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IMPLEMENTATION OF THE AFFORDABLE CARE ACT: UNDERSTANDING SMALL BUSINESS CONCERNS

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

JULY 24, 2013

Printed for the Committee on Small Business and Entrepreneurship

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IMPLEMENTATION OF THE AFFORDABLE CARE ACT: UNDERSTANDING SMALL BUSINESS CONCERNS

WEDNESDAY, JULY 24, 2013

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS
AND ENTREPRENEURSHIP,
Washington, DC.

The committee met, pursuant to notice, at 2:35 p.m., in Room SR–428, Russell Senate Office Building, Hon. Mary L. Landrieu, Chair of the Committee, presiding.

Present: Senators Landrieu, Pryor, Shaheen, Heitkamp, Markey, Risch, Vitter, Rubio, Scott, Fischer, Enzi, and Johnson.

OPENING STATEMENT OF HON. MARY L. LANDRIEU, CHAIR, AND A U.S. SENATOR FROM LOUISIANA

Chair LANDRIEU. Good afternoon and thank you all for joining us for this hearing. I call the Small Business Committee to order.

The purpose of today's hearing is to better understand how the Affordable Care Act is being implemented in various regions of the country, how it is helping America's 27 million small businesses as they struggle to afford health coverage that for too long has been out of reach, unattainable, and unsustainable, including 22 million self-employed Americans, as well as any special challenges of businesses with between 50 and 200 employees that are facing, as the implementation of the ACA continues.

As it is well-documented, this law has no requirement for coverage or a penalty on businesses with fewer than 50 employees, which comprise 96 percent of all small businesses in the country. In fact, it actually offers help to the smallest of those businesses who do want to provide coverage. In today's hearing we will also hear about those businesses with over 50 employees, which is about 3 to 4 percent of businesses in the country, very important businesses, many restaurants and others that I have heard from who are also important job creators and very much appreciated entrepreneurs in our country today.

During this hearing, we will hear from the Administration on the status of the implementation. We will also hear from small business owners who will be telling their own personal stories about how this Act is affecting them, their business plans, and their employees' access to quality care.

In order to set the table for today's hearing on where the Affordable Care Act implementation is now and what it will look like in

the future, I want to briefly take a look back at where we were just a few short years ago. In 2009, Congress took up the issue of national health care reform in earnest. It was not really, however, a new discussion. This issue had been debated in Washington for decades, going all the way back to President Theodore Roosevelt, and including Presidents and Congressional leaders from both parties.

Given that history, we knew that getting a bill passed was going to be a long and hard road, and some in Washington even felt it would be too hard and contentious to try it all. Looking back, while it was hard and was difficult, I believe it was an important issue to address, particularly in face of highly unstable, unpredictable, and constantly rising health care costs, large and small businesses were struggling with how to provide affordable health care coverage to their valued employees, many of whom are like family.

Many small businesses have paid historically, on average, of 18 to 25 percent more than large businesses for less coverage. They would see their health care costs increase faster than the price of their goods and services that they sold, four times faster than the rate of inflation, in fact, between 2001 and 2009.

Average annual family premiums for workers at small firms in that year, 2009, before the Affordable Care Act was passed, increased by 123 percent, from $5,700 to $12,700, while the percentage of small firms offering coverage fell from 65 to 59 percent.

And it is absolutely no wonder at all to me that since 1986, 24 years prior to the passage of the ACA, the number one concern for small businesses every year has been access to affordable health care, and this is according to the National Federation of Independent Businesses. I want to repeat, since 1986, 24 years prior to the Affordable Care Act, this has been the number one issue of the National Federation of Independent Business.

To address these concerns and many others during the passage of this Act, I held several hearings and round-tables to focus on how the current health care system then before ACA was undercutting our efforts to provide affordable health care to businesses and their employees, to curb volatile health care costs, and to ensure that small business had a voice in the legislative process.

