollment rates) would increase total spending by large businesses by 4.3 percent.

- Only mid-sized businesses (with 101 to 1,000 employees), as a group, experience an increase in costs per person insured, reflecting penalties on as many as 5 percent of these employers who are not currently providing coverage. Expanded enrollment, however, is the primary factor contributing to an increase in overall spending of 9.5 percent for these employers.

The ACA and employer health insurance offer decisions

Although most analyses (including those by the Congressional Budget Office and the RAND Corporation) have—like ours—concluded that the law will leave employer-sponsored health insurance largely intact, critics of the ACA, armed with reports from business consultants, nevertheless make the argument that CBO and others have seriously misjudged employers' incentives and significantly underestimated subsidy costs under the ACA. But the key to the ACA's actual impact on ESI will be whether most workers' employers continue to see their employees as valuing employer-provided health insurance over the alternative created by the ACA. And, under the terms of the ACA and the pressure of a competitive marketplace, our analysis shows they overwhelmingly will. Most workers' firms will be dominated by workers who will receive better benefits and, through the tax system, better subsidies through employer-provided coverage than through newly created insurance exchanges.[2]

That some workers now benefiting from ESI would be better off in exchanges is a fact. But a leap from that fact to the conclusion that employers have a powerful incentive to drop coverage runs counter to standard economic theory. ***First, over time, a competitive labor***

[2] For a complete discussion of the issues related to employer decisions to offer health insurance under the ACA, see Blumberg, et al., "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act," *Inquiry* 49, no. 2 (2012): 116–26.

market will not allow employers to save money by dropping employer-sponsored coverage. Employers pay workers a combination of wages and benefits at a level equal to the employee's value to the firm. The market will keep compensation at that level, whether employers pay a worker's value only in wages or in some combination of wages and benefits. If, in total, an employer compensates workers less than their value, that employer will lose those workers to competitors who offer them more. If, alternatively, an employer pays workers more than their value, the firm will lose money. That means, plain and simple, that in a competitive market, employers cannot "come out ahead" by dropping coverage and at the same time reducing compensation.

An array of additional factors also decrease the likelihood of employers currently offering insurance to their workers to change that decision due to the provision of the ACA. ***In general, better-paid workers remain better off with employer-sponsored coverage.*** Regardless of their perspective on dropping, analysts agree that it is only at or below an income of 250 percent of the federal poverty level that the ACA's combination of premium and cost-sharing subsidies make exchange coverage, on average, as good as or better than tax-subsidized employer-sponsored coverage. Nondiscrimination rules impede employers' ability to simply decide not to offer coverage to workers who have access to subsidies in the exchange while offering it to workers who do not. To deny coverage for those eligible for subsidies, they would have to drop it for everybody and therefore face a penalty. In addition to paying the penalty, keeping all workers "whole" would require that employers pay additional wages both to cover extra unsubsidized premium and benefit costs (for workers eligible and ineligible for subsidies) and to offset the fact that any premium payments would now be paid by employees out of after-tax, not pre-tax, dollars. Doing so would result in an overall increase in the firm's compensation costs, which would make firms worse, not better, off.

Within firms, "losers" from dropping far outnumber "winners," on average. Taking all this together, employers would only be likely to drop coverage if most of their workers would benefit from the exchange—in which case they could substitute extra wages for benefit reductions. But, because offsetting payments would increase their compensation costs, employers are not likely to drop coverage if most of their workers would not benefit from the exchange. When an employer contemplates a decision to drop coverage, it is the distribution of income among the firm's employees that matters. We know that only about one in five workers with their own ESI coverage has income below 250 percent of the federal poverty level. Given this, the share of workers in a particular firm who would benefit from dropping—based on income and subsidy calculations alone—will likely be far smaller than the share of workers who will not. If the firm dropped coverage, compensating all workers for lost benefits would increase employers' total compensation costs. These employers, therefore, will have a disincentive to drop coverage.

Complexities in assessing "winners" and "losers" increase reluctance to drop. Further reducing the likelihood that employers will drop coverage is the difficulty in a mixed-wage firm of assessing predominant coverage preferences among employees. Assessing preferences will be complicated by workers' particular circumstances—factors not taken into account by those who claim that dropping will be widespread. These factors include age, smoking status, alternative family coverage options, health status and related preferences, willingness to take risk, and

relative preferences for particular benefits. Given the complexity of employees' preferences, which an employer would be hard-pressed to assess or to synthesize, a decision to drop coverage exposes an employer to the risk of undermining worker loyalty, increasing worker turnover, and disrupting rather than enhancing employees' benefit expectations. Deciding whether and when to take that risk is far more complicated—and less likely—than a simple subsidy calculus might suggest.

Pre-ACA trends in employer-sponsored health insurance coverage

That the ACA leaves the future scope of employer-sponsored health insurance coverage largely unchanged does not mean that employer-sponsored insurance will necessarily expand to cover a growing proportion of Americans. On the contrary, the share of the population covered has been and is likely to continue to drop. The future of employer-sponsored coverage is overwhelmingly determined by the state of the economy and by the growth in health care costs. As long as health care costs grow faster than inflation, the proportion of the population ESI covers will continue to drop. That trend should not be confused with or attributed to the impact of the ACA.

That said, however, the ACA includes cost-containment measures that, if successful, have the potential to slow the growth in health expenditures. Health care costs have historically risen considerably faster than the economy, but overall spending growth has slowed significantly in recent years, partly because of the recession. This slowdown (for both private and public payers) actually began as early as 2004—before the recession—and may also reflect changes in the structure of insurance (in particular, a shift toward high-deductible plans) and provider payment and delivery changes (in particular, the evolution of value-based purchasing aimed at reducing unnecessary hospitalizations and promoting clinically integrated care).

The cost-containment measures in the ACA could sustain and extend the slowdown in health care cost growth. The law's provisions to slow growth in rates Medicare pays hospitals have already contributed to a substantial slowdown in the projections of Medicare per beneficiary cost growth. Arguments that these payment constraints undermine hospitals' economic viability or lead hospitals to shift costs to private purchasers are not supported by the evidence. Medicare payment constraints produce greater hospital efficiency in hospitals that are largely dependent on Medicare revenues and in markets with competition among private insurers that have no dominant hospital system. In these markets, employers committed to cost containment have the opportunity to adopt effective Medicare payment reform initiatives, slowing growth in their own health care spending.

The ACA's initiatives for payment and delivery reform are equally important in slowing cost growth over the long term. These initiatives—including pay-for-performance, accountable care organizations, and bundling—aim to move private as well as public insurance away from payment per service, which drives up volume, and toward payment for value, or rewards to integrated care. In piloting these initiatives, Medicare not only sets an example for employer-sponsored insurance, it also explicitly offers the opportunity for collaboration across public and private payers. If these initiatives are successful, future growth in health care costs will be slower than is projected, employer spending growth will slow, and employer-sponsored health

insurance will be more extensive than is now projected.

Even if that is not the case, the ACA's establishment of a viable nongroup insurance marketplace—with subsidies—not only benefits individuals whose employers do not offer coverage. It also benefits small employers of low-wage workers. These firms are unable to offset the costs of health insurance with reduced wages, as large employers employing a mix of low- and higher-wage workers are able to do. In addition, large firms have greater economies of scale in purchasing insurance, allowing them to obtain greater value for their health care dollar than small employers. Accordingly, the small low-wage employers are very unlikely to offer insurance coverage to their workers and often find themselves at a disadvantage in competing with large employers for workers. The ACA will create a much more level playing field for these small employers, owing to the law's market reforms, exchanges, and subsidies that will allow their workers to purchase affordable, adequate coverage directly.

Overall, the evidence simply does not support critics' arguments that the ACA will burden employers and undermine employer-sponsored health insurance. On the contrary, except for a cost increase to mid-sized employers due largely to enrollment increases, the ACA benefits rather than burdens small employers who want to provide health insurance, leaves the overall costs of employer-sponsored health insurance largely unchanged, and offers the potential, through cost containment, of slowing the growth in health care costs, benefiting private along with public purchasers of health insurance.

Will the ACA decrease employment?

All of this information taken together indicates that the incremental costs to employers of increased employer-sponsored insurance coverage and employer penalties are very small relative to current compensation – with the 2.7 percent increase in employer-sponsored coverage coming at a costs equal to .0003 percent of total wages. A change that small in relative terms could simply not have large implications for the overall level of employment. Also, as Holahan and Garrett[3] show, new revenues needed to pay for the entire health reform over the 2014 and 2019 period would amount to only .4 percent of GDP, and therefore be unlikely to have significant effects on employment. Plus, the increase in health care spending under reform will expand employment in the health sectors, largely if not completely offsetting any small employment effects in other sectors.

In addition, Dubay and colleagues,[4] consistent with analysis by Kolstad and Kowalski,[5] find that there is no evidence that the similar, comprehensive reforms implemented in Massachusetts in 2006 had a negative effect on employment in that state. In fact, Dubay et al.'s finding of no employment effects holds up even when looking specifically at the most

[3] Holahan J and Garrett B. "How Will the Affordable Care Act Affect Jobs" Washington, DC: Urban Institute, 2011.
[4] Dubay L, Holahan J, Long S, and Lawton E. "Will the Affordable Care Act Be a Job Killer?" Washington, DC: Urban Institute, 2011.
[5] Kolstad JT and Kowalski AE. "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform." NBER Working Paper No. w17933. Cambridge, MA: National Bureau of Economic Research, March 2012.

vulnerable employers, the smallest firms and those in the retail trade and accommodation and food services industries.

Concerns have also been raised about the ACA's definition of part-time being set at 30 hours per week, as opposed to the frequent practice today of considering fewer than 35 hours per week as part-time. Often large employers will offer insurance coverage to full-time workers, but not to part-time workers (e.g., 96 percent of employers with 50 or more workers offer health insurance to at least some of their workers, as does 99.5 percent of employers with 1000 or more workers, according the 2011 Medical Expenditure Panel Survey-Insurance Component). Some employers contend that they would lower the hours worked per week for workers in this 30 to 34 hours per week wedge to 29 hours or fewer, in order to avoid the possibility of penalties being assessed if some of those workers obtain subsidized coverage in the nongroup exchange. However, there are many factors that go into employers deciding the number of hours employees will work. These include the administrative costs of employing more workers to do the same work, competition for hiring workers that want to be employed with more hours and can find more hours elsewhere, potential costs of higher turnover, just to name a few. Keeping the potential magnitude of this issue in perspective is important as well. Only about 4 percent of the national workforce is typically employed 30 to 34 hours per week, and of this group, only about 1/3 or a little over 1 percent of the workforce have incomes that would make them potentially eligible for nongroup subsidies that could trigger employer penalties. Thus again, it is safe to assume that any employment effects related to this provision in the ACA would have to be quite small.

Again, the strong, consistent empirical evidence is that employment effects related to the ACA will not be large on net.

Mr. PITTS. Chair thanks the gentlelady. And now recognizes Mr. Boucher, 5 minutes for an opening statement.

STATEMENT OF TOM BOUCHER

Mr. BOUCHER. Thank you, Chairman Pitts, Ranking Member Pallone, and members of the committee. I appreciate this opportunity to testify on behalf of the National Restaurant Association. I am Tom Boucher, an independent restaurateur and owner and CEO of Great New Hampshire Restaurants, Incorporated. My business partners and I operate eight restaurants, doing business as T-Bones Great American Eatery, Cactus Jack's Great West Grill, and The Copper Door Restaurant. Like many people in our industry, my first job in our company was as a server.

Over the years, I worked my way up in the organization as a dining room manager, a head kitchen manager, and general manager. In 1995, I became a partner, and in 2004 chief executive officer. Our core business practice is to make decisions that equally benefit our guests, employees, and company. We call it our three-legged-stool approach to success. A high priority is to ensure that we take care of our 503 employees to the best of our ability. As a mature company, we have many veteran and long-term employees who perpetuate our culture and core values.

Over the years, it is our employee benefits, including health care, that have helped us recruit and retain the best people to contribute to our success. The food service industry is extremely diverse. Every operator will face a host of difficult decisions based on health care laws requirements. My partners and I have spent countless hours considering how to comply with the law, with a focus on maintaining employees' health care coverage. We have made changes since the law's enactment that we hope will help us better prepare for this transition.

For example, we offer benefits to our salaried full-time employees and hourly employees who work 30 hours a week. Currently, of our 242 hourly full-time employees eligible to enroll in our plan today, only 45 percent accept our coverage. We have found it challenging to predict how many of the remaining 55 percent will accept our offer of coverage in light of the individual requirement that begins January 1, 2014.

For instance, we can't determine how many of our young workforce will choose to pay the individual mandate tax penalty instead of accepting our offer of coverage in 2014, 2015, and beyond. The future coverage take-up rate is hard to predict, given many factors, but it could mean a significant increase in the costs employers may struggle to absorb when offering coverage.

This is merely one example of the uncertainty and challenges resulting from the law. Our team's best estimate is that 75 percent of the hourly full-time employees eligible today but are not accepting our offer of coverage today will do so in 2014. Assuming plan costs were to remain the same, which they likely will not, such an increase in the employee take-up rate of our plan would increase our company's health care costs from $500,000 a year to $700,000 a year, representing a 40 percent increase.

An industry that already operates on extremely low profit margins, these types of increased costs cannot be easily absorbed or paid for by merely raising menu prices.

While there are numerous aspects of the law that are complex, and my colleagues in our industry will struggle to implement, another that will impact my company is the requirement that businesses with 200 or more full-time employees automatically enroll their new and current full-time workers in their lowest cost plan unless they affirmatively opt out of coverage. This requirement changes the relationship that we have with our employees, especially those that may have health care from a spouse or parent. If that employee does not opt out of coverage, I am forced to enroll them on their 91st day of employment. This creates several problems for me. I do not like deducting premium contributions from my employees' paychecks without their authorization, especially if it leads to duplicative coverage. This reduced paycheck could create financial hardship on the employee. Moreover, it will lead to more administrative work and cost on my end as I have to remove them from the plan. Congress should eliminate this provision. There has been a lot of recent attention about the law's definition of full-time employment as 30 hours a week. The restaurant industry is not a 9:00 to 5:00, 5-day a week operation, we are an industry that requires flexible schedules and work weeks. By redefining full-time employment at 30 hours, employers are going to have to make a decision about how many hours their employees work and an unintended consequence of the law could be reduced hours, especially for employees that are just above the 30-hour threshold. As you can probably tell, I made a business decision to not reduce any of my employees' hours. However, this is something that everyone in the industry is going to be closely examining as they better understand the impact of the law on their business.

The National Restaurant Association and its members are hopeful that policymakers will remain open to constructive revisions to the health care law that will mitigate its effects on our Nation's job creating business. We look forward to working with Congress as we address these challenges. Thank you for the opportunity to testify today on the health care law impact, on our restaurant and food service industry, and the challenging environment it will cause for job creation and growth. And I will take questions and thank you for the opportunity.

[The prepared statement of Mr. Boucher follows:]

Statement
On behalf of the
National Restaurant Association

HEARING: OMABACARE'S IMPACT ON JOBS

BEFORE: SUBCOMMITTEE ON HEALTH
ENERGY & COMMERCE COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

BY: TOM BOUCHER, CEO AND OWNER
GREAT NEW HAMPSHIRE RESTAURANTS, INC.
BEDFORD, NEW HAMPSHIRE

DATE: MARCH 13, 2013

Statement for the hearing
"Obamacare's Impact on Jobs"

Before the

Subcommittee on Health, Energy & Commerce Committee,
U.S. House of Representatives

By
Tom Boucher, CEO and Owner
Great New Hampshire Restaurants, Inc.
Bedford, New Hampshire

On behalf of the
National Restaurant Association

March 13, 2013

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health of the House Energy & Commerce Committee, thank you for this opportunity to testify before you today on behalf of the National Restaurant Association. It is an honor to be able to share with you the impact the 2010 health care law is having on businesses like mine, particularly on our ability to create and grow jobs.

My name is Tom Boucher. I am an independent restaurateur and the CEO-Owner of Great New Hampshire Restaurants, Inc. My business partners and I operate eight restaurants doing business as T-Bones Great American Eatery, Cactus Jack's Great West Grill, and The Copper Door Restaurant with locations in Bedford, Derry, Hudson, Laconia, Manchester, and Salem, New Hampshire. I have the distinct honor to serve as a member of National Restaurant Association's Board of Directors, and have done so since 2004. I am very involved in my own communities serving on several other boards and with the New Hampshire Lodging & Restaurant Association, where I served as Chairman of the Board in 2004.

The National Restaurant Association is the leading trade association for the restaurant and foodservice industry. Its mission is to help its members, such as myself, establish customer loyalty, build rewarding careers, and achieve financial success. The industry is comprised of 980,000 restaurant and foodservice outlets employing 13.1 million people who serve 130 million guests daily. Restaurants are job creators. Despite being an industry of predominately small businesses, the restaurant industry is the nation's second-largest private-sector employer,

employing about ten percent of the U.S. workforce.[1] I like to say, "We teach America how to work."

THE GREAT NEW HAMPSHIRE RESTAURANTS, INC. STORY

Our company's story begins when T-Bones first opened its doors more than twenty-eight years ago. I joined the company, as many get their start in our industry, as a server. I had just graduated from college and came to find work before starting graduate school. I left T-Bones to begin my graduate work, but after a semester I returned to work at the restaurant during a holiday break, and never looked back! I worked my way up in the company as Dining Room Manager, Head Kitchen Manager, and General Manager. In 1995, I became a partner and we opened the first Cactus Jack's in Manchester. In 2004, I became CEO and continue in that role today providing strong leadership, entrepreneurial vision, and maintaining our fiscal health and the growth that has contributed to our success. The Copper Door Restaurant is our latest concept, opening its doors in late 2011 in Bedford, NH.

My vision for our company is to become the premier restaurant company in New Hampshire. To accomplish this vision we need the help of our 503 staff members whose excellent service and great smiles create a warm and inviting atmosphere for our guests. Our core values are to serve quality, fresh, appealing products by a staff that feels more like a family than employee, and wrapping our arms around the neighborhoods and customers our restaurants take pride in serving.

Our core philosophical approach to our business practice is to make decisions which equally benefit our guests, our employees and our company. We call it our three-legged stool approach to success. One priority is to ensure that we take care of our employees to the best of our ability. As a mature company, we have many veteran and long-term employees who perpetuate our culture and core values. Over the years, it is our great employee benefits – including health care benefits – that have helped us recruit and retain the best people who have contributed to our success.

As a result of the changes required by the law, we now offer our hourly full-time employees who average 30 hours per week over 52 weeks enrollment in one of our medical benefit plans after one year of service. We also offer the plans to our salaried full-time employees. Only 45 percent of our 242 hourly full-time employees eligible to enroll in our plans today accept our offer of coverage. Of the remaining 55 percent of hourly full-time employees eligible to enroll today, how many of them will accept our offer of coverage given the individual requirement that begins January 1, 2014 as well?

Business owners crave certainty and one of the most difficult things to predict about the impact of this law is the choice employees will make. Will they accept our offer of minimum essential coverage? Will exchange coverage be less expensive than what we can afford to offer

[1] *2013 Restaurant Industry Forecast.*

under the law? Will our young workforce choose to pay the individual mandate tax penalty instead of accepting our offer of coverage in 2014, 2015 and beyond? Future take-up rate of coverage is very hard to predict given many new factors, but could mean a significant increase in the costs employers must take on when offering coverage.

