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HEALTH CARE CHALLENGES FACING KENTUCKY'S WORKERS AND JOB CREATORS

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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HEALTH CARE CHALLENGES FACING KENTUCKY'S WORKERS AND JOB CREATORS

Tuesday, August 27, 2013

House of Representatives

Subcommittee on Health, Employment, Labor, and Pensions

Committee on Education and the Workforce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:02 a.m., at the Lexington Public Library, Farish Theater, 40 East Main Street, Lexington, Kentucky, David Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, Guthrie, and Yarmuth.

Also Present: Representative Barr.

Staff Present: Molly Conway, Professional Staff Member; Benjamin Hoog, Senior Legislative Assistant; Alex Sollberger, Communications Director; Todd Spangler, Senior Health Policy Advisor; and Mark Zuckerman, Minority Senior Economic Advisor.

Chairman ROE. The Subcommittee on Health, Employment, Labor, and Pensions will come to order.

Good morning, everyone, and welcome to today's hearing. I would like to first take a moment to welcome our witnesses joining us to discuss the important issue of healthcare.

I would also like to thank the staff at the Lexington Public Library for their warm hospitality, and what a terrific facility you have here. And I think libraries speak volumes about the community that you live in, and this certainly is a real plus for Lexington.

Since the President's plan for healthcare reform became law in 2010, employers and job creators have grown increasingly worried about the law's effect on their families and small businesses. More than 11 million Americans are searching for a job today, including 178,000 workers here in the Bluegrass State. Building a stronger economy for businesses to grow and hire new workers remains a national priority. As elected policy makers, we have to examine whether Federal policies are helping or hurting that effort.

According to the so-called experts in Washington, the healthcare law is working just fine. Secretary Kathleen Sebelius, the President's top healthcare official, described reports of job losses stemming from the law is speculation. I was there in the committee hearing the day she said that.

The White House called the law's pervasive incentive for businesses to rely more on part-time employees an urban legend, and the President himself has dismissed problems with implementation of the law as mere glitches or bumps.

However, news reports and personal experiences of everyday Americans reveal a much harsher reality than supporters of the Obamacare would like to admit. It seems each day workers and job creators encounter new challenges as they look to ease the pain this government takeover of healthcare has inflicted on their workplaces. The leading concern for many is the employer mandate, which requires businesses with 50 or more full-time workers to provide government-approved health insurance or pay higher taxes.

The non-partisan Congressional Budget Office has said this mandate will impose a $140 billion tax increase on employers. It is no secret what happens when job creators are forced to pay higher taxes. Fewer jobs are created and more costs are pushed to consumers. This is precisely what employers have said time and again. For example, a Gallup poll showed 41 percent of employers have frozen hiring due to the healthcare law. The same poll revealed more than half of small business owners expect the law will increase healthcare costs. As a result, 1 out of 4 small business owners may stop offering health insurance as they try to control the costs.

Perhaps this explains why President Obama decided to delay enforcement of the employer mandate for 1 year. While this temporary reprieve is certainly welcome news, it does not alter the fact that this fatally flawed law will destroy jobs regardless of when it is implemented.

The unilateral delay of the employer mandate is also an implicit admission that the President's healthcare law is not working. In fact, the law is making our economy and health system worse. As a doctor who practiced medicine for more than 30 years, I know our healthcare system is not perfect. It is far too expensive and too many families lack access to affordable care.

If we are going to put Americans back to work and advance smarter reforms that will lower healthcare costs, we must first repeal or dismantle the President's misguided law. Today's hearing plays a vital role in reaching these important goals.

I want to thank our witnesses again for being with us today and sharing their personal experiences with the committee.

With that, I now will recognize my distinguished colleague and good friend, John Yarmuth, the acting senior Democrat member of the subcommittee, for his remarks. Congressman Yarmuth?

[Applause.]

[Disturbance in hearing room.]

[The statement of Chairman Roe follows:]

Prepared Statement of Hon. Phil Roe, Subcommittee on Health, Employment, Labor, and Pensions

Good morning everyone and welcome to today's hearing. I'd first like to take a moment to thank our witnesses for joining us to discuss the important issue of health care. I would also like to thank the staff at the Lexington Public Library for their warm hospitality.

Since the president's plan for health care reform became law in 2010, employers and job creators have grown increasingly worried about the law's effect on their families and small businesses. More than 11 million Americans are searching for a job today–including 178,000 workers here in the Bluegrass State. Building a stronger economy for businesses to grow and hire new workers remains a national priority. As elected policymakers, we have to examine whether federal policies are helping or hurting that effort.

According to the so-called experts in Washington, the health care law is working just fine. Secretary Kathleen Sebelius, the president's top health care official, described reports of job losses stemming from the law as "speculation." The White House called the law's perverse incentive for businesses to rely more on part-time employees an "urban legend." And the president himself has dismissed problems with implementation of the law as mere "glitches and bumps."

However, news reports and personal experiences of every day Americans reveal a much harsher reality than supporters of ObamaCare would like to admit. It seems each day workers and job creators encounter new challenges as they look to ease the pain this government takeover of health care has inflicted on their workplaces.

A leading concern for many is the employer mandate, which requires businesses with 50 or more full-time workers to provide government-approved health insurance or pay higher taxes. The nonpartisan Congressional Budget Office has said this mandate will impose a $140 billion tax increase on employers. It's no secret what happens when job creators are forced to pay higher taxes: Fewer jobs are created.

This is precisely what employers have said time and again. For example, a Gallup poll showed 41 percent of employers have frozen hiring due to the health care law. The same poll revealed more than half of small business owners expect the law will increase health care costs. As a result, one out of four small business owners may stop offering health insurance as they try to control costs.

Perhaps this explains why President Obama decided to delay enforcement of the employer mandate for one year. While this temporary reprieve is certainly welcome news, it does not alter the fact this fatally flawed law will destroy jobs–regardless of when it is implemented. The unilateral delay of the employer mandate is also an implicit admission that the president's health care law isn't working. In fact, the law is making our economy and health care system worse.

As a doctor who practiced medicine for more than 30 years, I know our health care system isn't perfect. It is far too expensive and too many families lack access to affordable care. If we are going to put Americans back to work and advance smarter reforms that will help lower health care costs, we must first repeal or dismantle the president's misguided law.

Today's hearing plays a vital role in reaching these important goals. I want to thank our witnesses again for being with us today and sharing their personal experiences with the committee. With that, I will now yield to my colleague, Congressman Brett Guthrie, for his opening remarks.

Mr. YARMUTH. Thank you.

Chairman ROE. Would you yield for one moment?

Mr. YARMUTH. I will yield, Mr. Chairman.

Chairman ROE. Let me tell you all to start with, this is the fourth hearing I have had like this across the country. I am a very respectful person. This is not a town hall meeting. This is an official hearing of the U.S. Congress.

I want to start by reading the initial disruption of this hearing right now. Number one, the committee is not in order. I want to make it clear to our guests in the audience that any comments or disruptions during today's meeting from the public will not be tolerated, and if, necessary, will result in the removal of those disrupting from the committee room. That is the first one.

And I am going to say that we want you to be here. I want you to listen, and we are not going to comment. But if you do, that is the initial request I am making of you now respectfully.

Now, Mr. Yarmuth?

Mr. YARMUTH. Thank you, Mr. Chairman. And I will echo your remarks, and also certainly testify to the fact that you are an extremely honorable man and chairman, so I appreciate you calling this hearing. And also it is good to be here with my friends and colleagues, Congressmen Barr and Guthrie.

Thank you once again for holding this hearing. I also want to thank all of you in the audience for joining us today to discuss the Affordable Care Act, and for the witnesses, in particular. I know

it takes a lot of courage to share your stories in a congressional hearing, and I commend all of you for being here.

I also want to recognize Governor Beshear and Carrie Banahan, director of the Kentucky Health Benefit Exchange. Because of their great work in preparing Kentucky's health insurance marketplace, our Commonwealth is positioned to be a national model.

Today and in the next several months and in the years to follow, every person in this room will have a different story to tell about the Affordable Care Act. Some will have access to affordable, quality care for the first time. Others will have the benefit of insurance as they fight their second, third, or fourth battle with cancer. I have heard from individuals whose lives have been transformed, and several whose lives have been saved, by the law.

Under the law, preexisting conditions will no longer prevent you from getting coverage. The healthcare exchanges will offer new coverage options, and Kentuckians will be able to compare plans the way they shop for flights online. If you are a small business owner, you will be able to take advantage of tax credits to provide insurance to your employees and make yourself a more competitive employer.

I would just like to add that far from being a job destroyer, there is evidence that this act has already been a job creator. Last week in a released report, a national survey of small businesses under 50 employees, employment is up by 6 percent this year. Small businesses are borrowing to expand, and confidence levels of small business owners is at a high over the last 7 or 8 years.

If you are a young person embarking on a career for the first time, you can stay on your parents' insurance so you can focus on building a stronger future right from the start.

Healthcare affects everyone differently, which makes healthcare policy difficult to explain and easy to spin. But after 40 failed attempts to repeal, undermine, or defund the Affordable Care Act, I think that we owe it to our constituents to acknowledge that this is the law, and its implementation is ongoing and inevitable.

Over the next several months, we are going to make history here in the Commonwealth: 640,000 uninsured Kentuckians will become eligible for coverage, many for the first time. This builds on the progress we have made in Kentucky during the past 3 years as a result of the Affordable Care Act. So far, the law has saved 72,000 Kentucky seniors $112 million on prescription drugs by closing the prescription drug donut hole. It has enabled 48,000 additional young adults to get coverage through their parents' health insurance plan. It has provided critical preventive care for 650,000 women and 486,000 seniors and people with disabilities. And it has provided $15 million in rebates from insurance companies to a quarter of a million Kentuckians.

Across the country, the ACA is putting customers back in charge of their healthcare. For the first time in our history, insurance companies cannot say no to you if you have a preexisting condition, like diabetes, cancer, or heart disease. Your medical history is your business alone. You will not face annual or lifetime limits on coverage, meaning battling a major disease will not lead to bankruptcy. And you will get a rebate if your insurance company spends

less than 80 percent of your premium dollar on anything other than your care.

Investing in access to healthcare gives Kentucky families new opportunities to prosper. It also means economic prosperity and jobs for Kentucky. According to a University of Louisville study, new healthcare investment will create nearly 17,000 jobs and generate an additional $15.6 billion in economic activity in Kentucky over the next several years.

It is also fiscally prudent. The governor's actions on healthcare will mean hundreds of millions of dollars in savings for the State through 2021.

Now, we know there are some issues that need to be resolved with the law. For instance, the administration is continuing to work with the Restaurant Association and Retailers on safe harbor provisions that will largely address problems they are seeing with employee hour requirements. They have also delayed the employer mandate so that issues like the ones Mr. Kanaly and Mr. Bologna will raise in their testimony can be resolved.

So today I hope we will focus on what would be the most beneficial to our constituents and Kentucky businesses, ensuring that they are taking advantage of every benefit the law has to offer, and raising any concerns so that they can be addressed as we move forward with implementation.

I look forward to today's testimony. I yield back. Thank you, Mr. Chairman.

[The statement of Mr. Yarmuth follows:]

Prepared Statement of Hon. John A. Yarmuth, a Representative in Congress from the state of Kentucky

Chairman Roe and My Colleagues Congressmen Barr and Guthrie:

Thank you for holding today's hearing. I also want to thank all of you in the audience for joining us today to discuss the Affordable Care Act. And for the witnesses in particular, I know it takes a lot of courage share your story in a Congressional hearing, and I commend all of you for being here.

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If you're a small-business owner, you will be able to take advantage of tax credits to provide insurance to your employees and make yourself a more competitive employer. If you're a young person embarking on a career for the first time, you can stay on your parents' insurance – so you can focus on building a strong future right from the start.

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• Saved 72,000 Kentucky seniors $112 million on drugs by closing the prescription drug donut hole;
• Enabled 48,000 additional young adults to get coverage through their parents' health insurance plan;
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So today, I hope we will focus on what will be the most beneficial to our constituents and Kentucky businesses: ensuring that they are taking advantage of every benefit the law has to offer and raising any concerns so that they can be addressed as we move forward with implementation. I look forward to today's testimony.

Chairman ROE. I thank the gentleman for yielding.

I now will yield to my friend and colleague, Mr. Brett Guthrie, for his opening remarks.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thanks for coming to Kentucky today. I appreciate having you. He grew up just on the wrong side of the border in Clarksville, Tennessee, so he is very close to being a Kentuckian, but not quite.

And it is always great to be with Congressman Yarmuth and Congressman Barr. We have crossed paths a few times since we have been home in August, and it always great to cross paths with you guys.

And thank you for being here, and I appreciate you all coming here today, and everybody here today, to talk about the impact that the healthcare bill has on our employers in the Commonwealth.

And throughout August all the way through early September, I am doing 21 town hall meetings. And I have done 14, and I am doing them one in each county. And when we open it up, what most people want to talk about is the healthcare bill—that is the number one issue—and the impact it will have on them, their jobs, and their employer, and their healthcare coverage.

And there are a lot of questions that have been asked, and unfortunately we have yet to come up with answers to these questions, such as, will their employer reduce their hours so they will no longer trigger the requirement for health insurance? Will they be able to stay on their current health insurance plan? Will their premiums be affordable, or will they have to spend more for essen-

tially the same coverage? Will employers be able to continue to afford to provide insurance for their workers? And will they be able to hire the few extra workers they need, or will that cause them to trigger the employer mandate?

And so, this one-size-fits-all law is providing a great concern for consumers, employers, and healthcare providers alike.

In July, the non-partisan Government Accountability Office warned that because government officials have missed multiple key deadlines to set up the new healthcare exchanges, there is serious concern that the exchanges will be not ready in October as scheduled. And the IT data security testing necessary to open the exchanges was recently pushed back until September 30th, the day before the exchanges are expected to go live. This is after multiple missed deadlines and leaving them no buffer to correct any problems, risking possible security lapses.

Employers and families across Kentucky have expressed, in my town hall meetings in different ways, have expressed serious concerns about meeting the requirements of the law, and wondering if they will lose their coverage, be forced to choose different providers, or be saddled with enormous new costs. And given the Administration's move to delay only the employer mandate, families and small business owners are left with even more uncertainty.

Small businesses are the backbone of our economy and likely to be the hardest hit. Some local employers say the law could put them out of business. One restaurant owner says it will be a challenge for the whole industry, and many will be forced to lay off employees. Others simply say it will be extremely difficult to insure all of their existing employees.

With the lack of information and transparency from the Administration, business leaders do not even know what types of insurance programs they might be able to offer, or if they will be forced to alter the shape of their workforce in order for their business to stay afloat. Given the lack of information and tools available for implementation, it is evident that not only is this law not the solution to our healthcare problems, but it is not ready for implementation.

I hope that today's field hearing will offer us the opportunity to explore these concerns further and hear directly from employers about how the law is impacting them. I appreciate the committee's efforts in this area, especially those of Chairman Roe, and I welcome him to the Commonwealth. And I yield back the balance of my time.

[The statement of Mr. Guthrie follows:]

Prepared Statement of Hon. Brett Guthrie, a Representative in Congress from the state of Kentucky

Thank you, Mr. Chairman. I appreciate you all coming to Kentucky today to discuss Obamacare and the impact it's having on the economy and employers, particularly in the Commonwealth of Kentucky. Throughout August and the beginning of September, I am hosting 21 town hall meetings – one in every county in the Second District. Obamacare continues to be a top issue at each meeting, with Kentuckians wondering how it will impact them, their employees, their jobs, and their health care coverage.

Unfortunately, we don't have all the answers. The law that was famously "passed so we could find out what's in it" has yet to calm the fears of ordinary citizens. Will their employer reduce their hours so they no longer trigger the requirement for health insurance? Will they be able to stay on their current health insurance plan? Will their premiums be affordable or will they have to spend more for essentially

the same coverage? Will employers be able to continue to afford to provide insurance for their workers? Will they be able to hire the few extra workers they need or will that cause them to trigger the employer mandate?

There is no shortage of red flags when it comes to the train wreck known as Obamacare. The one-size-fits-all law is proving to be disastrous for consumers, employers and health care providers alike. In July, the nonpartisan Government Accountability Office warned that because government officials have missed multiple key deadlines to set up the new health insurance exchanges, there is serious concern that the exchanges will not be ready in October, as scheduled.

The IT data security testing necessary to open the exchanges was recently pushed back until September 30th – the day before the exchanges are expected to go live. This is after multiple missed deadlines and leaving them with no buffer to correct any problems, risking possible security lapses.

Employers and families across Kentucky have expressed serious concerns about meeting the requirements of the law and wondering if they will lose their coverage, be forced to choose different providers, or be saddled with enormous new costs. Given the Administration's move to delay only the employer mandate, families and small business owners are left with even more uncertainty.

Small businesses, the backbone of our economy, are likely to be hardest hit. Some local insurers say the law could put them out of business. One restaurant owner says it will be a challenge for the whole industry and many will be forced to lay off employees. Others simply say it will be extremely difficult to insure all of their existing employees. With the lack of information and transparency from the Administration, business leaders don't even know what types of insurance programs they might be able to offer or if they will be forced to alter the shape of their workforce in order for their business to stay afloat.

Given the lack of information and tools available for implementation, it is evident that not only is this law not the solution to our nation's health care problems, but it is not ready for implementation. I hope that today's field hearing will offer us an opportunity to explore these concerns further and hear directly from employers about how the law is impacting them.

I appreciate the Committee's efforts in this area, especially those of Chairman Roe. I welcome him to the Commonwealth and yield back the balance of my time.

Chairman ROE. Thank the gentleman for yielding.

I now yield to my friend and colleague, Mr. Andy Barr, for his opening remarks.

Mr. BARR. Thank you, Mr. Chairman. I would like to thank everybody for coming today and participating in this field hearing. I would especially like to thank the House Education and Workforce Committee for its interest and willingness to come to Lexington, Kentucky, my hometown, to hold this hearing.

Thank you to Chairman Roe, Congressman Guthrie, and Congressman Yarmuth, for traveling to the 6th Congressional District so that we can continue to assess the impact of the Affordable Care Act, commonly known as Obamacare, on American families and employers.

Finally, I would like to thank all of the witnesses with us today. You all are the most vital part of this hearing because you can provide vital, firsthand insights into the healthcare challenges facing workers and small businesses. We are here to listen to what you have to say.

It is clear that cracks in Obamacare are growing and getting deeper. Slowly but steadily, the Administration and its supporters have reluctantly had to acknowledge the shortcomings of the law. In the past few weeks and months, we have news stories about problems with implementation of Obamacare . We have seen front page stories about massive rate increases in the insurance market, and we have all heard about the Administration's decision to tem-

porarily delay for 1 year the implementation of the law's employer mandate.

And, in particular, what concerns me about that unilateral decision is whether or not the Administration's decision through administrative fiat complies with the take care clause in the Constitution.

While I certainly welcome the Administration's interest in saving businesses from Obamacare's costly and burdensome mandates, this does raise a number of questions that are central to the viability of the law.

First, if the employer mandate is simply so unworkable that it needs to be delayed until after 2014, nearly 5 years after the President signed it into law, why should employers believe that this mandate will become any more acceptable in 2015 and every year thereafter?

Secondly, why not provide for a permanent delay of the employer mandate as opposed to holding the specter of its implementation over the heads of employers?

And finally, if a reprieve from Obamacare mandates is going to be provided to America's businesses, should America's families not also receive that same benefit of delay from the high cost of Obamacare in the individual mandate?

Now, my opposition to Obamacare is not a partisan one. It is not simply because the President is a Democrat. It is not simply because—

[Disturbance in hearing room.]

Mr. BARR. I would yield.

Chairman ROE. I will interrupt you for a second. This is the second disruption we have got. I am not going to tolerate this in this hearing. Pursuant to House rules and rules of the committee, the chair has a duty to maintain order and decorum during committee meetings. This is not a town hall meeting.

Members of the audience must maintain order and refrain from manifestations of approval or disapproval of the committee proceedings or interfere with the conduct of the committee's business. It is the duty of the chair to order those in the audience causing the disruption to cease their actions immediately, and, if necessary, be removed by persons responsible for the disturbance. Those removed may be subject to arrest.

Please allow the committee to continue with the meeting. This is not a town hall.

And I will yield back.

Mr. BARR. Thank you, Mr. Chairman.

My opposition to Obamacare is not a partisan one. It is not simply because the President is a Democrat and I am a Republican. And, in fact, I very much appreciate the participation of Congressman Yarmuth in this hearing. I think this is an opportunity for all of us to look for solutions on a bipartisan basis hopefully as much as possible.

But my opposition is simply because I believe Obamacare is bad policy for the American people. Obamacare does nothing to lower healthcare costs, which are the main driver of our debt. Instead the law will lead to massive job losses, the rationing of care, insurance policy changes, trillion dollar tax increases, increases in the na-

tional debt, violations of religious liberties, increases to healthcare premiums, and costs on American families.

In fact, despite the President's promise that premiums would decrease by $2,500, the average family premium has grown by over $3,000 since 2008.

On top of all of this, it is worth noting that young people are among the most punished by this law. Reports indicate rate shock for young adults under this law with these individuals seeing premiums increase on the average between 145 and 189 percent annually.

As you can all see, there are many different aspects to this law. I am excited for today's hearing, though, because it is a great opportunity for us to dive further into one particular area: Obamacare's impact on jobs.

One of my top priorities in Congress is getting Kentuckians back to work, and I believe that Obamacare stands firmly in the way of this goal.

As I have traveled around the 6th District and spoken with employers throughout central and eastern Kentucky, a consistent theme I have heard is employers citing Obamacare as creating a severe chilling effect on their ability to retain and hire workers. It is important for us to listen to our constituents, and that is what they are telling us.

And this is certainly not a sentiment exclusive to Kentucky. A March report from the Federal Reserve specifically stated, "Employers in several districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff." Further, according to a study by the National Federation of Independent Business, an employer mandate, like the one included in Obamacare, could eliminate over 1 million jobs.

So I would just like to conclude my remarks by, again, thanking everybody for being here. There are significant concerns with how Obamacare will lead to shifting more and more full-time workers to a part-time basis. These are folks sometimes commonly known as the 29ers—29 hours to avoid the 30-hour threshold in the law. And while this may seem odd and counterproductive, the law is unfortunately forcing employers to get creative in order to free themselves from its mandate and higher costs.

The bottom line is that Kentucky's workers, families, and job creators deserve permanent relief from Obamacare, not a 1-year reprieve. I am hopeful that this hearing can play a constructive role in the process by shining a spotlight on the need to provide permanent relief from Obamacare. I look forward to hearing from the witnesses and, again, thank them for coming here today to share their story.

I yield back.

[The statement of Mr. Barr follows:]

Prepared Statement of Hon. Andy Barr, a Representative in Congress from the State of Kentucky

I'd like to thank everyone for coming today and participating in this field hearing. I'd especially like to thank the House Education and the Workforce Committee for its interest and willingness to come to Lexington, Kentucky to hold this hearing. Thank you to Chairman Roe, Congressman Guthrie, and Congressman Yarmuth for traveling to the Sixth District so that we can continue to assess the impact of the

Affordable Care Act – commonly known as Obamacare – on American families and employers.

Finally, I'd like to thank all the witnesses with us today. You are the most important part of this hearing because you can provide vital, first-hand insights into the health care challenges facing workers and small businesses. We are here to listen to what you have to say.

It's clear that cracks in Obamacare are growing and getting deeper. Slowly but steadily, the Administration and its supporters have reluctantly had to acknowledge the shortcomings of the law. In the past few weeks and months, we have seen the news stories about problems with the implementation of Obamacare; we have seen front page stories about massive rate increases in the insurance market; and we have all heard about the Administration's decision to temporarily delay for one year the implementation of the law's employer mandate.

While I certainly welcome the Administration's interest in saving businesses from Obamacare's costly and burdensome mandates, this does raise a number of questions that are central to the viability of the law:

• If the employer mandate is simply so unworkable that it needs to be delayed until after 2014 – nearly five years after the President signed it into law – why should employers believe that this mandate will become any more acceptable in 2015 and every year thereafter?

• Why not provide for a permanent delay of the employer mandate, as opposed to holding the specter of its implementation over the heads of employers?

• Finally, if a reprieve from Obamacare's mandates is going to be provided to America's businesses, shouldn't America's families also receive that same benefit of delay from the high costs of Obamacare?

Now, my opposition to Obamacare is not a partisan one – it's not simply because the President is a Democrat and I'm a Republican. My opposition is simply because I believe that Obamacare is bad policy for the American people. Obamacare does nothing to lower healthcare costs, which are the main driver of our debt. Instead, the law will lead to massive job losses, the rationing of care, insurance policy changes, trillion dollar tax increases, increases to the national debt, violations of religious liberties, and higher health care premiums and costs on American families. In fact, despite the President's promise that premiums would decrease by $2,500, the average family premium has grown by over $3,000 since 2008.

On top of all of this, it's worth noting that young people are among those most punished by the law. Reports indicate a rate shock for young adults under this law, with these individuals seeing premiums increase on average between 145 and 189 percent annually.

As you can all see, there are many different aspects to this law. I'm excited for today's hearing though because it's a great opportunity for us to dive further into one particular area: Obamacare's impact on jobs. One of my top priorities in Congress is getting Kentuckians back to work, and I believe that Obamacare stands firmly in the way of this goal.

As I have traveled around the Sixth District and spoken with employers throughout central and eastern Kentucky, a consistent theme I've heard is employers citing Obamacare as creating a severe chilling effect on their ability to retain and hire employees. And this is certainly not a sentiment exclusive to Kentucky. A March report from the Federal Reserve specifically stated, "Employers in several Districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff." Further, According to a study by the National Federation of Independent Business, an employer mandate like the one included in Obamacare could eliminate over one million jobs!

In addition to the lost jobs, there are also significant concerns with how Obamacare will lead to shifting more and more full-time workers to a part-time basis or to 29 hours. While this may seem odd and counterproductive, the law is unfortunately forcing employers to get creative in order to free themselves from its mandates and higher costs.