There was no doubt in my mind then, and no doubt in my mind now, that maintaining the status quo prior to the ACA of insecure, unaffordable, and unpredictable insurance was unsustainable for American families as well as small businesses. As Chair of this Committee, I take my role as advocate for the small business community very seriously. Once the amendment process began, I cosponsored several small business amendments that did become part of the final law.

I want to talk briefly about two of them that expanded the small business tax credit to more businesses and made the credits available immediately. First, to help small businesses bridge the affordability gap in providing insurance for their employees before the private marketplaces are up and running, the original bill created a temporary tax credit that would be phased in for small businesses with fewer than 25 or few employees with average wages of less than $40,000 beginning in 2011.

An amendment I co-sponsored passed the Senate and made the initial credit available in 2010 so more small businesses could immediately afford to provide health insurance, if they wanted to voluntarily, for their workers, particularly the smallest businesses that need the most help and could virtually find it nowhere in any affordable way, shape, or form prior to the ACA.

Second, the original bill only made the full value of these credits available to businesses with ten or fewer full-time employees with annual wages of $20,000 or less. Another one of my amendments increased the wage limit to $25,000 for both temporary and marketplace credits to allow more small businesses access to full credit. It expanded the wage limitation for partial credit from $40,000 to $50,000.

In all, these amendments made an additional $13 billion in tax credits for a total of $40 billion, which are helping small businesses today, in states that are cooperating, to provide quality health care coverage for their employees, including small business owners testifying today.

The law also included the creation of a new health care private marketplace known as the exchanges for small businesses with under 50 employees, and eventually under 100 employees, to allow them to pool together and access more affordable health care coverage. That had always been available for large businesses in America for a long time, but never to small businesses, either those with under 25 employees, under 50 employees, or between 50 and 200 employees.

These new marketplaces, if implemented correctly, will give small employers the ability to band together, spread risk over a large number of people, giving them the same leveraging power and lower cost that large businesses enjoy. This means small businesses in these private marketplaces will no longer see huge rate spikes just when one employee gets sick. And we have heard this over and over and over again for small businesses. One employee gets cancer, the rates would go up 30 or 40 percent. Those days are quickly coming to an end.

Today these marketplaces are being implemented, either by the state or, in some instance, by the Federal Government. Ultimately, the Affordable Care Act that was enacted builds on our existing private health care system and seeks to help those small businesses who need it most by, one, lowering premium growth costs that I said has been rising spectacularly 20 years before the ACA was passed, increasing access to quality, affordable health insurance, and encouraging a greater voice in competition in the health care marketplace, and most importantly, at least to me, is reducing what I call job lock, which prevents individuals from starting a new business and makes them stay in jobs they would otherwise leave because they have to have health insurance.

And in the previous world before ACA when only large companies could provide affordable insurance because of their buying power, many people were job-locked, unable to be entrepreneurs, unable to go out on their own because there was virtually no insurance available at an affordable cost. And if you had a health care challenge yourself or, let us say, your wife was in the second or

third stages of cancer, or your child was born with Down's Syndrome, you were in job lock. No longer.

Now the Affordable Care Act is the law of the land. It is in the process of being implemented. It is the role of this Committee to continue to ensure that we have oversight over how this law is either working or not working, to change what we can should it become clear to us that it is necessary, and to advocate on behalf of all small businesses.

And most small businesses have less than 25 employees, but many have less than 100, and there are some very important businesses that will testify here today that have between 100 and 200, and they are struggling with some of these requirements. I understand that.

Just because the Affordable Care Act became law does not mean that the job of fighting to make it work is over for us. After the law was enacted, for example, I worked with my colleagues on both sides of the aisle to repeal the burdensome 1099 reporting provision. I was happy to help lead that effort in a bipartisan manner. That was done and it was a great relief.

There are other things that could potentially be done to improve this law. As this law moves forward, I will continue to listen to small business owners in Louisiana and across the country to continue to fight to make sure their voice is heard and that the law works the way it was meant to work.