Based on our own experience and research, our team's best estimate is that 75 percent of the hourly full-time employees eligible today, but not taking our offer of coverage, will likely accept it in 2014. Assuming plan costs were to remain the same – which they likely will not – such an increase in the employee take up rate of our plan would mean an increase in our company's health insurance costs from $500,000 to $700,000. This represents a 40 percent increase over today. With such a large potential increase, you can understand why knowing the impact to the business and our employees is so important.

COMPLYING WITH THE HEALTH CARE LAW IS CHALLENGING FOR RESTAURANT AND FOODSERVICE OPERATORS GIVEN THE UNIQUE CHARACTERISTICS OF THE INDUSTRY

Since the law was enacted in 2010, we have been taking steps to educate ourselves about the requirements of the law, the details of the Federal agencies' guidance and regulations, and to understand how to implement the necessary changes within our relatively small organization. Understanding our compliance requirements has been time consuming and burdensome for both our Executive team. Fortunately, we are large enough that the restaurant does employ a human resources professional. Both she and I have spent a significant amount of time trying to understand the impact so that educated business decisions can be made. We have spent so much time focused on this that sometimes I think we may need to hire an additional human resources professional just to handle health care benefits going forward. Other restaurateurs in our state and around the country are not as fortunate to have such internal resources, and many in the industry are running their day-to-day operations of their business while trying to understand what they must do to comply.

Until the January 2, 2013 *Federal Register* publication of the Treasury Department's Proposed Rule regarding the Shared Responsibility for Employers provision, employers did not have any firm rules on which they could plan and make business decisions. Up until this time, proposals and guidance had been issued with numerous opportunities for public comment, but nothing had the weight of regulation. This proposed rule, while not finalized, does provide employers assurances that the rules proposed can be relied upon until further rules are issued. Our Association has been educating the industry since enactment and is spreading the word that now is the time to take action to comply. While many rules and guidance have been proposed, which we must implement, questions still remain regarding exact implementation of most of the employer requirements.

The unique characteristic of our workforce creates compliance challenges for restaurant and foodservice operators. As a result, many of the determinations employers must make to figure out how the law impacts them – for example the applicable large employer calculation – are much more complicated for restaurants than for other businesses who have more stable workforces with less turnover.

Restaurants are employers of choice for many looking for flexible work hours and so we employ a high proportion of part-time and seasonal employees. We are also an industry of small businesses with more than seven out of ten eating and drinking establishments being single-unit operators. Much of our workforce could be considered "young invincibles," as 43 percent of employees are under age 26 in the industry.[2] In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.[3]

All of these factors combine to complicate what a restaurant and foodservice operator must consider when implementing the necessary changes in their business to comply with the law. My company is a great example as we have spent an enormous amount of time trying to understand the law and what we must do to comply, but still do not know the answers to many questions.

APPLICABLE LARGE EMPLOYER DETERMINATION

The statute lays out a very specific calculation that must be used by employers to determine if they are an applicable large employer and hence subject to the Shared Responsibility for Employers and Employer Reporting provisions. Because of the structure of many restaurant companies, determining who the employer is may not be as easy as it would seem.

Aggregation rules in the law require employers to apply the long standing Common Control Clause[4] in the Tax Code to determine if they are considered one or multiple employers for the purposes of the health care law. While these rules have been part of the Code for many years, this is the first time many restaurateurs, especially smaller operators, have had to understand how these complicated regulations apply to their businesses. The Treasury Department has not issued, nor to our knowledge, plans to issue, guidance to help smaller operators understand how these rules apply to them. Restaurant and food service operators must hire a tax advisor to determine how the complicated rules and regulations associated with this section of the Code apply to their particular situation. It is common that business partners of one restaurant company own multiple restaurant companies with other partners. These restaurateurs consider themselves to be separate businesses, but because there is common ownership, under the rules many are discovering that all the businesses can be considered as one employer for purposes of the health care law.

Once a restaurant or foodservice operator determines what entities are considered one employer, they must determine their applicable large employer status annually. For a restaurant company such as mine, it is clear that we have more than 50 full-time equivalent employees

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[2] Bureau of Labor Statistics, U.S. Department of Labor.
[3] *2013 Restaurant Industry Forecast.*
[4] Internal Revenue Code, §414 (b),(c),(m),(o).

employed on business days in a calendar year, as we employ many more than 50 people in just full-time positions alone. However, given we are an industry of small businesses and that restaurants are labor intensive and require many employees to operate successfully, many small businesses will have to complete this calculation annually to determine their responsibilities under the law.

As you might imagine, operators on the bubble of 50 full-time equivalent employees are trying to understand what they must do to complete this complicated calculation each year. Generally, an employer must consider the hours of service of each of their employees in all 12 calendar months each year. However, the Treasury Department has allowed for transition relief in 2013 for businesses to use as short as 6 months to do this calculation. The Treasury Department recognized the fact that small businesses, who may not currently offer health coverage, will need time to determine their status and then negotiate a plan with an insurance carrier. However, there remain questions about the process in later years when January through December must be considered for status beginning the following January 1st. Will small employers just reaching the applicable large employer threshold find that they determine they are large on December 31, 2014, for example, and must offer coverage a day later on January 1, 2015? Rules are needed to clarify when such employers must offer coverage in future years.

The applicable large employer determination is complicated. Unlike the eligibility determination I use today to determine if my hourly full-time employees are eligible for health benefits (based on 1560 hours of service), for compliance beginning in 2014, employers must determine all employees' hours of service each calendar month, calculate the number of FTEs per month, and finally average each month over a full calendar year to determine the employer's status for the following year. The calculation is as follows:

1. An employer must first look at the number of *full-time employees* employed each calendar month, defined as 30 hours a week on average or 130 hours of service per calendar month.
2. The employer must then consider the hours of service *for all other employees*, including part-time and seasonal, counting no more than 120 hours of service per person. The hours of service for all others are aggregated for that calendar month and divided by 120.
3. This second step is added to the number of full-time employees *for a total full-time equivalent employee* calculation for one calendar month.

4. An employer must complete the same calculation for the remaining 11 calendar months and average the number over 12 calendar months to determine their status for the following calendar year.

This annual determination is administratively burdensome and costly, especially for those just above or below the 50 FTE threshold who must most closely monitor their status – most likely small businesses. Many restaurant operators rely on third-party vendors to develop technology or solutions to help them comply with these types of requirements but vendors are backlogged and a solution is not widely available today.

OFFERING COVERAGE TO FULL-TIME EMPLOYEES

The 2010 health care law requires employers subject to the Shared Responsibility for Employers provision to offer a certain level of coverage to their full-time employees and their dependents, or face potential penalties. The statute arbitrarily defines full-time as an average of 30 hours a week in any given month. This 30-hour threshold is not based on existing laws or traditional business practices. In fact, the Fair Labor Standards Act does not even define full-time employment. It simply requires employers to pay overtime when nonexempt employees work more than a 40-hour workweek. As a result, 40 hours a week is generally considered full-time in many U.S. industries. Certainly in the restaurant and foodservice industry, operators have traditionally used a 40-hour definition of full-time. Adopting such a definition in this law would also provide employers the flexibility to comply with the law in a way that best fits their workforce and business models.

Before this law, our company defined full-time employment differently for those employees working in positions in the Front of the House and the Back of the House. As a result of the definition in the law, we have changed our threshold and now use 30 hours per week. Such a definition is not typical in the restaurant in the restaurant industry. While it might seem that our definition aligns with the law, further adjustments to our current practice are needed due to the interplay of several provisions of the law. Beginning in 2014, group health plans cannot apply a waiting period (or eligibility period) of longer than 90 days. This maximum waiting period applies whether you are an applicable large employer or a small employer offering coverage. As of 2014, if we hire a new employee into a full-time position where they are expected to work at least 30 hours per week, we have only 90 days to offer them coverage and enroll them in the plan, if they accept our offer. Up until this point, we have used 52 weeks to determine if an employee is eligible for an offer of coverage but that must be changed under the law.

This is complicated by the fact that sometimes it is difficult to know who the full-time employees will be in a restaurant. For restaurant and foodservice operators who are applicable large employers, it is not easy to predict which hourly staff might work 30 hours a week on average and which will not. I think back to my first days working in our restaurant as a server as an example of how an employee's hours could be unpredictable week to week. During the summer and holidays I was scheduled for more hours as customer traffic was at its peak, but then

my hours were reduced as business slowed. Some weeks I might pick up extra shifts to earn a little extra in my paycheck that month, and others I'd prefer a few less hours because of commitments outside the restaurant. This is one of the attractive benefits of our industry - the flexibility to change your hours to suit your own personal needs. However, for the first time under this law, the federal government has drawn a bright line as to who is full-time and who is part-time. As a result, employers with variable workforces and flexible scheduling must be deliberate about scheduling hours because there is now potential liability for employer penalties if employees who work full-time hours are not offered coverage.

The industry appreciates that the Treasury Department has recognized that it may be difficult for applicable large employers to determine employee's status as full-time or part-time on a monthly basis, causing churn between employer coverage and the exchange or other programs. Such coverage instability is not in the employee's best interest and so the restaurant and foodservice industry is pleased that the Lookback Measurement Method is an option that applicable large employers may use. Our restaurant is still in the process of considering whether this is an option we will use.

The Lookback Measurement Method's implementing rules are complex but I believe that it could be helpful for both employers and employees. Employers will be better able to predict costs and offer coverage to employees they are required to offer to, and employees whose hours fluctuate have the peace of mind of knowing that if their hours do drop, coverage will not be cut short before the end of their stability period. Should we choose to utilize the Lookback Measurement Method, it can only be applied to variable hour or seasonal employees. Employers cannot consider the length of time of service of these employees, only that their hours are unpredictable and that they fluctuate.

Our restaurant's health plan begins on October 1 each year – a change we made several years ago when it became clear how difficult for the employees it was to conduct open enrollment during our busy holiday season. If we were to choose a 12-month measurement period and hence a 12-month stability period, the measurement period would begin Tuesday, July 2, 2013 and end Wednesday, July 2, 2014. The hours of service for our current variable hour and seasonal employees would be measured during this time period on a calendar month basis and averaged over the length of the measurement period. We could then utilize up to a 90-day period for administrative activity, including eligibility determinations and conducting our open enrollment process with employees. This could be as long as Thursday, July 3, 2014 – September 30, 2014. For those variable hour and seasonal employees determined to be full-time during the measurement period, they will be offered coverage during the October 1, 2014 – September 30, 2015 stability period, which coincides with our 2014 plan year. Regardless of whether their hours are maintained at full-time status or not, they will maintain enrollment in our coverage for the full 12-month stability. If a variable hour or seasonal employee is determined to be part-time during the measurement period, they will not be offered coverage and considered a part-time employee for the duration of the stability period. The dates for these periods of time will change each year depending on the calendar. There is a similar but slightly different process for new hires variable hour and seasonal employees, and also a process for transitioning new hires into the normal open enrollment process each year. Also, there are other rules guiding how these processes must be administered.

Applicable large employers who employ 200 or more full-time employees, as Great New Hampshire Restaurants does, are also subject to the Automatic Enrollment provision of the law. This duplicative mandate requires us to enroll our new and current full-time employees in our lowest cost plan if they have not opted-out of the coverage. This provision also interacts with the prohibition on waiting periods longer than days and effectively means that on 91 day, we must enroll a new full-time hire in our lowest cost plan if they do not tell us that they do not want to be enrolled. Employee premium contributions will begin to be collected and the industry is concerned that it could cause financial hardship and greater confusion about the law, especially amongst our young employees. Automatically enrolling an employee and then shortly thereafter removing them from the plan when the employee opts-out only increases costs unnecessarily without increasing our employee's access to coverage as the law intended. Under the law employers can ask employees to contribute up to 9.5 percent of their household income towards of the cost of the premium. We will educate our employees about how this provision impacts them, but if an employee misses the 90-day opt-out deadline, a premium contribution is a significant amount of money, which can be a financial burden. Since the same full-time employees must be offered coverage by the same employers subject to the Automatic Enrollment provision and the Shared Responsibility for Employer provisions, we believe the automatic provision is unnecessary and should be eliminated.

CHALLENGES FOR APPLICABLE LARGE EMPLOYERS OFFERING COVERAGE TO THEIR FULL-TIME EMPLOYEES AND THEIR DEPENDENTS

Once an applicable large employer has determined to whom coverage must be offered, he must make sure that the coverage is of 60 percent minimum value and considered affordable to the employee, or he may face potential employer penalties.

Minimum value is generally understood to be a 60 percent actuarial test; a measure of the richness of the plan's offered benefits. This is a critical test for employers especially as it relates to what an employer's group health plan covers and hence what the premium cost will be in 2014. I've mentioned that business owners like certainty and that means the ability to plan for their future costs. Employers are eager to know what their premium costs will be under the new law. Minimum value is key to determining that information.

On February 25, 2013 the Health and Human Services Department did include the Minimum Value Calculator, one of the acceptable methods to determine a plan's value, in its Final Rule, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Minimum value can now be determined using this calculator but still it is always difficult to know premium costs so far in advance. For our October 1 plan year start date, we generally are able to get data from our broker in August but it is always a fight to get the information from the insurance carriers. From there, budget decisions can then be made for the coming year. We do not anticipate that we will have premium information for the 2014 plan year until August of that same year. With a potential large increase in costs, this gives us a short timeframe within which to make business decisions in advance of the new plan year.

Employers must also ensure at least one of their plans is affordable to their full-time employees or face potential penalties. A full-time employee's contribution toward the cost of the premium for single-only coverage cannot be more than 9.5 percent of their household income, or else the coverage is considered unaffordable. Employers do not know household income, nor do they want to know this information for privacy reasons. However, employers needed a way to be able to estimate before a plan is offered if it will be affordable to employees. What employers do know are the wages they pay their employees. Almost always, employees' wages will be a stricter test than household income. Employers are willing to accept a stricter test in the form of wages so that they know they are complying with the law and are provided protection from penalty under a safe harbor. The Treasury Department will allow employers to use one of three Affordability Safe Harbors based on Form W-2 wages, Rate of Pay or Federal Poverty Line. We believe that the option of utilizing these methods will be helpful to employers as they determine at what level to set contribution rates and their ability to continue to offer coverage to their employees. Our company has begun to look at this test but is still in the process of determining how we will best implement this section of the law.

The law speaks to affordability for employees but is silent regarding whether the coverage required to comply with the Shared Responsibility for Employers section of the law is affordable to employers. We anticipate added costs as a result of this law, either through required changes impacting plan design or additional fees – such as the PCORI Funding Fee, the Exchange Reinsurance Program Fee, the Health Insurance Provider Fee – that will continue to drive up premiums for employers and employees as others pass along these increased costs. In addition, new taxes such as the "Cadillac" tax on certain employer-sponsored coverage, will also squeeze restaurateurs when it begins in 2018.

As restaurant and foodservice operators implement this law, considering all of the interlocking provisions that impact employers, some will be faced with difficult business decisions between offering coverage which they cannot afford and paying a penalty for not offering coverage that they equally cannot afford nor want to do. We encourage all policymakers to address the cost of coverage so that the employer-sponsored system of health care coverage will be maintained.

NEW NONDISCRIMINATION RULES APPLIED TO FULLY-INSURED PLANS

The health care law applies the nondiscrimination rule that self-funded plans cannot offer benefits in favor of their highly-compensated individuals now to fully-insured plans. This rule is not in effect as the Treasury Department has put implementation on hold until further guidance has been issued in this complex area. Under the law, these rules apply to all insured plans, regardless of where they are offered by an applicable large employer or a small business. The restaurant and foodservice industry is watching this rule closely as it may impact what plans may continue to be offered to employees.

Current group health plan participation often forces operators to carve out the group of employees who will participate in the plan. In our members' experience, these are almost always a group that would be considered in the top 25 percent based on compensation.

However, management carve-outs are not just for upper level executives who may receive richer benefit plans than the rest of the employees. In the restaurant and foodservice industry, management-only plans are sometimes the only option that operators have to provide health care coverage to those employees who want to buy it and pass participation requirements at the same time. As a result, these plans are quite common in the industry.

The rules the Treasury Department writes to apply non-discrimination testing to fully-insured plans will have an impact on our industry. Regardless of how they are written, restaurant and foodservice operators will need sufficient transition time to apply these rules as it could create upheaval for plans and employers alike.

APPLICABLE LARGE EMPLOYER REPORTING REQUIREMENTS

A key area of implementation that employers have received little or no guidance on are the employer notice and reporting requirements: the Fair Labor Standards Act Notice to Employees from the Department of Labor, the notices and appeals processes with Exchanges from the Department of Health and Human Services, and the required information reporting under Code §6055 and §6056 from the Treasury Department. These employer notice and reporting requirements are a key link in the chain of the law's implementation. They represent a significant employer administrative burden as well as rules that will help employers ensure that their employees are well informed about their options under the law.

Of particular concern is the flow of information and the timing of reporting employers must make to multiple levels and layers of government. Streamlining employer reporting will help ease employer administrative burden and simplify the process. The information provided by employers under Code §6055 and §6056 is critical in this process and can be used by the Treasury Department to verify if an individual had an offer of affordable minimum essential coverage of minimum value from an applicable large employer. The information provided by employers must be compared by the Internal Revenue Service to verify eligibility determinations made by the Exchanges for premium tax credits or cost-sharing reductions. The information can also be used to determine employer penalty liability. The restaurant and foodservice industry, along with other employer groups, have advocated for a single, annual reporting process by employers to the Treasury Department each January 31st that would provide prospective general plan information and wage information for the affordability safe harbors, as well as retrospective reporting as required by §6056 on individual full-time employees and their dependents.

We are anxious for guidance to be issued, especially by the Treasury Department on implementing §6056, as employers cannot just flip a switch and produce the detailed information reports required by the law. It will take time for employers to set up systems, or contract with vendors, to track and maintain the date needed to comply with the law. When I think of our own company and the detailed information we will have to track and report on all full-time employees and dependents, it is a large amount of data. The reporting will include not only the employees who remain with the restaurant for the entire year, but even our seasonal staff and others who

may only stay for a couple of months. Health plan benefit information as well as individualized payroll-sourced information must be merged to produce the report needed under the law.

TRANSITION RELIEF

Within the Proposed Rule for Shared Responsibility for Employers, the Treasury Department provided targeted transition relief. While appreciated, we believe that further transition relief is critical. The timeframe for compliance is short and getting shorter and safe harbor protections for good-faith compliance by employers in the law's early phases is necessary. Employers are still missing essential pieces of guidance and regulation necessary to construct their systems, make plan design changes and communicate with their employees. Under the threat of heavy penalties for not getting this exactly right the first time, some employers may opt-out of offering coverage to their employees and choose to pay the penalties instead. This is not what the restaurant and foodservice industry wants, but it may be a likely result of employers having to make difficult decisions under extremely uncertain conditions. The process should not discourage employers and employees from participating in the new system and so a good-faith compliance standard is appropriate. As with implementation of any law this size, it will take some time for the hiccups in the processes to be worked out and employers should be allowed adequate time to come into compliance.

CONCLUSION

Since enactment of the law, the National Restaurant Association has worked to constructively shape the implementing regulations of the health care law. Nevertheless, there are limits to what can be achieved through the regulatory process alone. Ultimately, the law cannot stand as it is today given the challenges employers such as restaurant and foodservice operators face in implementing it.