The bottom line is that Kentucky's workers, families, and job creators deserve permanent relief from Obamacare, not a one year reprieve. I am hopeful that this hearing can play a constructive role in the process by shining a spotlight on the need to provide permanent relief from Obamacare. I look forward to hearing from the witnesses and again thank them for coming today to share their story.

Chairman ROE. I thank the gentleman for yielding.

Pursuant to Committee Rule 7(c), all members will be permitted to submit written statements to be included in the permanent

hearing record. And without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced to during the hearing to be submitted for the official hearing record.

[The information follows:]

Chairman ROE. We have two distinguished panels of witnesses today, and I would like to recognize Mr. Brett Guthrie to introduce our first witness.

Mr. GUTHRIE. Thank you very much. I would introduce someone, a car dealer, Gary Force Honda, who is a dear friend of mine. His parents are my neighbors. His name is Tim Kanaly, and I welcome him here. He has Gary Force Honda in Bowling Green.

Mr. KANALY. Thank you, Congressman.

Chairman ROE. I thank the gentleman. Now, I would like to recognize Mr. Andy Barr to introduce our remaining witnesses.

Mr. BARR. Thank you, Mr. Chairman.

Mr. Joe Bologna is owner of John Bologna's Italian Pizzeria and Restaurant in Lexington, Kentucky. Mr. Bologna has been a restaurateur since 1973, and I will state for the record you have the best garlic bread sticks in town. And that might be a bipartisan sentiment, I will say.

Ms. Carrie Banahan is the executive director of the Office of Kentucky Health Benefit Exchange in Frankfort, Kentucky. Ms. Banahan is a graduate of the University of Louisville and has over 30 years of experience in State government.

Mr. John Humkey, our final witness on the first panel, is president of Employee Benefit Associates in Lexington, Kentucky. Mr. Humkey is a native of Lexington and began his career in insurance in 1977 after graduating from the University of Kentucky.

Thanks to all of the witnesses for being here.

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

After you have testified, the members will each have 5 minutes to ask questions, and the chairman will try to also adhere to the 5-minute rule. We will not interrupt you right in the middle, but we have two panels, so it should be a long morning.

I will now open it to Mr. Kanaly.

STATEMENT OF TIM KANALY, OWNER AND PRESIDENT, GARY FORCE HONDA, BOWLING GREEN, KENTUCKY

Mr. KANALY. Thank you. A year ago I started having some concerns about the Affordable Health Care law. I own 50 percent of Gary Force Honda located in Bowling Green, Kentucky, and 50 percent of Dixie Auto Sales in Louisville, Kentucky.

We currently have 46 employees at Gary Force Honda and 6 employees at Dixie Auto Sales in Louisville. I did not know that because of my joint ownership in the two companies if they would be grouped together for the Affordable Health Care law. If they were

put together, it would put us over the 50-employee threshold and require us to furnish insurance to both groups of employees.

We currently pay 100 percent of the insurance costs for the employees at Gary Force Honda in Bowling Green. We are unable at this time to furnish health insurance to the employees at Dixie Auto Sales in Louisville. We would like to be able to furnish insurance to the employees at Dixie Auto Sales at some time in the future, but being a new business, we cannot do it at this time.

I started looking for clarification on this issue by calling our group health insurance provider. After a couple of weeks they got back in touch with me. I was told that they have an expert that they could hire to advise me on the rules and regulations of the new health care law. I read their opinion on my situation and really got no definite answer.

I then asked my agent what he thought I should do. He told me to contact an attorney that specializes in these matters. I said that sounds good, could you refer me to one? He got back to me after a couple of weeks and said they did not have one they could recommend.

After asking around and trying to do some research on my own, someone recommended that I contact my accountant since the IRS would have a hand in implementing this new law. My accountant reviewed the regulations and gave me his opinion. He started his opinion by saying it was his best guess. He could not guarantee that any of the information he was giving me was correct.

He seems to think that the Affordable Care Act follows the same guidelines as the Family Medical Leave Act, and my two companies would be considered separate. He is the only person that I have talked to that would even give me an educated guess. I do not feel real good about his confidence on this subject, but I appreciated his effort.

I kind of tabled the issue until I was contacted by someone in Congressman Guthrie's office. I was referred to him by my insurance agent as someone who was having issues understanding the Affordable Healthcare Act. I explained this issue and some other concerns that I had with the new law.

I asked him to please give me the name and number of someone in the HHS or the IRS that could give me a definitive answer to my questions. After a couple of weeks, he called me back and he told me that with all the resources available to him, he could not give me anyone or even the right government agency to call.

In closing, I think there are serious questions about these huge changes. It concerns me deeply that no one can even answer my most basic questions.

Thank you.

[The statement of Mr. Kanaly follows:]

Prepared Statement of Tim Kanaly, Owner and President, Gary Force Honda

A year ago I started having some concerns about the Affordable Health Care law. I own 50% of Gary Force Honda located in Bowling Green, Ky and 50% of Dixie Auto Sales in Louisville, Ky. We currently have 46 employees at Gary Force Honda and 6 employees at Dixie Auto Sales in Louisville. I didn't know that because of my joint ownership in the two companies they would be grouped together. If they were put together it would put us over the 50 employee threshold and require us to furnish insurance to both groups of employees. We currently pay 100% of the in-

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In closing I think there are serious questions about these huge changes. It concerns me deeply that no one can even answer the most basic questions.

Chairman ROE. Thank you very much for your testimony.

Mr. Bologna?

STATEMENT OF JOE BOLOGNA, OWNER, JOE BOLOGNA'S ITALIAN PIZZERIA AND RESTAURANT, LEXINGTON, KENTUCKY

Mr. BOLOGNA. Thank you for letting me be here.

Just a little background on myself. I was born on April 23rd, '45, in Detroit, Michigan. I always loved to cook at home, and my grandmother was a fantastic cook, and my grandfather was a small businessman that only finished third grade, but had a business mind. I hope I have a little part of each of them.

At 17, I cooked at a little fast food place, and I always had a dream of owning my own restaurant since I was 16. I cooked in the Air Force from '65 to '69, and cooked for as many as 3,000 and as few as one, I was a general's aide in Vietnam.

My first job after being discharged from the service was at Matthew's Roast Beef, so I needed to learn how to manage. The second job, I went to management training school at Big Boy's in Michigan, and every place I have worked has been a part of my restaurant today.

I moved to Lexington in '72, and then I opened Joe Bologna's Restaurant and Pizzeria, and I have been in total food service for 54 years, and I am currently president and manager of Joe Bologna's.

When I started in 1973, I always cared about employees, and there were employees that made more than I did when I started being that I was working 16 hours a day, and figured I worked for

a dollar an hour. I have always had health insurance. It has been important to me and important to take care of employees. For full-time, I paid 100 percent, and have always offered full-time employees 50 percent that I would pay for it from the beginning. And I probably have 30 full-time and 35 part-time. I do not think I have ever more than 10 total employees on healthcare.

Sort of like the recession of '92, restaurants across the country and bars dropped 25 percent in sales, and they are now recovering. This is one of the first places customers and families cut under budget when the economy is not good. You cannot afford to go out to eat and go to bars, so.

And in passing this bill, the ultimate cost to the customer would be less people can go out to eat, and have already lost money in the last 2 years. Adding healthcare would put a lot of business out.

And today, you know, it takes a lot of money today to start up a business, and a lot of independents go under quick. A very small percentage survives. So why expand and putting in the risk and going in debt?

In 2007, we had 75 employees. At the beginning of 2013, we had 30 full-time employees and 38 part-time. And the idea we came up with is we closed on Mondays and reduced our total employees from 54 to 46 or 47. By taking all the part-times and adding them together and dividing that by 30 hours reduced us down to 47.

And I have talked to plenty of customers. A lot of times I am over there on Monday, and they talk to me about it. And they cannot blame us for doing what we are doing and understand. And hopefully later on if this changes, we will go back opening on Monday.

I feel Affordable Care causes fewer jobs because I am going to try to keep under that 50, and jobs are the biggest problem today. So we want to hire people.

If healthcare is to be fair, then it should be fair for everybody, no exceptions. I am for healthcare, but I think it should be the same from top to bottom. The government has not provided us with guidelines whatsoever, yet we are expected to follow them, and you have to try to find it yourself, and clear and compute information with unavailable rules, incomplete, and changing.

The Affordable Care does not into account varying hours and work per week. You might work 25 hours one week, and 35 hours another week to average 30 hours to equal full-time. We wind up being too low. It would be good to ask for solutions to healthcare issues, ones that are practical and affordable.

If this bill passes the way it is, looking out for employees—most employees live week to week, will have less money in their paychecks to spend, and will spiral the economy backwards. And it will be bad for all businesses because they are not going to have enough extra money to spend, whether it is going out to dinner or buying those extra things, even grocery shopping.

And I was thinking about it last night, and I was saying my grandfather came here in 1910 and worked 6 days a week from 5:00 a.m. until 6:00 p.m. And my grandmother had 11 kids at home, born in the home with no insurance at all. My grandfather worked hard to provide for them without insurance. And I think our country needs to really look at what our parents and grand-

parents did, and why our healthcare is like it is today. And that would be it.

Thank you.

[The statement of Mr. Bologna follows:]

Prepared Statement of Joe Bologna, Owner, Joe Bologna's Italian Pizzeria and Restaurant

Health insurance has always been important to me. I already pay health insurance for full time managers and offer to pay fifty percent for full time employees who want it. I currently have thirty full time and thirty five part time employees.

The recession of the last six years has taken a toll on restaurants and bars. This is one of the first places customers & families cut out of their budgets. Passing off cost to customer would mean less people can go out to eat for me and a lot of other restaurants. Have already lost money for last two years. Adding health care cost would put a lot of us out of business.

Why expand taking the risk of putting yourself in debt? In 2010, we had 75 employees. At the beginning 2013 we had thirty full time employees and thirty eight part time (24 FTE) so we closed on Mondays, to get below SO FTE. In 2010 we had 73 employees. This does not count all the administration cost of A.C.A.

The affordable care act causes fewer jobs. Jobs are the biggest problem today. If health care is to be fair It should be the same for everybody. No exception.

The government hasn't provided us with any guidelines whatsoever, yet we are expected to follow them. Have to try to find info yourself, clear and complete information unavailable -rules incomplete and changing.

A.C.A does not take Into account restaurant's varying hours worked per week. Example: EE works 25 hours (P/T) one week, 35 another (F/T) 30 hours== full time. TOO LOW.

Would be good to ask for solutions to health insurance issues - ones that are practical and affordable.

Chairman ROE. Okay. Thank you, sir. And, first of all, thank you for your service as a fellow veteran of the 2nd Infantry Division, and I know Mr. Guthrie is. We thank you for your service to our country.

Ms. Banahan?

STATEMENT OF CARRIE BANAHAN, EXECUTIVE DIRECTOR, OFFICE OF THE KENTUCKY HEALTH BENEFITS EXCHANGE, FRANKFORT, KENTUCKY

Ms. BANAHAN. Mr. Chairman and members of the Committee, my name is Carrie Banahan. I am the executive director of the Office of the Kentucky Health Benefit Exchange. I, along with members of my staff, have been given the responsibility by Governor Beshear to create a State-based exchange in Kentucky.

At the outset, let me say that I am not a lawyer, an actuary, a doctor, or an economist. I am a 30-year veteran of State government, with expertise in the areas of health insurance and Medicaid. However, because of the work conducted by our office, I believe that the Affordable Care Act will provide substantial opportunities to improve the health of the people of the Commonwealth.

Kentucky ranks 44th overall in health status when compared to other states, so there is much improvement to be made. To exacerbate an already troublingly unhealthy environment, an estimated 640,000 Kentuckians lack healthcare coverage. That translates to 1 in every 6 Kentuckians.

A multitude of State and national studies have demonstrated a direct correlation between healthcare coverage and health status.

Getting the healthcare coverage that Kentuckians need is critical to improving the health of our citizens and our Commonwealth.

Individuals without insurance are more likely to skip regular checkups, go without prescription medicines, and delay doctor visits until serious problems develop. As a result, they are more likely to seek treatment in an emergency room when their problems are more advanced and treatment is more difficult and more costly.

Children without health insurance are more likely to have unmet medical needs like untreated asthma and diabetes. They are also more likely to go for long periods of time without seeing a doctor, which means they do not get regular checkups for immunizations, preventive care, and the vision and hearing tests they need for healthy development.

In addition to the obvious health toll, being without insurance can also spell financial disaster for individuals and families, especially in a poor State. Without health insurance, patients must cover 100 percent of their medical costs, which can quickly add up. And just one visit to the emergency room can put a deep hole in the household budget for an individual or family. In fact, nearly two-thirds of all bankruptcies are linked to serious illness.

A critical step in making healthcare accessible to all Kentuckians was Governor Beshear's decision to establish a State-based health benefit exchange, which we are calling kynect, Kentucky's Healthcare Connection.

Education and outreach efforts for kynect are ongoing. Perhaps you have watched our television commercials, seen our print ads, or heard our radio spots. These efforts will ramp up as we move towards open enrollment on October 1st. If you have not already, I encourage you to visit our website at kynect.ky.gov.

In addition to paid advertisements, our office is doing a considerable amount of direct consumer engagement through our kynect mobile tour. We just completed 10 days at the Kentucky State Fair, during which we handled thousands of questions from interested consumers who were eager to learn more about the Affordable Care Act and how it will benefit them.

Beginning October 1st, kynect will operate as an online marketplace where individuals and families, as well as small businesses, can comparison shop for health insurance based on cost, benefits, and quality. It will also allow eligible individuals and businesses to receive premium subsidies and tax credits. And through kynect, individuals will also be able to apply and have their eligibility determined for Medicaid and KCHIP.

The kynect website is one of many ways Kentuckians will also be able to select health plans. They will also be able to shop through a toll-free contact center, which opened on August 15th, a mail-in application, or in person with kynectors.

Two kynector grant awards were recently awarded to Community Action of Kentucky and the Kentuckiana Regional Planning Development Agency. Funding to support the kynectors is also being awarded to several agencies within the Cabinet that have established partnerships with local agencies. We will soon be issuing another request for proposals to ensure we have a statewide network of kynectors.

Beginning January 1st, a number of significant changes in the healthcare coverage of our citizens will come to fruition. We are very excited about the possibility for dramatic improvements in Kentucky's health indicators that could result from the changing landscape of healthcare in the Commonwealth and our Nation.

Thank you.

[The statement of Ms. Banahan follows:]

Prepared Statement of Carrie Banahan, Executive Director, Office of the Kentucky Health Benefits Exchange

Mr. Chairman and Members of the Committee,

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Beginning January 1, 2014, a number of significant changes in the healthcare coverage of our citizens will come to fruition. We are very excited about the possibility for dramatic improvements in Kentucky's health indicators that could result from the changing landscape of health care in the Commonwealth and our nation.

Thank you.

Chairman ROE. Thank you for yielding back.

I am not going to tolerate these outbursts. I am going to have you removed if this continues. I want you to understand that. We are in a congressional hearing, and this is not a town hall. I will say it again one more time, and I am not going to say it after that. Be respectful to everyone up here.

Mr. Humkey?

STATEMENT OF JOHN HUMKEY, PRESIDENT, EMPLOYEE BENEFIT ASSOCIATION, INC., LEXINGTON, KENTUCKY

Mr. HUMKEY. I would like to thank you, Chairman Roe, Ranking Member Andrews, Congressmen Barr, Guthrie and Yarmuth, for the opportunity to testify about the challenges that many employers in Kentucky will face in the coming months as the Affordable Care Act is fully implemented.

My name is John Humkey. I am the president and founder of a benefits insurance agency here in Lexington. My clients are made up of individuals, small employers, and large employers. I have held a life and health insurance license in Kentucky since 1977. I am also a member of the National Association of Health Underwriters, and I am a past president of our local chapter, the Central Kentucky Association of Health Underwriters.

Today I would like to address the impact of the Patient Protection and Affordable Care Act, and, in particular, modified community rating on small employer groups, such as my clients here in Kentucky.

For those not familiar with modified community rating, this part of the Affordable Care Act impacts individual and small group health plans, employers under 50. This rating model only allows for an insured member's age, tobacco use, family composition, and geographic region to be used in establishing premiums. It eliminates the traditional underwriting considerations such as health status, gender, and, for groups, their industry.

So let me expand on some of these considerations. First, age. Currently, an insurer is allowed—excuse me—for a spread in premiums using a 5 to 1 ratio. To simplify, a male, age 25 may have a premium of $100 a month, and a male age 64 would be charged $500 a month; thus, a 5 to 1 ratio from the highest premium to lowest premium is charged.

The Affordable Care Act compresses this to a 3 to 1 ratio; thus, forcing younger insureds to subsidize a premium reduction for older insured members. Currently there is a bill before Congress, H.R. 544. It is a piece of bipartisan legislation introduced by Representatives Phil Gingrey, Republican of Georgia, and Jim Matheson, Democrat of Utah. It seeks to address this Affordable Care Act

reduction of compression rates. It does allow the States the flexibility to change that to a higher ratio, or it defaults a 5 to 1. I would encourage each of you to support that bill.

Second is gender. With the elimination of gender in modified community rating, young males can expect that their rates will increase significantly, while younger females, normally charged for maternity, will decrease.

Third, health status. The elimination of health status in modified community rating may have the greatest impact on individuals and small employer groups purchasing health insurance. In a nutshell, healthy individuals and groups may pay more for premiums to subsidize the unhealthy. Individuals will lose significant motivation to live a healthier lifestyle, or for an employer to implement wellness programs within their company. Why invest dollars to implement a wellness program when your employees, who are healthier, thus having lower claims, will not impact their premiums?

Admittedly there are other motivations and considerations to implement wellness programs, but it does take away a significant factor in calculating a rate of return on investment when deciding to spend money on implementing a wellness program within your company.

In addition, for modified community rating, for individuals and small employer groups, the Affordable Care Act mandates essential benefits to be included in health plans. There are 10 essential benefits in all. One that stands out that is not currently included in most plans is coverage for pediatric dental and vision. As noble and attractive as mandated benefits are, each mandate adds to the cost of claims, and, thus, increases premiums insurers must charge their customers.

So let me paint you a picture. The young, young males and the healthy will be required to pay significantly higher premiums under the Affordable Care Act. The older, young females, and those with significant health status or health conditions may pay less in premiums. In other words this law, in my opinion, picks winner and losers. This may force many young adults and healthy individuals to drop coverage as premiums under the Affordable Health Care Act increase or, in some cases, may double. As the young and the healthy leave these insured pools, the less healthy will enroll for coverage, and as a result, claims and premiums will go up.

As we move towards full implementation of the Affordable Care Act on January 1st, let me share with you some facts and the impact that the Affordable Care Act has on some of my small employer groups. Insurance carriers here in Kentucky have already begun to notify agents and brokers, as well as our clients directly here in Kentucky, that they may be looking at significant premium increases when their plans renew in 2014. It is not necessary to name insurance carriers because this trend is universal among the carriers. I have clients that have been notified of an increase of anywhere from 11 percent to 110 percent. The great majority of these rate increases are in the range of 50 to 90 percent.

I have great clients that provide good benefit packages to attract and retain skilled employees. Most of them pay a significant portion of those premiums. Many of those employers treat their employees as family. But next year, many employers in Kentucky and

around the country will face significant premium increases that will force them to radically change the way they provide benefits to their employees or, in extreme cases, like my client that faces a 100 percent increase, may be forced to drop health insurance altogether and send their employees into the exchanges.

Let me end my testimony with this thought. No matter how fair a market reform idea might seem on its surface, it is not at all fair if it also prices people out of coverage options. And I submit to you that this is what the Affordable Care Act will do to many Kentuckians come January 1.

Thank you.

[The statement of Mr. Humkey follows:]

Prepared Statement of John Humkey, President, Employee Benefit Association, Inc.

I would like to thank Chairman Roe, Ranking Member Andrews and Congressmen Barr, Guthrie and Yarmuth, for the opportunity to testify about the challenges that many employers in Kentucky will face in the coming months as the Affordable Care Act is fully implemented. My name is John Humkey. I am the president and founder of a benefits insurance agency here in Lexington. My clients are made up of individuals, small employers and large employers. I have held a Life and Health Insurance license in Kentucky since 1977. I am also a member of the National Association of Health Underwriters and I am a Past-President of our local chapter – The Central Kentucky Association of Health Underwriters.

Today I would like to address the impact of the Patient Protection and Affordable Care Act (ACA) and in particular "Modified Community Rating" on Small employer groups (my clients) in Central Kentucky.

For those not familiar with Modified Community Rating this part of the Affordable Care Act impacts individual and small group (50 employees or less) health plans. This rating model only allows for an insured members age (3:1), tobacco use (1.5:1), family composition and geographic regions (defined by each state) to be used in establishing premiums. It eliminates traditional underwriting considerations such as health status, gender & industry code if you are a group.

So let me expand on some of these considerations. Age – Currently an insurer may allow for a spread in premiums using a 5:1 ratio. To simplify, a male, age 25 may have a premium of $100 per month and a male age 64 would be charged $500 per month. Thus a 5 to 1 ratio, from the highest to lowest premium charged. The ACA compresses this to a 3 to 1 ratio thus forcing younger insured's to subsidize a premium reduction for older insured members. Currently there is a bill before congress – HR 544, a piece of bipartisan legislation introduced by Representatives Phil Gingrey (R–GA) and Jim Matheson (D–UT) that seeks to address the impact that the ACA's age-rating rules have on young Americans. Forty-two states nationwide now have in place a 5:1 age-band. This bill will change the 3 to 1 ratio that begins on January 1st and instead allow states the flexibility to determine their own age-band or default to a 5 to 1 ratio. I would encourage you to support this bill. Gender – with the elimination of gender in Modified Community Rating the load for maternity traditionally charged to younger females will now be shared with males. So young males can expect their rates to increase significantly in Modified Community Rating. Health Status – The elimination of health status in Modified Community Rating may have the greatest impact on individuals and small employer groups purchasing health insurance. In a nut shell healthy individuals and groups will pay more in premium to subsidize the unhealthy. Individuals will lose a significant motivation to live a healthier lifestyle or for an employer to implement wellness programs within their company. Why invest company dollars to implement a wellness program for your employees when healthier employees (i.e. lower claims) will not have an impact on their premiums. Admittedly there are other motivations and considerations to implement wellness programs but it does take away a significant factor in calculating a return on investment (ROI) when deciding to spend money on implementing a company wellness program.

In addition to Modified Community Rating for individuals and small employer groups the ACA mandates certain "Essential Benefits" be included in health plans. There are ten Essential Benefits in all. One that stands out that is not currently included in most health plans is coverage for Pediatric Dental & Vision. As noble

and attractive as mandated benefits are each mandate adds to the cost of claims and thus increases the premiums insurers must charge their customers.

So let me paint you a picture . . . . The young, young males and the healthy will be required to pay significantly higher premiums under the ACA. The older, young females and those with significant health conditions may pay less in premium. In other words this law in my opinion picks winner and losers. This may force many young adults and healthy individuals to drop coverage as premiums under the ACA double. As the young and healthy leave these insured pools the less healthy will enroll for coverage and as a result claims and premiums will go up.

As we move with the full implementation of the ACA on January 1, 2014 let me share with you some facts and the impact of the ACA upon some of my small employer groups. Insurance Carriers here in Kentucky have already begun to notify agents and brokers, as well as our clients directly that many of them will be looking a significant premium increases when their plans renew in 2014. It is not necessary to name the insurance companies because this trend is universal among carriers. I have clients that have been notified of an increase from 11% to a high of 110%. The great majority of these increases are in the range of 50% to 90%.

I have great clients that provide good benefit packages to attract and retain skilled employees. Most pay a significant portion of these premiums. Many treat their employees as family. But next year many employers in Kentucky as around this country will face significant premium increases that will force them to radically change the way they provide benefits to their employees or in extreme cases like my client that is facing a 110% increase, may be forced to drop health insurance altogether and send their employees into the exchanges. In speaking with my client that is facing the 110% increase in his health insurance premiums next year this small employer had some very colorful words to express his dismay that I will not repeat in my testimony today. He is now faced with significantly changing the benefits he now provides his employees or worst dropping coverage altogether.

Let me end my testimony with this thought: "No matter how fair a market reform idea might seem on its surface, it's not at all fair if it also prices people out of coverage options". This is what the Affordable Care Act will do to thousands of Kentuckians on January 1st.

Chairman ROE. Thank you, Mr. Humkey. And our first questions will be Mr. Guthrie.

Mr. GUTHRIE. Thank you very much. Thank you, Mr. Chairman, for yielding.

And, first of all, I want to say I know on this committee when we are in Washington quite often, Secretary Sebelius, I mentioned, Health and Human Services, came up and testified in front of our committee. And my understanding, if I did not miss this—I got in late last night from Breckinridge County, but I saw, I think, her father had passed away who was a governor of Ohio in the 70s. So our thoughts and prayers are with Kathleen Sebelius as she is going through a tough time now.

When I was, you know, looking at, you know, employers here and I was hearing some of the comments coming from the audience as people were talking, employers that I talk to, well, they are distressed. They really are distressed not just about how it affects their business, but how this business affects their employees. And I understand from your testimony how you have rearranged and given less time, Mr. Bologna. And I know I have talked with Tim several times, Mr. Kanaly, about his business, just the stress about how it has forced him to make decisions that change the earning power of their employees.

I mean, it is not something that, well, we have just got back off and not put more money in my pocket. They are truly distressed about, particularly in competitive retail environments, staying in business or making decisions that are adversely affecting their employees. And that is what you see.

And with you, Mr. Kanaly, I know we have talked several times about your 46 plus 6, and we cannot get you an answer because we cannot get an answer from the people who are administering the rules.

But if you are ruled to have 52 employees, what decisions does that force you to make? And if you are able to stay separate and you are Gary Force, that is 46, what does that limit you on growth?