I look forward to a spirited discussion and debate in our Committee today from both sides of the aisle. I welcome Senator Pryor, Senator Risch, Senator Rubio, Senator Johnson, Senator Enzi and others that will be joining us, and I am particularly interested in hearing about the Administration's efforts to implement the law in a way that focuses on helping small businesses that have for decades been priced out of being able to afford quality health care to their employees, many of whom are like family.

And they need to be able to compete for some of the best employees, to compete against some of the larger businesses in our country and internationally to help provide quality, affordable health insurance, which is important. I am also excited to hear some very compelling stories from small business owners who will be speaking to us about how this Act is working for them, some that have still questions and comments about how it is continuing to be a challenge.

We have an impressive list of witnesses here to talk about the implementation of the Affordable Care Act. I now turn to my ranking member, Senator Risch, for his opening statement. We will then accept opening statements in writing from the other members and go into our first panel of questions. That will be, hopefully, one round, potentially two, five minutes each. Senator Risch.

OPENING STATEMENT OF HON. JAMES E. RISCH, A U.S. SENATOR FROM IDAHO

Senator RISCH. Madam Chairman, thank you so much. Let us talk about how we got here to start with. When I first ran for this job back in 2008, America was focused on a real need to reform our health care system. Both parties were arguing that we should do

health care reform. The problem is, it turns out that we were singing off of two different sheets of music.

Our side was talking about redoing health care to lower costs and make it more affordable for every American. The other side was talking about expanding coverage. At that time, 87 percent of Americans were covered by some sort of health insurance coverage and they wanted to move it to 100 percent. At the end of the day, of course, that did not happen. They did move the needle 7 percent so that 94 percent were covered after the adoption of Obamacare.

In any event, we went through a spirited debate on the matter. The Democrats won; the Republicans lost. Indeed, the law was passed by an exact party line vote. And at the end of the day, we are saddled with Obamacare. Since Obamacare has come online, its difficulties, its problems, people who were disenchanted with it, grow every single day.

And indeed, that is why I originally conceived the idea of holding a hearing like this, but it was going to be strictly on the Republican side, and I want to thank you, Madam Chairman, for expanding this and making it an official Committee hearing with both parties participating.

We, on our side, are believing that this matter is a catastrophic failure and becoming more so every day. Indeed, the three groups that are affected by this, big business, small business, and individuals, average Americans, are learning every single day about what a horrible burden this is on them and how it is going to worsen the kind of medical care they get.

As a result of that, we are being deluged, at least those of us on our side are being deluged, by complaints from average Americans, from small business, and indeed, from big business. I am sure that my colleagues here have had the parade of big business CEOs, small business CEOs, and individuals into their offices complaining about Obamacare as it has unfolded—and, of course, we do not know how it is going to completely unfold—but as more and more is known, how it was going to affect them, detrimentally.

Now, somebody was listening. The White House was listening. And what did they do? They gave relief, but they gave relief only and solely to big business. What about the rest of Americans? What about small businesses in America? They want relief, too, and that is one of the reasons why I asked to have this hearing.

Hopefully, at the end of this hearing, everyone will agree that not only does big business need relief, so do the small businesses who this Committee is exactly dedicated to helping. They need relief, too. And small business should get the same relief that big businesses got. And the same is true with American individuals.

The first rule that every school child can tell you about the delivery of health care and the first thing they learn about doctors is that they take an oath, and the oath they take is, "do no harm." Well, we now know that Obamacare violated the very first principle—the very first doctrine of the delivery of health care services—and that is do no harm, because we are realizing every day that there is more and more harm being caused by this particular law.

Now, you say, well, you are a Republican, you voted against it, your party voted against it. Well, let us talk to the people who ac-

tually supported this law. I have here a letter dated July 11th, 2013, from the International Brotherhood of Teamsters signed by its General President, James B. Hoffa, also by the UFCW and Unite Here, three unions in America.