Broader transition relief is needed for employers attempting to comply with the law in good-faith as time is short to make the significant changes required by the law. The duplicative automatic enrollment provision should be eliminated as it could unnecessarily confuse and financially harm employees. Key definitions in the law must be changed: The law should more accurately reflect the general business practice of 40 hours a week as full-time employment. The applicable large employer determination over-reaches to include more small businesses than it should.

The National Restaurant Association looks forward to working with this Committee and all of Congress on these and other important issues to improve health care for our employees without sacrificing their jobs in the process. We also continue to actively participate in the regulatory process to ensure the implementing rules consider our industry's perspective.

Thank you again for this opportunity to testify today regarding the impact of the health care on the restaurant and foodservice industry, and the challenging environment it will cause for job creation and growth.

Mr. PITTS. Chair thanks the witnesses for their opening statements. And now we will begin questioning by the members. And I will begin questioning, recognize myself for 5 minutes for that question—for that purpose.

Ms. Furchtgott-Roth, when PPACA was enacted, the then-Speaker of the House, Nancy Pelosi, claimed that the health care law would create 4 million jobs and almost 400,000 jobs immediately. However, your testimony underscores that PPACA will do the exact opposite and hurt job creation. Job creators face major incentives to reduce hiring and shift employees to part-time work to reduce the damage of the law's employer tax penalty. Given your expertise and your experience as the former chief economist at the U.S. Department of Labor, does Former Speaker Nancy Pelosi's claim bear any resemblance to reality?

Ms. FURCHTGOTT-ROTH. I don't think that the Health Care Act is going to create 4 million jobs on net. It might—it is obviously going to create jobs in insurance and hospital administration. Apparently, it is going to create many, many jobs in the IRS. Because the IRS is going to have to evaluate whether individuals have paid the right taxes and penalties and how much subsidy they are entitled to, because anyone under 400 percent of the poverty line gets a subsidy. But it is also going to cost low-wage jobs. As Dr. Blumberg says, with high-wage jobs, employers are just going to subtract the costs of the insurance from the wage. But this means less cash wages.

So people are going to do—be able to, say, go out to eat at Mr. Boucher's restaurants less often. That is going to cost jobs. So it is primarily going to have a decrease in low-skilled jobs in the economy and probably other kinds too.

Mr. PITTS. Now, this claim seems particularly specious since PPACA included over 20 new taxes which amount to over $1 trillion over 10 years. One of the most economically damaging taxes is the 2.3 percent excise tax on medical devices. Studies have shown that the device taxes cost thousands of people their jobs, and cost the economy billions of dollars in lost economic impact.

Now, you personally studied and coauthored a paper on this issue. Could you elaborate on your findings on this one tax alone, how it will affect jobs?

Ms. FURCHTGOTT-ROTH. Yes. We are the only country putting the 2.3 percent excise tax on medical devices. And many medical device manufacturers export overseas. Many of them also have other plans overseas. So the incentive is when the tax is imposed here, what they would do is move production offshore to deal, certainly, this their offshore clients. Because they wouldn't move it offshore to import it in here because they would still face the tax.

So I calculate that if 10 percent of production moved offshore, which I think is reasonable, the lost jobs would be in the range of 43,000 to 64,000; if 20 percent of manufacturing moved offshore, there would be a loss of 84,000 jobs to 105,000 jobs; if 30 percent moved offshore, there would be a lost employment range of 125,000 to 146,000.

Mr. PITTS. All right. Thank you. Mr. Boucher, your testimony indicated that the President's health care law will add major costs for your budget. Three parts to this question: Can you explain how

this cost increase affects your ability to invest capital and new investments—new restaurants, create new jobs? Explain how the law's regulations and uncertainty have forced you to spend more money on human resources to comply with the law? And your ability to run your business and create jobs?

Mr. BOUCHER. Sure. You know, I have spent at a minimum 100 hours this year with my human resource person just trying to figure out the details of this law. And even most recently, we constructed a survey to send out to our staff to understand what their intentions might be, based on what they know of this law right now. That was a task that took some time itself. The response level was very low because they don't understand what's happening. So we had to resurvey them individually, person by person, with our general managers actually spending time with them to do that survey. So these are all times that are not normally spent by our staff or by myself. So that, in and of itself, has been an enormous task.

As far as the future growth of our company, that added $200,000 is a real number that will not allow me to spend on capital improvements, build new restaurants. And as a matter of fact, we opted not to open another restaurant this year because we knew that this was coming and we wanted to see how it was going to play out truly before we made a commitment that we didn't have the cash to do it.

Mr. PITTS. Gentlemen, my time is up. Recognize the ranking member, 5 minutes for questioning.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to ask Dr. Blumberg, obviously our Republican opponents of the Affordable Care Act make these claims that the law kills jobs. They argue that requiring employers to offer health insurance and to improve employee benefits will increase the costs of labor. And I know this is simply not true. In fact, the ACA is helping to create millions of jobs. Since the President signed the bill into law, the U.S. Has added 6 million private sector jobs, this includes 750,000 jobs in the health care industry, which so many opponents of the law would be crushed—they say it is going to be crushed with job-killing regulations.

The restaurant industry, which we hear from today, has added more than 800,000 jobs in that same time period. And independent fact checkers have examined the claim that the ACA kills jobs and call it false and a whopper and have rated it with three Pinocchios.

So, Dr. Blumberg, can you explain whether the ACA is a job killer? And can you give us some perspective on the other factors that we should consider when looking at the law's impact on job growth?

Ms. BLUMBERG. Sure. The empirical evidence is quite consistent that the Affordable Care Act is not a job killer. That what we have looked at over time repeatedly with doing comprehensive health care reform, all of the macroeconomic models indicate that when you invest additional funds in health care that some of—yes, some dollars are shifted from other products into the consumption of health care. But because health care is, by its nature, a locally-produced good, and when others are buying things that are coming from other countries, that what happens is that some of that money that shifted to health care from other sectors actually can

create a positive impact on jobs locally as a consequence of how health care is, by its nature, purchased.

So while health care reform is not expected to have enormous positive job impacts, it is expected to have small net positive impacts.

And, in fact, when you look at the impacts on small employers, who are most disadvantaged by the health care system today, there is very significant positive implications for them in terms of cost reductions and assistance in their ability to be competitive in purchasing labor with larger firms. So all of this on net, in addition to the fact that the change in costs in total to employers is very small. As I noted earlier, relative to total compensation, we can't have big effects when the change in compensation is that tiny.

Mr. PALLONE. All right. Now, prior to the ACA, only half of the States had the legal authority to reject a proposed insurance premium increase that was deemed excessive or unwarranted. But the ACA provides States with 250 million in health insurance premium review grants over 5 years to help States improve their rate review process and hold insurers responsible.

The ACA also establishes a new medical loss ratio requirement to require insurers to spend 80 to 85 percent of premium dollars on benefits. Consumers have already received over $1 billion in rebates from insurance companies that failed to meet this important new standard.

Together, these provisions have already saved consumers over $2 billion, and the number of double-digit premium increases has fallen dramatically. In March 2012, CBO projected that premiums are estimated to be 8 percent lower by 2021 than originally estimated. And this is an especially important finding because of all the ACA does to make sure consumers have, you know, overall, more valuable quality insurance.

So, Doctor, just talk a little about how policies like rate review and limiting excessive insurance company administrative costs benefit businesses and consumers.

Ms. BLUMBERG. The medical loss ratio changes that you talked about moving to across the board minimums of 80 percent in a small group and the non-group markets in particular are very significant changes. The medical loss ratios in large group coverage were already reasonably high. So the law doesn't have nearly as much impact on them. But we have looked very carefully at medical loss ratios prior to the implementation in reform by State. And found that, first of all, there is dramatic variation across States, with some States having the vast majority of enrollment in the small group and non-group market in plans that have lower medical loss ratios than the law required. And so the impact on them is going to be very substantial in terms of lowering premiums.

Those plans are—those carriers are going to have to restructure and are already in the process of restructuring their cost structure in order to be more efficient in terms of their administrative costs and the way that they market their plans. And, in addition, the exchanges will help with that in terms of doing more centralized marketing for coverage and lowering those costs.

In addition, we have had a great deal of experience going to a number of States to talk to them about their experiences in imple-

menting the Affordable Care Act so far. And one thing stands out on this topic that we—conversations we had with State regulators, insurance regulators across the country who noted to us that what was amazing was as soon as the medical loss ratio—or the medical loss ratios and the rate review rules came in, and the rate review rule indicates that there has to be clear evidence of a reason for increasing rates more than 10 percent; otherwise, they are prohibited. And what these regulators told us, as soon as the law went into effect, suddenly all the carriers were clustering, instead of having much higher increases that they were requesting, they were all requesting them at 9.9 percent.

Mr. PITTS. Time has expired.

Ms. BLUMBERG. And so this was evidence from the regulators' perspective that the law was already having a significant effect, even in the early years of implementation.

Mr. PALLONE. Thank you.

Mr. PITTS. Chair thanks the gentleman. Now recognize the ranking member, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Boucher, I am so glad you are here on this panel. I know it must be tough for you. I know that because every Friday night I go to my pizza restaurant, a Domino's on Southwest Parkway in Lewisville, Texas. And I get an earful from the owner who just, like you, doesn't understand how in the world they are going to comply with all of the things that are coming their way and coming pretty fast.

Staff printed off for me the 21-page application that an employee will have to fill out in order to go into the exchange. I mean, it is no wonder that when you polled your employees about what they think about this, they take one look at something like this and say, "I'm going fishing, I'm not going to think about it right now."

But let me ask you, you heard Dr. Blumberg's responses to some questions. Let me just ask you, do you think the Affordable Care Act is a job killer?

Mr. BOUCHER. It absolutely can be.

Mr. BURGESS. It hasn't been in your case, hasn't it?

Mr. BOUCHER. In this particular year, it was, because we didn't actively pursue opening a restaurant. We did open one in 2011. However, that was before the elections. And, quite honestly, we waited to see what was going what was going to happen with the elections for this year. So in this case, we opted not to.

Mr. BURGESS. You are not alone in that election stuff.

Does the Affordable Care Act reduce your insurance costs?

Mr. BOUCHER. Well, as it stands right now, it is going to increase it because of the amount of people that are going to come on our plan. It is not going to reduce the existing plan, because every year our insurance rates have gone up. What is going to happen next year, I can only assume they are going to go up, based on historical data. But certainly from what I testified earlier that the projected amount, and this is a real number, we did surveys, individually, that 75 percent of our uninsured right now will come on. Our plan, it is going to increase. It is going to increase our health insurance costs. $200,000 is a big, big number for us to try and find a way how we are going to pay for that.

Mr. BURGESS. Let me ask you this. I mean, you are a representative of the Restaurant Association; is that correct?

Mr. BOUCHER. Yes. I am on the board.

Mr. BURGESS. Do you have any experience dealing with cost and coverage for the State of Massachusetts after the implementation of their health reform?

Mr. BOUCHER. No, I don't. I just—even though we are States right next door to each other, I just don't have enough information about what exactly their plan is.

Mr. BURGESS. Fair enough. We might work on trying to find that out.

Ms. Furchtgott-Roth, let me ask you a question.

You talked about the, really, I think what I would refer to as entry-level jobs, people who are just starting in the workforce.

Ms. FURCHTGOTT-ROTH. Right.

Mr. BURGESS. They might find those jobs to be diminished as a result of the Affordable Care Act. Is that not correct? Did I infer correctly from your testimony?

Ms. FURCHTGOTT-ROTH. They will find that. And they are already finding that. We hear that 6 million jobs have been created since the Affordable Health Care Act was passed. It is about 4 percent of total payroll jobs. Our unemployment rate is 7.7 percent. Our labor force participation rate is at 63.5, which is the same as September 1981, the beginning of the decade, when millions of women moved into the market, before the Reagan revolution.

Our employment is shrinking. In normal recovery, as economic growth expands, then employment also expands, labor force participation rate goes up. Our labor force participation rates have been going down and shrinking. Unemployment rates for teens are about 25 percent, unemployment rates for African-American teens are 43 percent. Unemployment rates for low-skilled workers are about 11 or 12 percent. These are the people who are hurt by putting a mandate on employers. The other people are, as Dr. Blumberg says, they take it out of their wage. Well, there's also effects to having less cash wages. If people are paying more for their health insurance, they have less cash wages to spend, and they can't go Mr. Boucher's restaurant.

Mr. BURGESS. Have you had a chance to look at this application for employees to apply for health insurance in the exchanges?

Ms. FURCHTGOTT-ROTH. I have not. But even a 2- or 3-page application would be daunting to me; I can't imagine what a 20-page application would be.

Mr. BURGESS. Correct. To someone who is just starting in the workforce who has had no experience with this type of thing in the past.

I think someone brought up about constructive revisions to the Affordable Care Act. Do you have any thoughts on constructive revisions? I mean, in other words, we are sitting here now less than, what, 6 months away or 6 months away now from the implementation where people are supposed to be able to go online, live, and register for health insurance in the exchange, starting October 1st. Do you have a sense that this can all be accomplished in that time? Or should we be looking at something that would perhaps postpone by a little bit this exchange activity?

Ms. FURCHTGOTT-ROTH. I think we should definitely postpone it. HHS is behind in issuing regulations in helping set up exchanges. I would say that there are a number of things you could do. First of all, allow any plan to be listed on the exchange. Right now, only a qualified benefit plan can be listed on the exchange. Those are very large, generous expensive plans, no copayments, all these different mandates like mental health coverage, drug abuse coverage, contraceptive coverage, et cetera. Why not allow catastrophic health plans to be listed for everybody? Right now, it is just for 30 and under. What if everybody could buy a catastrophic health plan? I mean, that would make health insurance much less expensive right then.

Then also, the grandfathering provisions for employers. Mr. Pallone said that employers would continue to offer their coverage and that they continue offering coverage. Well, it is grandfathered only under certain circumstances. You make any little change in the plan, it is not grandfathered anymore. So why not extend grandfathering and just say employers can continue to offer whatever plans they want.

And, third, I don't think that employers should have to pay for employees' health coverage, just as they don't have to pay for their food, they don't have to pay for their housing, they don't have to pay for their clothing. If we want to do this, let's have a more general tax on everyone so we don't disadvantage hiring.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. Now recognize the ranking member emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Thank you for your courtesy, and I commend you for the hearing. I hope this hearing will be successful in establishing ways to improve and see to it that the Obamacare legislation becomes an effective support for our society and for employment. I want to commend our panel for being with us today. And I want to observe that it is very important action for this Congress to recognize that the people have spoken, the Congress has voted, the decision of the Supreme Court, and the voice of the voters in the last campaign have all been heard in support of the legislation we discussed today. My questions are to Dr. Blumberg, and they will require only a yes-or-no answer.

Doctor, the intent of the Affordable Care Act is improving the quality of health care delivered in our health care system as well as expanding the access to affordable health coverage for individuals and small businesses. This is done, in part, by offering subsidies for individuals to purchase health coverage and tax credits to small employers who opt to provide such coverage.

In 2014 and 2015, small employers with 50 or fewer employers will be eligible for the tax credits, and after 2015, those with 100 or fewer employees will be eligible for the tax credit. Is this correct? Yes or no.

Ms. BLUMBERG. Not quite.

Mr. DINGELL. Now, next question. The IRS has notified more than 4 million businesses that they will be eligible for this tax credit. Is that correct?

Ms. BLUMBERG. I believe that is correct, yes.

Mr. DINGELL. Now, Doctor, would you agree that these tax credits make it more affordable for small business to offer health coverage to their employees? Yes or no?

Ms. BLUMBERG. Yes.

Mr. DINGELL. Is that a consensus?

Ms. BLUMBERG. It is.

Mr. DINGELL. Now, Doctor, some of this hearing today will be directed at proving that ACA will increase costs and result in lost coverage for employees. But you have found differently in your research. In your coverage simulation, which included penalties and tax credits in ACA, you found that employer-sponsored coverage did increase, and the largest coverage increase occurred among employees from businesses with 100 or fewer employees. Is this correct?

Ms. BLUMBERG. Yes, it is.

Mr. DINGELL. Doctor, with the increase in employer-sponsored coverage, 2 percent, what was the cost in terms of wages to employers? Can you give me some comment on that? I believe the answer is that this is going to only constitute about .003 percent of total wages. Is that correct?

Ms. BLUMBERG. It was .0003 percent.

Mr. DINGELL. Now, this seems to be a relatively small cost to an employer. Would you agree?

Ms. BLUMBERG. Yes, I would.

Mr. DINGELL. Do you think that such relative small costs would have significant or negative impact on employment?

Ms. BLUMBERG. No.

Mr. DINGELL. A pollster, I think, would find this to be within the margin of error. Is that right?

Ms. BLUMBERG. Yes, it would.

Mr. DINGELL. And most scientific or credentialed research would also find this to be within the margin of error. Is that correct?

Ms. BLUMBERG. I agree.

Mr. DINGELL. Now, if then millions of small businesses will be receiving tax credits to help them purchase affordable coverage and the cost of an increase in employer-sponsored coverage is relatively small, do you believe that small businesses will be financially better off under the Affordable Care Act? Yes or no?

Ms. BLUMBERG. Yes.

Mr. DINGELL. They don't have a nod button; you have got to say yes or no.

Ms. BLUMBERG. Yes.

Mr. DINGELL. Dr. Blumberg, I thank you for your assistance to the committee.

Mr. Chairman, I just want to make this observation: The Congress has fallen to a place that I think all of us find to be very distressing. We are known for gridlock, for inaction, and for ineffectiveness. And the public generally has an attitude towards the Congress that is somewhere below bill collectors and just slightly above child molesters. I think that working together to resolve the questions that we have, to solve the budget concerns, to make Affordable Care Act is a laudable goal.

I know my colleagues want to do it. I hope that this hearing will have as its purpose the idea that we are going to do that, and that

we are going to work together on this committee to see to it that we don't just have carping and criticism but, in fact, that we do have steps taken by this committee that will make this a program which will be good for this country. We are the only nation in the world which doesn't have—the only major industrialized nation which doesn't have a program of this kind. So I look forward to working with you in a spirit of remarkable goodwill to accomplish that purpose. Thank you.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Hall, 5 minutes for questions.

Mr. HALL. Well, thank you, Mr. Chairman.

Mr. Boucher, you told us of your growth and the steps you took to reach, I guess, the top or reach where you are, and I admire you for that, and understand your hesitation to gamble on an additional facility after the election. I think I know what you were saying there, and I agree with you on that.

And the chair covered some of the complexity of the Act on your business now, but I want to ask you about your business as you started it and go back in the restaurant business and lay out some strategic goals for the success and growth that you had then. How do you think this obstacle would have affected your business when you were getting started as opposed to now that you are well established, or now that we are in what the chair called a sluggish economy?

Mr. BOUCHER. I mean, we likely would not be where we are today. Being where I have been in this position as the CEO since 2004, it has become more and more and more difficult to operate business because of legislation such as this that it is creating hardship that we hadn't seen in the past. And I know for a fact that we would not have opened the number of restaurants that we have opened had this been in place say, you know, 6 years ago.

Mr. HALL. And do you think that the law's definition of full-time employee comports with how most businesses operate today?

Mr. BOUCHER. Well, no, and——

Mr. HALL. Prior to the Health Care Act was, I think, 30 hours was the typical cutoff point for the part-time employees versus full-time employees.

Mr. BOUCHER. I think it is—the definition of full-time is not really clear because the definition of full-time, when you calculate overtime, is 40 hours a week. So the definition of 30 hours a week really doesn't make a lot of sense when you compare to that type of thought process.