Mr. KANALY. Well, what we would have to do is once we get an answer and somebody tells us exactly where we stand, I really, to be honest with you, Congressman, I do not know. We have to wait and see until that decision is made, and then we could take a look at all of our expenses and decide what we do going forward.

Mr. GUTHRIE. The 1-year delay, has that helped you, and has it brought more uncertainty?

Mr. KANALY. I do not think it changes anything. I started on this sometime last fall. I mean, somebody brought it up to me at the barbershop and other places that I go. I have run into a couple of other small business people. One guy had a bunch of assisted care facilities, and we just started talking about it. It kind of gets you talking, so everywhere we go we ask, you know, does anybody have anybody who can give you answer. And like I said in my testimony, so far I have not found anybody.

So I am kind of on hold, to be honest with you, until I find out where I stand.

Mr. GUTHRIE. That is creating a lot of uncertainty in the marketplace, I know, by not just knowing the answer to these questions.

And, Mr. Bologna, in your testimony, you describe you have 30 full-time and 34 part-time?

Mr. BOLOGNA. Yeah.

Mr. GUTHRIE. And you are having to reschedule, is it you do the Mondays off so you can get to the 34 part-time, is that—

Mr. BOLOGNA. Well, what we have done is being closed on Monday, of course, reduces the amount of employees for the whole week. So we took all the 34 part-time, and you add all those part-times together and divide it by 30, which is considered a full-time work week. And that brought us down from 34, to an average of 24.

And that reduces the total number of what they call full-time at 30 hours, because most employees I have got work two jobs because 30 hours a week is not going to make a living.

Mr. GUTHRIE. And then, so Mr. Humkey, in your testimony, you mentioned that businesses are considering dropping insurance coverage in the next year due to the premium increases. And what pressures will they be able to maintain, because you deal with a lot of small individual businesses.

Mr. HUMKEY. Correct.

Mr. GUTHRIE. And the $2,000 tax that you can pay in lieu of providing insurance versus dropping the cost of insurance.

So what are the incentives for employers to—the question is and one of the concerns about the law is so many people putting people into the exchanges. The estimates of the law, which is, you know, a trillion dollars already, would just be completely blown out because of people dumping people into the exchanges because of the costs.

What is the incentive with the $2,000 tax set up?

Mr. HUMKEY. That tax you are talking about, the $2,000, or it could be $3,000 as part of the pay or play penalty, but that is imposed on large employers only or what we define as 50 plus today.

When you look at the small employee marketplace, certainly it is the rate pressure upon employers to operate again in a very lean economy and very competitive times to try to take a 50 percent increase or an 80 percent increase and work those costs into their cost of operations.

I think most are going to make tough decisions to either pass that cost onto employees or pass part of that cost onto employees, or radically change their benefit plans. And even the Affordable Care Act in the small marketplace does put a limit on the deductible and out of pocket costs that you can have in a plan, again, further pressure. You cannot go too high with those deductibles and out of pockets. The law will not allow it. Yet as we force these plans on them, those premiums also become a complication. They also increase exponentially.

Mr. GUTHRIE. You say a lot of small businesses with less than 15 employees. Well, that is who you deal with. They were all for health insurance.

Mr. HUMKEY. Correct.

Mr. GUTHRIE. And their pressure will be to, as the premium goes up to put some people in the exchange. And they do it without the tax.

Mr. HUMKEY. If they find that it is unaffordable to continue to provide employees healthcare, yes, the one option is to cancel the coverage and send them to the exchanges.

Mr. GUTHRIE. I think I see my time has expired. Thank you.

Chairman ROE. Mr. Yarmuth?

Mr. YARMUTH. Thank you, Mr. Chairman. Since I only have 5 minutes, I want to make a couple of quick points.

First of all, Mr. Kanaly and Mr. Bologna, as I mentioned in my opening statement, some of the regulations that relate to the issues you have raised have not been finalized yet. And the administration is considering safe harbors for particular industries like yours, Mr. Bologna.

Since you are also my constituent, Mr. Kanaly, on Dixie Highway, I wish you had called me. We would have given you, I think, a little bit better information. We have arranged, by the way, for a person at IRS to talk to you about the issue, including whether you are considered jointly or separately your 2 businesses.

But even if you are considered jointly, the impact on you will be virtually nil because you do not have to cover 5 of the 6 employees you have in Louisville, which means you would have no additional cost under the act. So I hope that makes you feel better.

Mr. Humkey, I want to make two points. First of all, I disagree with you totally about gender discrimination. You know, women do tend to get pregnant, but men also have something to do with that.

[Laughter.]

Mr. YARMUTH. And the idea that women should be charged up to 80 percent more than men for the same coverage, to me, is fundamentally unfair.

And I was a small business person before I got into politics. I ran a business with about 20 employees. Virtually all of them were very young and healthy. We had one middle-aged woman who had cancer. So every year we were facing premium increases of 20 percent, 25 percent, dealing with the types of issues you talk about.

And so, the question of fairness is a curious one because to me that was very unfair that all of those young people either had to adjust their co-pays, their deductibles, and so forth, or raise their contributions because of one unhealthy employee.

So going back to what I suspect you are suggesting to the pre-Affordable Care Act situation is something I do not think would necessarily solve any of the issues that you raised. And, in fact, in 2008 and 2009 when we were actually debating the Affordable Care Act, premiums across the country were going up 25, 30, 38 percent in many cases, and that is what this act was designed to solve.

So I do not have a question. I just wanted to raise those points.

Mr. HUMKEY. I was going to ask if you were asking a question. [Laughter.]

Mr. YARMUTH. No, I was not asking a question.

Ms. Banahan, thank you for your testimony. And I would like you to take a few minutes briefly to walk us through what kynect will mean on October 1st, just 5 weeks away, less than 5 weeks away. What will Kentuckians experience as they utilize kynect to enter the healthcare system, and small businesses, I am sorry.

Ms. BANAHAN. Right. So individuals as well as small businesses—that would be those who had 50 or less employees—will be able to go online using the web-based portal to select health insurance companies. They can also utilize an agent or a kynecter, or they can file an application with our contact center.

Mr. YARMUTH. Okay. I know that the rates that we are expecting in the exchange have not been published yet, but there is some experience around the country when talking about increased rates. I assume you are familiar with some of the rates that have been published across the country, in California, and New York, and Oregon. What has been the experience in terms of the impact on rates and the Affordable Care Act would do?

Ms. BANAHAN. So our rates will be available October 1st. You know, we're in the process—our Kentucky Department of Insurance is in the process of reviewing and approving those rates. And they will be available probably around October 1st.

Mr. YARMUTH. But is it not true that where rates have been published in California, and New York, and Oregon, and other States, there has been a significant decrease in the rates—

Ms. BANAHAN. There have been decreases, yes, in some of the other States.

Mr. YARMUTH. In New York as much as 50 percent lower than pre-ACA rates, is that not correct?

Ms. BANAHAN. That is correct.

Mr. YARMUTH. I am not saying we can expect that we can—

Ms. BANAHAN. Right. Right. Right, yeah, I mean, you know.

Mr. YARMUTH.—in Kentucky, but there have been significant reductions in rates actually in other places.

So in order to put this rumor to rest, will kynect be ready on October 1st? Have the tests and reviews been completed?

Ms. BANAHAN. Certainly. Last week, HHS was in Frankfort conducting our operational readiness review, as well as our implementation review. Kentucky was the first State to have this review, and it went extremely well. So they found no major issues. And then, today we begin end-to-end user acceptance testings with the feds, and Kentucky is the first State to do that. And we will be open October 1st, and we will be able to take applications for individual coverage and small employer group coverage.

Mr. YARMUTH. All right, thank you.

Thank you, Mr. Chairman.

Chairman ROE. Thank the gentleman.

Mr. Barr?

Mr. BARR. Thank you, Mr. Chairman.

Mr. Kanaly, in response to my colleague, Mr. Yarmuth's, comments there, I wanted to get your reaction to the comment, in particular whether or not the delay, the 1-year delay in the employer mandate in any way gives you comfort in terms of your grouping of your employees and whether or not you are going to have to prepare for the 50-employee threshold employer mandate when it comes 1 year down the road.

Mr. KANALY. Again, I just do not know. By the way, I am not a constituent. I actually live in Bowling Green. I appreciate your help.

[Laughter.]

Mr. KANALY. Anything you can do to help me, I promise you.

Mr. YARMUTH. Your business is a constituent.

Mr. KANALY. Yes, sir. Thank you.

To answer your question, really I do not know. Like I said, like I told Congressman Guthrie, I am just going to wait. And it will not really change anything. I just need a decision. Once I have that decision, then I will move forward. But I really do not know. I am going to keep asking questions, and it sounds like I might get an answer.

[Laughter.]

Mr. BARR. Well, let me ask you this. Does the 50 or more employee threshold, the employer mandate, just generally speaking, does it encourage or discourage you from growing a business?

Mr. KANALY. I cannot really say either way. I would seriously consider not doing anything forward and continue to try to stay under the 50 if I can. If it is going to be harmful to my businesses, I probably would go ahead. I will have to look really hard at it.

Mr. BARR. Mr. Bologna, thank you for your entrepreneurship in the Lexington community for all these years. Thank you again for your service to the country and for your really American success story. We appreciate you sharing that.

You mentioned in your testimony that are now closed on Mondays due to the healthcare law. Describe the impact that has had on your profitability and also the welfare of your employees.

Mr. BOLOGNA. Well, you know, for some employees that were working just one day, for instance, and have a full-time job besides, we had to actually eliminate a couple of employees and sort of force them to leave to have fewer employees to balance it out. And in-

come wise, somehow we have got to make up for $20,000 a month because we are used to making a higher income and doing a lot of volume sales, you know.

So that is slowly coming around, and we will have to work on that for the rest of the year to see how that really works out. It is too early to exactly tell how it will balance out.

Mr. BARR. Thank you. Mr. Humkey, a couple of questions. Two categories of businesses probably that you work with are the small businesses, say, a 10-employee business, and then, say, a 45-employee business.

First describe the impact that you are seeing in terms of the decision making in the health benefits area, in the healthcare planning area for the medium-sized business, the 45-employee, 48-employee. What impact do you see in terms of those companies in terms of their expansion plans?

Mr. HUMKEY. Certainly the closer you get to 50, Congressman Barr, it is on the radar. They do understand the Affordable Care Act, if you are over 50 full-time and full-time equivalents will require you to provide both affordable and minimum value coverage, or it is going to assess a penalty on you. So they are aware of that. They are considering that in whether they grow to exceed that 50 benchmark that would throw them into a penalty.

So it is on the radar. They do consider it. Again, as Mr. Kanaly said, many of them find it very hard to understand how that calculation is made. I have combed over a lot of information, both from the government and from accounting firms, and it is not going to be an easy task for an employer to make that calculation.

Mr. BARR. And I see my time is running out, so I will spare you the second part of the question about the small because I think you have already testified that there is rate pressure applied even with the lower employee number of small businesses because of the modified community rating issue.

But let me ask you a final question with the last bit of time I have, and it has to do with the grandfathering provisions. The Obama Administration has repeatedly assured employers, like the ones that you serve here in central Kentucky, that they did not have to worry about their reform plan, that their plans would be grandfathered in. That is to say they would not be subject to the mandate's regulations and the minimum essential coverage requirements.

The Federal regulators are now telling us that only 1 in 5 small employers and 1 in 3 large employers will remain grandfathered. Please share your view whether the assurances of the grandfather provision in Obamacare is truly a safe harbor for employers. And if it is not, explain why employers are unable to escape Obamacare's mandates.

Mr. HUMKEY. Well, I think you are right with the statistics you cite. It is very true among my own clients. Very few have retained grandfather status, and one of the critical issues is that rates continue to increase even in the last 4 years. To be grandfathered, you had to change literally almost nothing. You could have no more than a 5 percent change in employer contributions or no more than a 5 percent change in some of your benefit design.

So employers were forced to give up their grandfather status just to continue to make healthcare affordable for their employees. Very few employers are grandfathered, so if you are not grandfathered, you are subject to the full extent of the Affordable Care Act, which has all the pressures that we have talked about here today.

And the second part of your question was? The last part?

Mr. BARR. That was it. Thank you. I yield back.

Chairman ROE. Thank you for yielding. I will now yield myself 5 minutes.

I am Phil Roe. I am from Johnson City, Tennessee, a veteran of the United States Army, and I practiced medicine there for 31 years in rural Appalachia. We started out with four doctors in our groups and 12 employees. We now have 100 providers and 450 employees still providing care for rural Appalachia. I also teach in the medical school. So I have been involved deeply in healthcare my entire adult life.

And one of the problems with the American healthcare system was, number one, it cost too much money. That is why I retired from my practice and ran for Congress was I knew I could see patients that could not afford the care they were given.

Number two, we had people out there who were working every day, husband and wife, but they could not afford the care. They did not have access to affordable care.

When you look at the healthcare system in America, you look at it in three phases, and then you look at the part that just defined those people I just mentioned. And number one, if you are in an employer-based ERISA plan, it covers 160 million people, just like my office. We provided health insurance just like these businesses have forever. Why? Because it is the right thing to do.

And number two, you want good employees, and this is a good way to get that, to attract good employees to your practice. I have had people working with me for 35 years in my practice that are still there. And why? They are great people to work with. They are like family members.

So we have the ERISA-based plans. Companies over 50 in this country, 96 percent provide health insurance coverage right now today. So they were not involved.

Number two, and so preexisting conditions do not matter in ERISA-based plans. You have to cover everybody. Number two, I am Medicare age now, so when you hit 65 you hit that button. And you also do not have a preexisting condition. Number three, if you are Medicaid you do not.

So what group of people are we actually looking at? We are looking at the small group market, and the individual market, and the uninsured. Now, what did we do? We passed a 2,700-page bill, which I unfortunately have read every word of it, and 28,000 pages of rules right now to look at this segment of the population. We could have covered two-thirds of everything the Affordable Care Act did in two paragraphs. One is the 26-year-olds and expanding Medicaid. That would have done two-thirds of what you wanted right there, those two items.

Now, let me talk about just a moment the New York plan dropping. And it did, and let me tell you how that happened. The 1992 the individual market in New York had 1.2 million people. Gov-

ernor Cuomo won, passed a no preexisting conditions, no lifetime limits, and caps. So by 10 years later, there were 120,000 people in the individual market in a State of 19 and a half million people. Today there are 32,000 people. That is why the rates are so high.

And what you said, Mr. Humkey down there, was when you bring these young people in, they are going to pay a lot more to lower the rates for a few people in that State. I do not think that is fair. There is a better way to do that, and to provide that coverage for those folks, and we go into that.

I want to talk a little bit, Mr. Humkey, about those small businesses in our State. I have talked to our insurance commissioner. In the individual market, the rates are expected to go up 45 to 70 percent. And I asked her, if we did absolutely nothing, what would have happened to the rates. They would have gone up by 10 percent. And the small group market, small business market, about 50 to 55 percent.

Are you seeing that here in Kentucky?

Mr. HUMKEY. Yes. Many insurance carriers are telling them that if their plans were to renew in this year, they might be looking at single digit 10 percent, 15 percent renewals.

Chairman ROE. Which is a lot.

Mr. HUMKEY. Yeah, which in this day and time, if you get a single-digit renewal you are presented, you are pretty fortunate. But, yeah, compared to when their plans renew and go into modified community rating.

As I said, there will be winners and losers. There will be some groups who have unhealthy or older employees that rates may come down, but they are a lot fewer than the employers. These rates will go up.

Chairman ROE. I think that one of the things that was brought up earlier that we have to do is in prevention. I have seen certainly in preventive care in our district, we had businesses that changed the metric for that. In other words, we incentivize wellness, not illness, right now.

So what are doing, we have seen businesses actually lower rates by saying, let us say if you are a diabetic who smokes and you change those behaviors, and you lower your hemoglobin A1C to less than 60 with good care, that those rates come down. And I think those are the kinds of things we need to look at in expanding coverage, a lot of good ideas.

One other thing I want to mention before my time runs out is a part of the market we have not talked about, and that is the self-insured. Our self-insured people, it is going to cost my city $177,000 each year, for which they get absolutely nothing for. And what that is a $63 fee-per-person fee that they have to pay for each person insured for the first 3 years to help the indemnified insurance companies, which I find remarkable that you are doing that. And there is also going to be an exchange fee that they are going to have to pay, which I do not know how much money it is. So I know it is at least $177,000 debt for my local community where I was mayor.

I see my time has expired. I want to thank the great panel. I want to thank the witnesses for taking your time to testify. I will

now ask the second panel to come forward and take your seats. Thank you all very much.

Exactly a 5-minute break. I will be back in 5 minutes.

[Recess.]

Chairman ROE. Call the meeting to order. It is my pleasure to yield to Mr. Andy Barr to introduce our second panel of witnesses.

Mr. BARR. Thank you, Mr. Chairman, and thanks to the second panel for coming and participating in our hearing here today.

I would first like to introduce Ms. Janey Moores, president and CEO of BJM & Associates in Lexington, Kentucky. Ms. Moores is a well-known vocational consultant, who is knowledgeable regarding issues affecting today's labor market, wages, compensation, and current employment trends. She has been a long-time member of the National Association of Women Business Owners.

Mr. Donnie Meadows is the vice president of human resources for Food City Stores in Kentucky. Previously, Mr. Meadows worked for Walmart in its corporate labor division.

Ms. Debbie Basham works at the Southwest Breast Cancer Awareness Group in Louisville, Kentucky. Ms. Basham works with women and families battling breast cancer to coordinate support and help ensure access to healthcare resources.

Mr. John McPhearson is the CEO of Lectrodryer in Richmond, Kentucky, a company I have had the pleasure of visiting, and it is a great operation down there, great employer in Madison County. Lectrodryer dehumidifiers are used by 90 percent of the top 100 industrial firms in the United States.

I yield back.

Chairman ROE. I thank the gentleman for yielding, and before I recognize you, you have heard this before. But the lighting system is you each have 5 minutes to present your testimony, and the light will turn green. At 4 minutes, the light will turn yellow. And when your time has expired at 5 minutes, it will turn red, and we will ask you to wrap up your remarks as best as you can at that time. And each member has 5 minutes to ask questions.

I will start with Ms. Moores.

STATEMENT OF JANEY MOORES, PRESIDENT AND CEO, BJM & ASSOCIATES, INC., LEXINGTON, KENTUCKY

Ms. MOORES. My name is Janey Moores. I am the President and owner of BJM Staffing, BJM Medical Staffing, and Technitron. These are all employment services that place people in jobs in professional offices, accounting, law firms, IT professionals, as well as my nursing agency, placement in the healthcare field. I have placed over 250,000 people in jobs in the last 42 years.

Let me open by sharing with you the phone call that I received last week from my company's health insurance agent. Our group health insurance plan renews each May, so I was surprised to be receiving her call so soon after just renewing our premium rate a few months earlier.

She explained to me that I was receiving the same phone call that she had made to 78 other businesses before she called me. She stated that if we renewed our group before this coming January 1, we would only have a 10 percent premium increase. If we wait

until our standard renewal month of May next year, our renewal rate will have a 92 percent renewal rate.

Once I picked myself up off of the floor and started breathing again, I asked her what in this world could cause our rate to double after January 1. She explained to me that there is a provision in the Affordable Healthcare Act called community rating, and that it is having a horrific impact on all private health insurance plans. She then reminded me that even if we can get an early renewal rate before January 1 that my business is still facing that same gigantic premium increase in another 12 months after we get the renewal. This no doubt will be the death knell for businesses throughout the country.

So I have spoken with all of our business clients and medical facilities, and they are all receiving these same phone calls, and are paralyzed with fear about hiring any employees whatsoever. And can you blame us?

What is the true unemployment rate? Well, what we receive in government numbers does not reflect people who have been moved from the unemployment rolls to the social security disability rolls. Once they are on the disability rolls for 2 years, they are moved onto the Medicaid rolls where they pay no premiums, no co-pays, and no deductibles.

When you have students who cannot find full-time work, they are not counted as unemployed. Any students remaining in school after graduation because they cannot find full-time work are not counted. And those who have never paid into the unemployment insurance fund, if they have been self-employed, independent contractors, small business owners who have lost their businesses, retirees, who are forced to leave retirement, students who have graduated but still cannot find full-time jobs, people retiring early, these people are not counted.

My own business used to place thousands of people each year in some of Kentucky's finest manufacturers. However, reports have shown that Kentucky has lost over a third of our manufacturing jobs in the last 10 years, with the largest job loss occurring in the last 3 years. Accordingly, my company no longer places manufacturing employees.

America has a rapid transition now going on from a Nation of full-time careers to a Nation of part-time jobs. Even now, the longer-term temporary projects that we used to get have disappeared, and we are only asked to fill an occasional short-term employee here and there to help only during peak workloads. Also, with so many people unemployed now, the few remaining jobs have lower wages.

There has been an alarming increase in the number of Americans now dependent upon disability payments from our government. According to a recent NPR report, every month 14 million people now get a disability check from our government. Kentucky ranks as the third highest State for the number of residents receiving social security disability payments.

My own business has had a growing number of our employees submitting forms to us to complete for them in order for them to quit working and start receiving disability payments. Once we complete those forms they bring to us, they pick them up, and we

never see or hear from them again. Yet people relying on disability payments are often overlooked because they are considered not part of the labor force and are not counted among the unemployed.

We have over 128 million Americans now receiving government assistance payments each month. My company spends a large and growing amount of our time each week completing and returning our employees' government assistance forms for food stamps, housing assistance, disability forms, and more. In addition, my business is also forced to spend more and more time responding to our employees' financial problems relating to their mortgage foreclosures, wage garnishments, credit card collections, school loan garnishments, and more.

My business is open 24 hours a day, 7 days a week, 365 days a year trying to find jobs for people, then sending them to work. We get excited when we finally do get a job filled, and only to hear, well, two of the doctors are taking early retirement now, so our practice does not need to hire anyone else. And by the way, we would like to send you a couple of our employees' resumes because we are going to be letting them go this week.

One northern Kentucky taxi cab company stated that they were reducing their 20 full-time drivers to part-time schedules and hiring another 20 part-time drivers due to the Obamacare healthcare law.

Over the 42 years that I have been putting people to work, I have seen the job market go up and down from time to time. However, in the last few years, the job market has dropped off of a huge cliff and is likely to never return.

So what is different now that was not a factor over the last few years? No one can deny that the toxic ingredient in today's job market is the so-called Affordable Healthcare Act. We now have an entrenched bureaucracy in the United States that is now the fourth branch of our government, and it will be the IRS who will ram the Affordable Healthcare Act down everyone else's throats but their own. I never, ever dreamed that I would live to see the day when my own government would work day and night to put me out of business.

Esteemed members of the Congress, you see before you a vanishing species, an independent business owner who has paid millions of dollars in taxes to our government and put over 250,000 Americans to work in first-class careers, only to be threatened with total extinction by a single, albeit unconstitutional, law being foisted upon America's hardworking citizens, we the people.

Thank you.

[The statement of Ms. Moores follows:]

Testimony to Congressional Subcommittee on Health, Employment, Labor, and Pensions

By Barbara Jane Moores
President & CEO, BJM & Associates, Inc.
Tuesday, August 27, 2013

My name is Janey Moores. I am the President and owner of BJM Staffing, BJM Medical Staffing, and Technitron. These are all employment services that place people in jobs in professional offices, accounting, legal offices, IT professionals, as well as the healthcare field (nurses, medical assistants, allied health professionals, and more). I have placed over 250,000 people in jobs for the last 42 years.

I am honored to be asked to share with this committee my personal business experiences that relate to your hearing today on the "Healthcare Challenges Facing Kentucky's Workers and Job Creators." These challenges are indeed major and alarmingly real.

Let me open by sharing with you the phone call that I received last week from my company's health insurance agent. Our group health insurance plan renews each May, so I was surprised to be receiving her call so soon after just renewing our premium rate a few months ago.

She explained to me that I was receiving the same phone call that she had made to 78 other businesses before she called me. She stated that if we renewed our group before this coming January 1, we would only have a 10% premium increase. If we wait until our standard renewal month of May next year, our renewal rate will have a 92% increase!!!

Once I picked myself up off of the floor and started breathing again, I asked her what in this world could cause our rate to DOUBLE after January 1?! She explained to me that there is a provision in the Affordable Healthcare Act called "community rating" and that it is having a horrific impact on all private health insurance plans. She then reminded me that even if we can get an early renewal date before January 1 that my business is still facing that gigantic premium increase in another 12 months after we get this early renewal. That will no doubt be the death knell for countless businesses in the near future.

As I have spoken with all of our business clients and medical facilities that my business has staffed with good employees for the past 42 years, they are all receiving these same calls and are paralyzed with fear about hiring any employees whatsoever. Can you blame us?

So, I can hear some people asking, "Now how can that be, since the latest unemployment reports from our government claim that our "jobless rate dropped to a more than four-year low of 7.4%." Really? Then, what is the true unemployment rate in the U.S. now?

On August 22, 2013, the Bloomberg Report had these conflicting statements regarding the most recent Department of Labor's unemployment report claiming that "U.S. Jobless Claims Fell to Five-Year Low Over Past Month":

1) "The Labor Department revised the previous week's figure to 323,000 (first-time unemployment claims) from an initially reported 320,000."
2) "The number of people continuing to receive jobless benefits increased by 29,000 to 3+ million in the week ending August 10. The continuing claims figure does not include the number of Americans receiving extended benefits under federal programs." (This additional number of Americans receiving extended benefits is nearly 2 million recipients.)
3) "Twenty-five states (and three U.S. territories) reported a decrease in claims, while 25 states reported an increase (in unemployment claims)."
4) "Employers in July added the fewest number of workers in four months, even as the jobless rate dropped to a more than four-year low of 7.4% from 7.6%, the Labor Department reported earlier this month."
5) "Companies trimming their workforce include Cisco Systems, Inc., the largest manufacturer of networking equipment. The San Jose, California-based company on August 14 said it is cutting 4,000 jobs or 5% of its workforce."
6) "Federal Reserve officials are watching the job market along with other economic data to determine when to begin scaling back the central bank's $85 billion in monthly bond purchases. In July, policy makers affirmed a pledge to continue the purchase program until they see signs that the outlook for the labor market had 'improved substantially.'"