They start out by writing to Senate Majority Leader Harry Reid and House Minority Leader Nancy Pelosi, quote, "When you and the President sought our help for the Affordable Care Act"—and by the way, they got it. They got it enthusiastically by these unions—"you pledged that if we liked the health plans we have now, we could keep them."

Now, those of us who were on the other side of this were saying, "You know, I am hearing you guarantee that you can keep your health care plans, but how can you be talking out of one side of your mouth saying that, while out of the other side of your mouth saying, "Yes, but all of the plans are going to be written by the United States Government." Indeed, nobody's health care plan would exist after Obamacare was enacted.

In any event, they go on to say, "On behalf of millions of working men and women we represent and the families they support, we can no longer stand silent in the face of elements of the Affordable Care Act that will destroy the very health and well-being of our members along with millions of other hardworking Americans."

They go on to say, "We continue to stand behind real health care reform, but the law as it stands will hurt millions of Americans including the members of our respective unions." This is from the people who supported this law when the President brought it on board. Well, Madam Chairman, I would ask unanimous consent that the July 11th letter be included in the record, together with the response that Senator Hatch gave, dated July 18th, 2013, and I will have some more items for the record.

Chair LANDRIEU. Without objection.

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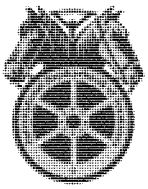


July 11, 2013

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

RM Risch.
Union
letter +
response

Dear Leader Reid and Leader Pelosi:

When you and the President sought our support for the Affordable Care Act (ACA), you pledged that if we liked the health plans we have now, we could keep them. Sadly, that promise is under threat. Right now, unless you and the Obama Administration enact an equitable fix, the ACA will shatter not only our hard-earned health benefits, but destroy the foundation of the 40 hour work week that is the backbone of the American middle class.

Like millions of other Americans, our members are front-line workers in the American economy. We have been strong supporters of the notion that all Americans should have access to quality, affordable health care. We have also been strong supporters of you. In campaign after campaign we have put boots on the ground, gone door-to-door to get out the vote, run phone banks and raised money to secure this vision.

Now this vision has come back to haunt us.

Since the ACA was enacted, we have been bringing our deep concerns to the Administration, seeking reasonable regulatory interpretations to the statute that would help prevent the destruction of non-profit health plans. As you both know first-hand, our persuasive arguments have been disregarded and met with a stone wall by the White House and the pertinent agencies. This is especially stinging because other stakeholders have repeatedly received successful interpretations for their respective grievances. Most disconcerting of course is last week's huge accommodation for the employer community—extending the statutorily mandated "December 31, 2013" deadline for the employer mandate and penalties.

Time is running out: Congress wrote this law; we voted for you. We have a problem; you need to fix it. The unintended consequences of the ACA are severe. Perverse incentives are already creating nightmare scenarios:

First, the law creates an incentive for employers to keep employees' work hours below 30 hours a week. Numerous employers have begun to cut workers' hours to avoid this obligation, and many of them are doing so openly. The impact is two-fold: fewer hours means less pay while also losing our current health benefits.

Second, millions of Americans are covered by non-profit health insurance plans like the ones in which most of our members participate. These non-profit plans are governed jointly by unions and companies under the Taft-Hartley Act. Our health plans have been built over decades by working men and women. Under the ACA as interpreted by the Administration, our employees will treated differently and not be eligible for subsidies afforded other citizens. As such, many employees will be relegated to second-class status and shut out of the help the law offers to for-profit insurance plans.

And finally, even though non-profit plans like ours won't receive the same subsidies as for-profit plans, they'll be taxed to pay for those subsidies. Taken together, these restrictions will make non-profit plans like ours unsustainable, and will undermine the health-care market of viable alternatives to the big health insurance companies.

On behalf of the millions of working men and women we represent and the families they support, we can no longer stand silent in the face of elements of the Affordable Care Act that will destroy the very health and well-being of our members along with millions of other hardworking Americans.