Different restaurants will categorize it differently, and I think, you know, I am an exception where I categorize it, but just like the restaurant industry, it is a very diverse industry and business owners in this industry will categorize it differently.

Mr. HALL. Ms. Furchtgott-Roth and Dr. Blumberg, do you have a different opinion of the answers that Mr. Boucher gave us or any comment you want to make on it? I have about 2 minutes left.

Ms. FURCHTGOTT-ROTH. I think it is important to look at the difference between the cost of health care as an average cost of the average wage, as a fraction of the average wage which is very well a small fraction of the average wage, and the cost of a health policy to an employer as a percent of a particular wage. So the fraction

of a percent is a fraction of a percent overall, but it is 9 to 11 percent of the wage in low-cost occupations such as retail and food.

And so whereas to an average employee it might not make so much difference, it is very important to low-skilled workers, it is very important that they be able to get their foot on the first wrung of the career ladder. Health insurance policies are going to be very expensive. In March 2012, CBO estimated that for a family of four, a health insurance policy was going to cost $20,000 a year in 2016.

Ms. BLUMBERG. I do have a different perspective. The situation that we need to keep in mind is comparing to where we are today, and one of the things that has been clear to large employers for a long time is that health care costs of employ-—of their employees have absorbed the costs associated with covering dependents who were employed by medium-sized and smaller firms for many years.

And so what we are—the situation here when the requirements, the employer requirements become more consistent across employer sizes over 50 is that it basically levels the playing field across employers.

The other thing to keep in mind is that there are demonstrated savings from our analysis for small employers, and there are about twice as many workers in the labor force work for small employers than do for the medium-sized firms, and so there are some distributional issues that occur when playing fields are leveled and individuals and firms that have been disadvantaged in the past are put on more equal footing with their other counterparts, but overall it should have positive implications for the——

Mr. HALL. And I thank you. And I yield back.

Mr. PITTS. The chair thanks the gentleman. The chair now recognizes the gentleman from North Carolina, Mr. Butterfield 5 minutes for questions.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, and thank the witnesses for their testimony today.

You know, Mr. Chairman, when I received the notice of this subcommittee hearing a few days ago, I saw that the title of the hearing was "Obamacare's Impact on Jobs," and quite frankly, I thought we were going to be talking about a positive impact on jobs because the evidence seems to me to be indisputable. There have been 6 million private sector jobs added since the signing of the Affordable Care Act. 750,000 of those jobs have been right in the health care sector, and 800,000 of those jobs have been in the restaurant industry, and so, quite frankly, I thought we were going to be talking about the positive impact on jobs.

I am just having difficulty, Mr. Chairman, understanding how one can, with a straight face, suggest that the Affordable Care Act is in fact killing jobs. That is absolutely not the case. It just seems to me that having a healthy and happy workforce must be a net positive for businesses, and so I want to continue this conversation and learn more, but I don't see how the Affordable Care Act is killing jobs. In my estimation, we are creating jobs.

Let me direct my attention to Ms. Roth. Thank you for your testimony. A few minutes ago, Dr. Blumberg, when she began her testimony, she—and I wrote it down, she said that her words should not be attributed to the Urban Institute. Is that what you said, Dr. Blumberg? Those were your individual words?

Ms. BLUMBERG. Yes.

Mr. BUTTERFIELD. So let me ask you, Ms. Roth, should your words be attributed to the Urban Institute or are these your words?

Ms. FURCHTGOTT-ROTH. I work for the Manhattan Institute.

Mr. BUTTERFIELD. I am sorry, the Manhattan Institute.

Ms. FURCHTGOTT-ROTH. And these are my words.

Mr. BUTTERFIELD. So we should not attribute these words at all to the Manhattan Institute?

Ms. FURCHTGOTT-ROTH. Right. All the individual scholars speak on their own behalf. The Manhattan Institute has not even seen my testimony.

Mr. BUTTERFIELD. But you are on the payroll of the Manhattan Institute?

Ms. FURCHTGOTT-ROTH. That is correct.

Mr. BUTTERFIELD. All right. I am interested to know where the funding for the Manhattan Institute comes from. Can you tell us the source of your funding?

Ms. FURCHTGOTT-ROTH. I have no idea of the source of my funding.

Mr. BUTTERFIELD. You don't know how the Manhattan Institute is funded?

Ms. FURCHTGOTT-ROTH. No. I mean, I don't have to go out and get grants. They pay me a salary. I don't have anything to do with funding.

Mr. BUTTERFIELD. What is the budget of the Manhattan Institute; do you know that?

Ms. FURCHTGOTT-ROTH. I do not have that number, but I can get that for you. I am sorry.

Mr. BUTTERFIELD. All right. Do you know if by any chance any political organizations or any political operatives contribute to the Manhattan Institute?

Ms. FURCHTGOTT-ROTH. I don't know the answer to that question.

Mr. BUTTERFIELD. All right. Let me now direct the next question to Dr. Boucher. Thank you so much for your testimony. I am a little confused, Mr. Boucher. You mention in one part of your testimony that this could really increase your company expenses by 5- to $700,000 if you were to add hourly employees?

Mr. BOUCHER. No, it would increase it from 500- to 700,000.

Mr. BUTTERFIELD. Oh, so, I was going to try to ask about the 200,000. I see what you are saying.

Mr. BOUCHER. Right.

Mr. BUTTERFIELD. So it will increase from 500,000 to 700,000.

Mr. BOUCHER. Right.

Mr. BUTTERFIELD. Now, this is not the Restaurant Association. This is your company?

Mr. BOUCHER. That is right.

Mr. BUTTERFIELD. And your company, I believe, is the Great New Hampshire Restaurants, Incorporated.

Mr. BOUCHER. Right.

Mr. BUTTERFIELD. What percentage? I heard the .0003 figure a moment ago. What percentage of your gross sales would that represent?

Mr. BOUCHER. I believe it was on not gross sales.

Mr. BUTTERFIELD. But if you had to spend an extra $200,000 to provide coverage to your hourly employees, you are saying that would——

Mr. BOUCHER. I would have to do the calculation in my head.

Mr. BUTTERFIELD. But it would be less than one-tenth of 1 percent, I suppose.

Mr. BOUCHER. No.

Mr. BUTTERFIELD. Yes. Give me—what are your gross sales?

Mr. BOUCHER. We are doing somewhere around 28 million, so if you do the math.

Mr. BUTTERFIELD. And of course that is gross sales. I mean, you have a lot of overhead, and so we figure maybe a 15 percent bottom line, and so——

Mr. BOUCHER. How much?

Mr. BUTTERFIELD. Maybe a 15 percent bottom line?

Mr. BOUCHER. No.

Mr. BUTTERFIELD. It is not that much. You wish. You wish it was.

Mr. BOUCHER. You are not even close, sir.

Mr. BUTTERFIELD. All right. But notwithstanding, a $200,000 increase in contribution to help your employees would not be a significant amount of money in comparison to your overall operation?

Mr. BOUCHER. Sir, our bottom line is 9 percent.

Mr. BUTTERFIELD. All right.

Mr. BOUCHER. Then we still have to pay taxes, then we still have to do our capital improvements, which is depreciation, and then we have to pay our business loans. At the end of that, I am left with about 4 cents of every dollar that I take in. So that 200,000 represents another penny off that 4 cents. Now, that is significant.

Mr. BUTTERFIELD. You have hourly employees and then you have the higher executive employees within the company. Do you now provide insurance to any of your hourly employees?

Mr. BOUCHER. Yes.

Mr. BUTTERFIELD. All right. But not all of them?

Mr. BOUCHER. We offer it to every single hourly employee, and as I testified, about 45 percent—55 percent choose not to take the coverage.

Mr. BUTTERFIELD. So that would be 30 hours or more?

Mr. BOUCHER. Correct.

Mr. BUTTERFIELD. All right. Mr. Chairman, I am out of time. Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. I think my colleague, who just spoke, it brings to the point, and we had it in my subcommittee, when we invite people to testify, we shouldn't impugn their comments based upon who they are employed by. And I only say this because this was raised in my subcommittee. We want to thank you all for being here and appreciate your testimony.

Having said that, the—you are from the Manhattan Institute, and Dr. Blumberg, you work for the Urban Institute, so you are not employers. You get a check. You sign the back of the check, correct?

Ms. FURCHTGOTT-ROTH. Right.

Mr. SHIMKUS. You get a check for your work?

Ms. BLUMBERG. Correct.

Mr. SHIMKUS. So there is only one employer here on our panel, and that is you, Mr. Boucher; is that correct?

Mr. BOUCHER. Yes.

Mr. SHIMKUS. So you sign the front of the check.

Mr. BOUCHER. That is correct.

Mr. SHIMKUS. So you are the expert on how rules, regulations, and taxes affect your business and the people you would like to hire, and the people you hire are the people you would like to keep under employ, and is that correct?

Mr. BOUCHER. Yes.

Mr. SHIMKUS. So you are the expert.

Mr. BOUCHER. I am the expert in my business for sure.

Mr. SHIMKUS. Thank you. And I guess the other thing that kind of rankled me was this debate about gross and net. That is a big difference, and in this Bill the medical device tax is a tax on gross, not counting the net, not taking out the expenses of producing a good. It is a gross tax across the board; is that correct?

Ms. FURCHTGOTT-ROTH. Yes, that is correct. That is a definition of——

Mr. SHIMKUS. And that is why it is so damaging for our jobs?

Ms. FURCHTGOTT-ROTH. Right.

Mr. SHIMKUS. Is that correct?

Ms. FURCHTGOTT-ROTH. That is right, yes.

Mr. SHIMKUS. No one else has a tax in this sector in the world on gross.

Ms. FURCHTGOTT-ROTH. No other country has singled out the medical device industry for a special tax, correct.

Mr. SHIMKUS. And Dr. Blumberg, don't you think a gross tax on a good that only this country has that other countries may produce might be a disincentive in the competitive market?

Ms. BLUMBERG. I would say that there is already a disconnect in the medical industries in terms of what is being charged and——

Mr. SHIMKUS. Let's stay on the point on the gross versus the net tax. Does that not raise the cost of a good?

Ms. BLUMBERG. Well, the costs are already higher in the U.S. plus the firms charge us more than——

Mr. SHIMKUS. Will the gross calculation raise the cost of a good versus a competitor, everything else being equal?

Ms. BLUMBERG. True.

Mr. SHIMKUS. Of course. Of course it would.

So, Doctor—Ms. Furchtgott-Roth, you mentioned job possible losses in the medical device industry, did you not?

Ms. FURCHTGOTT-ROTH. Yes.

Mr. SHIMKUS. In your testimony. And they are and they could and they already are going to be large; is that correct?

Ms. FURCHTGOTT-ROTH. Right.

Mr. SHIMKUS. So that is why part of this hearing is important, and if we want to fix parts of the bill, the medical device tax would be one way that we could fix it to create jobs.

Ms. FURCHTGOTT-ROTH. I would definitely recommend repealing that tax, yes, absolutely.

Mr. SHIMKUS. Thank you.

Ms. FURCHTGOTT-ROTH. And I also question the fact that you-all seem to think that the labor market is healthy and 6 million jobs are being created. Well, the unemployment rate is still 7.7 percent, including discouraged workers, it is 14.3 percent. The youth unemployment rate is 13 percent, and these are people who have student loans and they can't get jobs. The teen unemployment rate is 25 percent. This is not a healthy labor market.

Mr. SHIMKUS. Yes. I mean that brings——

Ms. FURCHTGOTT-ROTH. And saying that 6 million jobs are being created as though that proves that our labor market is healthy, well, we might have created many, many more without the Affordable Care Act and our employment rate might be lower.

Mr. SHIMKUS. And that is part of the debate about even youth employment, entry-level jobs, where can they get part-time employment to bus tables, or we even have a debate about raising the minimum wage. Isn't that a disincentive, Mr. Boucher, on hiring high school kids?

Mr. BOUCHER. What particularly?

Mr. SHIMKUS. Either/or? You could talk about increasing the minimum wage. You could talk about these rules and regulations, these forms in respect to job creation.

Mr. BOUCHER. Any regulation that mandates that I operate my business in a particular manner without me having the choice to do what I think is best for my business is damaging because I am not going to be able to give wage increases to, say, cooks because I have to give it somewhere else, and that is because of a mandate, so——

Mr. SHIMKUS. And I will end on this. My time is up, and I do think that there is—as we raise the cost of employment through health care coverage, there is a result, and I think, Dr. Blumberg, in your opening statement, you said there could be a reduction or a slower increase in that wage for that individual consumer. So there are effects, and we just need to have this debate and I appreciate you all being here. Yield back my time.

Mr. PITTS. Thank you, gentlemen. And I now recognize the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. One of the key design features of the Affordable Care Act is the way it builds on our existing health insurance system to fill in gaps and make improvements rather than making more radical and disruptive change. This is especially true in the employer-based insurance market. Both prior to and after the Affordable Care Act, the majority of the Americans receive health care through their employers, but we also know in the last three decades, the percentage of employers covering their employees for lots of reasons has gone down.

And so, but the Affordable Care Act builds on it. People are going to be protected from the worst insurance abuses. They will have access to quality insurance through a fair, individual marketplace and if they change jobs or do not want their employer coverage, but the overall employer-based system is still going to be strong. There have been a host of scare tactics used suggesting employers will fire thousands of workers or drop coverage en masse in response to health reform. And I know particularly the restaurant industry,

minimum wage is a big issue, and over the years, so—and I know every time we increase minimum wage, there is concern about losing employees or that you can't afford it, similar with health care.

Two of the most heavily cited examples are the Westgate Resorts and Darden Restaurant Group which completely reversed their course. Darden employed thousands of people across the country, and it indicated they were planning to limit employee hours to avoid providing health coverage, but Darden reversed course and said it would not limit the hours or drop coverage following an outcry from both its employees an its customers.

The same with Westgate Resorts. The CEO warned its employees of mass layoff if President Obama won re-election. Instead he gave them a 5 percent pay increase.

I have talked with restaurant owners in my area in Houston, and one of them is a long-time friend, actually a Republican, told me he costed it out and he owns a number of restaurant locations, so he is pretty large, and he said it is not what he was concerned about. In fact, he said it is going to give him some options to offer to his employees.

In fact, Mr. Chairman, let me say that we have heard a lot today from supposed burdens of health reform on businesses and I want to talk for a moment about the benefits and new opportunities that health care provides small business.

Mike Brey is the owner of a Hobby Works, a hobby and toy store he owned for more than 20 years. Mike has always offered health insurance to employees because it is a great way to attract and retain good employees, but before the Affordable Care Act, Mike's health premiums had tripled, and my experience in the private sector, small business, 13 employees, every year we had to negotiate out our rates because we would sign a 3-year contract, and they would raise our rates after the first year and second year thinking we wouldn't go out, but we negotiated every year.

Before the Affordable Care Act, his premiums tripled. He began to see his employees putting off necessary preventative care for themselves and children. In 2014, when Mike and his employees will have more choice of their quality health insurance and competition and cost containment and health reform will begin to drive down cost. Mike says because of the ACA, he finally has hope, and I quote, Spiraling escalating cost and depreciating the quality of coverage might end.

And I would like to submit, Mr. Chairman, ask unanimous consent to submit Mr. Brey's full statement for the record from the small business majority.

Mr. PITTS. Without objection, so ordered.

[The prepared statement of Mr. Brey follows:]

STATEMENT FOR THE RECORD

BEFORE THE HOUSE ENERGY AND COMMERCE COMMITTEE

ON

HEARING ON OBAMACARE'S IMPACT ON JOBS

MARCH 13, 2013

MICHAEL BREY
OWNER
HOBBY WORKS

This testimony is submitted in support of the small business perspective on the Patient Protection and Affordable Care Act and its impact specifically on my small retail business.

My name is Mike Brey, I'm the owner of Hobby Works, a hobby and toy store I opened in 1992, which I've since grown to five stores in Maryland and Virginia. I'm also a member of Small Business Majority's Network Council. Small Business Majority is a national small business advocacy organization that works to find solutions to the biggest problems facing small businesses today. As a network council member, I volunteer my time and entrepreneurial expertise to help Small Business Majority find pragmatic solutions to many of those problems—one of which is the rising cost of health insurance. That's what I'd like to talk to you about today.

Almost from the start, I offered health insurance coverage to keep and retain good employees. One of the first questions people ask when you're hiring is if you provide health insurance I've always taken great pride in being able to say, "Yes, you get good coverage—it's the same coverage the President of the company uses."

While my business has been successful and we've been able to grow, the ability to keep my workers happy and secure by providing health insurance coverage has eroded. Our health plan once cost $100 per person, most of which was covered by the company. Over the years our premium has tripled. My employees have seen their costs increase five times as they pay more of the premium and face a higher deductible. My workers are burdened by high deductibles and are putting off preventive care for themselves and their children and avoiding the doctor. The passing of the Affordable Care Act was the first thing in years that gave me hope that this spiral of escalating costs and depreciating quality of coverage might finally end.

I'm very much looking forward to full implementation of the Affordable Care Act next year when our state exchange opens and additional cost containment provisions go into effect. I may finally start to have the certainty and stability I need when it comes to health insurance premiums and choices of plans.

Benefits of the ACA for my small business

The high cost of health insurance has been one of my top business concerns for the past decade. As I mentioned, costs have continued to skyrocket while quality of coverage has decreased. The status quo was completely unacceptable. Doing nothing would have wreaked havoc on my and other small business owners' bottom lines and our ability to create jobs. Small Business Majority commissioned MIT economist Jonathan Gruber to conduct an analysis on the consequences of doing nothing. Gruber's analysis found that, without reform, small employers would pay $2.4 trillion in healthcare costs by 2018, costing 178,000 jobs, $834 billion in small business wages and $52.1 billion in profits.

Those numbers show why passage of the ACA was so important.

There have been objections from small business owners about this law, but I believe that discontent is largely based on misinformation and myths. As an employer in Maryland with fewer than 50 full-time-equivalent employees (I'll add here that 96% of all businesses in this country have fewer than 50 employees), I'll be able to use our state small business health insurance exchange next year to purchase coverage. This is huge. In Maryland, we don't have a lot of choice in insurance providers. In fact, we only have three. The Small Business Health Options (SHOP) exchange will allow business to pool their buying power when purchasing insurance. With a larger pool of businesses, ideally we will have more insurers offering coverage, and therefore more options to choose from. Presumably, this will make the market more competitive and I expect prices to come down as a result. Simply knowing I'll be able to shop for other plans as insurers change and costs fluctuate makes me feel more secure.

Another way the law will help me personally and rein in costs across the system is that up until now, a huge and largely unknown cost associated with private health insurance has been a hidden cost passed onto the insured when the uninsured receive medical care. When an uninsured individual receives care they can't fully pay for, health providers recoup a portion of unpaid-for care by passing the costs on to the insured with higher rates and premium costs. When everyone is required to have insurance, there won't be the need to pass those costs on.

Many provisions of the ACA are key to making health insurance more accessible and affordable for small businesses like mine. In addition to the exchanges, a multitude of cost containment provisions will go into effect next year that will help lower costs throughout the system. And as a businessman, it's important to me the country balance its books. The ACA helps lower costs while reducing the federal deficit by more than $200 million by 2020 and more than $1 trillion over the 10 years after that.

The ACA isn't perfect and it won't solve all of our health insurance problems overnight. However, it is the first meaningful law in decades that meets many of small businesses' core needs in regards to rising healthcare costs. In this fragile economy, policies that allow us to spend less on health premiums so we can keep more of our profits to reinvest in our companies and create jobs are what we need the most.