Here's how the true unemployment numbers are masked or hidden when American workers are:

1) Moved from the unemployment rolls to the social security disability rolls
2) Moved from the disability rolls after 2 years into the Medicaid rolls (where they pay no premiums, no deductibles, and no co-pays)
3) Moved into Medicare
4) Become students, since they can't find full-time work
5) Remain in school after graduation because they can't find full-time work
6) Never paid into the unemployment insurance fund, so aren't counted if they were:
   a) Self-employed
   b) Independent contractors
   c) Small business owners who have lost their businesses
   d) Retirees who are forced to leave retirement due to shrinking retirement funds and increasing costs of living
   e) Students who have graduated, but who still can't find full-time jobs
   f) People retiring
   g) People forced into early retirement

The reality in today's economy in America and in Kentucky is:

1) There has been a tremendous loss of jobs in America within the last few years. Many of these jobs may have left our country forever. A number of those jobs were here in Kentucky. My own business used to place thousands of people to work each year in some of Kentucky's finest manufacturers. However in a December 21, 2012, report from the Kentucky Center for Economic Policy, Kentucky has lost over a third of all manufacturing jobs in the last ten years—with the largest job loss occurring in the last three years. Accordingly, my company no longer places manufacturing employees.
2) America has had a rapid transition from a nation of full-time careers to a nation of part-time jobs. My permanent career placement division has struggled for the past few years. My temporary placement division has seen its lows in the past few years, too. Even now, the longer-term projects have disappeared and we are only asked to send an occasional short-term employee to help only during peak workload periods.

3) With so many people unemployed now, the few remaining few jobs offer lower wages.
4) There has been an alarming increase in the number of Americans now dependent upon disability payments from our government.

According to a recent NPR report entitled ***Unfit for Work: The Startling Rise of Disability in America***: "Every month, 14 million people now get a disability check from the government." Kentucky ranks as the third highest state for the number of residents receiving social security disability payments with 8.1% of Kentuckians receiving disability payments. Add these 14 million to the 14+ million on unemployment benefits and we have over 28 million Americans not working who are receiving at least one, if not both of these government payments each month. My own business has had a growing number of our employees submitting forms for us to complete for them in order for them to quit working and start receiving disability payments. Once we complete the forms that they bring to us, they pick them up and we never see or hear from them again.

In that same NPR report, the following facts emerged: "The federal government spends more each year on cash payments for disabled former workers than it spends on food stamps and welfare combined. Yet people relying on disability payments are often overlooked…because they are not technically part of the labor force. Thus, they are not counted among the unemployed.

"In Hale County, Alabama, nearly one in four work-age adults is on disability. On the day government checks come in every month, banks stay open late, Main Street fills up with cars, and anybody looking to unload an old TV or armchair has a yard sale."

5) Food stamp recipients in the U.S. now total over 101 million people in August. According to SNAP (the Supplemental Nutrition Assistance Program) that oversees the food stamp program, Kentucky has had over a 3.3% increase in the last year of Kentuckians receiving food stamps—bringing the total to nearly 900,000 Kentuckians now receiving food stamps each month. That is 20% of the state of Kentucky receiving food stamps each month.

6) With over 128 million Americans now receiving government assistance payments each month, my company spends a large and growing amount of our time each week completing and returning our employees' government assistance forms for:
   - Food stamps
   - Housing assistance
   - Child care payments
   - Utility assistance
   - Disability forms
   - Unemployment claims
   - Medicare claims forms
   - Medicaid claims forms
   - And many other government assistance forms

In addition, my business is also forced to spend more and more time responding to our employees' financial problems related to their:

- Mortgage foreclosures
- Wage garnishments for:

-child support
-credit card collections
-school loan garnishments
-non-payment for additional taxes owed
-Medicare and Medicaid assistance forms
-and so many other forms

My business is open 24 hours a day, 7 days a week, 365 days a year trying to find jobs for people, then sending them to work in businesses and medical facilities all over the Central Kentucky area. We are excited whenever we do find a potential job to fill, then are extremely disappointed when we're told:

- Sorry, we decided to wait on filling this position. It costs so much to hire people these days.

- Two of the doctors are taking early retirement now, so our practice doesn't need to hire anyone else. In fact, we'll send you a couple of our employees' resumes who are being let go this week.
- Our law firm is splitting apart and the attorneys will just do their own work, so we don't need to hire anyone now.
- One Northern Kentucky/Cincinnati cab company stated that they are reducing their 20 full-time drivers to part-time schedules and hiring another 20 part-time drivers due to the ObamaCare health law.
- Our pharmacy is reducing the hours we're open and is reducing everyone's hours here in order to save on employee costs.
- Our dental practice is closing because the two dentists here are going to work for the government at the VA Hospital. They were near bankruptcy with too many employee costs and overhead and only patients with emergency dental needs.
- Our hospital isn't hiring any more people because most everything is done on an out-patient basis, then the patients are sent home within a few hours after their baby is born or their surgery is over. We are reducing staff every week.

I have dedicated my life to finding people good jobs. Other than saving a person's soul or saving their life medically, I believe that the most important thing I can do to help people is to get them a good job so they can support themselves and their families.

Over the 42 years that I have been putting people to work, I have seen the job market go up and down from time to time. However in the last few years, the job market has dropped off of a huge cliff and is likely to never return.

What is different now that wasn't a factor over the last few years? No one can deny that the toxic ingredient in today's job market is the so-called Affordable Healthcare Act.

We have an entrenched bureaucracy in the U.S. that is now the fourth branch of our government. It will be the IRS who will ram the Affordable Healthcare Act down everyone

else's throats but their own. I never, ever dreamed that I would live to see the day when my own government would work day and night to put me out of business.

Esteemed members of our United States Congress, you see before you a vanishing species…an independent business owner who has paid millions of dollars in taxes to our government and put over 250,000 Americans to work in first-class careers…only to be threatened with total extinction by a single, albeit unconstitutional law being foisted upon America's hardworking citizens…..WE, the People.

Thank you for your time and your deepest consideration of this most crucial issue that has ever faced America.

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Chairman ROE. Thank you for your testimony.

Now, Mr. Meadows?

STATEMENT OF DONNIE MEADOWS, VICE PRESIDENT OF HUMAN RESOURCES, K-VA-T FOOD STORES, INC., ABINDGON, VIRGINIA

Mr. MEADOWS. Chairman Roe, Congressman Yarmuth, Guthrie, and Barr, good morning. My name is Donnie Meadows, and I am the vice president of human resources with K–VA–T Food Stores. And as such, one of my responsibilities is the administration of health plan benefits. So thank you for allowing me this opportunity to appear here today and to express some of the challenges we are facing as we continue to comply with the Patient Protection and Affordable Care Act.

I will condense my comments to a few key points, but respectfully request that you review the written testimony previously provided.

K–VA–T Food Stores is headquartered in Abingdon, Virginia. We currently operate 106 retail supermarkets, employing over 13,000 associates throughout the tri-state region of Kentucky, Virginia, and Tennessee. Fourteen of our retail supermarkets are located in Kentucky where we employ approximately 1,500 associates.

We were also one of the voices of the Food Marketing Institute and the supermarket industry. Food retailers and wholesalers employ about three and a half million workers, many operating under fluctuating schedules to meet employees' needs and consumer demands. Generally, the supermarket industry operates at approximately a 1 percent margin on average, so our industry has been diligent in seeking to minimize new burdens associated with implementing regulations and/or changes to the Affordable Care Act to allow retailers and wholesalers to continue to provide quality healthcare that is affordable to both the employee and to the employer.

I would like to touch on some of the challenges to food retailers and offer support to some proposed solutions that are before Congress and the Administration.

The Affordable Care Act has defined a full-time employee as someone who averages working 30 hours per week for an employer to be obligated to offer healthcare coverage. K–VA–T employs a significant number of part-time associates, and those folks are in age groups that possibly actually have health coverage from other sources, such as their parents or Medicare. At the present time, 67 percent of our part-time workforce falls into one of two age groups: those who are less than age 26 and those who are age 65 and older.

K–VA–T currently provides health benefits to associates working full-time, but a 30-hour per week threshold is beyond what we can afford without potentially impacting the quality of coverage offered to our current full-time associates. It also impacts how our stores hire, how we structure responsibilities, and offer benefits to new hourly associates.

The Affordable Care Act's 30 hour per week full-time threshold does not fit into the realities of supermarkets which operate outside of a traditional 9:00 to 5:00 work schedule. Our stores are staffed based on customer needs and those of our associates who

often are seeking flexible work arrangements. Many do not want full-time work.

Earlier this year, the Administration released look back period rules in an attempt to reduce those circumstances by tracking and averaging out associate hours over a longer period of time, but the administration of this is complex. We have developed our systems to track the look back periods, and we have conducted training with our management staff. And this results in fewer hours for some of the part-time associates just to ensure they do not trigger additional liabilities associated with working 30 hours or more per week, which adds a financial burden for some of those who were accustomed to working more hours, and honestly reduces our flexibility to serve customers.

We support legislation, H.R. bill 2575, introduced and co-sponsored by Chairman Roe and representatives here today, and others to address the issue. Frankly, we support any legislation that is honestly trying to correct ACA's definition of full-time and bring it in line with what is a more practical work environment.

Under the Affordable Care Act, when our company offers health coverage to our full-time employees, we could still get penalized if premium costs of an associate are more than nine and half percent of their household income, or if the benefits do not cover at least 60 percent of the average costs. Regulatory agencies have offered some options, such as an affordability tests based upon employee wages and a calculator to certify coverage value. But we are still awaiting guidance on reporting and interactions with health exchanges to protect against someone being mistakenly awarded an ACA tax credit and/or to protect our company from getting penalized even when we have attempted to follow the rules.

Mandatory auto enrollment is one of the provisions under the Affordable Care Act, and honestly is putting increased administrative costs and caused confusion potentially between employers and employees. K–VA–T supports legislation, H.R. bill 1254, that will repeal the mandatory enrollment provision, helping to ensure that associates are allowed to opt in to employer-sponsored coverage rather than opt out.

Temporary reinsurance and other fees for employers. The charge to our company will be $63 per participant in a benefit year of 2014. That is over $400,000 in incremental costs and other annual costs going forward. And that is on top of some additional fees for the Patient-Centered Research Outcome Institute. These new fees not only affect our business, but given the low margin environment of our supermarket industry, they would eventually directly impact our consumers.

Thank you for allowing me the opportunity to testify.

[The statement of Mr. Meadows follows:]

Testimony of Donnie Meadows
Vice President Human Resources
K-VA-T Food Stores, Inc.

before the

Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
United States House of Representatives

August 27, 2013

"Health Care Challenges Facing Kentucky's Workers and Job Creators"

Farish Theater
Lexington Public Library
140 East Main Street
Lexington, Kentucky

Chairman Roe, Representative Guthrie, Representative Barr, good morning. My name is Donnie Meadows, and I am the Vice President of Human Resources for K-VA-T Food Stores, Inc. One of my responsibilities includes the administration of health plan benefits; on behalf of the company I strive to meet the needs of our associates by offering a wide range of benefits that are a good value for our associates while maintaining a reasonable cost for the company. An important function of benefits administration is to insure compliance with the various laws and regulations, which brings me here before you. Thank you for allowing me the opportunity to appear here today to express some of the challenges we are facing as we continue preparing to comply with the *Patient Protection and Affordable Care Act*.

K-VA-T Food Stores is headquartered in Abingdon, Virginia. We currently operate 106 retail supermarkets throughout the tri-state regions of Southeast Kentucky, Southwest Virginia and Northeast Tennessee. In addition to our retail outlets we operate a distribution center and water bottling plant in Abingdon, Virginia. In total, we employ over 13,000 associates. Today, we have 14 retail supermarkets in Kentucky where we employ approximately 1500 associates. KVAT is committed to our associates and is very community-oriented; we are involved in local efforts as well as initiatives like School Bucks, in which the company has donated 14.4 million dollars in equipment to schools throughout the K-VA-T trade area.

We are also here as one of the voices of the Food Marketing Institute and the overarching supermarket industry. Food retailers and wholesalers employ 3.5 million full-time, part-time and seasonal workers—many operating under fluctuating schedules to meet employee needs and varying consumer demand. Generally, the supermarket industry operates at approximately a one percent margin, on average, so our industry has been steadfast in seeking to minimize new burdens in implementing regulations and/or changes to the Patient Protection and Affordable Care Act (ACA; PL 111-148) so retailers and wholesalers can continue providing quality health coverage that is affordable to both the employee and the employer. While the Administration has provided flexibility within the scope of the ACA's regulations, they remain complex, and there are outstanding concerns

with the law itself that are impacting how food retailers manage their workforces, adjust work schedules and offer employee benefits well beyond health care.

We are committed to provide competitive wages and benefits to our associates. Today, we have a wide selection of benefits that we offer to our associates and many of those apply to our part time workforce. Through our profit sharing plan and 401-k plan, we provide all eligible associates (age 21 and 1000 hours) with retirement benefits and company ownership. Other offerings made available include vision, life, short term & long term disability, critical care, and accident insurance. Some are 100% paid by the company; others are on a cost share basis or paid by associates. Our health plan is grandfathered and provides a 100% paid wellness plan along with pharmacy and dental benefits. We have a full time nurse and registered dietician on staff to provide education, coaching, and guidance to our associates.

Challenges Facing K-VA-T Food City Stores and Associates under the Affordable Care Act

Under the *Patient Protection and Affordable Care Act*, K-VA-T is considered a "large employer", so the law requires our company to offer health coverage to full-time employees that is "affordable" to the employee and meets a certain "minimum value" or our company will face a tax penalty based on the number of people we employ.

Even though K-VA-T has long offered—quality, affordable health coverage to its full-time associates; you might be surprised by the challenges that our company, distribution network, and by each of our 106 stores are facing in order to comply with this new law. Over the past couple years, I have spent a significant amount of time attending conferences, reading the regulations, engaging with consultants and legal counsel to interpret the Affordable Care Act and its many new rules—some of which we are still awaiting— and to figure out the administrative details along with the development of system reports to ensure that our workforce management and benefits system will be in proper compliance.

While we appreciate the Obama Administration's decision, as well as legislation (H.R. 2667) passed by the House of Representatives, to delay enforcement of some of the ACA's employer provisions, our operations are still being impacted as we continue preparing to comply with the law's regulations.

I would like to outline some of these challenges and offer support to some proposed solutions that are before Congress and the Administration. There are still outstanding concerns that need to be addressed in the ACA, such as the law defining a full-time employee as working 30-hours per week, a mandatory auto-enrollment that will increase administrative costs and cause confusion between employers and employees, and some provisions outside of the law's employer coverage mandates that are impacting our retail business.

Definition of Full-Time Employee

The ACA has defined a full-time employee as someone who averages working 30-hours-per-week for an employer to be obliged to offer health coverage. K-VA-T employs a significant number of full-time and part-time associates. Currently, 42% of our associates are in full time positions. We also employ a large number of associates in age groups that possibly have other health coverage from

other sources such as their parents or from Medicare. At present time, 67% of our part time workforce falls into one of two age groups, those less than age 26 and those who are age 65 or older. As I mentioned earlier, K-VA-T currently provides health coverage to people working full-time, but a 30-hour per week threshold is beyond what we can afford without potentially impacting the quality of coverage to our current full-time associates. It also impacts how our stores hire, structure responsibilities and offer benefits to new hourly associates.

The health care law's 30-hours per week full-time employee threshold does not fit into the realities of supermarkets that operate outside of a traditional 9-to-5 work schedule. Our stores are staffed based on customer needs and our associates who are seeking flexible work arrangements. Think about a peak period, between the hours of 3 to 7 p.m., when people are shopping for dinner or during other peak times associated with preparation for holiday gatherings; to meet customer needs requires the availability of flexible staffing. Or conversely, think about the student or retiree who wants to pick-up or swap shifts based on family travel or funds for holiday shopping.

Earlier this year, the Administration released "look-back period and stabilization period" rules in an attempt to reduce these circumstances by tracking and averaging out employees' hours over a longer period of time, but this tool remains complex. Until we can trust our systems and our store managers to properly operate and track these look-backs, we are compelled to base staffing decisions on ensuring part-time employees do not trigger the additional liabilities of working 30-hours or more per week. By effectively capping part-time employees' at 30 hours per week, reduces our ability to offer jobs to people seeking flexible schedules or periodically higher-hour work periods.

We support legislation (H.R. 2575) introduced and co-sponsored by Chairman Roe, Representatives Guthrie, Barr and more than 100 Member of Congress to address this issue. We also support similar legislation (H.R. 2988) introduced by Rep. Dan Lipinski and other House members and S. 1188 introduced by Senators Susan Collins and Joe Donnelly. And quite frankly, we support any legislation or legislator that is honestly trying to correct ACA's definition of full-time employees (Sec. 1513 of ACA) so it is in-line with practical working environments.

Affordability, Value and Reporting of Employer-Sponsored Coverage

Under the Affordable Care Act, when our company offers health coverage to our full-time employees, we may still get penalized if the premium costs the associate more than 9.5% of his/her household income or if the benefits do not cover at least 60% of the average costs. Again, the regulatory agencies have offered some options, such as an "affordability test" based on employee wages and a calculator to certify coverage value. But we still are awaiting guidance on reporting and interactions with Health Exchanges to protect against someone being mistakenly awarded an ACA tax credit and/or to protect our company from getting penalized even when we've attempted to follow all of the rules.

Mandatory Auto-Enrollment

We are also concerned that the Affordable Care Act's mandatory, auto-enrollment provision will increase administrative costs and cause confusion between employers and employees. We anticipate scenarios where our company offers coverage to a qualified, full-time employee who ignores the offer due to already receiving health benefits from a parent, spouse or other retiree program. Under this ACA provision, the employer is required to deduct a premium from the associates' paycheck. As a result, an employee is being charged a premium (and the employer is paying an even higher

percentage) for coverage the employee does not want or need. K-VA-T supports legislation (H.R. 1254) introduced by Rep. Richard Hudson and co-sponsored by Chairman Roe, Representatives Guthrie, and Barr that would repeal the *Affordable Care Act's* mandatory enrollment provision(Section 1511), helping to ensure that associates opt-in to employer-sponsored coverage rather than forcing an employer to make that decision.

Temporary Reinsurance and PCORI Fees
We are also being forced to absorb a $400,000 reinsurance fee on top of all the compliance costs associated with offering health coverage under these rules. The ACA's "Temporary" Reinsurance fee for employers offering self-insured plans that will charge our company $5.25 per month per participant in benefit year 2014 ($63 per capita for all of 2014) and annual costs going forward. In addition, we are being assessed for each person our company insures in order to fund the Patient-Centered Research Outcome Institute (PCORI). These new, additional fees, not only affect our business, but given the low margin environment of the supermarket industry, they would directly impact consumers.

Flexible Spending Account/Over-the-Counter Medicine Purchases
As a retailer that also sells medicine, we are also being impacted by a separate provision in the ACA that prohibits individuals' ability to purchase Over-the-Counter medicine (OTCs) with a Flexible Spending Account (FSA) debit card unless a consumer obtains a doctor's prescription. In 2008--prior to the ACA--retailers—including K-VA-T Food Stores-- sunk costs and investments into creating a point-of-sale system to comply with Internal Revenue Service regulations to accept customers' FSA cards for approved healthcare and pharmacy items. We support legislation (H.R. 2835) introduced by Rep. Lynn Jenkins that would restore Flexible Spending Account (FSA) purchases of Over-the-Counter (OTC) medicine without a prescription.

Conclusion

Thank you for allowing me to testify today and for listening to K-VA-T's and the supermarket industry's concerns as you consider the impact of the Affordable Care Act. K-VA-T Food Stores remains committed to our community and to providing competitive, quality benefits to our associates. As I mentioned, we find ourselves in an uneasy position as an employer that is currently providing health coverage to our full-time associates but is also anxious about the impact that these new mandates are having on our associate benefits, workforce, and business operations. We support addressing the law's 30-hour full-time employee definition, repealing the mandatory auto-enrollment provision, and restoring the use of Flexible Spending Account debit card purchases without a prescription. These are common-sense measures that help correct some of the unforeseen challenges that the ACA imposes on businesses like ours. K-VA-T Food Stores and the supermarket industry remain committed to work with Congress and the Administration to address these issues as soon as possible.

Again, thank you for your time; I will answer any your questions you may have for me.

Chairman ROE. Thank you, Mr. Meadows.

Ms. Basham, you have 5 minutes.

STATEMENT OF DEBBIE BASHAM, SOUTHWEST BREAST CANCER AWARENESS GROUP, LOUSIVILLE, KENTUCKY

Ms. BASHAM. Thank you for having me, and thank you for what everyone is doing.

Seventeen years ago, I was diagnosed with late third stage breast cancer. According to the doctors, the chances of me living out my life were slim. After 6 months of chemotherapy, the doctors estimated I had 3 months unless we found a miracle. I was 44 years old.

Fortunately, my husband's professional association provided good health coverage for our family, and I was accepted into an experimental treatment program for late third stage breast cancer at Duke University. When we arrived home 3 months later, I had won my battle. The treatment worked. But we faced $200,000 in bills to cover costs not paid by the insurance company.

We were a middle-class American family, and we suddenly realized the cost of breast cancer was not over. We faced down the disease, but with the day-to-day expenses of raising two children, our bills kept mounting. My husband spent many hours of his day negotiating bills so we could keep our heads above water and keep our insurance paid up. No longer did we have financial security in our lives, but I had learned just how important having health coverage meant to my survival.

I was also beginning to understand the constant state of confusion and fear when dealing with our healthcare system: office visits, hospitals, insurance companies. We would wait for answers. Would I be allowed to take the next test or get the pills that I needed? We were always calculating to see whether I would reach my annual limit and the insurance company would stop paying. And our family was not alone.

That is why 15 years ago I started the Southwest Breast Cancer Awareness Group, which is now the largest participating breast cancer survivor group in Louisville. And having worked with thousands of women and their families since I beat the cancer, I have come to realize that you live or die based on the kind of insurance you have. You can get insurance and you can get some treatment without insurance, but the kind of treatment that alleviates suffering and saves lives simply is not available unless you have insurance to pay for it.

I have held crying women in my arms knowing—I knew—they were doomed to die because their coverage was not good enough, had been cancelled, or because they could no longer afford the skyrocketing premiums, they had reached their limits, or they had found themselves reliant on guaranteed-issue policies with outrageous costs, like the one that I ended up with, because when our family policy no longer covered me, I was suddenly locked out of the system. No insurer would cover me because of my pre-existing conditions. The guaranteed-issue plan I eventually obtained through Kentucky Access cost me $1,500 a month. With my husband's care, we were paying at $2,000.

One by one, the women in my group come with their stories and their struggles, first medical, then financial. We struggle together, we pray together, and we hold on for dear life. I want to tell you about a few of these courageous women.

Karen Blake and her husband, Kevin, owned a small business and had a privileged life when she joined our support group. But as the cancer came back, her standard of living started to fall, and her insurance company questioned life-saving treatments her doctors said that she needed. Her out-of-pocket expenses were very overwhelming. She was taking chemo in her doctor's office when she received a bill for $7,000 from the hospital. She called and explained she had not been to their hospital, but because the doctor was associated with the hospital, it was treated as if she had been admitted. Her insurance company would not pay. Is this the quality care some claim is the envy of the world?

Lisa was 28 years old and her children's ages were 2, 4, 6, and 8. She was a skinny, spunky redhead. She had been diagnosed with stage four breast cancer. The doctor found the lump in her breast shortly after the birth of her fourth child. Lisa and I talked often and had become friends. She would sometimes call me at 2:00 a.m. because she could not sleep. She would always say, sorry, is it too late, is it okay? I would pray in the silence of my mind for God to give me the right words to ease her fears.

She and her husband lost everything fighting breast cancer, their house and their car. They live below the poverty level now, and she spoke about how often she was ashamed when she could not pay her bills. Early on in our group, Lisa shared her sorrow when she thought of leaving her children behind. She always thought I was her rock, that I was holding her up, but little did she know her valiant courage made me determined to do something more about healthcare in our country.

I spent the last Christmas of Lisa's life with her. When we arrived at her rented home, they had moved her bed into the small living room and the children all surrounded her, sitting as close on the bed as they could get. Children need a mother. Our breast cancer group had sent the children gifts and baked goodies, and sent gift cards to help with the expenses.

The children played and they sang carols with us. Lisa did not seem sick that day. We were surrounded by laughter and giggles the way an American family should be. Time stood still, and Lisa had a wonderful day. As I left her house later on, our eyes met. In her beautiful smile I could see a wordless goodbye. I felt her strength and courage. Lisa gave a good fight, but in the end, her lack of care and the stress of overwhelming bills conspired, and her body caved in on top of her. She was never bitter, but she wondered why, and we talked often, why America could not do better for those less fortunate. This American girl deserved better.

So did my friend Carla Norton. Even as breast cancer attacked every part of her body, she remained hopeful and brought light into our group. Her bare-bones insurance paid for virtually nothing, and she told me she knew she was muzzled in the fight for her own life. She left behind two teen boys and a mother that was devastated emotionally and financially.

As women come in and out of our breast cancer support group, I know who will live and who will die based on what kind of insurance they have. I have seen this, oh, so many times. Where medical necessity should determine our outcomes in healthcare, greed often does instead.

It has been 17 years since I first beat breast cancer, and yet I still cannot find an insurance company that will sell me a policy. But because of the Affordable Care Act, that will never again prevent me or the millions of women like me across our country from getting the coverage and the care needed. Annual and lifetime limits will no longer shift the tremendous burdens of cancer onto its victims. Families will no longer lose out on all the opportunities our Nation offers simply because they get sick.