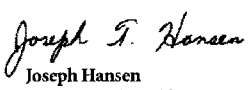
We believe that there are common-sense corrections that can be made within the existing statute that will allow our members to continue to keep their current health plans and benefits just as you and the President pledged. Unless changes are made, however, that promise is hollow.

We continue to stand behind real health care reform, but the law as it stands will hurt millions of Americans including the members of our respective unions.

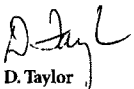
We are looking to you to make sure these changes are made.

Thank you.

James P. Hoffa
General President
International Brotherhood of Teamsters



Joseph Hansen
International President
UFCW



D. Taylor
President
UNITE-HERE

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AMBER COTTLE, STAFF DIRECTOR
CHRIS CAMPBELL, REPUBLICAN STAFF DIRECTOR

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

July 18, 2013

James Hoffa
President
International Brotherhood of Teamsters
25 Louisiana Avenue, N.W.
Washington, D.C. 20001

Joseph T. Hansen
President
United Food and Commercial Workers
1775 K Street, N.W.
Washington, D.C. 20006

D. Taylor
President
Unite Here
1775 K Street, N.W. Suite 620
Washington, D.C. 20006

Dear Messrs. Hoffa, Hansen, and Taylor:

I write to express my agreement with the concerns you have outlined in letters to the Obama Administration and Congress regarding the Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act, which we all can agree is a title that does not ring true.

In a letter to Senate Majority Leader Harry Reid and House Minority Leader Nancy Pelosi you expressed concerns regarding the rising cost of union-sponsored health insurance plans as a result of PPACA. Specifically, you noted that the President's health care law threatened to make these plans, of which 20 million people are currently enrolled, less competitive and more difficult to offer to your members. Similar concerns were expressed earlier this year calling the rising cost of coverage "not acceptable."

Your letter also highlighted the fact that, as a result of the law's mandate on employers to offer insurance to full-time employees – defined as those working more than 30 hours per week – businesses are opting to reduce workers' hours in order to avoid paying additional costs and

fines. I agree with your assessment that the law will "destroy the foundation of the 40 hour work week that is the backbone of the American middle class."

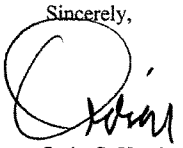
My colleagues here in Congress – members of both parties – have highlighted similar concerns with the law. Some have suggested it will be a "train wreck," and others have introduced and cosponsored numerous pieces of legislation that will repeal individual provisions that lead to higher costs and fewer work hours.

Since your activities to encourage changes to the law have, to date, been unsuccessful, I want to invite you to join me in an effort to help the Obama Administration and Congress understand the full impact the law has had and will continue to have on the labor and health insurance markets once it is fully implemented and call for a permanent delay on the law until we are able to come up with a plan that will achieve the law's stated goals of reducing healthcare costs and improving access.

We know today that costs are skyrocketing and estimates on coverage continue to drop as confidence in the administration's ability to get the health insurance exchanges up and running dwindles. This is in addition to the confusion that has been created by delaying the employer mandate, but providing no relief to individuals who will be subject to a penalty for not purchasing health insurance.

I hope you will accept my invitation to provide relief from the law to all Americans and ensure that the law will no longer threaten access to insurance, increase costs, or deny individuals from keeping their existing health insurance plans as the President had promised.

Sincerely,



Orrin G. Hatch
Ranking Member

Senator RISCH. At the end of the day, I hope, Madam Chairman, that you and your party will join us as we attempt to go back to the fundamental principle of this and that is to do no harm. That is, go back to what we had before. It was not great, there is no question about it, but by going forward with Obamacare, we are violating that standard of doing no harm. At the very least, every single American—every single small business—should get the same relief that the White House has given to big business, and put this off.

I know it is only until after the election and I know that you hope that the brouhaha will calm down after that point, but I think if we give this time to reflect, maybe people will come to their senses and realize that we should do no harm. Thank you, Madam Chairman.

Chair LANDRIEU. Thank you. I am happy for that spirited introduction, happy to know that you are an advocate for the Teamsters. I will be happy to share that with all the members of both the House and the Senate.