Conclusion

Implementing and strengthening the Affordable Care Act is the only path forward to lowering the overall cost of healthcare, providing more options for coverage for small business owners like myself and enabling small businesses to resume our traditional role as primary job generators.

Mr. GREEN. Dr. Blumberg, you have gone in depth of empirical research on employer, health insurance and labor market. Do you think that threats or frightening projections are justified, or do you think most employers around the country should continue to offer coverage and support to their workforce just as Darden, Westgate and Mr. Brey did at Hobby Works?

Ms. BLUMBERG. We do not expect there to be a significant change in the rate of offer, although we expect to see an increase among small employers in offering as a consequence of the exchanges. And the truth is, is that there is a great deal of misinformation out there, and when you talk to employers, give them the facts about the Affordable Care Act, they are often relieved relative to what they have heard, but ultimately, employers, as we have seen in many different circumstances, ultimately have to respond to market forces trying to attract labor and stay competitive with others who are hiring, and that is really what drives their decisions, not the fear and the anxiety that comes before something is actually in place.

Mr. GREEN. I have one of the highest districts in the country of people who work that don't get insurance through their employers. Before the Act, employers are dropping coverage, and again, I have an example of that. But after the Act, if employers make that decision to drop coverage, won't workers have better options in the individual market than they had before the reform?

Ms. BLUMBERG. That is absolutely true. The nongroup market is highly dysfunctional in virtually every State, except one in the country, and the improvements in the nongroup—operation of a nongroup market for consumers will be a big boom for those without offers.

Mr. GREEN. Well, even in Texas, even though our State won't have a State exchange, the law requires HHS to set up an exchange. For those employers who decide to drop it, their employees will have that option, whereas, before the Affordable Care Act, they didn't have anything.

Ms. BLUMBERG. That is correct.

Mr. GREEN. Thank you.

Mr. PITTS. The chair thanks the gentleman. Now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Thank you.

Dr. Blumberg, I got to tell you, when I speak to small employers, I mean, it is just so interesting because you walk in, they are not making a big deal about it, they just say we are going to stay at 49 employees. And they don't make a big deal about it, and you just say, well, why, and then they, oh, now that you ask, it is so because once we get to 50, we are hit with a penalty.

If you will, if we have 49 employees and whatever we do for insurance we do, but once we go to 50, we have to pay $40,000 in penalties for that 50th employee so that person's worth has to be their salary plus $40,000. And I am struck that you don't think this will have a negative impact upon small businesses hiring.

Ms. BLUMBERG. Well, I will explain why. Number 1, it shouldn't be a $40,000 penalty because they pay on—the only time an employer pays a penalty at all is if at least one of their workers goes

into the nongroup exchange and qualifies for a subsidy because of not having affordable coverage. So it is not automatic that——

Mr. CASSIDY. But at that point, if they do, then they get credit for 30 employees and it is the 20 that are left that they are 2K per person penalty, correct?

Ms. BLUMBERG. That is correct, if that is the way that——

Mr. CASSIDY. But that wouldn't inhibit somebody from going to 49, because they tell me it does. So, are their irrational or——

Ms. BLUMBERG. I am happy to respond. I think that you are correct that if an employer is looking to move from 49 to only 50 employees in the long term, that they are unlikely to make the decision to add that next worker unless the value that that worker brings to the firm is going to compensate for any additional cost.

Mr. CASSIDY. So that will be their salary plus 40K?

Ms. BLUMBERG. Let me finish, please. However, that is not the way that employers generally make decisions about hiring. When they are growing, they are growing because they see a long-term expansion in profit that would swamp the——

Mr. CASSIDY. I know you are saying that, but can I go on because we have a limited time, and I tell you the employers I talk to, they are actually factoring it in.

Secondly, I am struck, when I speak to employers, they are decreasing the number of employees who are full-time down to part-time, and I am struck that Mr. Butterfield says we created more jobs. According to the Bureau of Labor Statistics, we created a lot of part-time jobs, but we actually have 200,000 fewer full-time. There is, I think, 212,000 fewer full-time jobs in the last statistics, and there is 372,000 more part-time jobs, which to me is consistent with what I am reading and hearing that people are converting full-time employees to 30 hours or less.

Now, I grant you we have more employment, but it is more employment with fewer benefits. How would you respond to that?

Ms. BLUMBERG. Well, in any recovery, there is going to be an expansion of part-time jobs, and I haven't seen the specifics on how many of these jobs are full-time versus part-time, but you would expect there to be an increase in both part-time and full-time.

Mr. CASSIDY. But there is actually a decrease in full-time. There is decrease by 212,000 in full-time jobs in the last Bureau of Labor Statis-—Labor whatever.

Ms. BLUMBERG. From the prior period?

Mr. CASSIDY. From the prior period.

Ms. BLUMBERG. First of all, the full reforms that would—if anything was going to have an impact on part-time status, those reforms are not in place at the present time. And the complexity of the economy and the dynamics that have been going on with regard to the recession and the recovery from the recession are so large and complex compared to the costs associated with the Affordable Care Act that it would be impossible to attribute those changes——

Mr. CASSIDY. So even though Mr. Green gave some high profile cases of people converting to part-time, they are embarrassed, whatever, intimidated not to do so, but we know that is the tip of the iceberg and far more have actually gone ahead and done so. We are not going to attribute it to what we are being told is the attri-

bution, but rather, we are to assume that the answers are too complex for us to understand?

Ms. BLUMBERG. No. I am saying that complexity of what has been going on with the economy because of the issues related to the financial services district and decisions that were made there with regard to deregulation and other concerns are much more overriding in terms of what has been going on in the economy than the terms of the Affordable Care Act.

Mr. CASSIDY. The Federal Reserve recently had a report from all their districts, employers in several districts citing the unknown effects of the Affordable Care Act is reasons for planned layoffs and reluctance to hire more staff. There, they seem to put a point on it.

Ms. BLUMBERG. I think that those were very isolated reports on anecdotal evidence and we don't see any implications of the Affordable Care Act for significant changes in employment over time. So, anecdotal evidence can be frightening, and I appreciate that, but they also——

Mr. CASSIDY. This is Federal Reserve. They are not Drudge Reports——

Ms. BLUMBERG [continuing]. Market prices.

Mr. CASSIDY [continuing]. They are Federal Reserve, so presumably, they would vet a little bit and try and put it in context.

Ms. BLUMBERG. At this point I looked at that report. There was no data behind that. I do believe that they were conversations with particular employers, and I do understand that there is misinformation and anxiety that is being provoked in employers at this point prior to implementation of the full reforms.

But as I noted earlier, employers are interested in making profit, they are interested in pursuing labor and hiring the right types of workers. In order to get the kinds of workers they want, they have got to compete with other employers and so they have to provide them with the benefits and compensation——

Mr. CASSIDY. So just because we are out of time, we have to yield back. I will point out that also there is a CBO report that shows those who are most vulnerable are low-wage workers. Their elasticity of employment is the greatest. I grant you the CEO or the solar engineer is going to have a job. It is going to be the low wage earner who is going to be most vulnerable, and that is per CBO, but I yield back. I am out of time.

Mr. PITTS. The chair thanks the gentleman. And now recognize the gentlelady from the Virgin Islands, Dr. Christensen 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Roth, your testimony—you make a number of assertions that really seem to run counterto the facts supported by independent sources like the Bureau of Labor Statistics as well as CBO about the impact of the ACA job creation.

For example, the restaurant industry which you claim and Mr. Boucher suggests would likely drop coverage and downsize their employees as a result of health care reform, of the law, actually has added more than 800,000 jobs since the passage of the Affordable Care Act. And as we heard from Dr. Blumberg, you would expect some to be part-time, some to be full-time, but 800,000 new jobs.

But my question relates to one particular threat posed by—that you pose to health care reform in your testimony that I found particularly interesting. You wrote that because of health care reform, businesses have an incentive to become more automated or machinery intensive, and your examples are the fast food restaurants might serve precooked rather than freshly cooked food or that DVD rental stores might close in favor of automated DVD rental machines, or the convenience stores might start allowing for self-checkout. These dangers that you cite as a part of Obamacare are particularly interesting because they have really been occurring for a very long time.

Automation and increasing use of technology are enormous seismic shift in our global economy. Is it really your contention that these trends would not be occurring if health care reform were repealed?

Ms. FURCHTGOTT-ROTH. Well, thanks for that excellent question. My contention is that more employers will choose to substitute capital for labor as labor becomes more expensive, and of course, our economy has been continually getting more mechanized. What I was saying is that these trends would be faster.

Also, with the 800,000 jobs added to the fast food and restaurant industry, there might be even more of them added without the Health Care Act. But I think more importantly, the incentives to choose part-time workers over full-time workers will mean that actually there will be more employees in the restaurant and retail and other low wage sectors, because employers will have an incentive to keep them to fewer than 30 hours a week because if it is fewer than 30, they won't have to pay a penalty, so it makes sense for companies to share.

Mrs. CHRISTENSEN. Yes. But my question is really about tying it to the increasing use of technology, which is happening at a really fast speed, not only here, but across the country, and so, you know, there are a lot of wild predictions of the impacts of health care reform, but I think examples that were used in your testimony are really beyond explanation.

We have a global economy in which every other advanced country has some form of universal health care, and they are experiencing the same dramatic technological advances that are happening every day, and to blame Obamacare because Netflix is popular and Blockbusters closing just defies belief.

As other people have pointed out, some of the assertions that are made about job losses from Obamacare are really over the top, but I wanted to use the rest of my time for Dr. Blumberg, if I might. Marcellus Owens——

Ms. FURCHTGOTT-ROTH. Am I allowed to respond?

Mrs. CHRISTENSEN. No, I need to use my time.

He was 11 years old when he stood next to President Obama when he signed the Affordable Care Act into law, and his mother's poor health has cost her a job, her health insurance. She is a person with a pre-existing condition and she eventually died, and that is an example of what happens every day in our country, especially to minorities and people living in rural communities, and it not only costs lives, maybe as many as 100,000 are what is reported

and it costs the country an excess of over $80 billion a year by some reports.

So, it is an example of just why health care reform is so important. Uncompensated care costs to providers such as hospitals and community health centers will flourish if the numbers of uninsured rise, and more people will use emergency rooms, they will become more overcrowded, hospitals will be bearing more of unpaid care.

Could you please just elaborate for us, Dr. Blumberg, on how detrimental uninsurance is for individual families and for our country overall?

Ms. BLUMBERG. Sure. The uninsured—or the research evidence is very clear on this, that the uninsured receive less medical care and they receive less timely care and they have worse health outcomes, and in fact, the risk of death with a given medical condition controlling for health status appears to be about 25 percent higher for the uninsured than for those who are insured.

We have seen, from the experience with comprehensive health care reform similar to that of the Affordable Care Act in Massachusetts, that since its implementation, individuals have had greater access to care, they have had lower rates of not being able to afford care, and that that has stayed consistently increasing even throughout the recession period.

In addition, the lack of insurance, as you know, provides a very substantial financial burden on many families, and this also decreases their use of care and causes many bankruptcies.

Mrs. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Thank you. And the chair recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes for questions at this time.

Mr. GUTHRIE. Thank you, Mr. Chairman.

Ms. Furchtgott-Roth, you were going to respond to Dr. Christensen. I was interested in what you had to say. If you would just take a couple of seconds or half a minute what you were going to respond back, I would like to.

Ms. FURCHTGOTT-ROTH. OK. Well, thank you very much.

Well, as the cost of labor gets higher and we had the minimum wage start to go up from $5.15 an hour in 2007 and gradually rise, as the cost of labor steadily gets more expensive, employers have an incentive to substitute machines for labor. This MIT professor called Alberto Alesina who has written in great detail about that, I would be happy to provide any of you with any of the papers, show—he compared Europe and the United States, showing how high cost of labor in Europe resulted in more capital intensity there in the production.

Mr. GUTHRIE. Thank you.

And Mr. Boucher, somebody said earlier that you couldn't say with a straight face that jobs had been either on hold or some way because of the President's health care bill, but you—I think your face was straight, and I am not sure if I know what a straight face is or not, when I looked, but I looked. But you did make a decision not to open a restaurant because of the uncertainty affiliated with the health care; is that true?

Mr. BOUCHER. That is correct, and the key word being "uncertainty." That was—and it still exists right now with regard to a fair

amount of the rules that are not real clear right now. There is still a slot of uncertainty.

Mr. GUTHRIE. And that is what you hear. I mean, I hear that quite a bit. I know it is anecdotal, and I appreciate research and appreciate that, but on Friday, we were in our districts and I was working at a call to go see a gentleman who just went to a business owner, that just had gone to a seminar. He had got his group together with their insurance agents and the anxiety was not settled with him, and he was really concerned about decisions he was going to make in his business, the part-time work and so forth. Those are the real issues.

I know we are talking about 6 million new jobs in the labor force, and we are grateful to have 6 million new jobs, but you look at labor force participation, you look at the underlying part of it, and even last month, when the new jobs—I think it was 170,000 new jobs or something, but they say, we need to make 250,000 to keep up, so I don't think any—even though we are glad we are not going the other direction like we were, I don't think anybody is saying that we have a robust economy moving forward, and I don't think you can just point out one thing, and say it is this health care bill, and I think it is a conglomeration of a lot of things that are going on to create uncertainty. But I certainly think, and I do know and it is anecdotal, but it is everybody I see that is in business are just concerned about—even people who offer good plans of what is going to be an essential benefits plan, what are the rules going to be and how they are going to have to treat those, and so it is a real concern that businesses have, and this just isn't a us get together and try to point out different things.

This is what we hear when we go home. You hear concerns about we are not even thinking about—I mean, I walked, somebody says, well, if the rebate comes back from the health insurance company to my employee because of the medical loss ratio, do I get that? Does it come to me? Does it come to the employee? I paid 80 percent of the premium. Do I get that back? Well, we got to sort that out.

Then the question, next question was, well, is it going to be chargeable to this year's wages or next year wages, do I have to go do another W–2? So there are just all these things that are out there that really that maybe in the future will be, obviously, will be settled and people will get—if it is the law of the land, then we will figure out how to make it work, but you can't say it is not affecting people's business decisions today, I don't think. And I can say that with a straight face.

Mr. BOUCHER. And if I may, you know, I am considered someone who is knowledgeable on this topic, and I still don't know nearly what I need to know, and I have fellow restaurateurs calling me asking me, so, what are you going to do? And my answer to them is I am not sure yet, and they are relying on me to help them kind of walk through this, and truly, I am not exactly sure what we are going to do yet.

Mr. GUTHRIE. Because the other concern being in the restaurant business, you have three restaurants and each restaurant has 20 employees. Then you got to decide, do I keep the third restaurant? Or if you have two restaurant, do you open a third? If you have

three, do you close one. I mean, those are real concerns out there, and it is not, as some people have said that we are sitting here just trying to do political points.

My family is in business, we offer health insurance and pretty good health insurance actually, and we are in that midsize employer category, and I guess, Dr. Blumberg, you talked about the change in compensation would be tiny. I think I wrote that in a quote. Doesn't it really depend on the level of skill of your employee? The people were trying to—there is a book called "Chutes and Ladders," it was interesting about getting people into—it was a fast food restaurant study, the ones who showed up for work, came to work every day, they studied him over a course of time, and they are all managers. I think that is how you said you started, managers in restaurants.

And so the question is, if you are low skilled, and those are the people I work with and deal with, how do you get them into the workforce if you make them too expensive to bring to the workforce? Do you think that will have an effect?

Ms. BLUMBERG. I do take that into account. One of things that is important to remember is that for very low wage workers, the Medicaid expansion provides very comprehensive no-cost coverage to those individuals for the states that are choosing to participate, and those individuals, those workers, when they participate in Medicaid, they incur no penalties on the employers as a consequence.

In addition, while the midsize employers are obviously a concern, we know that most of—there is about twice as many workers in the small employer group than in the midsized employer group, and they are significantly more likely to have lower wage, those workers, and as a consequence of the small employers being consistently low, they will continue to be less likely to offer them their larger counterparts for a number of reasons. But the nongroup market and its financial assistance for the modest income who are above Medicaid eligibility is going to be a huge boon for low-income workers and small firms as a consequence of reform.

Mr. GUTHRIE. Thank you. Yield back.

Mr. PITTS. Gentleman 's time has expired. Chair recognizes the gentleman from Maryland, Mr. Sarbanes, for 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman.

Before I turn to the panel, I just wanted to caution. I had heard this discussion a moment ago about repealing the medical device tax, and I do want to point out that Congressman Ryan's budget plan includes the revenue from that tax in his proposal, so it is a little bit like that game "Pick-up Sticks" where you throw them down, they are all tangled and you start pulling sticks out of the thing, the whole thing will collapse, and we need to make sure that that and other things related to the budget proposal are in the record.

Now, Mr. Boucher, just real quick, you said in response to a question, you made a decision not to open another restaurant. When was that decision made?

Mr. BOUCHER. In July of last year as we were heading towards the elections.

Mr. SARBANES. Right. I want to follow up on something that Dr. Blumberg said. I think it is a terrific point, and that is, the ultimate fate of the ACA was in question really until this election was over. It was kind of a three-part drama. We had the passage of the bill, which was highly contested, then we had a judicial challenge to it. The Supreme Court removed that piece of uncertainty, and then we had a referendum in effect on whether it should go into effect, and that was the election, and it is now the law of the land, as Speaker Boehner has indicated.

There are a lot of people, and I would imagine you were among them and many of your colleagues, who were sort of saying to themselves, until I know whether this is actually going to be the law and implemented, why am I going to spend a lot of time trying to figure it out? And so there was good reason why many, many people remained uninformed about the details of implementing this.

Now, I think, you have got people that are very eager to know how it is going to be implemented. You indicated, Dr. Blumberg, that as you talked to small business people, they are exhibiting a tremendous amount of relief in many instances when they understand what is, in fact, required as against a lot of the misinformation that was put out, which gets further distorted in the midst of a highly charged political campaign, of course. We end up with sloganeering instead of real attention to what the regulations would require.

So I think that is going to be a make a difference now as small business people and others, frankly, come to the table and try to understand better what we were trying to achieve.

Now, a lot of what we are trying to achieve was to address the situation as small business people in this country who are dealing with stratospheric health care costs, having to make these tough decisions affecting their work force, and much of what we designed was meant to address that anxiety, specific anxiety of small businesses. And I say that because if we determine over time that there are certain things that we need to go in and tweak and fix and address to make sure that the concerns of small businesses are met, we are going to do that because that was largely the original motivation behind many of our investing so heavily and putting a lot of the political capital behind the ACA.

I remember a statistic that small businesses, on average, are paying somewhere between 18 and 22 percent more in premiums for the same exact benefit packages than large employers because they didn't have the benefit of pooling. I imagine that is going to be addressed, and you see that playing out in your models; is that correct?

Ms. BLUMBERG. That is correct. It is both the lack of pooling that has been in place for small employers so that the health status of even one of their workers or dependents can have a very dramatic effect on their average premium, plus the fact that they were charged considerably higher administrative costs for purchasing coverage than were their larger counterparts, plus the fact that they tend to employ lower wage workers, and as a consequence, there is less flexibility in terms of adjusting wages versus benefits.

Mr. SARBANES. Right. So we have good expectation that that can be addressed over time.