I only wish this law had gotten here in time for Lisa and Carla and the millions of women who deserved more than what they got. I am here today for them, and I thank you.

[The statement of Ms. Basham follows:]

Prepared Statement of Debbie Basham, Southwest Breast Cancer Awareness Group

Seventeen years ago, I was diagnosed with late 3rd stage breast cancer. According to the doctors, the chances of me living out my life were slim. After six months of chemotherapy, the doctors estimated I had three months unless we found a miracle. I was 44 years old.

Fortunately, my husband's professional association provided good health coverage for our family, and I was accepted into an experimental treatment program for late-stage breast cancer at Duke University. When we arrived home three months later, I had won my battle—the treatment worked. But we faced a $200,000 bill to cover costs not paid by the insurance company. We were a middle-class American family, and we suddenly realized the cost of breast cancer wasn't over. We faced down this disease, but with the day-to-day expenses of raising two children, our bills kept mounting. My husband spent many hours of his days negotiating bills so we could keep our heads above water and keep our insurance paid up. No longer did we have financial security in our lives, but I had learned just how important having health coverage meant to my survival.

I was also beginning to understand the constant state of confusion and fear when dealing with our health care system—office visits, hospitals, and insurance companies. We would wait for answers: Would I be allowed to take the next test or get the pills I needed? We were always calculating to see whether I would reach my annual limit and the insurance company would stop paying. And our family wasn't alone.

That is why 15 years ago, I started the Southwest Breast Cancer Awareness Group, which is now the largest breast cancer survivor group in Louisville. And having worked with thousands of women and their families since I beat my cancer, I have come to realize that you live or die based on the kind of insurance you have. You can get some treatment without insurance, but the kind of treatment that alleviates suffering and saves lives simply isn't available unless you have the insurance to pay for it.

I have held crying women in my arms knowing they were doomed to die because their coverage wasn't good enough, had been cancelled because they could no longer afford the sky-high premiums, had reached their limits, or had found themselves reliant on guaranteed-issue policies with outrageous costs—like the one I ended up with. Because when our family policy no longer covered me, I was suddenly locked out of the system: No insurer would cover me because of my pre-existing condition. The guaranteed-issue plan I eventually obtained through Kentucky Access cost $1,500 per month.

One by one, the women in my group come with their stories of struggle—first medical, then financial. We struggle together, pray together, and hold on for dear life. I want to tell you about a few of these courageous women.

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She and her husband lost everything fighting breast cancer—their house, their car. They lived below the poverty level, and she spoke often about being ashamed when she couldn't pay her bills. Early on in our group, Lisa shared her sorrow when she thought of leaving her children behind. She always thought I was her rock, that I was holding her up. But little did she know her valiant courage made me determined to do something more about health care in our country.

I spent the last Christmas of Lisa's life with her. When we arrived at her rented house, they had moved her bed into the small living room and the children all surrounded her, sitting as close on the bed as they could get. Our breast cancer group had sent the children gifts, baked goodies, and gift cards to help with their expenses.

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So did my friend Carla Norton. Even as breast cancer attacked every part of her body, she remained hopeful and brought light to our group. Her bare-bones insurance paid for virtually nothing, and she told me she knew she was muzzled in the fight for her life. She left behind two teen boys and a mother—devastated emotionally and financially.

As women come in and out of our breast cancer support group, I know who will live and who will die based on what kind of insurance they have. Where medical necessity should determine our outcomes in health care, greed often does instead.

It has been 17 years since I first beat breast cancer, and yet I still can't find an insurance company that will sell me a policy. But because of the Affordable Care Act, that will never again prevent me or the millions of women like me across our country from getting the coverage and care we need. Annual and lifetime limits will no longer shift the tremendous cost burdens of cancer onto its victims. Families will no longer lose out on all the opportunities our nation offers simply because they get sick.

I only wish this law had gotten here in time for Lisa, Carla, and the millions of other women who deserved more than they got. I am here today for them. Thank you.

Chairman ROE. Mr. McPhearson?

STATEMENT OF JOHN MCPHEARSON, CEO, LECTRODRYER, RICHMOND, KENTUCKY

Mr. MCPHEARSON. I would like to start by emphasizing that our company, Lectrodryer, and I personally, believe in universal healthcare. We have during our tenure as owners offered the best possible healthcare coverage to our employees. Our current cost averages $3.68 per hour per employee, far in excess of any of the proposed penalties or fines in the Affordable Healthcare Act. Our costs have increased every year in the last 12 years, and the quality of coverage we are able to offer has declined steadily since the health insurers have continued to reduce the quality of their best plan.

What I would like to present is the impact the AHA has had on our company to date, current concerns, and what we believe are the issues going forward.

To date the impact on Lectrodryer has been a significant investment of time by our HR manager and upper management to understand the Affordable Healthcare Act. This has involved seminars and meetings with health care professionals and HR professional groups. It has been complicated by the massive size of the act and the continuing clarification rulings and changing dates.

Additionally at this time, there is no information about the required State exchanges that we will have to offer on October the 1st. While we are required to notify our employees about these options by that date, we at this time have no details or information to answer the questions we are sure will come. Businesses do not like uncertainty. At this time there is significant uncertainty about the Affordable Healthcare Act's impact on Lectrodryer, both financially and operationally.

The period from now until the end of 2013, assuming no additional date changes, will require us to do additional work in HR to document our employees' participation and meet the other reporting requirements of the Affordable Healthcare Act. At this time we believe that will be, at a minimum, 2 weeks of work for our HR manager. Considering that this constitutes 11 percent of her time, it is no small cost.

Going forward our concerns are considerable. The decision to manage the Affordable Healthcare Act through the insurance companies is a decision that will have significant long-term repercussions. We believe the four plans offered in the Affordable Healthcare Act, platinum down to bronze, will become the de facto plans offered by the healthcare companies. While some of the features of the plans, like lifetime maximums, are improvements, we feel the overall coverage will deteriorate for most of our employees. Our current plan co-pays and prescription benefits are better than those of the platinum plan we have seen offered. These everyday costs will have an impact on our employees.

As a small business, one of the ways we have been able to distinguish ourselves as a better company has been to offer superior healthcare benefits. This has also helped us retain our employees. If we are correct that all companies will wind up with the same plans, this will simply take away one of the few options we have had to attract and retain the best employees for our company.

I am also concerned that the AHA does not address what has been a key concern in recent years for our company to control costs. It is personal responsibility. As an example, Lectrodryer offers a monthly monetary incentive for health club membership, but the employee must provide proof of use or attendance. While the AHA provides benefits for preventative measures like annual physicals, it offers no penalty for not participating. It only guarantees you will be taken care of regardless of your personal behavior.

One of the unique parts of the Lectrodryer business is that we have for the last five years exceeded 70 percent export sales. This has required me to travel extensively to many countries, including a number which have what is widely reported as universal

healthcare coverage. It is my conclusion that healthcare is about good, affordable access to doctors and healthcare facilities.

I am sure that was the intent of the Affordable Healthcare Act, but the reality is the law seems to be a lot about insurance companies, additional regulations, and the IRS. I do not see anything that guarantees that people in eastern Kentucky will have enough doctors and hospitals that they can access easily.

Lectrodryer as a responsible employer has provided the best available healthcare benefits to our employees for the entire time we have owned the company. But now I believe the Affordable Healthcare Act will increase the cost of coverage, reduce the quality plans we can offer, and add additional regulatory burdens and costs to our company, this in a world that every day demands we be more efficient and competitive. As I started, we believe in universal healthcare. We just wonder why we as one of the small businesses of Kentucky have yet another burden added to our workload.

Thank you.

[The statement of Mr. McPhearson follows:]

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August 26, 2013

REF: AHA Testimony

I would like to start by emphasizing that Lectrodryer and I personally believe in universal healthcare. We have during our tenure as owners offered the best possible healthcare coverage to our employees. Our current cost averages $3.68/ hour per employee far in excess of any of the proposed penalties or fines in the AHA. Our costs have increased every year in the last twelve years and the quality of coverage we are able to offer has declined steadily since the health insurers have continued to reduce the quality of their best plan.

What I would like to present is the impact the AHA has had on our company to date, current concerns and what we believe are the issues going forward. To date the impact on Lectrodryer has been a significant investment of time by our HR manager and our upper management to understand the AHA. This has involved seminars, meetings with health care professionals and HR professional groups. It has been complicated by the massive size of the act and the continuing clarification rulings and changing dates. Additionally at this time there is no information about the required state exchanges that we will have to offer on October 1st. While we are required to notify our employees about these options by October 1st we at this time do not have any details or information to answer the questions we are sure will come. Businesses do not like uncertainty. At this time there is significant uncertainty about the AHA's impact on Lectrodryer, both financially and operationally.

The period from now until the end of 2013 (assuming no additional date changes) will require us to do additional work in HR to document our employee's participation and meet the other reporting requirements of the AHA. At this time we believe that will be at a minimum 2 weeks of work for our HR manager. Considering that this constitutes 11% of her time for the remainder of the year it is no small cost.

Going forward our concerns are considerable. The decision to manage the AHA through the insurance companies is a decision that will have significant long term repercussions. We believe the four plans offered in the AHA, Platinum down to Bronze will become the defacto plans offered by the heath care companies. While some of the features of the plans like no lifetime maximums are improvements, we feel the overall coverage will deteriorate for our employees. Our current plan co-pays and prescription benefits are better than those of the Platinum Plan we have seen offered. These everyday costs will have an impact on our employees.

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As a small business one of the ways we have been able to distinguish ourselves as a better company has been to offer superior health care benefits. This has also helped us retain our employees. If we are correct that all companies will wind up with the same plans this will simply take away one of the few options we have had to attract and retain the best employees for our company.

I also am concerned that the AHA does not address what has been a key concern in recent years for our company to control health care costs. It is personal responsibility. As an example Lectrodryer offers a monthly monetary incentive for a health club membership but the employee must provide proof of use or attendance. While the AHA provides benefits for preventative measures like annual physicals it offers no penalty for not participating. It only guarantees you will be taken care of regardless of your personal behavior.

One of the unique parts of the Lectrodryer business is that we have for the last five years exceeded 70% export sales. This has required me to travel extensively to many countries including a number which have what is widely reported as universal health care coverage. It is my conclusion that healthcare is about good affordable access to doctors and health care facilities. I am sure that was the intent of the AHA but the reality is the law seems to be a lot about insurance companies, additional regulations and the IRS. I do not see anything that guarantees that people in Eastern Kentucky will have enough doctors and hospitals that they can access easily.

Lectrodryer as a responsible employer has provided the best available health care benefits to our employees for the entire time we have owned the company, but now I believe the AHA will Increase the cost of coverage, reduce the quality plans we can offer and add additional regulatory burdens and costs to our company. This in a world that everyday demands we be more efficient and competitive. As I started, we believe in universal health care. We just wonder why we as one of the small businesses of Kentucky have to have yet another burden added to our work load.

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Chairman ROE. Thank you.

Mr. Guthrie?

Mr. GUTHRIE. Thank you very much. Thank you, the second panel, for being here today. And I appreciate it very much.

We hear from a lot of businesses, and I talk to businesses. It is affordability as well. It is, can we afford to provide this for employees? A lot of businesses do, as Congressman Roe talked about. And I can tell you from experience, you said insurance has increased every year for the last 12 years, which obviously pre-dated the Affordable Care Act.

And so, the battle, I think, that we have or the issue is, how do we get a handle on the costs? And for a lot of people, one of the criticisms of the Affordable Care Act, it did not really try to deal with the costs of providing healthcare. And is there any of the three employers here that you see that this law is going to make the health insurance—and I read your testimony. I know where you are going with it. Is the health insurance you provide to your employees cheaper or more affordable?

Ms. MOORES. It certainly won't for my business or any of the clients we have been working with. Mr. Meadows. Unfortunately the opposite for us.

Mr. MCPHEARSON. Our indications from our insureds is that we will be facing significant increases, as everyone else has reported here.

Mr. GUTHRIE. So it has been increasing, and whether it increases more or not, it is increasing at least at the same level, so it really has not—

Mr. MCPHEARSON. The indications are it will be a much more significant increase next year.

Mr. GUTHRIE. And you said 92 percent, I think.

Ms. MOORES. Ours went from a 10 percent increase to 92 percent.

Mr. GUTHRIE. And, Mr. Meadows, you said that you are still waiting for guidance, because this hearing is about how the Affordable Care Act is affecting job creation in Kentucky, guidance. And Mr. Kanaly was here earlier. We asked him how some provisions would affect him. He said, well, I just do not know. I would have to know what provisions, how they affect me, and then I have to see how much it is going to cost me.

And so, you know, for the last 3 years, I guess, and everywhere I go when I talk to employers, that is what you hear. It is, we just cannot make decisions, and, you know, we are October 1st going live. And we do not how much to buy on the exchange, and we do not how much exchange is going to cost us. We are 5 weeks away from my family having to make healthcare decisions, and we do not have that available to us.

And it just seems that talk about how the uncertainty that the employers have—I am talking about employers and I am talking about job creation—has affected your ability to move forward on growing your business or making business decisions. I think that is replicated throughout the whole country. Is that kind of how that has affected your decisions?

Ms. MOORES. Well, I would agree with you because at one point I had three offices: Lexington, Georgetown, and Frankfort. And

now, we are operating strictly out of the Lexington office, so that meant reducing staff, causing people looking for work to have to come to us instead of if we are filling a job in Scott County, we could have had our Scott County office.

You have to cut your overhead wherever you can, and that involves some real sad decisions sometimes as far as locations, employees. You want to be near your clients. You want to be near people who are looking for work, job seekers. But you just cannot afford it with all of these expenses.

Mr. GUTHRIE. How has the uncertainty affected your business, Mr. Meadows?

Mr. MEADOWS. The uncertainty of the Affordable Care Act certainly has an impact, but more related to just the not knowing necessarily until certain regs are unveiled and so forth.

But the economy itself has made it questionable, and the growth that we had in past years versus what we have had in most recent years, it has truly been a challenge. It is an extremely competitive marketplace. It is not a marketplace today that lends itself to adding costs.

So I would say most retail employers in such a competitive environment, you are doing all you possibly can to control your expenses and your costs simply because growth is so restrictive at this point.

Mr. GUTHRIE. Is there a difference?

Mr. MCPHEARSON. Yeah. Well, certainly the worldwide economy is an interesting subject. As I mentioned, we export over 70 percent of our business. We are a manufacturer, also one of those that is a little bit of—everybody wonders how you do that, and we think we can compete very well from Kentucky.

But the fact of the matter is that all of our customers have moved even though we have not. And so, all of the major manufacturing firms are now located somewhere else in the world. And businesses are springing up there trying to compete with us in China, in India, a variety of places. So we face those challenges and have to be extraordinarily competitive.

So this year we made the decision because of a variety of things—there were also some other issues in Congress which left us with some uncertainty—that we were going to try and consolidate. And we have been growing constantly. We have had years of 40 and 60 percent growth. This year we just plan to stay level, to be quite frank.

Mr. GUTHRIE. I think I see my time is just expiring, so thank you for your answers. And I yield back.

Chairman ROE. I thank the gentleman for yielding.

Mr. Yarmuth?

Mr. YARMUTH. Thank you, Mr. Chairman. I am going to ask a few questions, but I first want to make one comment. Ms. Moores, there is a lot about your testimony I disagree with. But one thing is irrefutably wrong, and while you may feel that the Affordable Care Act is unconstitutional, the Supreme Court has said it is constitutional, and that is the only judgment that matters in that regard.

Ms. Basham, I thank you for your testimony. Thank you for sharing your story and those of women you have worked with.

When we get back to Washington in a few weeks, we will face a debate about whether to defund the Affordable Care Act or in some way shut down the government, and maybe take some other action.

For those you have worked with and for yourself, what would the impact of defunding the Affordable Care Act be?

Ms. BASHAM. Well, the impact would be absolutely what my testimony said. We would lose American citizens. We would lose mothers, and sisters, and wives. We would lose the dignity of our country, for our fellow Americans.

We would lose families being able to have coverage and have a choice in what they want to have. We would lose care. Many women cannot get insurance, nor small children that are born with defects or with preexisting conditions. So I believe that our country would lose immensely when we have grown and grown as a country over every problem that we have ever had.

I truly believe that business is wise enough to come up with ideas to work around the situation because what is more important, your American workers living a healthful life, and coming to work, and giving out a good product, or them going through what will happen to them health-wise if we do not have this?

Mr. YARMUTH. I thank you. And I understand that when you told people in your support group that you were going to testify here, you asked them to share their stories, email and letters. Would you be willing to share those stories with us?

Ms. BASHAM. Yes. There are a few here.

Mr. YARMUTH. Just if you have them documented.

Ms. BASHAM. I have them—

Mr. YARMUTH. Not read them. Will you be able, for the record?

Ms. BASHAM. For the record, yes, I will.

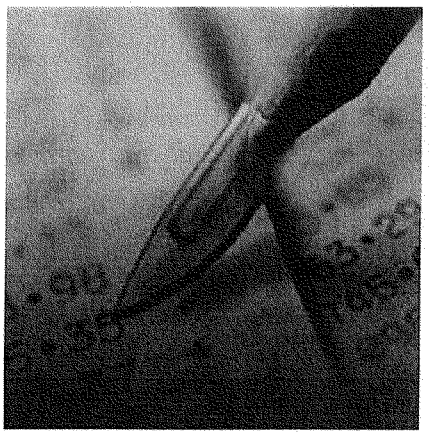
Mr. YARMUTH. Mr. Chairman, I ask unanimous consent—

Ms. BASHAM. Yes, I will be glad to give them.

Mr. YARMUTH.—that we put them in the record.

Chairman ROE. Without objection, so ordered.

[The information follows:]



Dissecting Health Reform
On a Company Level

Report on PPACA Impact

And

Potential Mitigation of Costs

Tuesday, July 16, 2013

Report Prepared By:

Randall Childers Consulting
F. Randall Childers, Jr.,CFC
Certified Forensic Consultant
Specializing in Health Benefit Plans

This report has been funded exclusively by F. Randall Childers, Jr., CFC.

The information is compiled as an objective basis on the understanding of The Patient Protection and Affordable Care Act (PPACA) Public Law 111-148. We reserve the right to change, modify or correct any and all comments or conclusions expressed in the written objective observations should we be given additional information that would warrant such actions.

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Executive Summary

This white paper is designed to provide information and provoke a thought process for the top legal minds, top employee benefit organizations, insurance companies, contracted administrators and employers with the emphasis on helping the American people and the American businesses / employers in mitigation of the additional mandated fees, taxes and costs associated on PPACA (The Patient Protection and Affordable Care Act) from the review of the language in Public Law 111-148.

The impact of PPACA also known as "Obama Care", Affordable Care Act (ACA) is significant to the American Business environment and individuals in the employment sector. The effect of PPACA is significant to the economic and financial structure of American businesses as a cost of doing business.

Recently, on July 9, 2013, the IRS (Internal Revenue Service) delayed the future impact of the "Play or Pay" or "employer mandate" via Notice 2013-45 provisions of PPACA from a January 1, 2014 effective date to January 1, 2015 effective date. Although this extension effected many of the provisions of ACA, other provisions remain intact. This notice addressed the delay until 2015, and encourages employers and other reporting entities to voluntarily comply in 2014 with the reporting provisions. ***This delay has no effect on the effective date of other Affordable Care Act Provisions. The delay does not apply to the individual mandate, which takes effect in 2014.*** A link to the Notice 2013-45 is: http://www.irs.gov/pub/irs-drop/n-13-45.pdf.

The information contained in this report shows the potential mitigation of several of the additional cost imposed on the American business by PPACA.

The following areas have been reviewed on a comparative analytical base utilizing a forensic approach for possible mitigation of these expenses.

1. **Transitional Reinsurance Fee** - this fee is assessed on a per member basis, Employees + all dependents. This fees is **$63.00** per member per year or **$5.25** per member per month. (This fee applies to both fully insured and self funded plans).
2. **Patient Centered Outcomes Fee** - This fee is assessed on a per member basis, Employees + all dependents. This fees is **$2.00** per member per year. (This fee applies to both fully insured and self funded plans).

3. **Health Insurance Industry Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fee is **1.9%** of the premium monthly. (This fee applies to fully insured plans).
4. **Federal Facilitated Exchange User Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fees is **3.5%** of the premium monthly. (This fee applies to fully insured plans).

Additionally, mitigation for the employer mandate for "Play or Pay" has been analyzed and observations utilized for a formula based structure in the elimination of this expense to the American business.

This white paper details utilization of the potential ambiguitas nature of the law which on its merits may have an implication on the Letter of the Law, Intent of the Law and Spirit of the Law as it pertains to the "rules" of engagement and enforcement of PPACA.

Attorney Response to questions posed

"This has been a very interesting discourse and exchange of ideas. As always, what we have provided before and provide now merely represents our opinion and does not in fact reflect the state of the law, or constitute a formal legal or consulting opinion.

The bottom line is that this is virgin territory. The law is new, the theories are untested, and there is no precedent. Your question, for instance, regarding whether the requirement that a plan's renewal date be set prior to December 2012 is intriguing. The question really is, does "any" date need to be established prior to December, or does "the" date need to be established prior to December? To answer this, and the other questions you present, we can only rely upon our own ideas and, for instance, our own interpretation of the law's intent. There are no hard and true facts, precedent, or case law we can rely upon!

We have not, and will not charge a fee for the materials exchanged or research performed for the reasons we've shared above. The following, meanwhile, as with all other correspondence we've provided to date, continues to represent our personal opinions in this matter. How you proceed in light of our opinion is entirely your decision. At this point, however, we believe that the only way to know anything for certain would be to either get a definite answer from the applicable regulators... or... try your theories

out in the real world. As mentioned, how to proceed is up to you. That being said, at this time we do not think we can add much more to the process. Please keep us in the loop and let us know how you proceed; we are curious to see how this shakes out."

HERE WE GO !!

Analysis Merits

The following are areas which in the analysis may have merit. Currently, the fully insured companies are sending email blast to their group clients, agents, brokers and consultants on avoiding the increase in cost due to PPACA (Obama Care). These blasts are specific to renewing on December 30, 2013 to avoid the increases.

With this in mind, the following structures could come into play for reducing the anticipated costs of PPACA. There are various areas of concern and clarification when viewing the various focuses of PPACA vs ERISA.

Letter of the Law
Intent of the Law
Spirit of the Law
Ambiguity of the Law

An area of concern with PPACA is the ambiguitas nature of the law which on its merits may have an implication on the Letter of the Law, Intent of the Law and Spirit of the Law as it pertains to the "rules" of engagement and enforcement of PPACA.

The establishment of the renewal date must be in place prior to 12/27/2012 in order to qualify for transitional relief.

Attorney Response Transition Rules

"The transition rules say that if you maintained a fiscal year plan as of December 27, 2012, and all your full-time employees are offered affordable coverage that provides minimum value no later than that first day of the plan year that starts in 2014, penalties will not be assessed for the months prior to the first day of the plan year that starts in 2014 for:

1. Any employee (whenever hired) that would be eligible for coverage, as of the first day of the first plan year that begins in 2014 under the eligibility terms of the plan as in effect on December 27, 2012; and

2. Any other employees if (a) your fiscal year plan was offered to at least one third of your employees (full-time and part-time) at the most recent open season; or (b) your fiscal year plan covered at least one quarter of your employees; and (c) they would not have been eligible for coverage under any other of your group health plans that has a calendar year plan year.

Therefore, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), you will not be subject to a penalty for those employees until the first day of your fiscal plan year that starts in 2014 if they are offered affordable coverage that provides minimum value no later than that first day of the plan year that starts in 2014.

For any other employees that were not eligible to participate under the terms of the plan in effect on December 27, 2012, if you offered coverage under your fiscal year plan starting on July 1, 2012 to at least one third of your employees, or if your plan covered at least one quarter of all your employees, you can avoid liability for a penalty for those non-eligible employees until July 1, 2014 if 1) you expand the plan to offer coverage that is affordable and meets the minimum required value to the full-time employees who had previously not been eligible for coverage; and 2) they would not have been eligible for coverage under any other of your group health plans that has a calendar year plan year. For purposes of determining whether your plan covers at least one quarter of your employees, you may determine the percentage of employees covered as of the end of the most recent enrollment period prior to December 27, 2012, or any date between October 31, 2012 and December 27, 2012."

Questions for Review

If the plan was established in 2009 with a plan year of January 1 to December 31, does this not establish the plan and its renewal date prior to 12/27/2012?

If an employer / plan sponsor decides to change their effective date for legitimate business reason would this not be allowed if the original effective date was prior to 12/27/2012?

Definition of Plan Year *- 1997 Quick Reference to ERISA Compliance - Panel Publishers - "The* ***plan year*** *is the calendar, policy, or fiscal year for which a plan's*

records are kept. (ERISA §3(39)). The plan year should be stated in the plan document and does not have to coincide with any insurance policies or other contracts relating to the plan."

Questions for Review

With the above definition using "policy", why would a plan not be able to utilize a true policy year which is defined within the plan document and as well corresponds to the plan deductible, out-of-pocket maximums on the same basis for coordination?

There is no definition that I can find which states the length of a plan year or policy year. There are short plan years, calendar plan years, fiscal plan years and policy plan years. Of which the duration of a short plan year or policy plan year has no definition. Thus, is a policy year one (1) month, twelve (12) months, fifteen (15) months, thirty (30) days, three hundred sixty five (365) days, three hundred seventy (370) days? Where is it defined for a plan year and or policy year?

The research did not find any prohibition of a employer / plan sponsor in changing their policy year or plan year anywhere in ERISA 1974.

Does PPACA and ERISA not conflict on the basis of a policy year / plan year with regard to a employer / plan sponsor from changing the plan year to a policy year for legitimate business reasons or does the "transition rules" utilizing the date of December 27, 2012 pre-empt ERISA?

Question for Consideration

Is there an existence of the ambiguitas nature of the law as it pertains to PPACA and ERISA?

Report on PPACA Impact and potential Mitigation of Costs

In the research on the PPACA (The Patient Protection and Affordable Care Act) the following probabilities arose from the review of the language in Public Law 111-148.

After extensive reading of PPACA, a query was initiated and completed on the following: "Effective Date" this query resulted in 100+ hits. This query became an important part of the findings. An additional query was completed on the date "January 1, 2014". This query had 39 matches. A comparative analysis of these terms to the act was pursued and the following was noticed from the key terms "on January 1, 2014" and "plan years beginning on or after January 1, 2014". From this end the precursor for these key terms is "Effective Date". The following were extracted from the PPACA Public Law 111-148 as an example of the comparative analytics.

```
Public Law 111-148
111th Congress
An Act
Entitled The Patient Protection and Affordable Care Act. <<NOTE: Mar.
23, 2010 - [H.R. 3590]>>

SEC. 1253. <<NOTE: 42 USC 300gg note.>> EFFECTIVE DATES.

    This subtitle (and the amendments made by this subtitle) shall become
effective for plan years beginning on or after January 1, 2014.

        Subtitle D--Available Coverage Choices for All Americans

            PART I--ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 2711. <<NOTE: 42 USC 300gg-11.>>  NO LIFETIME OR ANNUAL LIMITS.

    ``(a) Prohibition.--
            ``(1) In general.--A group health plan and a health
        insurance issuer offering group or individual health insurance
coverage may not establish--
                    ``(A) lifetime limits on the dollar value of
                benefits for any participant or beneficiary; or
                    ``(B) except as provided in paragraph (2), annual
                limits on the dollar value of benefits for any
                participant or beneficiary.
            ``(2) Annual limits prior to 2014.--With respect to plan
        years beginning prior to January 1, 2014, a group health plan
        and a health insurance issuer offering group or individual
        health insurance coverage may only establish a restricted annual
        limit on the dollar value of benefits for any participant or
        beneficiary with respect to the scope of benefits that are
        essential health benefits under section 1302(b) of the
        PatientProtection and Affordable Care Act, as determined by the
        Secretary. In defining the term `restricted annual limit' for
```

> purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

The following areas became prevalent in a forensic analysis of the language in PPACA. The following is a premise which is also deemed a high probability of a basis for legal implementation of the following:

Since many of the areas in PPACA refer to the Effective Date for plan years beginning on or after January 1, 2014, and there is no effective date / renewal date in 2014, then the letter of the law is utilized and not the intent due to the following example:

Example

A company has a fiscal plan year July 1, 2013 to June 30, 2014. The application of the provisions as written in PPACA do not take effect until the "Effective Date for plan years beginning on or after January 1, 2014", meaning in this example July 1, 2014. With this being noted, if a plan has no renewal or effective date in 2014 then no provisions of PPACA can be applied to the employer or plan whether self funded or fully insured. The following provisions of PPACA have the effective date for plan years beginning on or after January 1, 2014.

ASSUMPTION: The Plan is amended to establish the renewal/effective date of December 31, 2013 with January 1, 2015 as the next renewal date. Thus, 2014 has neither a renewal or effective date. (Note: PPACA does not define a year / plan year or policy year). As with any plan, a short year may exist, a fiscal year, a calendar year or a policy year. There is no definition establishing a plan year, a fiscal year, a calendar year or a policy year - essentially, this could be 365 days, 366 days, 367 days or more for the effective plan whether self funded or fully insured. Thus, the following is applied based on the assumption which encompasses both self funded plans and fully insured plans.

The Grandfathered health benefit plan is still able to exist with the limitations established. The application of the unlimited and various other requirements for the plan are Effective Date for plan years beginning on or after January 1, 2014. A change in the plan would take effect on January 1, 2015 as this is the first effective date on or after January 1, 2014.

Mandated Fees / Taxes

Health Insurance Industry Fee also known as the Health Insurance Tax (HIT). This is estimated to increase the fully insured premiums by 1.9% to 2.3% in 2014 and, by 2023 increase premiums 2.8% to 3.7% (study by Oliver Wyman; October 31, 2011). The cost of this is not tax deductible.

Reinsurance Assessment Fee. This is applied to both the fully insured and self funded plans. In 2014 the annual fee assessed is $5.25 per covered person per month or $63 per year. This fee is tax deductible.

Patient-Centered Outcomes Research Institute Fee (PCORI). This is applied to both the fully insured and self funded plans. This fee may or may not apply to the effective date for plan years beginning on or after January 1, 2014. But, if it does it would only apply to the plan year ending on or after October 1, 2013, through September 30, 2014. The fee is $2 per covered person. Thus, there would be a calculation of fees for 2014 as the application date is prior to 2014.

Federally Facilitated Exchange User Fee. This applies only to fully insured plans. The amount is 3.5% of premium proposed for 2014. The ASSUMPTION is there is no premium proposed for 2014 and only for 2013 and 2015.

Full Time Equivalent (FTEs). This is based on 50 or more employees from PPACA based calculation. Effective for months beginning after December 31, 2013. This has a potential for the penalty to range from $2000 to $3000 per year based on the calculation dependent on the circumstances for application.

Section 4980H

Section 4980H was added to the Code by § 1513 of the Patient Protection and Affordable Care Act (Affordable Care Act) (enacted March 23, 2010, Pub. L. No. 111-148) and amended by § 1003 of the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152).[1] Section 4980H applies to "applicable large employers" (generally, employers who employed at least 50 full-time

employees, including full-time equivalent employees, on business days during the preceding calendar year).

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[1] Section 4980H was further amended by section §1858(b)(4) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10), ***effective for months beginning after December 31, 2013.***

Scenario - Self Funded Plan

The plan sponsor desires to change their renewal date and plan year to a policy year to December 30, 2013 through December 31, 2014. (The original plan year start was January 1, 2009). The deductibles, coinsurance, out-of-pocket maximums would also be changed within the plan document to correspond to the new "policy year". The policy year would further be documented within the plan document for the future plan year(s) to be on a January 1 to December 31 thereafter.

Question for Consideration

Can the plan change the basis of the "plan year" (January 1, to December 31) to a "policy year" (December 30, 2013 to December 31, 2014 and January 1 to December 31 thereafter), renewal date for a legitimate business reason thus, receiving the transitional relief and mitigation of the mandated fees and taxes?

Or, if not, would this be considered ambiguitas whether, Letter of the Law, Intent of the Law or Spirit of the Law as PPACA and ERISA conflict?

If considered ambiguitas then, enforcement may not be possible by HHS, DOL or IRS on PPACA as it is not clear and the interpretation can not be fully established.

The following is a supposition of a self funded plan currently in existence. This plan has a normal renewal date of January 1 and plan year January 1 to December 31. The plan went into existence January 1, 2009. The plan is a "Grandfathered Plan". The plan parameters are below.

Report on PPACA Impact and potential Mitigation of Costs

	Current Plan	
Description	**In Network**	**Out of Network**
Annual Deductible	Single $2,000.00 Family $4,000.00	Single $4,000 Family $8,000
Annual Out-of-Pocket Maximum	Single $3,000.00 Family $6,000.00 Excludes prescription drug Co-Pays and all other Co-Pays	Single $6,000 Family $12,000 Excludes prescription drug Co-Pays and all other Co-Pays
Co-Insurance	Plan: 80% Member: 20%	Plan: 60% Member: 40%
Doctor's Office Visits	Co-Pay: $25 PCP; $25 Specialist	60% after deductible
Physician Care (Inpatient/ Outpatient/Other)	80% after deductible	60% after deductible
Diagnostic Tests In Doctor's Office (Same Site/ Same Day as Office Visit) **Other Laboratory**	Office Visit Co-Pay Deductible then 20%*	60% after deductible Deductible then 40%*
Inpatient Hospital (Semi-Private Room	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Outpatient Hospital/Surgery	80% after deductible	60% after deductible
ER Physician Care	80% after deductible	60% after deductible
Emergency Room	$150.00 copayment then paid at 80%	$150.00 copayment then paid at 80%
Ambulance	80% after deductible $2,500.00 per ground trip maximum $10,000.00 per air trip maximum	80% after deductible $2,500.00 per ground trip maximum $10,000.00 per air trip maximum
Urgent Care Center (Facility)	$50.00 copayment.	60% after deductible
Mental Health	80% after deductible	60% after deductible
Allergy Injections	$25.00 copayment	60% after deductible
Maternity Care (See SPD for Specifics)	80% after deductible Dependent daughters not covered.	60% after deductible Dependent daughters not covered.

Report on PPACA Impact and potential Mitigation of Costs

	Current Plan	
Description	**In Network**	**Out of Network**
Routine Well Child Care (0-18 Years Old)	$25.00 copayment	60% after deductible
Routine Well Adult Care (Over 18)	$25.00 copayment	60% after deductible
Autism Service (Benefits payable based on services rendered)	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible $4,000.00 (excluding Prosthetic Devices and Medical Supplies) Calendar Year maximum	60% after deductible $4,000.00 (excluding Prosthetic Devices and Medical Supplies) Calendar Year maximum
Therapy Services (Per Visit; Physical, Occupational, Speech)	80% after deductible Maximum of 20 visits per calendar year, per therapy service type. Occupational 60 Visits Calendar Year maximum	60% after deductible Maximum of 20 visits per calendar year, per therapy service type. Occupational 60 Visits Calendar Year maximum
Chiropractic Care	$25.00 copayment 12 Visits Calendar Year maximum	60% after deductible 12 Visits Calendar Year maximum
Prescription Drugs		
30-Day Supply Tier 1 - Generic Tier 2 - Formulary Tier 3 - Non-Formulary	$10 $35 $50	Non-Participating Pharmacy Coverage includes ingredient cost and dispensing fees only
90-Day Supply (Retail or Mail Order) Tier 1 - Generic Tier 2 - Formulary Tier 3 - Non Formulary	$30 $105 $150	Not Applicable
Special Notes	None	None

The plan above meets the criteria as set forth with the "minimum value standard" and meets the "Maximum out of pocket limitations". As a self funded grandfathered plan many of the PPACA requirements do not have to be met vs a fully insured plan.

Premiss questions - If the organization desires to change their effective date / plan year from January 1 through December 31 to a policy year December 31, 2013 through December 31, 2014 and January 1 to December 31 thereafter:

Would this allow the retention of the "Grandfathered Plan Status" through the new policy year without changes to the "Plan" due to the non existence of the "2014 Plan"?

The deductible calculation is changed from a "calendar year" to a "Policy year". The plan sponsor currently pays 100% of the eligible employee single costs.

With this in mind, would this not avoid the increases in plan cost as depicted by the "fully insured carriers" and allow for the "transitional relief"?

Since the renewal date was established prior to December 27, 2012 and the desire of the "Plan Sponsor" to change their "plan year" to a "policy year" as stated above, would this not qualify for the transitional relief?

If the above meets the criteria to avoid the mandated fees / taxes as listed below whether a self funded plan or fully insured plan apply for avoidance with the exception of the PCORI mandated fee / tax?

The Grandfathered plan is still able to exist with the limitations established. The application of the unlimited and various other requirements for the plan are Effective Date for plan years beginning on or after January 1, 2014. A change in the plan would take effect on January 1, 2015 as this is the first effective date on or after January 1, 2014.

The following fees as applied based on the presumptions for plan year change to a policy year, a question arises as to the applicability of the fees utilizing a new policy year established by the employer / plan sponsor of December 30, 2013 to December 31, 2014.

Health Insurance Industry Fee also known as the Health Insurance Tax (HIT). This is estimated to increase the *fully insured premiums* by 1.9% to 2.3% in 2014 and, by 2023 increase premiums 2.8% to 3.7% (study by Oliver Wyman; October 31, 2011. The cost of this is not tax deductible.

If the fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the HIT apply?

Reinsurance Assessment Fee. This is applied to *both the fully insured and self funded plans.* In 2014 the annual fee assessed is $5.25 per covered person per month or $63 per year. This fee is tax deductible.

If the self funded or fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the TRF apply?

Patient-Centered Outcomes Research Institute Fee (PCORI). This is applied to *both the fully insured and self-funded plans.* This fee may or may not apply to the effective date for plan years beginning on or after January 1, 2014. But, if it does it would only apply to the plan year ending on or after October 1, 2013, through September 30, 2014. The fee is $2 per covered person. Thus, there would not be a calculation of fees for 2014 as there is no date for 2014 in the ASSUMPTION. The deductibility of this fee is not currently known.

It is understood this fee would apply to both the self funded or fully insured plan based on the original effective date of this Letter of the Law.

Federally Facilitated Exchange User Fee. This applies only to *fully insured plans*. The amount is 3.5% of premium proposed for 2014. The ASSUMPTION is there is no premium proposed for 2014 and only for 2013 and 2015. The deductibility of this fee is not currently known.

If the fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the Federally Facilitated Exchange User Fee apply?

Since these fees /taxes /penalties are the Letter of the Law and the transitional relief date of 12/27/2012 for establishing a renewal date is the Letter of the Law, and the plan established the above scenario for changing their plan renewal date to a policy year, which the original renewal date was established prior to 12/27/2012, could this if not allowed for avoidance for these costs be considered ambiguitas?

If the fully insured carriers are currently stating to renew on December 30, 2013 to avoid the increased cost of PPACA, is this not meeting the premiss of and application of the Letter of the Law to avoid the above fees /taxes /penalties?

The following pertains to the "Play or Pay".

Full Time Equivalent (FTEs). This is based on 50+ employees. Effective for months beginning after December 31, 2013. This has a potential for the penalty to range from $2000 to $3000 per year based on the calculation and or a plan offered or not.

The calculation is straight forward for establishing the Full time equivalents for the employer.

Question for Consideration

If an employer has "Full Time Employees" who work 30 hours or more per week and are age 65 or older and have Medicare A and B, and are eligible for the employers health plan, *can these individuals be subtracted from the calculation of the employers FTE?*

The following chart shows there are a total of 65 employees with the FTE calculation showing 61.

Of the 52 full-time employees 12 are 65 or older with Medicare A and B. Can those medicare employees be subtracted?

If so, then the calculation in the below chart would show 49 FTE and fall below the 50 or more?

Additionally, there are 7 additional part-time employees who work less than 30 hours which are 65 or older and have medicare A and B - could these be subtracted from the FTE calculation?

Calculation chart including medicare participants.

Category	Data Analysis
Total Full Time Employees	52
Total Part Time Employees	13
Total Employees	65
Full Time Equivalent Employees	61
Full Time Equivalent Employees for "Play or Pay"	31
Pay or Play Penalty	$62,066.67
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

Calculation chart excluding medicare participants.

Category	Data Analysis
Total Full Time Employees	52
Full Time Medicare Age 65+ with Parts A&B	12.00
Total Part Time Employees	13
Part Time Medicare Age 65 + with Parts A&B	7.00
Total Employees Age 65 + With Parts A&B	19
Full Time Equivalent Employees Less Medicare	42.70
Full Time Equivalent Employees for "Play or Pay"	12.70
Pay or Play Penalty	N/A
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

This calculation subtracts out the Full Time, (+> 30 hours per week), employees who are (= > age 65) with Medicare Parts A & B as well as calculates the subtraction of the part time employees (< 30 hours per week) 65 (+) with Medicare Parts A & B and the full time equivalence calculation.

This calculation may serve to show, if (= > Age 65) with Medicare A & B are cut from the calculation and those who are full time are moved to a part time status of (< 30 hours per week) will affect the calculation of the "Play or Pay".

This may be significant if employers take this approach with their health benefit plans. This approach has many distinguishing effects to the fully insured health plan and self funded health plan. This creates a reduction in average age of the group and provides a basis for reduction of risk exposure. Additionally, the claims impact is reduced for both medical and prescription claims.

Questions Posed and Attorney response regarding Medicare for employees (= > Age 65)

"Below is some information from the AARP website that you may find helpful:

[http://www.aarp.org/health/medicare-insurance/info-03-2011/ask-ms-medicare-question-94.html

Q. I am 65 and plan to keep working for some years. I have health insurance from my employer. Do I have to sign up for Medicare Part B now?

A. Probably not. In most cases, for as long as you have group health insurance provided by an employer for whom you are *still* working, you can delay enrolling in Part B, which covers doctors visits and other outpatient services and requires a monthly premium. When you eventually retire, or leave work, you'll be entitled to a special enrollment period of eight months to sign up for Part B without incurring a late penalty.

This also applies to most people who are covered beyond age 65 by insurance from the employer of their working spouse.

But, there are some exceptions:

- **If the company or organization you work for has fewer than 20 employees,** your employer may require you to sign up for Part B when you turn 65. If so, Medicare would become your primary coverage (meaning it pays bills first) and your employer coverage would be secondary. In this case, you need to find out exactly how your employer plan will work with Medicare.
- **If you are in a same-sex marriage or relationship and receive health insurance from your partner's employer as his or her dependent,** you will not be entitled to a special enrollment period if you delay signing up for Part B—even if you are legally married under the laws of your state or country. So to avoid late penalties in the future when your partner stops work, you should sign up for Part B at age 65.

Will I get the same health benefits at work as I get now?

By law, people who continue to work beyond age 65 still must be offered the same health insurance benefits (for themselves and their dependents) as younger people working for the same employer. So your employer cannot require you to take Medicare when you turn 65 or offer you a different kind of insurance — for example, by paying the premiums for Medicare supplemental insurance or a Medicare Advantage plan — as an inducement to enroll in Medicare and drop your employer plan. However, this law (known as ERISA) applies only to employers with 20 or more workers. So if you work for a smaller business or organization, you may be required to enroll in Part B at age 65.

Do I need to do anything about Part B at age 65 if I continue to be insured at work?

It depends on whether you're already receiving Social Security retirement benefits. If you are, Social Security will automatically enroll you in Part A and Part B just before your 65th birthday. The letter sent to you with your Medicare card explains your right to opt out of Part B if you have employer insurance. To opt out, follow the instructions included in that letter within the specified deadline.

Should I still sign up for Medicare Part A?

With one exception (see next item), there's no reason not to enroll in Part A, which covers hospital stays, around the time you turn 65 because if you contributed enough Medicare payroll taxes while working there are no premiums for Part A.

You can sign up for Part A during your initial Medicare enrollment period, which runs for seven months, starting three months before the month of your 65th birthday and ending three months after that month. Just call Social Security, which handles Medicare enrollment, at 1-800-772-1213 and schedule an appointment for an interview, which can be done on the phone or at your local Social Security office. This interview gives you the opportunity to make sure that an official enters into your record the fact that you have declined Part B because you have health insurance through the current employment of you or your spouse. You may be required to provide documents showing you have this coverage.

What if I have a health savings account at work?

You need to be careful if your employer insurance takes the form of a high-deductible plan with a health savings account. Under IRS rules, you cannot continue to contribute to an HSA if you are enrolled in Medicare (even Part A) or, after age 65, are receiving Social Security retirement or disability benefits. You can draw on funds already in your account, but you cannot add to them. For details, see "Can I Have a Health Savings Account as Well as Medicare?"

You'll be able to sign up for Part A without risking a late penalty during the same special enrollment period when you enroll in Part B, after you finally stop working.

If you are married to somebody who has an HSA at work, and you are covered by that plan, it doesn't make any difference whether you are enrolled in Medicare or not — you can still use the HSA for your medical needs. The IRS rule applies only to the working employee who is contributing to the plan.

Will I need Part D prescription drug coverage?

Probably not. If your employer plan offers prescription drug coverage that is "creditable" — meaning that Medicare considers it at least of equal value to Part D coverage — you don't need to enroll in a Part D drug plan at age 65. Instead, when your employer coverage ceases, you'll be entitled to a two-month special enrollment period to sign up with a Part D plan without penalty. Your employer plan can tell you whether it's creditable or not. If it's not, you would need to enroll in Part D during your initial enrollment period at age 65 to avoid late penalties if and when you eventually signed up.

What if my employer offers me COBRA or retiree health benefits?

It's confusing, but different rules apply to Part B and Part D in either of these situations:

Part B: You can delay Part B enrollment without penalty *only* while you or your spouse is still actively working for the employer that provides your health insurance. But if you receive COBRA benefits — a temporary extension of your employer coverage that usually lasts 18 months — or retiree benefits, by definition you are no long working for this employer. So if you wait until these benefits have expired before enrolling in Part B, you won't qualify for a special enrollment period. Instead, you'd likely pay late penalties, and you would be able to enroll only during the general enrollment period that runs from Jan. 1 to March 31 each year, with coverage not beginning until the following July 1.

Part D: As long as your COBRA or retiree drug coverage is creditable, you do not need to enroll in Part D until these benefits end, as explained above.

Patricia Barry is a senior editor with the AARP Bulletin.]"

Question for Consideration

With the above example which can change the costs of the health plan by reducing the hours of those (= > Age 65) to (< 30 hours per week) for purposes of avoidance of having (= > 50 employees) for purpose of the calculation of the FTE and potential corresponding liability of the "Play or Pay" be exercised by employers due to PPACA?

In light of the question above, would this pose possible discrimination litigation to employers who exercise this structure based on a class of employees?

If this does pose discrimination litigation, then would this pose litigation on other employees reduced in hours who are (< Age 65) in transitioning from (= > 30 hours per week) to (< 30 hours per week)? --Or--

Will this likely be the structure employers may use if there is no discrimination or possible litigation for changing one or both classes of employees meaning those (= > Age 65) or (< Age 65)?

Has PPACA produced an ambiguitas nature of the Law as it pertains to classes of employees or age?

A. Section 4980H

Section 4980H was added to the Code by § 1513 of the Patient Protection and Affordable Care Act (Affordable Care Act) (enacted March 23, 2010, Pub. L. No. 111-148) and amended by § 1003 of the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152).[2] Section 4980H applies to "applicable large employers" (generally, employers who employed at least 50 full-time employees, including full-time equivalent employees, on business days during the preceding calendar year).

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[2] Section 4980H was further amended by section 1858(b)(4) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10), ***effective for months beginning after December 31, 2013.***

The 9.5% of cost calculation of single coverage as an affordable basis for the employee who is eligible for coverage is also a factor. As this is also effective January 1, 2014.

Two Methods of contribution formulas

Traditional formula - employer/sponsor establishes a contribution formula based on premium for employer coverage only. The employee is responsible for any costs associated with dependent coverage. Assume a $300.00 per month premium for employee only coverage with the employee contribution of $150.00 per month. In this method, the employee is paying 50% of the cost for employee only coverage. Assuming the employee hourly wage is $7.25 per hour based on a 30 hour work week - the employee monthly income using the factor of 4.33 to encompass a 52 week work year. The employees monthly income is $941.78. The contribution required is $150.00 per month. The percentage required for participation is 16%. This fails the 4980H of the maximum of 9.5%.

New Formula - employer/sponsor establishes a formula for calculation of the contribution requirements for participation in the employee only coverage. This calculation is designed to not only meet the "9.5%" but also to avoid any eligible employee from receiving a "credit or subsidy" from the exchange and avoiding an employer penalty. The understanding is if the employee has to contribute more than 9.5% of their employer provided income (W2) to participate in the "Minimum Value" (Bronze) health plan or lowest cost health plan, that participant would be able to go to the exchange and if qualified to receive a subsidy then the employer

would have to pay $3,000 per year or $250 per month for each of the full time employees receiving a subsidy from the exchange.

Secondly, if the employee falls between 8% and 9.5% and fits the federal poverty level definition, then the employer may also have to pay $3,000 or $250 per month for each full time employee meeting this criteria and receives a subsidy.

Thus, the employer can place a contribution formula which in its merit can avoid any of the exchange subsidy or other penalties that could be assessed.

Since the formula from PPACA is based on letter of the law with the parameters based on the employer provided income, the following exists.

The minimum wage is $7.25 per hour. The full time basis is 30 hours per week. The employer establishes a formula which provides the following. Secondly, the calculation is based on an employee making $30.00 per hour working 30 hours per week. (Assumes 4.33 weeks per month as factor - based on 52 weeks per year).

The cost of the employee only coverage employee contribution for the qualified health plan offered is 8% of gross pay (W2) to a maximum of $150 per month.

Hourly Wage	Formula	Cost per Pay	Calculated Monthly	Cost per Month max $150
$7.25	8% to a maximum $150 per month	$17.40	$75.34	$75.34
$30.00	8% to a maximum $150 per month	$72.00	$311.76	$150.00

Based on this formula and the existence of the "Minimum Value Standard" plan being the lowest cost and qualified health plan meets the criteria so no full time employee can receive a subsidy from the "Exchange" thus, the avoidance of any penalty being assessed ie $3,000.00 or $250.00 per month.

Additionally, the employer offers the plan to 100% of the eligible employees meeting the criteria set forth by PPACA thus the elimination of not meeting the "Non Discrimination Rules" of 95%.

The 8% keeps the employee exempt from the individual mandate should they decide to waive coverage from the employer/sponsor plan. The employee could still apply for exchange coverage using the premium assistance tax credit, enroll in the employers health plan despite the cost, or remain uninsured without paying a penalty.

SAMPLE REPORT ON PPACA IMPACT

to a

Small Employer

(Information utilized in this analysis is based on an actual small employer data set which utilizes a self funded health benefit plan. The impact viewed is substantial for budgeting the additional cost to cover those employees who work 30 to 39 hours per week. The current plan provides for only those working 40 hours or more to qualify for the health plan. The employer currently pays 100% of the employee cost to the health plan and offers the plan to 100% of those eligible for the health plan).

Note: the algorithms utilized will show the employer currently FAILS based on the rules of the eligibility 30 hours vs 40 hours, thus opening them up to penalties in the "Play or Pay" on the full time employees.

Example of Findings PPACA Calculation

The following is based on the information provided and the calculations per PPACA Law for Health Plans effective on or after January 1, 2014.

Category	Data Analysis
Total Full Time Employees	52
Total Part Time Employees	13
Total Employees	65
Full Time Equivalent Employees	61
Full Time Equivalent Employees for "Play or Pay"	31
Pay or Play Penalty	$62,066.67
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

If any of the above calculations state "FAIL" the penalties will apply specific to those categories.