The other thing is, I recall another statistic that the cost shifting that went on, because you have people showing up in an emergency room, that cost had to be borne some place and it was going to be borne by those who did have health insurance to the tune potentially, in some instances, of $1,000 per person in terms of increased premium.

Now, I don't know if it was a thousand in certain instances and not others, but there was an extra premium being put in there because of the cost shifting; isn't that correct?

Ms. BLUMBERG. Depending upon the market power of the hospitals, yes. There is some potential for cost shifting. There are a lot of those uncompensated care costs are paid through State and local governments that will have some relief and should lead to lower taxes.

Mr. SARBANES. So I guess I am going to run out of time here, but if there is an uptake of 75 percent of the 45 percent that currently have not uptake your offer, if 75 percent will do, and I recognize it represents a cost for your business, but that is less people that are going to show up in an emergency room and result in cost shifting, it is a burden on your business and others, and the point is, over the long term, the trajectory where we were headed for small businesses and their costs was going like this. I think with ACA, it is going to still be going up for awhile like this but it is going to start going like this eventually, and we are going to get the benefit of this reform, and that is going to be a significant benefit for small businesses in this country. I yield back.

Mr. PITTS. Gentleman's time has expired. The chair now recognizes the gentlelady from North Carolina, Mrs. Ellmers for 5 minutes for questions.

Mrs. ELLMERS. Ms. Roth, I have a—going back to the medical device tax, I have a question for you. You know, the administration and other supporters argue that there will be a "windfall" from the increase from newly insured patients as a result of ACA and the tax will be offset.

Based on your analysis, do you believe that there will be a windfall for medical device companies or will the tax hurt device startups, capital investment and job creation?

Ms. FURCHTGOTT-ROTH. So, I think that it will hurt medical device companies because quite a lot of their products are exploited overseas, and they also have foreign plants, so they will probably shift the production of the export into their foreign plants.

First, and also, I don't really see as much of a decline in the uninsured as Dr. Blumberg and others seem to think, because with the Supreme Court's decision, it was legal to pay a tax of $95 in 2014, about 315 in 2015, about 690 in 2016, and then you don't have to buy insurance. Well, CBO says the cost of a premium for a family of four is 20,000; for a single person, it is about 12,000. A lot of people are just going to pay the tax, which is legal, according to the Supreme Court.

Mrs. ELLMERS. Right.

Ms. FURCHTGOTT-ROTH. And then go uninsured. They will then continue to get their care from community health centers or emer-

gency rooms, and then when they get sick, then they can sign up for insurance because right now, if you are sick, you can't write—you can't sign up for insurance. You have to be—because of the pre-existing condition.

Mrs. ELLMERS. Right.

Ms. FURCHTGOTT-ROTH. You are insured already, but under the new law, anyone can sign up at any time.

Mrs. ELLMERS. At any time.

Ms. FURCHTGOTT-ROTH. It is completely rational to stay uninsured until you are sick.

Mrs. ELLMERS. Sure.

Ms. FURCHTGOTT-ROTH. And then the pool of insured is going to get sicker and sicker. The price is going to go up. Every time the price goes up, it will be more worthwhile for someone to pay the tax instead of getting the insurance.

Mrs. ELLMERS. Versus the insurance. Thank you so much for your testimony. Thank you to the entire panel. This is very helpful.

Dr. Blumberg, I do have some questions for you. You know, you had just mentioned that the study shows that, you know, putting patients on Medicaid, that that is actually a much better situation, and I actually have a study that is completely the opposite.

In 2010, the University of Virginia released a landmark study on patients who have had surgery, and it is in stark contrast to what you—the testimony you just gave, and I would ask the chairman if we would be able to submit that study for the purposes of this subcommittee.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mrs. ELLMERS. Great. Thank you. And I won't get into the details of it, but basically, it is startling to know that if you are on Medicaid, you actually have a 13 percent higher chance of dying than if you are uninsured, according to this study, and actually double the amount if—versus someone who is insured. So it is an interesting thing. And also the cost of health care actually increases because you are—if you are on Medicaid, your health care stay in the hospital would actually be 42 percent longer than if you had insurance.

So, that being said, you had given your testimony about your study, and I am—I would like to submit mine. But I also, you know, to this point about anecdotal discussions that are being had by employers, you know, I have these discussions with my constituents every day, and they are so concerned about the cost of doing business and the ability to provide jobs in the future as a result of the Affordable Care Act.

I have one particular constituent, Mr. Gerald Kivit who, you know, he produces church furniture, the old-fashioned way, and his business, it has been a family-owned business for over 55 years. Five years ago he had 150 to 200 employees. He is now down to 46 employees and that is as a result of the economy. That obviously is not a result of Obamacare, but let's look at the facts.

You know, the issue of, you know, adding employees, the economy is going to turn around at some point and he is going to want to hire employees. How can he go beyond that 49th employee? And that is his question. If he were here today, he would ask you di-

rectly, you know, he said—he has asked me how can I, you know, afford this when my bottom line already is in the negative? So if Mr. Kivit were here today, how would you describe to him what you have been saying, which is that the Affordable Care Act is actually going to help small businesses?

Ms. BLUMBERG. I would like to respond to that, and I would also like to mention that it is not true that an individual can buy insurance coverage at any time regardless of their health status because there are open enrollment periods in the Affordable Care Act, so people can only buy at certain times of the year; otherwise, they will not be able to enroll.

In addition, with regard to the Virginia study, there has been a great deal of experimental research done by rather—with economists at Harvard University who have looked specifically at experimental data from the implementation of public coverage in Oregon and shown that in a very short period of time, there was actually very positive health status effects for those that were randomly enrolled in the expansion of public coverage there relative to those who are remaining uninsured.

So I just want to say that the analysis that you are referring to, I haven't seen specifically, but it is inconsistent with all of the other economic research and health that I have seen on that topic.

Mrs. ELLMERS. We will make sure that you get that study as well.

Ms. BLUMBERG. That will be great.

Mrs. ELLMERS. Thank you. And to, you know, again, if I were Mr. Kivit, what would you say as far as, you know, how is this going to help him to be able to provide health care for his—continue to provide health care for his employees?

Ms. BLUMBERG. Well, right now it is going to save him a considerable amount of money potentially and help his workers obtain health insurance coverage even if he doesn't offer coverage today. If he does offer, he is going to have new opportunities to offer coverage in the insurance exchange if he wants to; otherwise, he can continue to offer coverage outside the exchange as he may or may not do today, depending upon his situation.

If he doesn't offer and his workers need—would like to obtain coverage, don't get it through a spouse, they can then go into the nongroup exchange. There is no penalty assessed on him. They can get financial support if they need it to buy coverage, so those are——

Mr. PITTS. The lady's time has expired. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Appreciate it very much.

Ms. Roth, recently a major Florida employer announced that they were dropping health care coverage for part-time workers because the health care law effectively outlawed the low premium limited coverage plans that were offered to their employees.

I am concerned that this law is making coverage more expensive for Florida and causing premiums to increase an average of 61 percent according to actuarial studies. Could you elaborate on the provisions of the ACA that will raise the cost of coverage for small employers and other individuals that might stay in?

Ms. FURCHTGOTT-ROTH. So one element that is going to raise the cost of coverage is requiring a very large generous plan rather than the plans that the employer you mentioned had before, so those are not going to be permitted, so that is one thing that raised the cost of coverage.

Another thing that raised the cost of coverage is being able to sign up at—I shouldn't have said any time—at any open enrollment period because that means that you can go without insurance, you can pay the tax legally, and then you can sign up at the next open enrollment period, and in the meantime, go to hospital emergency rooms.

A third thing is just the big—a new administrative cost of providing health insurance with a mandatory electronic record, all the administrators, all the new IRS officials who are going to have to calculate what kind of penalties people are going to pay; also, the subsidies which reach up to 400 percent of the poverty line. When you go to exchange the amount you pay, it is going to depend on how much you earn. Again, this is a very big administrative burden.

The tax credits for small business, those phase out. That is not for all small business. It phases out between 10 and 25 workers, so you get the most tax credit if you have 10 workers, declining to 25. You employ 26 workers, you don't get a tax credit. It also declines if your average wage is between 25,000 and 50,000, so it will steadily decline from 25- to 50,000. If you pay an average wage of 50,000, you don't get the tax credit, even if you have over 10 workers.

So, all these different things increase the cost of health care. I would say the Number 1 is mandating a large generous plan and completely disallowing the smaller plans where people shop around and so they pay more attention to their health expenditures.

Mr. BILIRAKIS. Thank you. Mr. Boucher, do you feel HHS has been forthcoming with the guidance on how to implement the health care law, the provisions of the health care law? If not, has this made it very difficult, of course, for you and others in the industry to manage?

Mr. BOUCHER. Well, I think they have in some cases, but there is still a lot of uncertainty with regard to many of the rules. You know, there is a laundry list of items that I am still not clear on how it is going to affect our business, or even our employees, and we are anxious to hear how it is going to be defined so that we can plan and strategize for our future because right now the Association is trying to work and find solutions that work for both parties, but we need some answers that work.

Mr. BILIRAKIS. Thank you. Again, last question for Mr. Boucher. Has navigating the ACA regulations forced you to incur any additional costs?

Mr. BOUCHER. Well, as I stated earlier, I personally have spent and my human resource person has spent in upwards of 100 hours just filtering through all of this, and I anticipate it to continue not at that pace because we are up to speed pretty good now, but there is still a fair amount of work to do once these rules continue to work out.

And then ongoing, the administrative efforts that we are going to need to track and enroll employees if the auto enrollment stays as it is at 90 days, which, you know, we are opposed to, that, that is going to be an extremely difficult process for us. And even right now, looking back to try and determine the look-back period, we are having to deal with two different sets of data because we switched payroll companies at the end of the year. So we are trying to meld one payroll company's data with this year's payroll company data, they don't really talk to each other that great, and neither one of them has a great system in place right now for helping us to track that looking forward.

So, I feel like we are behind schedule here, and I personally would appreciate some relief in some fashion so that we are not subject to some kind of penalty because either the payroll companies aren't up to speed or the rules haven't been defined yet, and that is really the crux of the uncertainty that we are facing.

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

Mr. PITTS. Chair thanks the gentleman. And now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. I have heard numerous people here today say that this probably shouldn't have a big impact on jobs. I have even heard some folks say they thought when they heard the title of the hearing was "Health Care Act and Jobs," they thought it was going to be, you know, something positive. I am here to tell you that is just not the case. I am proud to represent the Commonwealth of Virginia. Served in the General Assembly there for 17 years. Virginia, which would be closer to a big business than a smaller business, has made the decision, both the House and the Senate at the request of the Governor, have limited part-time hours for State employees.

Now, it still sits on Governor's desk and has not yet been signed into law. But since he requested it, I doubt he is going to amend it out. And so we are facing a situation where 7,000 workers in Virginia are going to find that their hours are being cut. A trend of a friend, it has been reported to me that a friend of a friend is now looking for new work. She had been working for the Department of Health. But with the cutback in the hours, she has got to find something else in order to take care of her family.

These are the real impacts. This is the real impact on jobs. And it is just not the Commonwealth of Virginia alone. And I don't know about other States. But in my district, the town of Wytheville—now, it is not a big town, and I am sure it is not nearly the 7,000 people who are affected Statewide, but the town of Wytheville is also considering cutting back on their part-time hours. And in an editorial, and I think they said it very, very well, in an editorial that ran on the Tricities.com site, which usually means it is either the Wythe paper, or more likely, the Bristol Herald Courier, they said that, "Consider these cuts in referencing the fact that the town of Wytheville." And Councilman Hunley said, "It would be cost prohibitive to provide all the town's part-time employees with health insurance. So they are cutting their hours back." And then they reference the Commonwealth of Virginia and they said, "Consider that these cuts are coming from entities with no profit motive, no corporate board demanding rightsizing, no

shareholders screaming for costs to be held down, and no customers who can take their business elsewhere. Then ask yourself what the average business, which does not face those extra demands, is going to do."

Well, I will tell you that what I hear from numerous small- and medium-sized businesses, what they are going to do is that they are also going to cut the hours of their part-time workers. And in some cases, and I will ask you this, Mr. Boucher, I know you haven't done it, but if you are not hearing from lots of your colleagues that they are, in fact, shutting down stores in advance, knowing that if they have a store—now, it is not all the PPACA or Obamacare, but as one of the restaurant chains in my area's CEO told me, he said, we are not going to shut all our stores down. It is going to make life harder. But in those stores that are marginal stores, we are going to shut down. And I don't know if that was the only factor, but I did notice about 6 months ago, an announcement that one of his stores in area that is probably a marginal area had, in fact, shut down.

Are you already seeing in the industry—I know you didn't do it—but are you seeing in the industry that folks are eliminating those stores that may be in the black but are just barely in the black, and the cost of this additional cost to them with their part-time employees will hurt and, therefore, they are just going ahead and making the decision to shutter the doors.

Mr. BOUCHER. You know I can't speculate on what other restaurateurs are doing. But I will tell you that there are different business models for different levels of dining. You know, fine dining has different business model than fast food than casual. And as I stated earlier to the gentleman that our end of the day is $0.04 of every dollar. If there are restaurants that are $0.01 on every dollar this——

Mr. GRIFFITH. You can see under certain business models—because I have limited time—you can see under certain business models that this might very well affect those entry-level workers and folks working in the restaurant industry. Am I correct?

Mr. BOUCHER. There are restaurants that are right on that tipping edge that could be pushed over.

Mr. GRIFFITH. And let me say this, in Virginia, the vast majority, although I referenced somebody at the Department of Health, the vast majority of these employees actually work in our 23, 2-year community college systems. And one of those community colleges spokesmen was quoted as saying that one of the big detriments that they have from the State taking this action as a result of the PPACA, that they are going to lose an asset. And I quote, Josh Meyer, spokesman for Virginia Western Community College, "One of the great advantages of community colleges, like Virginia Western, is that we can agilely adapt the training and educational needs of the region. Our adjunct faculty gives us the flexibility to create new courses as the need arises. This new policy will limit the hours that such faculty can teach." He wrote that in an email to the newspaper. And, obviously, if you need to gear up for some new area, and you don't have the personnel to do it, you are actually going to impact the ability to retrain folks who need jobs. Am I correct?

Mr. BOUCHER. That is correct.

Mr. GRIFFITH. I thank you and yield back my time, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. That concludes our first round of questions. We will go to one follow-up per side. And chair recognizes Mr. Pallone for 5 minutes for follow-up.

Mr. PALLONE. Thank you, Mr. Chairman.

As we hold this hearing today, I have mentioned that our colleagues on the Budget Committee are debating the House Republicans' latest budget. The Republican budget repeals coverage provisions of the ACA and will leave 27 million additional Americans uninsured. It will roll back all of the consumer protections the law has put in place, allowing insurers to discriminate on the basis of preexisting conditions, charge women more than men for the same insurance, et cetera. And it turns Medicaid into a block grant.

So I just wanted to ask Dr. Blumberg, much of the discussion today has been around the changes the ACA represents for our Nation's businesses. But I wonder if you can help give us some perspective here. If the ACA were repealed and Medicaid faced significant cuts that Chairman Ryan envisions, are the millions of Americans who lost health coverage likely to have affordable coverage options in the private market? And then secondly, what would the loss of benefits associated with these cuts do to the economic and physical well-being of these Americans.

Ms. BLUMBERG. There would be very dramatic, negative effects of repeal and block granting Medicaid. Not only on middle-income Americans who are looking forward to the relief that the Affordable Care Act could provide them, but most especially on low-income Americans who really don't have other options. Very relatively small percentage of people even in profit, adults in poverty today are eligible for public insurance coverage. They don't have the financial wherewithal to be able to purchase coverage. In addition, a signet to the financial implications for the low-income and modest-income population, repealing would also have very negative implications for those that have poor health status, who are highly disadvantaged and being able to obtain health insurance coverage today if they don't have access to an employer-base offer of coverage.

So they would have—they would basically set us back to all of the problems that we have experienced in the past. The block granting is another issue. Because the way that that block grant is designed is that to give a particular amount of money to each State to diagnose their Medicaid costs. But the Federal dollars would not grow over time at the same rate at which medical expenses increase. So not only are you losing all the potential cost containment implications of the Affordable Care Act, but you are also then putting State budgets at a serious disadvantage relative to where they are today in order to provide coverage for the low-income population that they do currently have eligible.

And so over time, they either have to cut substantially back on the benefits, cut substantially back on eligibility for the benefits that they have been providing. And this can have very damaging—or to spend a significant amount more money of their own budgets in order to keep coverage where it is today, which it is often not

feasible at the State level. So there would be a lot of negative ramifications, both for individuals and for State government as a consequence of doing—taking those steps.

With regard to the implications for the economy in general of repeal, as we talked about, there is often at least small net employment gains as a consequence of investing more in health care, which is a locally produced and purchased good, and so those would be eradicated as well.

Mr. PALLONE. Now, I know the ACA includes an employer responsibility requirement that encourages employers with more than 50 employees to offer affordable coverage. And then there is a penalty if an employer chooses not to offer coverage. However, 96 percent of small businesses in the U.S. have fewer than 50 employees and are therefore exempt from the requirement, and the firms that will be subject to the requirement, more than 95 percent already provide health insurance.

So just talk a little bit—there is not much time here—about some of the economic benefits of the ACA for small businesses.

Ms. BLUMBERG. Well, particularly for small businesses, they are hugely disadvantaged today by not being able to buy, as you referred earlier, to not being able to buy employer-based coverage for their workers at the same price as do their larger counterparts. This is because the administrative costs that carriers charge the smaller groups are much higher because they are selling small group by small group and they are doing medical underwriting, they had been doing medical underwriting of those policies, will continue to do that until January 1st, 2014.

All of those considerations increase administrative costs significantly for those small employers, which would be decreased substantially under the Affordable Care Act. So lowering administrative costs would be a very significant change because that is a big burden on small employers today, one of the reasons they are less likely to offer. In addition, they tend to employ a lot of low-wage workers compared to their larger firm counterparts. And that means that under the Affordable Care Act those that don't offer their workers will be able to have access, guaranteed access to affordable coverage through the non-group exchanges, which they don't have today. And that makes it easier for them to hire workers in the small group market. In addition, right now, the small employers are disadvantaged because by their nature of being small they—the average risk for them that they are bearing in terms of looking at a price for health insurance can be extremely variable. So——

Mr. PITTS. Gentleman's time has expired.

Chair recognizes the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for follow-up question.

Mr. BURGESS. Thank you, Mr. Chairman. I do appreciate the panel being here today. I know it has been a long morning. Just a couple of things I would like to kind of close the loop on. Mr. Sarbanes mentioned the issue of cost shifting and why it was so important to get the Affordable Care Act done because all this cost shifting that is going on by the free riders of the system, people show up in emergency rooms who don't have insurance. But, in fact, really look at the cost shifting that is going on, it is happening in the

Federal programs. Right now, we have real difficulty in the State of Texas because a lot of providers are not opening their doors to Medicare or Medicaid patients. Why is that? Because the Federal reimbursement is lower than what that it is on the private side. What happens then is the private side, private insurance or self-paid patients end up making up the difference.

I have got to tell you one of the most frustrating mornings I have spent in the last 2 years was the morning, the second morning of oral arguments over at the Supreme Court. I was fortunate enough to be there. And listening to the Solicitor General base his entire case on the fact that, well, you got people who are showing up at the emergency rooms without health care coverage, and this cost shifting is costing all of us a bundle. Wait a minute. The patient who is covered by Medicaid—we are going to expand that by a bunch; I don't know how much, but 16, 20 million people with full implementation of the Affordable Care Act in a year's time. If they can't get a doctor's appointment, then they are not going to a clinic, what are they going to do? They are going to show up in the emergency room, because that is what they have always done. And that cost shifting will still occur. Because the government's reimbursement for Medicare and Medicaid is less than the cost of delivering the care, the cost shifting continues, and if anything, we are doubling down on that.

This is not to disparage the person who is covered under Medicaid, but to disparage the agency that is responsible for the oversight of this. And for heaven sakes, this committee, the best we could do if we want to extend coverage to more Americans, we sit here in this committee, the best we can do is to expand a program that is 45 years old that was intended to be a safety net program back in 1965. Ranking member was chairman at that time. I just submit that there were better ways, but we never bothered, we never bothered to even ask.

So I had to get that off my chest. Mr. Sarbanes said it was cost shifting that was costing the program. Well, cost shifting may be costing the program. It is not free rider, it is not the 27-year old who would rather buy a basketball than an insurance policy. The problem is the expansion, the vast expansion of Medicaid is going to make this problem a great deal worse.

Let me just ask you a question, Dr. Blumberg. And it is a relatively simple question. I think Ms. Furchtgott-Roth touched on the subject that some dependent coverage is going to go away as a consequence of the requirements under the Affordable Care Act. Is that a fact?

Ms. BLUMBERG. There should not be a decrease in dependent coverage. It is——

Mr. BURGESS. Let me stop you there. Ms. Furchtgott-Roth, you suggested that there would be. Will there be a decrease in dependent coverage under the Affordable Care Act?

Ms. FURCHTGOTT-ROTH. Employers are required to offer an affordable policy, affordable for a single person. So say you have somebody who earns more, is ineligible for Medicaid. Say, someone who earns $30,000 a year or $40,000 a year who has a wife and three children. His employer offers him affordable single coverage.

Under the law, he is required to take that affordable single coverage. Also under——

Mr. BURGESS. Now, that is an important point. So he is required, he or she is require to take that coverage.

Ms. FURCHTGOTT-ROTH. Cannot turn it down. Right. Exactly. And his wife and children then are not allowed to get subsidized coverage on the exchange. Because he is getting affordable single coverage from his employer.

Mr. BURGESS. I have got to tell you——

Ms. FURCHTGOTT-ROTH. They can buy coverage on the exchange, but it has to be at full price. They don't qualify for the subsidies for people making 400,000—under 400 percent of the poverty line. This is a very serious problem——

Mr. BURGESS. Serious.

Ms. FURCHTGOTT-ROTH [continuing]. Dealt with in the discussions. Because, originally, employers were required to provide affordable coverage for families, not just for singles.

Mr. BURGESS. Here is the deal. The Fort Worth Star Telegram, in the middle of January, headline of "500,000 Children to Lose Health Care Under the Affordable Care Act." I mean, that is a big deal. Can you imagine if a Republican president pushed through a law that kicked 500,000 children off their health insurance? I mean, we would be hearing screaming from the mountaintops if that had occurred under a Republican administration. I don't know why it barely rated a news story. Now, the good news for those uninsured children, I think the Internal Revenue Service, under the Department of Treasury has promulgated rules where those children will not be fined for not having health insurance that they then lost because of the Affordable Care Act. Is that your understanding as well?

Ms. FURCHTGOTT-ROTH. I just don't know the answer to that question. There was a headline about it, an editorial in The New York Times last August, the editorial was entitled "A Glitch in the Health Care System."

Mr. BURGESS. Mr. Chairman, there are a lot of glitches in the health care system as we have heard this morning. I hope this committee continues its due diligence to, not just to expose these problems, but we need to work on solutions. I mean, after all, we can argue about the political stuff. But Mr. Boucher has got to deal with it on a very real, personal basis. He is not a think tank, he is not a public employee like we are. He is out there grinding it out every day, trying to battle the forces and to make it all work and to provide for his employees. We shouldn't make the landscape harder for him, we should try to empower him.

Thank you, Mr. Chairman. I will yield back my time.

Mr. PITTS. Chair thanks the gentleman.

That concludes our questions for the panel. I would like to thank the witnesses for their testimony, for their answers. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly.

Members should submit their questions by the close of business on Wednesday, March 27th.

Excellent testimony, excellent hearing. Thank you very much. Without objection, the subcommittee is adjourned.

[Whereupon, at 11:31 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. PHIL GINGREY

I believe today's hearing couldn't be more timely. The coming wave of regulations that businesses will be forced to confront due to Obamacare provisions is already influencing the decision for businesses to hire new employees. As our country continues to show lackluster job growth, it is essential to focus on how this law forces companies to delay hiring workers and reduce employee compensation.

This week, I spoke with a coalition of small business owners from the 11th Congressional District to learn how President Obama's health care law has affected the day-to-day operations of their companies. Across the board, they expressed frustration with its new rules and "moving target" regulations, the increase in health care costs, and the uncertainty the law has created. "We're afraid to grow," said one business owner. "The lack of information is creating fear, and it's not good for the economy."

You see Mr. Chairman; this law is already having a direct impact on hiring decisions in my district. Even though most of these provisions will not take effect until 2014, job creators and employees in Georgia and nationwide are already feeling the pain. If we really want to put America back to work, we need to lift these onerous provisions on our small businesses.

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Primary Payer Status Affects Mortality for Major Surgical Operations

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Abstract

Objectives—Medicaid and Uninsured populations are a significant focus of current healthcare reform. We hypothesized that outcomes following major surgical operations in the United States is dependent on primary payer status.

Methods—From 2003 to 2007, 893,658 major surgical operations were evaluated using the Nationwide Inpatient Sample (NIS) database: lung resection, esophagectomy, colectomy, pancreatectomy, gastrectomy, abdominal aortic aneurysm repair, hip replacement, and coronary artery bypass. Patients were stratified by primary payer status: Medicare (n = 491,829), Medicaid (n = 40,259), Private Insurance (n = 337,535), and Uninsured (n = 24,035). Multivariate regression models were applied to assess outcomes.

Results—Unadjusted mortality for Medicare (4.4%; odds ratio [OR], 3.51), Medicaid (3.7%; OR, 2.86), and Uninsured (3.2%; OR, 2.51) patient groups were higher compared to Private Insurance groups (1.3%, $P < 0.001$). Mortality was lowest for Private Insurance patients independent of operation. After controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs ($P < 0.001$). Medicaid ($P < 0.001$) and Uninsured ($P < 0.001$) payer status independently conferred the highest adjusted risks of mortality.

Conclusions—Medicaid and Uninsured payer status confers increased risk-adjusted mortality. Medicaid was further associated with the greatest adjusted length of stay and total costs despite risk factors or operation. These differences serve as an important proxy for larger socioeconomic and health system-related issues that could be targeted to improve surgical outcomes for US Patients.

The influence of socioeconomic factors and insurance status among United States patients has been a primary focus of many public health initiatives and current health care reform investigations. According to the US Census Bureau, from 2007 to 2008, the number of uninsured Americans increased from 45.7 to 46.3 million, the number of people covered by private insurance decreased from 202 to 201 million, and the number of people covered by government insurance increased from 83.0 to 87.4 million.[1] The Medicaid and Uninsured patient populations have been shown to have worse medical outcomes compared with

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Privately Insured patients as a result of socioeconomic and patient-related factors.[2,3] Further, disparities in disease treatment and resource utilization may occur as a function of insurance and primary payer status. With a rising elderly population and increased initiatives for government-sponsored health care, such trends provide an important platform from which to examine contemporary surgical outcomes as a function of primary payer status.

Recent efforts to examine the impact of primary payer and insurance status within surgical populations have focused on specific patient populations and surgical subspecialties. A recent study examining insurance status among vascular surgery patients collected from 2 statewide (New York and Florida) data registries, demonstrated that type of insurance predicts disease severity at the time of treatment.[4] Other studies have focused on disparate differences in type of surgical treatment as a result of payer status.[5,6] Moreover, recent data suggest that important differences exist in trauma care outcomes and resource utilization with respect to Medicaid and uninsured payer status.[7–9] Few studies, however, have comprehensively examined the overall influence of primary payer status on outcomes among a broad population of patients undergoing major surgical operations.

The objective of this study was to examine the effect of primary payer status on outcomes and resource utilization within a diverse surgical population. We used a large, national administrative database to more completely examine this important question and hypothesized that outcomes following major surgical operations in the United States are independently influenced by primary payer status.

METHODS

Data Source

Data for this study were obtained from the Nationwide Inpatient Sample (NIS) databases for the years 2003 to 2007. NIS is the largest, publicly available all-payer, inpatient care database in the United States, and is maintained by the Agency for Healthcare Research and Quality as part of the Healthcare Cost and Utilization Project.[10] Each year, it contains data from 5 to 8 million hospital admissions from about 1000 hospitals, representing an approximate 20% stratified random sample of all hospital discharges in the United States. NIS includes hospitals designated as "community hospitals" ("all non-Federal, short-term, general, and other specialty hospitals, excluding hospital units of institutions") in the American Hospital Association Annual Survey. Sampling strata used by the NIS is based on 5 hospital characteristics (geographic region, urban or rural location, ownership/control, teaching status, and hospital bed size) contained in American Hospital Association hospital files. Data include in-patient hospital discharge records collected for patients of all ages and sources of insurance. A discharge weight is included for each patient record, which represents the relative proportion of the total US in-patient hospital population represented by each record.[11] Consequently, the surgical population included in this dataset is broadly representative of individuals undergoing major surgical operations in the United States during the study period. Due to the absence of patient identifiers in collected data and the fact that the data are collected for purposes other than research, the University of Virginia Institutional Review Board did not perform a formal review of this study as it was determined that this study does not meet the regulatory definition of human subjects research.

Patients

Using International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM) procedure codes,[12] we identified all patients in the NIS dataset undergoing at least 1 of 8 major surgical operations: lung resection (ICD-9-CM codes 323, 3230, 3239,

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324, 3241, 3249, 325, 3250, 3259), esophagectomy (ICD-9-CM codes 424, 4240, 4241, 4242), colectomy (ICD-9-CM codes 457, 4571, 4572, 4573, 4574, 4575, 4576, 4579, 458, 4581, 4582, 4583), pancreatectomy (ICD-9-CM codes 526, 527, 525, 5251, 5252, 5253, 5259), gastrectomy (ICD-9-CM codes 435, 436, 437, 439, 4391, 4399), abdominal aortic aneurysm (AAA) repair (ICD-9-CM code 3844), total hip replacement (ICD-9-CM code 8151), and isolated coronary artery bypass grafting (CABG) (ICD-9-CM codes 3610, 3611, 3612, 3613, 3614, 3615, 3616). We chose these operations to include a group of commonly performed complex procedures, representing a broad range of surgical subspecialties, associated with significant risk of morbidity and mortality. Patients undergoing lung resection, esophagectomy, colectomy, gastrectomy, or pancreatectomy were not limited to those undergoing cancer-specific operations. For CABG operations, only isolated operations were included; concomitant valve or other cardiac operations were excluded. Patients were stratified by primary payer status into 4 comparison groups: Medicare, Medicaid, Uninsured, and Private Insurance. The Uninsured payer group included patients with reported no-charge and self-pay status.

Patient comorbid disease was assessed using 30 different Agency for Healthcare Research and Quality comorbidity measures and categories developed by Elixhauser et al.[13] The Elixhauser method has been demonstrated to provide effective adjustments for mortality risk among surgical populations and has been shown to be superior to the Charlson/Deyo method.[14,15]

Outcomes Measured

The primary outcomes of interest in this study were adjusted in-hospital mortality, in-hospital complications, hospital length of stay, and total costs. In-hospital complications were categorized into 8 classifications (wound, infections, urinary, pulmonary, gastrointestinal, cardiovascular, systemic, and procedural) according to the ICD-9-CM based coding scheme developed by Guller et al (Table 1).[16] Death occurring during the in-patient stay was identified from the patients' discharge status. Unadjusted mean length of stay and total costs were determined from discharge records.

Statistical Analysis

All group comparisons were unpaired. Incidence of preoperative and hospital variables as well as unadjusted outcomes were compared using analysis of variance for continuous variables, and either Pearson χ^2 analysis or Fisher exact test for all categorical variables as appropriate.

Multivariable logistic regression was performed to calculate the adjusted odds of in-hospital death and in-hospital complications among patients undergoing major surgical operations. All preoperative variables entered as covariates (patient age, gender, elective operative status, mean income, hospital geographic region, teaching hospital status, type of operation, primary payer status, and categories for comorbid disease) were selected a priori based upon established clinical risk or were considered potential confounders for the effect of payer status among patients. All covariates contributing cases to each estimated outcome, including nonsignificant variables, were retained in the final models. The estimated odds of in-hospital death and in-hospital complications were adjusted for all covariates. All logistic regression models included appropriate adjustments for variance components estimated from the weighted study population.[17] The statistical significance of the association between primary payer status and in-hospital death or complications was assessed using the Wald χ^2 test. Confidence intervals for all adjusted odds ratios (OR) were calculated using an alpha of 0.05. The discrimination achieved by these models was assessed using the area under the receiver operating characteristics curve (AUC). AUC values of 1.0 indicate perfect

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discrimination between outcome groups, while values of 0.5 indicate results equal to chance. The Hosmer-Lemeshow test was used to assess the statistical significance of differences in each model's calibration across deciles of observed and predicted risk.

Multivariable linear regression models were created to estimate adjusted length of stay and total costs for each payer group. In each model, the same covariates entered into logistic regression models were used. Each linear regression model generated an unstandardized coefficient for each payer group, reflecting the slope of each linear regression trend. These coefficients were used to calculate adjusted means for hospital length of stay and total costs for each payer group.

Sensitivity analyses for each multivariable logistic regression model were performed. For each model, sensitivity was assessed to evaluate the possibility that the estimated effect of primary payer status on outcomes could be a spurious result, reflecting the influence of a closely related but unmeasured confounder. Accordingly, each model was re-estimated after removing the most statistically significant covariate as measured by the Wald statistic. The potential for spurious results is reduced if the originally observed effect is not substantially attenuated and remains statistically significant after re-estimation.[18] For each multivariable logistic regression model, operative category was the most highly significant covariate. After removing this covariate from each logistic regression model, the effect of primary payer status on the estimated odds of each outcome were not significantly attenuated (<10%), validating the sensitivity of each original model.

Frequencies of categorical variables are expressed as a percentage of the group of origin. Continuous variables are reported as means ± standard deviation. ORs with a 95% confidence interval are used to report the results of logistic regression models while adjusted means are reported for the results of linear regression models. Reported P values are 2-tailed. Statistical significance was identified by $P < 0.05$. Data manipulation and analysis were performed using SPSS software, version 17 (SPSS, Chicago, IL).

RESULTS

Patient and Hospital Characteristics

During the 6-year study period, a total of 893,658 patients underwent 1 of 8 major surgical operations, representing a weighted estimate of 4,351,163 patients nationwide. Frequencies of all patient characteristics stratified by primary payer group are listed in Table 2. Patients with Medicare (55.0%) or Private Insurance (37.8%) represented the largest payer groups. Mean age was highest in the Medicare (73.5 ± 8.6 years) group. Female gender was more common in the Medicare (49.6%) and Medicaid (48.8%) payer groups, and elective operations occurred more commonly among Medicare (62.8%) and Private Insurance (68.4%) patients. Isolated CABG was the most common operation among all payer groups followed by colectomy and hip replacement, respectively. Medicaid (41.3%) and Uninsured (33.6%) patients had the highest incidence of the lowest quartile for median household income.

Few important clinical differences in preoperative comorbid disease existed across payer groups. Chronic pulmonary disease and diabetes were more common within Medicare (22.2% and 22.1%, respectively) and Medicaid (19.5% and 19.9%, respectively) patients while alcohol abuse was more common among Medicaid (5.0%) and Uninsured (5.8%) patients. Medicare patients had the highest incidence of preoperative congestive heart failure (6.5%), hypertension (61.1%), hypothyroidism (10.0%), peripheral vascular disease (8.5%), renal failure (6.5%), and cardiac valve disease (4.3%).

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The frequencies of hospital characteristics among all payer groups are listed in Table 3. The large majority of surgical operations occurred in an urban setting for all payer groups and within large hospital bed size hospitals. Medicaid (60.4%) patients had the highest proportion of operations performed at teaching hospitals. The Southern geographic region performed the highest proportion of major surgical operations for all payer groups.

Unadjusted Outcomes

Unadjusted outcomes by primary payer group appear in Table 4. Private Insurance patients incurred the lowest incidence of all in-hospital complications except for systemic complications (Appendix B). Medicaid patients incurred the highest incidence of postoperative wound complications (1.7%), infections (3.4%), gastrointestinal complications (4.7%), and systemic complications (1.8%). Medicaid payer status conferred the highest unadjusted mean hospital length of stay (12.7 ± 18.5 days) and total costs ($93,567 ± 111,039) among all payer groups followed by Uninsured payer status. Unadjusted mortality for Medicare (4.4%; OR, 3.51), Medicaid (3.7%; OR, 2.86), and Uninsured (3.2%; OR, 2.51) patient groups were higher compared with Private Insurance groups (1.3%, $P < 0.001$). Moreover, Private Insurance patients also had the lowest unadjusted in-hospital mortality despite the operation (Table 5). Overall, in-hospital mortality was highest among patients undergoing AAA repair (11.3%) and lowest for those undergoing hip replacement (0.2%) independent of payer status. Importantly, in-hospital mortality following AAA repair was highest for Uninsured (14.8%) and Medicaid (14.5%) patients.

Adjusted Outcomes for the Effect of Primary Payer Status

Results of multivariable logistic regression models used to estimate the effect of primary payer status on postoperative outcomes appear in Table 6. After adjustment for the concurrent effects of patient, hospital, and operative factors, Medicaid and Uninsured patients incurred a 97% and 74% increase in the odds of in-hospital death, respectively, compared to those with Private Insurance. The independent effect of primary payer status on in-hospital death was highly significant ($P < 0.0001$, AUC = 0.86).

Multivariable logistic regression models constructed for inhospital complications further implicated Medicaid payer status as an independent predictor of morbidity. Among payer groups, Medicaid payer status conferred the highest adjusted odds of wound complications (OR, 1.23), infectious complications (OR, 1.24), pulmonary complications (OR, 1.13), and systemic complications (OR = 1.12) compared with Private Insurance. Adequate discrimination of each multivariable logistic regression model for in-hospital complications was achieved (Table 5).

Multivariable linear regression models similarly demonstrated that Medicaid payer status was associated with the longest adjusted length of stay ($P < 0.0001$) compared with the Private Insurance group as well as the highest adjusted total costs ($P < 0.0001$, Table 6).

DISCUSSION

To our knowledge, this study represents the largest and most comprehensive review of contemporary outcomes for major operations as a function of primary payer status. In this study, we have demonstrated disparate differences in short-term surgical outcomes among payer groups. The inclusion of a broad surgical population, comprising several different surgical subspecialties, allows us to more confidently comment upon trends that have been previously reported among smaller, more specific, surgical patient groups. Our results indicate that Medicaid and Uninsured payer status confers worse unadjusted and adjusted outcomes compared with that of Private Insurance. We have shown that Medicaid and

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Uninsured status also independently increases the risk of adjusted in-hospital mortality, and that Medicaid status further increases the risk of adjusted in-hospital complications compared with those with Private Insurance. Moreover, our results demonstrate significant differences in resource utilization among payer groups as Medicaid patients accrued the longest adjusted hospital length of stay and highest adjusted total costs. These findings bolster those of other smaller series that have been performed in select surgical populations, and it extends the examination of payer status to include a large, nationwide, diverse surgical population.