For a complete analysis and consultation on how to mitigate these areas which show "FAIL", contact F. Randall Childers, Jr., CFC for the proper structure of the plan parameters. A full report on XYZ Corporation is available with an engagement of F. Randall Childers, Jr., CFC.

Preliminary Information

The Patient Protection and Affordable Care Act was passed by Congress and then signed into law by President Barack Obama on March 23, 2010. The Affordable Care Act was challenged in the Supreme Court of the United States and on June 28, 2012 a decision was rendered to uphold the health care law. The Affordable Care Act is also referred to as "Obama Care". Through this documentation it will be referred to as "PPACA".

PPACA has two distinct avenues, the Employer provisions and plan provisions. Each of these have "penalties", "fees" and/or "taxes" associated with PPACA. The provisions do not reward employers for compliance with PPACA and requires payments via fees, taxes and penalties to be paid because you are an employer and have employees.

This report is designed to educate XYZ Corporation with regard to its standing as an employer with employees and to show the cost, financial impact, associated with PPACA.

This report is broken down into distinct components to understand the differences in each of the avenues - Employer and Plan as well as information on options to mitigate most of the cost associated with PPACA.

This report will only refer to plan designs as minimum or medal plans as distinguished by the Exchange programs. The Medal plans will be referred to as: Bronze (minimum), Silver, Gold and Platinum (Maximum). These will be referred to as illustrative only.

The Plan XYZ Corporation currently has may be a "Grandfathered" or "Non-Grandfathered" plan. This report does not distinguish which plan designs XYZ Corporation is providing to its employees if any.

The first area to discuss is the Employer fees and the determination if XYZ Corporation is considered a "Large Employer".

The following information was provided and analyzed utilizing the formulas extracted from PPACA encompassing, full time employees, part time employees, hours utilized in compiling the information from the import of information provided by John Doe, HR Director from XYZ Corporation, 850 Any Street, Any City, KY 42001.

Statistical Information

Category	Full Time = > 30 Hours	Part Time < 30 Hours	Totals
Employees	52	13	65
Full Time Equivalent	52	9.033	**61.033**

Employer Calculation and Cost Results.

There are **two categories** and **two options under each category** as to how the Full Time Equivalent penalty will apply, commonly known as "Play or Pay". These are based on the employer being considered a "Large Employer". The "Large Employer" under PPACA is defined as having 50 or more Full Time Employees.

This calculation encompasses employees who work 30 or more hours per week with the addition of the "Part Time - Full Time Equivalent (FTE)" calculation. Part -Time employees are defined as those working less than 30 hours per week. The Part Time - FTE calculation consists of: the number of Part-time workers multiplied by the aggregate number of hours worked per week divided by 120.

This calculation can be done from an annual basis by taking the total number of hours worked in a calendar year divided by 12 multiplied by the number for Part-time workers divided by 120. This calculation provides the number of Part-Time FTE. This is added to the Full time employees giving the true full time equivalent for determination of a "Large Employer)

The calculation shown for XYZ Corporation is based on the following from the information provided. (*Full Time 52 + Part time (Full Time Equivalent)) 9.033 - 30 = 31 x $2000 (Potential penalty) =* ***$62,066.67.***

Calculation Table "Play or Pay"

Category	Calculation FTE
Full Time Employees = > 30 Hours	52
Part Time (FTEs)	9.033
Credit (30)	-30
Full Time Equivalent	31
Penalty "Play or Pay"	$2,000.00
Total Potential Penalty Employer	**$62,066.67**

The following section will describe how and when the penalty can be applied. The descriptions are broken into two categories:

3. Employer Does Not Offer Health Coverage
4. Employer Offers Health Coverage

The application is important when making a decision on the "Play or Pay" rules established by the PPACA Law. It is important to look at the big picture when making the decision on Offering Health Coverage or Not to Offer Health Coverage.

How the FTE penalty is applied

(This penalty is only applied to full time employees not to part time employees).

Employer does not offer health coverage

1. No full time employees receive credits from the exchange. **No Penalty is Assessed.**
2. One or more full time employees receive credits for exchange coverage. The annual penalty for XYZ Corporation is based on the FTE penalty calculated which is FTE 31 x $2000 = **$62,066.67**. This penalty would not vary if *only one employee received the credit* from the exchange. The penalty is assessed monthly which would apply to XYZ Corporation for $5,172.22.

Employer offers health coverage

1. No full time employees receive credits for exchange coverage. **No Penalty is Assessed.**
2. One or more full-time employees receive credits for exchange coverage. The *actual number of full-time employees receiving credits* are used in the penalty calculation for XYZ Corporation. The Penalty applies and can be substantial. The following is based on XYZ Corporation assuming 31 FTE.

   (a) 31 x $2,000 = **$62,066.67**

   (b) # FTEs receiving credit from the Exchange X $3,000.

To understand the impact to XYZ Corporation with 31 FTEs and have 10 FTEs who receive premium credits from the exchange, the fine is calculated as:

- *10 FTEs x $3,000 or $30,000. IF XYZ Corporation FTE Amount of **$62,066.67** is greater than the # of FTE's receiving the credit then the penalty is the lesser of the two.*

- *30 FTEs x $3,000 or $90,000. IF XYZ Corporation FTE Amount of **$62,066.67** is greater than the # of FTE's receiving the credit then the penalty is the lesser of the two.*

*The Following information will describe the various fees associated to the Fully Insured Health Plan and or the Self Funded Health Plan on calculating the additional cost to the health plan. These are know as **plan fees**.*

Health Plan Fees from PPACA

The following are fees which are added to the current health plan offered by XYZ Corporation. These fees will not apply if XYZ Corporation does not offer health benefits to the full time employees. However, if no plan is offered, it only takes one full time employee to purchase from the exchange and receive a credit which will cost XYZ Corporation **$62,066.67** annually or **$5,172.22** monthly. This is known as "Play or Pay".

The following fees are described and their application to either a fully insured plan or self funded plan.

1. **Transitional Reinsurance Fee** - this fee is assessed on a per member basis, Employees + all dependents. This fees is **$63.00** per member per year or **$5.25** per member per month. (This fee applies to both fully insured and self funded plans).
2. **Patient Centered Outcomes Fee** - This fee is assessed on a per member basis, Employees + all dependents. This fees is **$2.00** per member per year. (This fee applies to both fully insured and self funded plans).
3. **Health Insurance Industry Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fee is **1.9%** of the premium monthly. (This fee applies to fully insured plans).
4. **Federal Facilitated Exchange User Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fees is **3.5%** of the premium monthly. (This fee applies to fully insured plans).

The following chart shows the impact of these Plan Fees and the Employer potential penalties "Play or Pay" for XYZ Corporation.

Report on PPACA Impact and potential Mitigation of Costs

The following chart shows the impact for **XYZ Corporation** of PPACA using a Self Funded Medical Plan Approach.

Self Funded Plan - The current plan maximum cost is **$268,678.80.** The total members eligible for the health plan is **61**. The plan fees assessed, based on current participation, by PPACA is **$3,510.00**. The Pay or Play Full Time Equivalent employees are **31** which has a potential additional cost of **$62,066.67** annually. This is considered a maximum basis for cost if the number of employees receiving coverage from the exchange and receiving a credit. Fee will not apply if the employee gets coverage from the exchange and receives no credit. The cost of the self funded plan will increase by a minimum of **$3,510.00** based on current participation.

NOTE: The potential exists to mitigate the plan costs from PPACA. The plan cost will range from the Fully Insured Plan of $18,018.66 to the Self Funded Plan of $3,510.00.

The following table uses the annualized health plan cost as provided by XYZ Corporation which may or may not include the additional full time employees (= > 30 hours). Based on the information provided XYZ Corporation is a Self Funded Health Plan thus, the applicable fees and "Play or Pay" is the potential of additional cost in fees and or "Play or Pay" cost.

Report on PPACA Impact and potential Mitigation of Costs

The following chart shows the potential impact of PPACA. The actual participation in the health plan will be the actual impact based on the fees. The "Play or Pay" and fees potential cost will not change unless an increase or decrease in full time employees and or full time equivalent employees occurs.

Categories	Self Funded Health Plan
Covered FT Employees	52
Dependents	2
Total Lives Covered	54
Annual Health Plan Cost	$268,678.80
Transitional Reinsurance Fee	$3,402.00
Patient Centered Outcomes Fee	$108.00
Health Insurance Industry Fee	N/A
Federal Facilitated Exchange User Fee	N/A
Total Fees	$3,510.00
Full Time Equivalent	31
Pay or Play Cost	$62,066.67
Total Additional Potential Fee Cost and Pay or Play - PPACA	$65,576.67
Current Annual Premium	N/A
Total Cost Potential 2014	$334,255.47
% Increase from Fees	1.31%
% Increase Potential Non-Compliance	24.41%

Report on PPACA Impact and potential Mitigation of Costs

The following chart will show the potential impact of costs with the addition of the new eligibility rules established by PPACA Law. This calculation is taking the current participating employees and comparing to the potential new participants (Employees working 30 or more hours per week). This will show a gross impact assuming all full time employees are participating. *This calculation does not include the additional fees from PPACA and only includes the current Employee Premium on the lowest plan offered.*

Categories	Current Participation	New Participation PPACA	Totals
Employee	28	19	47.00
EE Only Premium	$350.00	$350.00	$350.00
Total Gross	$9,800.00	$6,650.00	$16,450.00
Less Employee Contribution	$0.00	$0.00	$0.00
Employer Cost Monthly	$9,800.00	$6,650.00	**$16,450.00**
Employer Cost Annually	$117,600.00	$79,800.00	**$197,400.00**

Compare to "Play or Pay" $62,066.67 for new participants.

Fully Insured vs Self Funded

The following is an illustration on the impact to the cost of PPACA based on the fees as it pertains to a comparison in cost of a fully insured plan vs a self funded plan. The fees have been calculated and totaled as it relates to the Fully Insured and Self Funded Plan categories. (Factors assumed for Employee + Children (2) and Employee+Spouse (2) and Family (3). Based on the make up of dependents for Employee+Children and Employee + Family, the calculations below should be increased to reflect the actual number of dependents in the calculation.

Category	Employee	Employee + Children	Employee + Spouse	Family
Monthly Premium	$350.00	$489.00	$512.00	$880.00
Transitional Reinsurance Fee	$5.25	10.50	10.50	15.75
Patient Centered Outcomes Fee	$0.17	$0.34	$0.34	$0.50
Health Insurance Industry Fee	$6.65	$9.29	$9.73	$16.72
Federal Facilitated Exchange User Fee	$12.25	$17.12	$17.92	$30.80
Fully Insured Plan	$374.32	$526.25	$550.49	$943.77
Self Funded Plan	$355.42	$499.84	$522.84	$896.25
Difference $	$18.90	$26.41	$27.65	$47.52
Difference %	5.32%	5.28%	5.29%	5.30%

The self funded plan offers many advantages vs the fully insured plan, not only from a cost basis but also a retention basis.

When reviewing the self funded plan vendor architecture, most plan sponsors have the ability to improve the out comes based on the vendor architecture and utilization of a fully transparent contracting with application of the "New Matrix" as described in the book "Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level". It is highly recommended for plan sponsors to utilize this book as a reference in structuring the self funded health plan and vendor architecture. This reference book will provide better results for the self funded plan.

Employer Requirements Reporting

Information on Minimum Essential Coverage

Every person (including employers, insurers, and government programs) that provides minimum essential coverage to any individual must provide a return to the IRS, (*Section §1502 of P.L. 111-148, which creates Section 6055 of the IRS Code of 1986).* This information must also be provided to each primary insured person along with contact information.

- Name, address and tax identification number of the primary insured and others covered under policy;
- The period for which each individual was provided coverage;
- Whether or not the coverage is a qualified health plan offered through and exchange and, if so, the amount of any advance payment of any cost-sharing reduction or premium tax credit;
- For coverage provided through a group plan of an employer, the portion of the premium, if any, paid by the employer; and
- Other information required by the Secretary of the Treasury.

Minimum Essential Coverage Table Sample

Name	Address	Tax ID	P = Primary Insured or D= Dependent	Coverage Period	Exchange Qualified Health Plan Offered Through Exchange	Premium Portion Paid by Employer Group Health Plan
Mickey Mouse	1234 International Drive, Orlando, FL 12345	123-45-6789	P	January 1 to December 31	N	$350.00
Minnie Mouse	1234 International Drive, Orlando, FL 12345	987-65-4321	D	January 1 to December 31	N	$0.00
Donald Duck	1235 International Drive, Orlando, FL 12345	234-56-7890	P	January 1 to December 31	N	$350.00

This table is a sample. The table for XYZ Corporation may be different by the addition of the columns for advance payment of cost sharing reduction and or premium tax credit.

Health Insurance Information Provided by Employers to Employees

Requires employers to provide employees at the time of hiring written notice of;

- The existence of an exchange, including services and contact information;
- Eligibility information for premium credits and cost-sharing subsidies, if the employers' plans' share of total allowed cost of benefits provided is less than 60%;
- Notice that the employee may lose any employer contribution if the employee purchases a plan through the exchange.

Sample Notification Written Notice

This is notification as required by the Patient Protection Affordable Care Act (PPACA) from XYZ Corporation to inform you as a new hire on Health Insurance availability.

The XYZ state has an exchange available which will provide you information on choices of coverage available and any potential credits available. The XYZ State provides Navigators to help you with your questions. You may contact them at 1234 State Drive, Any City, Any State, Zip or toll free (888) 123-4567. You may also visit their web portal www.stateexchange.XX.gov.

XYZ Corporation meets the minimum requirements set forth under the Patient Protection Affordable Care Act (PPACA). The XYZ Corporation plans' share of total allowed cost of benefits PASS this requirement. The contribution formula established by XYZ Corporation PASS the requirements of the Patient Protection Affordable Care Act (PPACA).

As an employee of XYZ Corporation you may lose any employer contribution if you purchase a plan through the exchange.

Should you have any questions please feel free to contact: John Doe, HR Director, XYZ Corporation, 850 Any Street, Any City, KY 42001 or by phone at (270) XXX-XXXX.

Information Provided by Certain Employers to Full Time Workers

Large employers (defined as those with more than 50 full-time equivalent employees must provide a return to the IRS per *(Section §1514 of P.L. 111-148, which creates Section §6056 of the Internal Revenue Code of 1986)*. The employer must also provide its full-time employees the specific information included in the return for that individual, along with contact information. *(See IRS Notice 2012-33)*.

- Name, date, and employer identification number of the employer;
- A certification as to whether the employer offers its full-time employees (and dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan;
- The length of any waiting period, months of coverage was available, and monthly premiums for the lowest cost option;
- The employer's share of total allowed cost of benefits (i.e., the percentage of covered benefits paid for by the plan);
- The number of full-time employees, and the name, address and tax identification number of each full time employee; and
- Additionally, an offering employer must provide information about the plan for which the employer pays the largest portion of the costs (and the amount for each enrollment category).

Table Transmission to IRS on Full Time Workers Sample

Date	Monday, March 25, 2013	
Employer Name	XYZ Corporation	
Employer Identification Number	12-3456789	
Certification of minimal essential coverage	Minimum essential coverage Employer Sponsored Plan - PASS	
Waiting Period	Maximum 90 days - PASS	
Months coverage available	January 1 to December 31	
Monthly Premium Lowest Option	$350.00	
Total Allowed Cost of Benefits	Minimum 60% Allowed cost of benefits - PASS	
Number of Full Time Employees	52	
Enrollment categories	**Plan Cost**	**Employer Share**
Employee Only	$350.00	$350.00
Employee + Children	$489.00	$350.00
Employee + Spouse	$512.00	$350.00
Employee + Family	$880.00	$350.00
Employee Name	**Employee Address**	**Tax Identification Number**
Mickey Mouse	1234 International Drive, Orlando, FL 12345	123-45-6789
Donald Duck	1235 International Drive, Orlando, FL 12345	234-56-7890

This table is an illustration of the requirements in providing the return to the Internal Revenue Service per *(Section §1514 of P.L. 111-148, which creates Section §6056 of the Internal Revenue Code of 1986).*

This table may also be used in providing the specific information to the individual full time employee. *(See Internal Revenue Service, Notice 2012-33).*

The format on the transmission has yet to be determined. However, it should be be provided in a secure basis to avoid interception and potential identity theft.

It is recommended that XYZ Corporation have an institutional coverage of a potential breach of transmitted information. Contact Randall Childers Consulting to discuss the application of the Institutional Coverage option available.

Mitigation to "Play or Pay"

PPACA has set out a specific set of rules with regard to the percentage of pay for the Health Benefit Plan. If the percentages are exceeded on the "Self Only Premium" compared to the gross income of the participant then the "Play or Pay" rules becomes effective.

If the plan contribution requirements for self-only coverage exceeds 9.5% of the employees income and the plan offered by XYZ Corporation pays for less than 60% of the covered expenses on at least one full time employee and the employee obtains a premium credit from the exchange then the "Play or Pay" is invoked.

To avoid this circumstance, a contribution formula should be created based on the minimum plan such as a "Bronze Plan" should be invoked. The proper formula can be established over the full time employees for self only coverage.

Constructing and implementing the language within the plan documentation and coordination with the architectural vendors for the health plan is vital in implementing the non-existence of the 2014 plan year in avoidance of the above mentioned calculations on the self funded and fully insured health plans. There is a great significance in this analysis as employers who can self fund their health plan and assume the risk associated will substantially help them selves and will continue a basis of affordable coverage for the members of the health benefit plan for changing to a policy year of December 31, 2013 through December 31, 2014 renewing on January 1, 2015 through December 31, 2015 thereafter.

The impact of the proposed structure is monumental to the United States of America and provides a level of stability if only for a one year period to the economic base of the Employer and economy.

Through the Forensic comparative analytics of PPACA, a structure exists to mitigate the plan fee costs for 2014 and the impact of the "Play or Pay" contained in the PPACA Law. F. Randall Childers, Jr. CFC, Certified Forensic Consultant specializing in Health Benefit Plans, analyzed The Affordable Care Act (PPACA) and presented the forensic

findings for the legal application. Between the forensics and the legal basis of application, a potential mitigation exists for 2014. For more information on the application structures contact Randall Childers Consulting, F. Randall Childers, Jr., CFC, randall_childers@me.com

I reserve the right to change, modify or correct any and all comments or conclusions expressed in my written observations should I be given additional information that would warrant such actions.

F. Randall Childers, Jr., CFC

Suggested Reference: Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level. by: F. Randall Childers, Jr. This may be ordered by going to the website: www.forensicsofamedicalplan.com. Amazon.com, Barnes & Noble.com, iBooks and many others or through your local book store.

Self Funding vs Fully Insured

In this review a basis for self funding is established in controlling health benefit plan cost for the employer and the participants of the health benefit plan.

Protectionism for State and/or Federal Health Exchanges

The Patient Protection and Affordable Care Act (PPACA) passed by Congress and then signed into law by President Barack Obama on March 23, 2010. The Affordable Care Act was challenged in the Supreme Court of the United States and on June 28, 2012 a decision was rendered to uphold the health care law. The Affordable Care Act is also referred to as "Obama Care". Through this documentation it will be referred to as "PPACA".

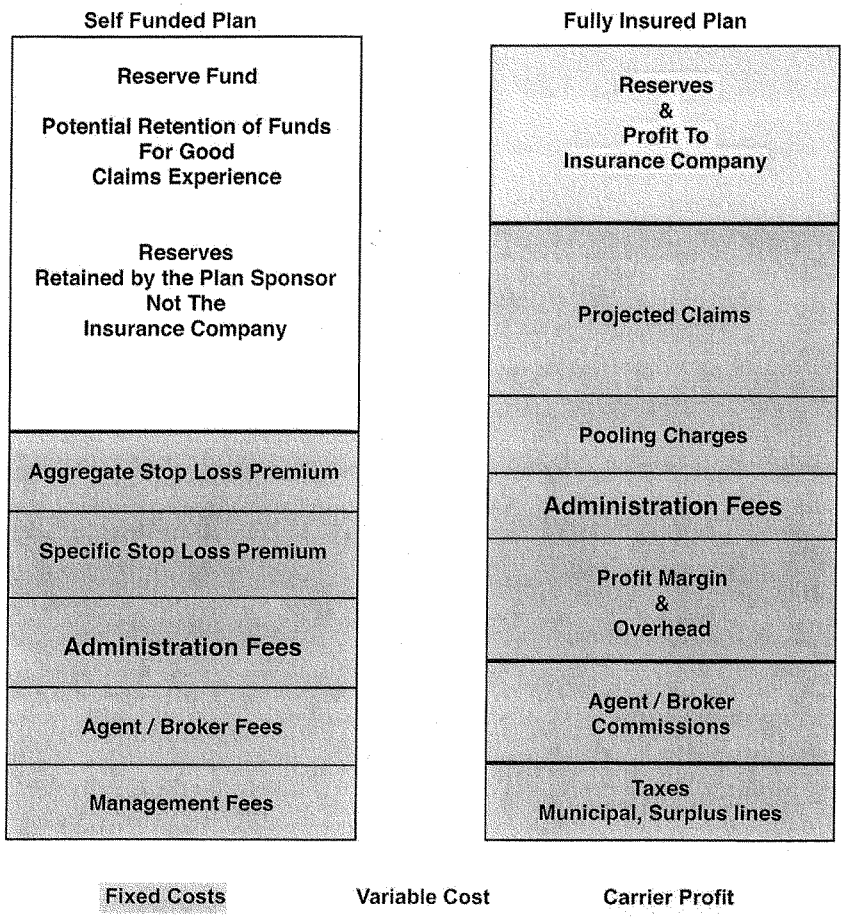
The NAIC with several of the various states insurance commissioners have taken to protectionism of "PPACA" or commonly know as "Obama Care" to protect the Health Exchanges by trying to implement restrictions on Stop Loss Coverage for employers sponsoring self funded health plans. This is primarily to force small employers and their employees to the health exchanges. While this is an ongoing base, it is important to understand why employers who can establish self funded plans want to do so. The following is an overview of the differences.

Prior to The Patient Protection and Affordable Care Act there was minimal activity to restrict Stop Loss coverage for employers sponsoring self funded health plans.

In the following example Self Funded vs Fully Insured, the components of the structure are the same with the difference being who owns the plan. In the self funded plan the employer / plan sponsor owns the plan. In the fully insured plan the insurance company owns the plan and the employer with their participants are simply members of the plan. The other substantial difference is who retains the surplus of the plan. In the self funded plan, the plan retains the surplus for good experience. In the fully insured plan, the insurance company keeps the surplus as profits.

There are other significant differences in the architectural structures which drives the cost of the health plan whether self funded or fully insured.

Self Funded Vs. Fully Insured Plan

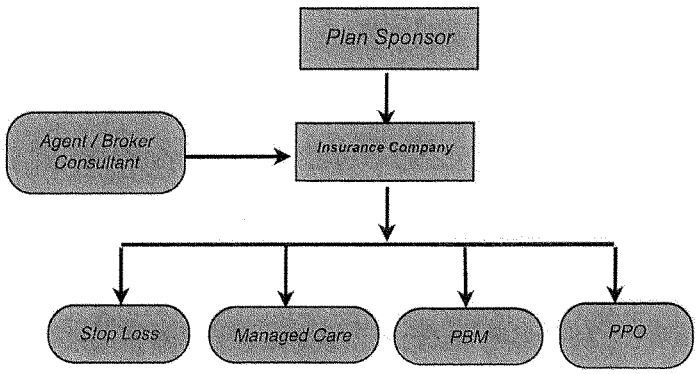


This chart shows the break down of the structure of a Self Funded Plan and a Fully Insured Plan. The Self Funded Plan provides an upside for retention of dollars as well as reduces the Fixed Cost or Hard Dollars. In the fully Insured Plan there is no upside as you have 12 cancelled checks to show for the plan which is all fixed cost or hard dollars.

Structure of Matrixes

There are substantial differences in the matrix of a fully insured health plan and that of a properly structured self funded plan. We will refer to these as the Traditional Matrix (Fully Insured Health Plan" and New Matrix (Self Funded health Plan).

Traditional Matrix

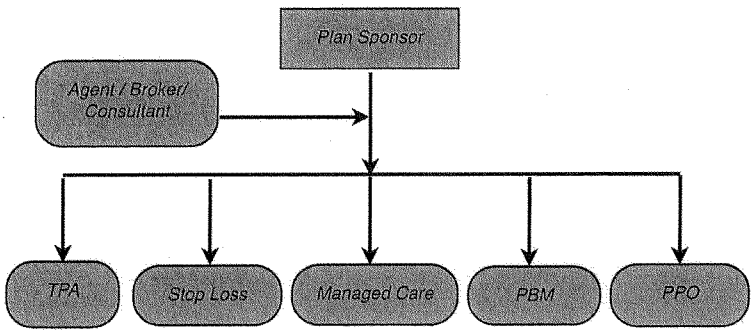


With the Traditional Matrix is contracting with the Insurance Company for the health plan. The Insurance Company is directly contracting with the various vendors to the plan. The Agent / Broker / Consultant is receiving compensation with the contracting with the Insurance Company with either fees and/or commissions.

The compensation for the Insurance Company as well as the Agent / Broker / Consultant may not be fully disclosed in this model due to arrangements with the various vendors. The Insurance Company may have non transparent agreements which provides additional compensation whether disclosed or non-disclosed with the vendors. As the Plan Sponsor with the traditional matrix the Insurance Company is controlling the Plan and the Vendors to the Plan.

Notice the vendor Stop Loss. Fully Insured carriers utilize this type of protection for themselves with either an internal basis or external basis to protect against the losses. In the same way, a Plan Sponsor will use to protect them from the potential losses of their Self Funded Plan.

New Matrix for a Self Funded Plan



This is the New Matrix for a Self Funded Medical Plan. The difference is how each of these components are handled in the architecture and contracting to the Plan Sponsor.