The effect of insurance status on treatment allocation and surgical outcomes has been a recent focus of many investigators. In a study by Giacovelli et al (2008), insurance status was demonstrated to predict disease severity among a vascular surgery population of over 225,000 patients.[4] Alternatively, Kelz et al (2004) reported that Medicaid and uninsured patients encountered worse outcomes following colorectal cancer resections.[19] In their review of 13,415 patient records, Medicaid patients were found to incur a 22% increased risk of complications during hospital admission and a 57% increased risk of in-hospital death compared with those with private insurance. These findings are consistent with the results of our study. After adjusting for the potential confounding influence of several patient and hospital related factors, we found that Medicaid payer status conferred 97% increase in the odds of postoperative death compared with Private Insurance patients while Uninsured status independently increased the risk of in-hospital mortality by 74%. Interestingly, the adjusted odds of in-hospital death for both Medicaid and Uninsured patients were higher than that for Medicare patients after controlling for comorbid disease. We further demonstrated similar trends among the estimated odds of postoperative complications for Medicaid patients. Importantly, even after adjusting for socioeconomic status through mean income, primary payer status served as a significant independent predictor of risk-adjusted surgical outcomes.

The demonstrated effect of primary payer status on outcomes in this study is likely multifactorial in origin. First, among all payer groups, elective operations were more commonly performed in patients with Medicare or Private Insurance while Medicaid and Uninsured patients more commonly underwent nonelective (urgent and/or emergent) operations. The higher incidence of emergent operations among Medicaid and Uninsured populations and the presumed negative effect on outcomes is in agreement with previously published surgical literature.[4,20,21] However, in our analyses operative status was accounted for in the estimates of adjusted outcomes and the differences in payer groups were still significant. It is also likely that the confounding influence of inadequate preoperative resuscitation and planning that occurs in the emergent operative situation may have contributed to compromised outcomes for these populations. Second, it is plausible that the influence of healthcare provider and system bias may impact surgical outcomes for Medicaid and Uninsured payer groups. For many surgical patients, private insurance status often allows for referral to expert surgeons for their disease. Alternatively, Medicaid and Uninsured patients may have been referred to less skilled and less specialized surgeons. In this study, the most frequent operations performed were CABG, colectomy, and hip replacement. For these operations, the impact of surgeon volume on outcomes has been well established, and expert surgeons have been shown to significantly impact outcomes.[22] Third, differences in comorbid disease may serve as a proxy for larger social and lifestyle influences between payer groups. Both Medicaid and Uninsured payer groups had the highest incidence of drug and alcohol abuse. In addition, Medicaid patients had the highest incidence of acquired immunodeficiency syndrome, depression, liver disease, neurologic disorders, and psychoses. Furthermore, Medicaid patients had the highest incidence of metastatic cancer, which likely reflects the combined influence of deficits in access to care, poor health maintenance, and delayed diagnosis resulting in the presentation of advanced

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disease stage within this population. Another possible explanation for the differences we observed among payer groups is the possibility of incomplete risk adjustment due to the presence of comorbidities that are either partially or unaccounted for in our analyses. Nevertheless, multivariable logistic regression identified Medicaid and Uninsured payer status as the highest significant independent predictors of in-hospital mortality after controlling for all patients, hospital- and operation-related variables.

Several explanations for inherent differences in payer populations have been suggested. Factors including decreased access to health care, language barriers, level of education, poor nutrition, and compromised health maintenance have all been suggested.[2,23] However, there is no question that payer status has significant implications on multiple processes of health care delivery. Differences exist in not only access but also in the type of primary care that Medicaid and Uninsured populations receive compared with Private Insurance patients. For example, studies have shown that Medicaid and Uninsured populations often receive the majority of primary care within Emergency Departments.[24,25] In a recent study by White et al (2007), Uninsured patients visiting the emergency department were shown to have significantly lower number of radiographic studies and were less likely to be admitted to the hospital following consultation as compared with private insurance patients.[26] In addition, the Medicaid and Uninsured populations often present with more advanced stages of disease, a reflection of cost prohibitive health maintenance, delayed diagnosis, and the higher incidence of comorbid disease. In fact, type of insurance has been shown to impact access to cancer screening, treatment, and outcomes.[27,28] Other social and lifestyle factors, including drug and alcohol abuse, psychiatric illness, obesity, and high-risk behavior, may further contribute to differences in payer group populations. The impact of the economic burden of poverty may also influence patients' ability to seek medical care and to be discharged from the hospital in a timely manner due to lack of support and resources to be cared for properly at home.

There are several noteworthy limitations to this study. First, inherent selection bias is associated with any retrospective study; however, the strict methodology and randomization of the NIS database reduces the likelihood of this bias. Second, NIS is a large, administrative database, and the potential for unrecognized miscoding among diagnostic and procedure codes as well as variations in the nature of coded complications must be considered. Further, we are only able to comment on short-term outcomes as data collected for NIS reflects a patient's inpatient admission. Consequently, the results reported herein may underestimate true perioperative mortality and morbidity rates that may have occurred following the patient's discharge. Assumptions regarding payer groups and status may also impact data analyses. Among payer groups the potential for cross over exists, and the possibility for miscoded payer status must be considered. For example, the proportion of Medicaid patients may be artificially inflated due to the fact that normally Uninsured patients may garner Medicaid coverage during a given hospital admission. In addition, it is possible that a small proportion of Privately Insured patients may actually have inadequate insurance coverage and may functionally represent an Uninsured patient with respect to the effects of poor health maintenance and presentation with advanced disease. However, as the NIS dataset is validated both internally and externally for each year, we believe it is reasonable to assume that payer status is accurately represented in our data analyses. With respect to comorbid disease, we are unable to comment on disease stages or severity. Finally, in our data analyses and statistical adjustments there exists a potential for an unmeasured confounder. Due to the constraints of NIS data points, we are unable to include adjustments for other well-established surgical risk factors such as low preoperative albumin levels or poor nutrition status. However, upon sensitivity analyses our statistical models proved resilient to the presence of a potentially unmeasured confounder.

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CONCLUSION

In this study, we conclude that Medicaid and Uninsured payer status confers increased risk adjusted in-hospital mortality compared with Private Insurance for major surgical operations in the United States. Medicaid is further associated with higher postoperative in-hospital complications as well as the greatest adjusted length of stay and total costs despite risk factors or the specific major operation. These differences serve as an important proxy for larger socioeconomic and health system-related issues that could be targeted to improve surgical outcomes for US patients.

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TABLE 1

International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM) Diagnostic Codes for In-Hospital Complications

Mechanical wound complications
Delayed wound healing: 989.83
Postoperative hematoma: 998.12
Postoperative seroma (noninfected): 998.13
Disruption of operative wound: 998.3
Persistent postoperative fistula: 998.6
Infections
Postoperative infection: 998.5
Postoperative skin abscess: 998.59
Postoperative septic wound complications: 998.59
Postoperative skin infection: 998.59
Postoperative intra-abdominal abscess: 998.59
Postoperative subdiaphragmatic abscess: 998.59
Postoperative infected seroma: 998.51
Urinary complications
Postoperative urinary retention: 997.5
Postoperative urinary tract infection: 997.5
Pulmonary complications
Postoperative atelectasis: 997.3
Postoperative pneumonia: 997.3
Mendelson syndrome secondary to procedure: 997.3
Postoperative acute respiratory insufficiency: 518.5
Postoperative acute pneumothorax: 512.1
Adult respiratory distress syndrome: 518.5
Postoperative pulmonary edema: 518.4
Gastrointestinal complications
Postoperative small bowel obstruction: 997.4
Postoperative ileus: 997.4
Postoperative ileus requiring nasogastric tube: 997.4
Postoperative nausea: 997.4
Postoperative vomiting: 997.4
Postoperative pancreatitis: 997.4
Complication of anastomosis of gastrointestinal tract: 997.4
Cardiovascular complications
Postoperative deep venous thrombosis: 997.79
Postoperative pulmonary embolism: 415.11
Postoperative stroke: 997.02
Phlebitis or thrombophlebitis from procedure: 997.2
Cardiac arrest/insufficiency during or resulting from a procedure: 997.1
Systemic complications

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Postoperative shock (septic, hypovolemic): 998.0
Postoperative fever: 998.89
Complications during procedure
Accidental puncture or laceration, complicating surgery: 998.2
Foreign body accidentally left during procedure: 998.4
Bleeding complicating procedure: 998.11

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TABLE 2

Patient Characteristics for All Patients Undergoing Major Surgical Operations by Primary Payer Group

Variable	Medicare	Medicaid	Uninsured	Private Insurance
No. cases (unweighted)	491,829	40,259	24,035	337,535
National estimate of cases (weighted)	2,394,698	196,951	116,070	1,643,444
Age (yr)	73.5 ± 8.6	49.8 ± 16.4	51.8 ± 12.8	55.5 ± 11.4
Female	49.6%	48.8%	35.8%	39.7%
Elective operation	62.8%	47.7%	36.9%	68.4%
Operation				
Lung resection	5.0%	6.1%	4.6%	4.9%
Esophagectomy	0.4%	0.7%	0.5%	0.6%
Colectomy	29.1%	36.0%	37.6%	32.0%
Pancreatectomy	1.1%	2.1%	2.2%	1.6%
Gastrectomy	1.6%	3.3%	2.9%	1.7%
AAA	2.8%	1.1%	1.3%	1.3%
Hip replacement	26.5%	17.6%	9.3%	27.1%
CABG	33.6%	33.1%	41.7%	31.0%
AHRQ comorbidity				
AIDS	0.1%	0.4%	0.1%	0.1%
Alcohol abuse	1.4%	5.0%	5.8%	2.0%
Deficiency anemia	15.2%	13.6%	11.6%	11.0%
Arthritis/collagen vascular disorder	2.5%	2.0%	0.9%	1.7%
Chronic blood loss anemia	3.3%	2.6%	2.4%	1.8%
Congestive heart failure	6.5%	3.1%	1.5%	1.5%
Chronic pulmonary disease	22.2%	22.1%	16.7%	14.6%
Coagulopathy	6.0%	5.3%	4.3%	3.4%
Depression	4.9%	7.1%	3.8%	5.5%
Diabetes mellitus (uncomplicated)	19.5%	19.9%	17.7%	15.5%
Diabetes mellitus (complicated)	2.8%	3.6%	2.0%	1.9%
Drug abuse	0.3%	3.4%	3.2%	0.5%
Hypertension	61.1%	43.8%	42.8%	47.1%
Hypothyroidism	10.0%	4.2%	3.5%	6.2%
Liver disease	0.9%	2.8%	1.5%	1.1%
Lymphoma	0.6%	0.3%	0.2%	0.3%
Fluid and electrolyte disorder	19.2%	18.3%	16.5%	12.1%
Metastatic cancer	7.0%	7.8%	7.0%	6.2%
Neurologic disorder (not CVA)	3.6%	3.8%	1.5%	1.6%
Obesity	6.2%	9.1%	8.3%	10.2%
Paralysis	1.0%	1.6%	0.5%	0.4%
Peripheral vascular disease	8.5%	5.5%	4.5%	4.1%
Psychoses	1.5%	3.4%	1.3%	0.8%
Pulmonary circulation disorder	0.7%	0.4%	0.3%	0.2%

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Variable	Medicare	Medicaid	Uninsured	Private Insurance
Renal failure	6.5%	4.6%	2.3%	2.3%
Solid tumor (without metastasis)	2.1%	1.4%	1.2%	1.1%
Peptic ulcer disease (non-bleeding)	0.1%	0.1%	0.1%	0.1%
Valvular disease	4.3%	1.4%	0.9%	1.9%
Weight loss	3.7%	4.4%	3.1%	1.9%
Median household income national quartile for patient ZIP code				
I ($1–24,999)	24.2%	41.3%	33.6%	17.3%
II ($25,000–34,999)	27.0%	27.6%	23.8%	29.6%
III ($35,000–44,999)	25.5%	19.6%	27.8%	21.5%
IV (>$45,000)	23.3%	11.4%	31.1%	15.3%

AAA indicates abdominal aortic aneurysm; CABG, coronary artery bypass grafting; AHRQ, Agency for Healthcare Research and Quality; AIDS, acquired immunodeficiency syndrome; CVA, cerebrovascular accident.

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TABLE 3

Hospital Characteristics for all Patients Undergoing Major Surgical Operations by Primary Payer Group

Variable	Medicare	Medicaid	Uninsured	Private Insurance
Rural location	10.1%	8.5%	9.8%	6.6%
Teaching hospital	49.1%	60.4%	55.2%	54.2%
Hospital bed size				
Small	10.0%	8.6%	10.5%	10.2%
Medium	22.8%	21.9%	20.8%	22.5%
Large	67.2%	69.5%	68.7%	67.3%
Hospital region				
Northeast	19.8%	22.2%	15.5%	20.0%
Midwest	25.2%	19.8%	18.3%	25.1%
South	37.8%	37.2%	55.7%	35.2%
West	17.3%	20.8%	10.5%	19.7%

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TABLE 4

Unadjusted Outcomes for all Patients Undergoing Major Surgical Operations by Primary Payer Group

Outcome	Medicare	Medicaid	Uninsured	Private Insurance	*P*
In-hospital mortality	4.4%	3.7%	3.2%	1.3%	<0.001
Wound complication	1.4%	1.7%	1.4%	1.1%	<0.001
Infectious complications	2.0%	3.4%	2.8%	2.0%	<0.001
Urinary complications	1.8%	1.0%	0.8%	1.0%	<0.001
Pulmonary complications	9.7%	9.3%	8.3%	6.7%	<0.001
Gastrointestinal complications	4.5%	4.7%	4.6%	4.3%	<0.001
Cardiovascular complications	6.7%	4.1%	4.3%	4.0%	<0.001
Systemic complications	1.5%	1.8%	1.4%	1.5%	<0.001
Procedure-related complications	3.9%	3.8%	3.5%	3.1%	<0.001
Length of stay (d)	9.5 ± 0.1	12.7 ± 0.4	10.1 ± 0.3	7.4 ± 0.1	<0.001
Total cost ($)	76,374 ± 53.1	93,567 ± 251.4	78,279 ± 231.0	63,057 ± 53.0	<0.001

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TABLE 5

In-Hospital Mortality for all Patients Undergoing Major Surgical Operations by Primary Payer Group

Outcome	Medicare	Medicaid	Uninsured	Private Insurance	*P*
Lung resection	4.3%	4.3%	6.2%	2.0%	<0.001
Esophagectomy	8.7%	7.5%	6.5%	3.0%	<0.001
Colectomy	7.5%	5.4%	3.9%	1.8%	<0.001
Pancreatectomy	6.1%	5.8%	8.4%	2.7%	<0.001
Gastrectomy	10.8%	5.4%	5.0%	3.5%	<0.001
AAA	12.4%	14.5%	14.8%	7.0%	<0.001
Hip replacement	0.4%	0.2%	0.1%	0.1%	<0.001
CABG	4.0%	2.8%	2.3%	1.4%	<0.001

CABG indicates coronary artery bypass grafting; AAA, abdominal aortic aneurysm.

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TABLE 6

Adjusted Outcomes for the Effect of Primary Payer Status Among Patients Undergoing Major Surgical Operations

Outcome	Medicare	Medicaid	Uninsured	Private Insurance	AUC
In-hospital mortality	1.54 (1.48–1.61)*	1.97 (1.84–2.10)*	1.74 (1.60–1.90)*	1.0	0.86
Wound complication	1.16 (1.13–1.18)*	1.23 (1.18–1.28)*	1.06 (1.01–1.12)*	1.0	0.68
Infectious complications	1.11 (1.09–1.14)*	1.24 (1.20–1.27)*	1.02 (0.98–1.06)	1.0	0.79
Urinary complications	1.15 (1.12–1.18)*	1.02 (0.97–1.08)*	0.94 (0.88–0.99)*	1.0	0.72
Pulmonary complications	1.06 (1.05–1.07)*	1.13 (1.11–1.15)*	0.96 (0.94–0.99)*	1.0	0.77
Gastrointestinal complications	1.08 (1.06–1.09)*	0.99 (0.97–1.02)	0.88 (0.86–0.91)*	1.0	0.81
Cardiovascular complications	1.12 (1.10–1.13)*	1.04 (1.01–1.07)*	1.00 (0.97–1.03)	1.0	0.78
Systemic complications	0.99 (0.97–1.01)	1.12 (1.08–1.16)*	0.94 (0.90–0.99)*	1.0	0.61
Procedure related complications	1.10 (1.08–1.12)*	1.10 (1.07–1.13)*	0.97 (0.94–1.01)	1.0	0.69
Length of stay (d)*	8.77 % 0.01	10.49 % 0.04	7.01 % 0.03	7.38 % 0.01	—
Total costs ($)*	$69,408 % 53.1	$79,140 % 251.4	$65,667 % 231.0	$63,057 % 53.0	—

*$P < 0.05$. In-hospital mortality and postoperative complications reported as adjusted odds ratios (95% confidence interval). Length of stay and total costs reported as adjusted means ± standard deviation. Reference group: primary payer status (private insurance). Outcomes adjusted for patient age, gender, elective operative status, mean income, hospital geographic region, teaching hospital status, type of operation, primary payer status, and categories for comorbid disease.

AUC indicates area under receiver operator curve.

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April 5, 2013

Ms. Diana Furchtgott-Roth
Senior Fellow
Manhattan Institute for Policy Research
52 Vanderbilt Avenue
New York, N.Y. 10017

Dear Ms. Furchtgott-Roth:

Thank you for appearing before the Subcommittee on Health on Wednesday, March 13, 2013, to testify at the hearing entitled "Obamacare's Impact on Jobs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Wednesday, April 17, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at Sydne.Harwick@mail.house.gov and mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr. Ranking Member, Subcommittee on Health

Attachment

Dear Chairman Pitts,

In response to your question for the record "During the hearing you responded to a question regarding the relationship between healthcare reform and the use of technology. Would you please elaborate on the trend of automation and how the increasing use of technology is impacting our workforce and global economy?" I submit the following statement for the record.

As the cost of labor rises, technology replaces labor. The Affordable Care Act will raise the cost of labor for low-skill and minimum wage individuals, because employers cannot take the $2,000 annual penalty out of their wage. A few examples. First, food trucks are part of a trend towards labor-saving arrangements in the restaurant industry. Second, customers are scanning purchases at supermarkets and drugstores. Third, retailers are selling more online. Fourth, companies are turning to automated systems for airline reservations and banking.

The enclosed article, which shows how tablets are replacing employees in the restaurant industry, describes one practical example of technology replacing labor as the cost of labor rises. I would like to include the article for the record.

Increases in the cost of labor, such as the penalties in the ACA, hurt the lowest-skill workers in the economy. That's why the teen unemployment rate is 24.2% and the African American teen unemployment is 33.8%. Employers will manage fine, but these low skill workers will not get their foot on the first rung of the career ladder. That is an enormous tragedy.

Diana Furchtgott-Roth
Senior Fellow
Manhattan Institute for Policy Research

Article:

Needleman, Sarah and Angus Loten, "Can the Tablet Please Take Your Order Now?" *Wall Street Journal*, March 27, 2013, http://online.wsj.com/article/SB10001424127887323501004578386321069156006.html.