Note: In the past the TPA/ASO would have presented each of these components as part of their "Quote" to the Plan Sponsor. The Plan Sponsor would only see the numbers in the quote and not what is going on behind the scene. What is not shown in the quote is the additional income via fees, markups, commissions, rebates etc. that are being received by the various vendors to the TPA/ASO, Agent, Brokers and Consultants. The following structures will describe each of the functions in the New Matrix above.

This matrix is the new structure for employer sponsored self funded health plans. The Plan Sponsor contracts with each entity directly giving total control on the benefit plan. The Agent / Broker / Consultant is the conduit in the architecture of the structure bringing the various partners/vendors to the Plan Sponsor. This structure allows for total transparency in cost and compensation with each vendor partner.

The vendors in this model must perform, especially the TPA / ASO as they are now a provider to the plan and not controlling the partners / vendors as with insurance companies on fully insured plans for their financial gain. The TPA/ASO only receives their disclosed Fees. All stop loss and vendor agreements are net of commissions allowing a pure rate on the stop loss without mark up or commissions. The PBM, Prescription Benefit Manager, is contracted to pay 100% of the rebates to the Plan.

This structure allows for accountability and transparency in all aspects of the plan. If a vendor is not performing then a new vendor can be put in without jeopardizing the architecture or integrity of the plan. All vendors utilized are chosen in their ability to help control cost and provide outstanding service to the Plan Sponsor and the participants in the self funded health plan.

The following will discuss each of the architectural vendor components of a fully insured plan and a self funded plan with respect to controlling costs. The discussion will consist of Plan, Prescription Benefit Managers (PBM), Stop Loss, Managed Care (UR/PreCert/ DM/CM and networks whether PPO, ACO, HMO etc. This discussion will also describe the off book ledger profits from these architectural vendors and how this profit is applied to fully insured carriers which do not apply to the Minimum Loss Ratios (MLR) to the insurance carrier for the 80% and 85% cost for claims vs premiums. This is substantial and an area which has not been addressed in PPACA.

Comparative Fully Insured vs Self Funded

Plan Comparative

Fully insured health plans have full containment of all parameters of the Plan Document, Protection of insurance company assets contained due to the simple nature they control all vendor architecture to the fully insured health plan. The insurance company assumes 100% risk of the plan.

Self funded health plans require the employer also known as the plan sponsor / administrator / fiduciary to develop the plan for the benefit of their employees / participants. This plan is normally developed under ERISA 1974. The employer takes 100% of the risk of the plan. Once the plan is designed, an optional stand alone risk management basis exists for the plan and that is Stop Loss coverage with it having internal options for the plan -- *Specific Coverage* which protects against losses to the plan based on thresholds or risk protection on each member of the plan. *Aggregate Coverage* for the plan in protection of risk for the plan as a whole.

Stop Loss Comparative

Fully insured health plans will utilize a type of stop loss coverage to protect them against losses. This is normally done and has many different terms utilized within the fully insured environment such as "Pooling Levels". This is an agreement done by the insurance company. Normally, there is a % received back to the insurance company contracting for this coverage as well as a % for good experience (favorable loss ratios) which becomes an internal profit center and not calculated against the Minimum Loss Ratio (MLR). The funds from this are received by the insurance company normally in a "off book ledger" compensation/profit. The external basis for calculation of the MLR is the gross premium of the health plan vs claims and management of claims. The internal basis is not credited to the insured plans in the offset of costs.

Self Funded health plans may or may not utilize stop loss based on size and is an option for risk management. Self funded health plans do not utilize a % back as compensation. In the New Matrix contracting with stop loss is done on a net basis thus,

no compensation. Additionally, stop loss carriers will have a favorable renewal for good experience which is passed along to the plan.

Based on this comparative, the self funded plan will be more favorable in the control of risk and cost vs fully insured plans.

For employers wanting to utilize stop loss as a risk management basis for the self funded health plan should not be limited to certain minimum levels as a protectionist basis from the various NAIC state insurance commissioner members trying to utilize this to protect the "Health Exchanges". The protectionism potentially taking place is due to the Health Exchanges not being competitive in the health benefit market place. To keep cost down for all types of plans whether fully insured, self funded, state or federally run health exchanges or Co-ops a competition must exist between all.

PBM Comparative (Prescription Benefit)

Fully insured health plans will contract directly with the Prescription Benefit Management Company for the prescription benefit portion of the insured health plan. In this structure, "Rebates" from the manufactures are are derived which are considered refunds. These "Rebates" are paid to the insurance company as well and not passed along to offset cost of the insured plans. These "Rebates" are another form of "off book profit" to the insurance company and are not calculated to reduce the costs of the premiums. Additionally, a margin sharing may exist between the insurance company and the PBM which becomes another revenue source as an "off book ledger" profit center. The gross cost of the prescriptions are utilized as part of the gross claims for the cost of claims in calculation of the MLR.

Self Funded health plans will contract directly with the Prescription Benefit Management Company for the prescription benefit portion of the vendor architecture of the self funded health plan. In this structure, "Rebates" from the manufactures are derived which are considered refunds. These "Rebates" are paid to the self funded health plan as refunds and calculated back into the self funded health plan to reduce losses and improve loss ratios. The calculation of the rebates back to the plan reduce the risk exposure of the self funded health plan and improve the loss ratios. (Important note for plan sponsors - make sure your agreement includes 100% of the rebates and not the terms eligible rebates).

Managed Care Comparative

The managed care vendor normally provides the following. Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM) as a basis for vendor services to the health benefit plan.

Fully insured health plans will contract directly with the Managed Care Company for Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM). There is normally a per employee per month (pepm) fee for the (UR PreCert) as well as the (DM). The (CM) is normally done on an hourly rate but can be done on a pepm basis. A mark up or a revenue sharing is normally done by the insurance company on the managed care. These mark ups or revenue sharing are paid to the insurance company and not passed along to offset cost of the insured plans. These mark ups or revenue sharing are another form of "off book profit" to the insurance company and are not calculated to reduce the costs of the premiums. In case management, this cost if an hourly basis is calculated into the cost of the claim vs the pepm basis which is not calculated in to the claim. The gross cost of the managed care are utilized as part of the gross cost in calculation of the MLR and not offset by the revenue sharing.

Self Funded health plans will contract directly with the Managed Care Company or Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM). This agreement is normally done on a net pepm basis thus keeping the cost of these services down. Thus, there is no revenue sharing or mark ups due to the net vendor architectural contract directly with the plan sponsor health benefit plan. This allows for reduction of cost compared to the fully insured health benefit plan. Note: The services are the same, the difference is the cost calculated.

Network Comparative

A network whether a PPO, ACO, or HMO is an access point to an in network benefit.

Fully insured health plans will have either their own network, contract with an external network or a combination. This also becomes an internal "profit center" or "off book ledger" basis for profits. These cost may have increase or mark ups from the net

internal cost and the markup cost being calculated on a gross basis for the inclusion in the insurance premium.

Self Funded health plans will contract on a net basis either directly with the network or through an aggregator on the net cost. By doing this, the self funded health plan reduces its cost for this vendor architecture.

Networks only provide a discount to an in network benefit. The actual savings for health benefit claims comes from good claims management, billing review of charges etc.

With the above information on the fundamental vendor architecture to the health benefit plans, cost reductions are better with self funded health benefit plans. Utilizing the new matrix allows a plan sponsor for the health benefit plan to replace on a "plug in" any vendor to the plan which is not performing without jeopardizing the integrity of the health benefit plan. *The plan sponsor has no say in the vendor architecture of the fully insured health plan.*

For the reasons explained above, PPACA and the NAIC are trying to restrict employers from providing self funded health plans by restricting stop loss. The bottom line is that the Exchanges will not be able to compete with employers who establish self funded health plans.

There are many more areas within the structures of the self funded health plan to implement and put in the right vendor architecture. The information contained in the self funded vs fully insured is derived from sections of "Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level". This book is an excellent guide for those companies who are self funded or contemplating implementation of a self funded health plan.

It is important to note who's plan is it: the insurance company, the contracted administrator or the government. In the self funded plan, you are the owner.

Reference: Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level. by: F. Randall Childers, Jr. This may be ordered by going to the website: www.forensicsofamedicalplan.com. Amazon.com, Barnes & Noble.com, iBooks and many others or through your local book store.

About the Author

F. Randall Childers, Jr. graduated from Hanover College with a BA in Business Administration in 1983. Mr. Childers is a ACFEI Certified Forensic Consultant specializing in Health Benefit Plans, and licensed as: Third Party Administrator, Employee Benefits Consultant and Life and Health Insurance Agent. 29+ years of experience in employee benefits.

He has authored a book - Forensics of a Medical Plan "Dissecting Health Benefits on a Company Level".

He has developed the forensic tools for the investigation and dissecting health benefit plans.

He is available to help you with your health plan by consulting, evaluation, structuring or at the highest level of forensics. He is available to consult with you as a *second opinion* on your health benefit plans as well.

He is a member of NAIFA, National Association of Insurance and Financial Advisors and currently serves on the Board of Directors Louisville Metro as President as well as Chairman of Health. This includes Legislative Advocacy, Public Relations, Educational Programming, and Professional Development.

Mr. Childers has designed a model for Medical Plans which allows the Plan Sponsor total control of their benefit plans. This model has been proven to reduce excess cost in the administration of the programs as well as claims. All of the organizations which have utilized this Model have reduced their cost across the board.

Through his experience of 29+ years, Mr. Childers has worked with and structured, analyzed and provided forensic reviews of corporate health benefit programs within the goals, objectives and timelines set forth by the Plan Sponsors in a comprehensive basis from plan design to the benefit delivery system.

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Mr. YARMUTH. Thank you. Mr. McPhearson, just out of curiosity, how many employees do you have at Lectrodryer? I just do not know enough—

Mr. MCPHEARSON. Sixty-three full-time and 70 counting the co-ops, temporaries, and interns.

Mr. YARMUTH. Great. In terms of, you know, I know there is a lot of speculation, and, Ms. Moores, you talked about your insurance carrier said that rates would go up by 92 percent in the second year. Have you checked with any other insurance companies as to about what similar coverage might cost, because there is a lot of speculation out there. And I know insurance companies are throwing out these numbers, but we do not know for a fact that is what your coverage would cost, I mean, do we?

Ms. MOORES. Yes, we do because we shopped six companies, and the actuaries are the ones who gave us the 92 percent and the 10 percent.

Mr. YARMUTH. But you have not actually been sent a bill. You do not know it?

Ms. MOORES. No.

Mr. YARMUTH. You do not know. That could change considerably, could it not?

Ms. MOORES. We shopped that out, and with what we have got that is coming down the pike with this Affordable Healthcare Act, that is what they have available.

Mr. YARMUTH. That is what they have available. Did they explain why, because, for instance, I have talked to a major employer the other day who said that their rates were going to go up 7 percent, so—

Ms. MOORES. It is the community rating section provision that is in the Affordable Healthcare Act that is getting the actuaries to have these astronomical increases for everyone.

Mr. YARMUTH. Well, and that is what I am saying, that there is a lot of speculation out there, and we really do not know for sure what rates are going to be as we go forward.

Ms. MOORES. If we get that law the way that it is in place right now—

Mr. YARMUTH. Well, it is—I am sorry.

Ms. MOORES.—community rating is there, and that is it.

Mr. YARMUTH. I am sorry. It is the law. It is the law. It has been upheld by the Supreme Court.

Ms. MOORES. The community rating is in it.

Mr. YARMUTH. What was your experience before the Affordable Care Act? Well, I am sorry, let me ask another question. Everybody I know is concerned about jobs. We are all concerned jobs and job creation, and I know a lot of opponents of the Affordable Care Act talk about its impact on employment. But since the Affordable Care Act was enacted in 2010, and many of the provisions have been in effect, including people being able to stay on their parents' insurance until 26, and the limitation on the lifetime benefits, and so forth.

The private sector has added 6.7 million jobs. There have been 808,000 additional jobs created in the healthcare sector. And as I said, a national survey of small businesses just recently showed

that small businesses under 50 have added 6 percent employment just this year.

Do you not think that is somewhat evidence that the Affordable Care Act is not having a deleterious impact on jobs?

Ms. MOORES. I am glad you asked me that because I had to keep my remarks to 5 minutes. So I attached a list of sources that I used. There are 15 sources there. Those are not the real facts that you just quoted.

Unfortunately, businesses cannot run their business based on projections that the government is giving us. That is not the true unemployment picture. That is not the true growth. If you will read what I put in there from the U.S. Department of Labor, for one thing, Forbes, just 15 different articles that I have pulled there, and they are all within the last few months, that will show you what the true numbers are, not what you just gave us.

Chairman ROE. The gentleman's time has expired.

Mr. YARMUTH. Yes. Thank you, Mr. Chairman.

Chairman ROE. Mr. Barr?

Mr. BARR. Thank you. Before I ask questions, I would want to just make an observation about the question of the constitutionality of the Affordable Care Act, and that is that while a slim majority of the Supreme Court upheld the taxing power of the Congress to impose the individual mandate, it is noteworthy that a majority of the Supreme Court denied the Administration's principle rationale for the constitutionality of the act, namely the commerce power. And it should be noted for the record that the Supreme Court specifically denied that Congress has the power under the commerce clause to mandate individuals by particular product.

Also, the question about whether or not the executive branch has the power to unilaterally pick and choose what provisions of statutory law it elects to implement and what provisions it elects to not implement, I think is clearly still an open question. And I think whether or not by unilaterally delaying the employer mandate for one year falls within the President's power is an open question, I think, subject to scrutiny.

Mr. McPhearson, let me ask you a quick question about—I was particularly interested in your testimony that you travel a great deal across the globe. And many people compare the American healthcare system to the Canadian healthcare system, for example, as an example of government-run healthcare versus our partial market-based system prior to Obamacare.

The chief justice of the supreme court of Canada in commenting on the Canadian healthcare system made an important observation, that access to a waiting line is not access to healthcare. Do you care to comment, Mr. McPhearson, in terms of your international travels about whether or not access is something that your employers under a market-based private health insurance system, whether or not access is something that you are able to provide for your employees?

Mr. MCPHEARSON. I do not think there is any doubt that my employees get extraordinary care by comparison to most places in the world, but they are well insured. You know, part of my comments certainly deals with that part of the issue that it has gone forward, and I think that is problematic.

What we do see or what I have seen personally, and because it is a topic of discussion, I try and talk with people that I work with at other places. And what you see evolving is while you may have access, you do not choose your doctor, you do not choose when you get the care. And in many places, there are two levels of care: those that are in the general population and those that have the money, although some would argue that exists here already as well.

Mr. BARR. But one quick follow-up question for you, Mr. McPhearson, and that is, you testified that your HR manager will spend a significant percentage of her time working on issues related to compliance with the healthcare law. What steps—well, let me just ask you this. What does that do in terms of taking time away from your staff to do the other parts of your job, and how is that going to negatively impact the other health benefits or other employee benefits that you provide?

Mr. MCPHEARSON. It certainly is an issue. You know, HR is responsible for health and safety, all the issues that are typically under that umbrella in our company. And we are approaching the point where we might to have add a second employee just to deal with that. That is a potential.

Mr. BARR. Mr. Meadows, if I could ask you a question about your testimony. Have you all made any changes regarding for planning for the healthcare law as a result of the Administration's unilateral decision to delay the employer mandate?

Mr. MEADOWS. We have not. We have continued in the same mode that we currently are, so we did not change our course.

Mr. BARR. So it remains a great uncertainty for your employees and for your business planning, the fact that there remains the prospect of this employer mandate hanging over your head.

Mr. MEADOWS. Certainly that is true.

Mr. BARR. And another question. Are the benefits that you currently provide to both your part-time and full-time employees, are they in jeopardy as a result of some of the costly mandates of the Obamacare law, including your testimony about the $63 reinsurance fee? Does that jeopardize other benefits that you provide for your employees?

Mr. MEADOWS. I would not speculate that it is necessarily going to jeopardize any other benefit. But benefit administration, you have a budget, so how you are going to allocate that budget if healthcare takes a greater portion of it, then, yes, potentially some other benefit may, in fact, feel the repercussion from it.

Mr. BARR. I see my time has expired. I yield back the balance of my time.

Chairman ROE. I thank the gentleman for yielding, and I, again, thank the panel for being here.

And I want to just with a couple of statements that I would make. First of all, I believe a healthcare decision should be made between a physician, the patient, and that patient's family. It should not be made in consultation with the government. It should not be made in consultation with insurance companies. It should be made between a patient and the doctor.

I have sat down and had the conversations, Ms. Basham, many, many times in my career. As a matter of fact, my practices aver-

aged seeing one new female cancer a week for over 30 years that I was there, the same for breast cancer. Very aware of that.

And a couple of statements, and I want to tell you that this goes from the time I was in medical school, to show how things have changed in this Nation. In the late 1960s when I was a medical student in Memphis, I went and started IVs at St. Jude's Children's Hospital. I can still see some of those children's faces today 40 years later. Ninety percent of those children died. Today, 90 percent of those children live, and each child that is sent to St. Jude's Children's Hospital is treated for free. Their families are transported and put up for free.

We have a branch of St. Jude's Children's Hospital in Johnson City, Tennessee where I practiced, and the same thing happens there. It is a phenomenal place. And cancer survival rates—if you came to me in 1977 as a woman with breast cancer, I would have to tell you had a 50/50 chance of surviving 5 years. That has gone up astronomically. And are we there yet where we need to be? Absolutely not.

And there are situations, and certainly the cases you talked about I have seen in my practice. But the thing that I have never seen is a patient denied care, at least in our community. I cannot speak for Lexington.

Ms. BASHAM. But—

Chairman ROE. I am going to finish. There are things we can do to make sure that does not happen in this country.

And I also want to thank Mr. Meadows and his company at Food City. They have 5 stores in my—we shop there, full disclosure. It is a great company. I know the leadership of that company. They hire a lot of people in my community. Thank you for being in our community.

One of the effects that has not been talked about, because this is on employer based. I live in rural Appalachia. There are three hospitals in my district and counties in my district that may go broke. They may go out of business. And across the country, there may be as many as 400 or 500 rural hospitals that because of the payments not necessarily with the employer side, but with the Medicare and Medicaid side, that may not survive the Affordable Care Act. And I do not know whether you all have seen that here, any of you all in rural Kentucky or not, and certainly probably eastern Kentucky where we are going to drive today.

But I think the key issue we have today, and Mr. Yarmuth and I have talked about it and others today, jobs are the key. If we can get our economy cranked up and going, a lot of these problems go away because companies do want to do what you are doing at that great company in Richmond, Kentucky, is to provide jobs. We want to hire people. That is absolutely what we want to do.

And so, I would ask, Ms. Moores, if you would comment, since that has been your life's work is to provide employment for people. Am I correct or incorrect?

Ms. MOORES. You are exactly right. And when we are employers, we are providing jobs, keeping people off the unemployment rolls, keeping them off the disability rolls, keep them off of workers' comp, and all these other government assistance programs. Plus they are paying taxes, and we are paying taxes.

So the answer is to increase the jobs. That is where the money comes back into the government.

Chairman ROE. I totally agree. And if you do not think it does not have a paralyzing effect, our largest employer in our community is our hospital system, 9,000 employees. We have a medical school, a pharmacy school, and we are a large referral area. I have been there 35 years. It is the first time that hospital has laid off anybody. It laid off over 300 people. My practice is not hiring anybody right now because of the uncertainty.

Hopefully this will get better, and I would hope going forward that we would wait. I would like to see this delayed a year until we have a longer time to digest what was going on.

To give you an example, and I think Mr. Guthrie referred to it. Each year around July, we would try to get our insurance straightened out for first of the year. I cannot even tell the people who work for me in the U.S. government 5 weeks from now, and neither can anybody on this panel, what the rates are going to be for the people who work for me in my congressional office. I do not know. We are mandated by law to buy our health insurance through the exchange, so I cannot tell anybody what their rates are going to be.

That is uncertainty, folks. And if you are a business out there trying to figure out what to do come January 1, you have payroll to meet. If you do not have the money, you go out of business. Mr. Barr has already made some huge—not just the Affordable Care Act in fairness. It has been the economy, too. It has been more than just one thing. It has not just been the Affordable Care Act. It has been the costs of energy, uncertainty in the world. It is a world economy now. There is no question all of that is true. But this uncertainty right now certainly has added to it.

Well, I see my time has expired, and I will gavel myself now.

So anyway, I want to thank all eight witnesses. Let me tell you how much I want to thank—we will do that first. I want to thank all of you for being here today. This is the way America—I put a uniform on and left this country 40 years ago right now to serve this Nation in the U.S. military so that we could be free and have these kinds of events out here. And I want to thank those of you all that sat here attentively and not disrupted this. I appreciate what you have done. You are what make this country great and make all of us up here, regardless of our political affiliations, proud to serve you all.

Lexington is a great community. I have been here many, many times, and we have great representatives here. And I commend you on the people you have sent, and thank you for attending. And I want to thank our witnesses again for being in front of the committee.

I will now ask if any members, Mr. Guthrie, have any closing comments.

Mr. GUTHRIE. Just welcome you to Kentucky. It is great to be here. It is great to represent this part of Kentucky. I do not have Lexington and Fayette County. I do have some of Jessamine, a good bit of Jessamine. And I always like to say, I know Representative Barr says he is from the district of Henry Clay. Well, I know the Ashland house is nearby, but Henry Clay represented the 2nd District of Kentucky during that era.

[Laughter.]

Mr. GUTHRIE. So I appreciate following in his footsteps. Thank you.

Chairman ROE. Mr. Yarmuth?

Mr. YARMUTH. Actually I think Henry Clay represented Louisville for one term.

[Laughter.]

Mr. GUTHRIE. He represented all of us.

Mr. YARMUTH. Yeah, it did not make much difference. No, I want to thank my colleagues and assure those who are here today and those who may read the accounts of this hearing that we all on this panel want to make sure that we do the best job we can for the American people. And I wish the environment was such that we could work to make the Affordable Care Act function as well as possible rather than having a debate over whether we preserve it in the law.

But ultimately, I totally respect particularly the business people who are here. Again, I have been in business. I come from a family of business people. And I know the struggles that all businesses face, particularly in tenuous times, and this is one of those. So thank you for trying to do the best by your employees.

Ultimately, we need to have a country that works for everybody, and I think those of us who supported the Affordable Care Act, even when we would have preferred something different, and I am one of those.

[Disturbance in hearing room.]

Mr. YARMUTH. I think there are plenty of countries in the world that could offer us an important lesson about how to provide healthcare, even though I do believe that we have the best healthcare on earth if you can afford it.

And that is what we just have to do our best to make sure that same level of care is accessible to as many people as possible. And that is what I certainly have been trying to do in my work on the Affordable Care Act. And I look forward to continuing to work with it within the system to make sure it functions as efficiently and effectively as possible.

I thank my colleagues for holding this hearing and allowing me to participate. And, again, thanks to the witnesses, and thanks for your work. And we look forward to working with you, again, to make sure that we solve whatever problems exist with the law and work to make it work efficiently both for employees and for employers.

Thank you, Mr. Chairman.

Chairman ROE. I thank the gentleman for yielding.

Mr. Barr?

Mr. BARR. Thank you, Mr. Chairman, and thank you, Chairman Roe, for holding this field hearing in my congressional district, the 6th Congressional District. I want to thank the Education and Workforce Committee for bringing this important hearing to our congressional district where we could hear from our constituents, my constituents, right here in central and eastern Kentucky to hear about the impact that the Affordable Care Act will have on them, their businesses, their employees, patients, doctors, and everybody who interfaces with the healthcare system.

I want to thank my colleagues, both Congressman Guthrie, Congressman Roe, and Congressman Yarmuth. And I will say as the successor to Henry Clay's seat in Congress that he did have an impact. He delayed the Civil War for 10 years. Obviously we would have wanted to avoid that terrible time in our Nation's history.

But I think what we are doing here is very, very important. And no matter where you fall on the political spectrum or where you fall in terms of this particular issue, you know, this is important work because it impacts one-sixth of the American economy. So we have got to get it right.

And what we all want is access to affordable healthcare, low-cost healthcare, and we want doctors to be in charge. We want patients and doctors to have viable relationship. And we do not want to put the government as the intermediary between patients and doctors. We want access to healthcare. We want affordable healthcare. We do not want waiting lines, and we certainly do not want uncertainty for employers in a time of economic distress and high unemployment.

So thank you to our witnesses for testifying here today, for bringing a lot of light to this very heated discussion. Thank you very much.

Chairman ROE. Well, thank you very much, and I appreciate the audience staying around for most of this. We do this all the time in D.C. This is the sixth committee hearing I have held outside I have been part of. I think the best results I get are outside Washington where we do not have paid lobbyists and so forth that come. We have regular folks that come in and testify, and I want to thank them as the rest of the panel has.

Look, healthcare decisions, when I went to Congress, one of the most disappointing things that happened to me was that I went to Congress 5 years ago naively thinking somebody cared what I thought. And I was disappointed because bringing 30 years of experience as a physician, also going through the healthcare reform we went through in Tennessee and then the reform of that, which was extremely painful, our TennCare plan that we went through. I thought I had something to offer to the debate.

There were nine physicians in the House of Representatives, and I say this in all honesty, in all the years I served as a physician, I never saw a Republican heart attack or a Democrat heart attack. I never have operated on a Republican cancer or a Democratic cancer. It is something that affects every single American citizen in a personal way.

And not one of us on the physician's caucus was asked anything about this bill. And quite frankly, the bill that was passed, as my friend John Yarmuth said, was not what a lot of us would have wanted. It was not even the House bill that was passed, which, in my opinion, was a better bill.

So I think we do have a lot to do here, to do in this to make health insurance—healthcare, I should say, not insurance, but healthcare more affordable and available to all of our citizens. And I agree with you. There is enough money in the system, I think, to cover everybody, but I will oppose because of what I have seen in many a government-run plan.

Again, I want doctors and patients making those decisions.

I thank you all very, very much for being here today. With nothing further, the meeting is adjourned.

[Whereupon, at 12:19 p.m., the subcommittee was adjourned.]

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