Senator RISCH. Madam Chairman, I cannot tell you how much I am an advocate for exactly what the Teamsters have said.

Chair LANDRIEU. For the Teamsters, great. Our first panel is Mark Iwry as Senior Advisor to the Secretary of Treasury and is Deputy Assistant Secretary for Retirement and Health Policy at the U.S. Treasury Department. In that role, he is heavily involved in retirement and savings policy as a regulatory process relating to implementation of the Affordable Care Act. We welcome you, Mr. Iwry.

Chiquita Brooks-LaSure is the Deputy Director of Policy and Regulation at the Center for Consumer Information Insurance Oversight. In this role, she oversees development and clearance of policy and regulation related to the implementation of private insurance reforms. We thank you for being here.

And then finally, we have Meredith Olafson. Her role is Senior Policy Advisor to the Administration. She is responsible for overseeing the Small Business Administration education and outreach efforts around health care and the Affordable Care Act. And so we look forward to having all three of you.

As we stated, Mr. Iwry, we will start with you and we will have five minutes for your opening statements and then a round of questions.

STATEMENT OF J. MARK IWRY, SENIOR ADVISOR TO THE SECRETARY, U.S. DEPARTMENT OF THE TREASURY

Mr. IWRY. Thank you, Chairman Landrieu, Ranking Member Risch, members of the Committee, appreciate the opportunity to discuss implementation of the provisions of the Affordable Care Act that relate to small businesses.

The Affordable Care Act provides benefits for employees and owners of small businesses.

Chair LANDRIEU. Can you try to pull the mic a little bit closer to you? It is a little difficult, but you have got to press the button and speak directly into your microphone.

Mr. IWRY. Is this better?

Chair LANDRIEU. Better.

Mr. IWRY. For years, many small businesses across America have struggled to provide health coverage to their employees. The Affordable Care Act helps small businesses by increasing their bargaining power and lowering their costs. Small employers with 50 or fewer employees will be able to pool their buying power and reduce their administrative costs by purchasing affordable insurance through the Small Business Health Options program, or SHOP, and small business owners will receive standardized information that will make it easy to compare insurance policies on an apples-to-apples basis.

New market rules will ensure that premiums small employers pay for most health insurance plans will not vary based on the type of business that purchases the coverage, or the health status or their employees. While the Affordable Care Act makes it easier for small businesses to offer health coverage if they so choose, the great majority of small businesses will not be required to offer coverage.

Those with fewer than 50 full-time employees are completely exempt from the law's employer responsibility provisions. That means about 96 percent of all firms in the U.S. are exempt from those requirements. And almost all businesses with 50 to 200 employees already offer coverage, the great majority of those.

The Affordable Care Act also provides tax credits for many small businesses that offer coverage to their workers. CBO has estimated that the tax credit will save small businesses around $14 billion over the current ten-year budget window. The small business qualifies for the credit if it employs fewer than 25 full-time or full-time equivalent employees during the taxable year, and if those employees have annual full-time equivalent wages that average less than $50,000.

During 2010 through 2013, the maximum credit is generally 35 percent of the employer's contributions to premium, and for 2014 and later years, generally 50 percent. The credit is phased out on a sliding scale between 10 and 25 full-time equivalent employees, and between an average annual wage of $25,000 and $50,000.

The Administration's budget for the last two years includes a proposal to simplify and expand the small business tax credit in order to increase its utilization. In addition to the tax credit available to small employers, the Act provides for a premium tax credit that will help about 20 million Americans afford health insurance on the new health insurance marketplaces.

The Act also includes insurance market reforms providing important protections for employees and other individuals. The Treasury Department recently provided transition relief with respect to the employer reporting and employer-shared responsibility provisions. These provisions affect only employers with 50 or more full-time employees, which constitute less than 5 percent of all U.S. businesses.

So most businesses, and particularly most small businesses, are not affected by the employer reporting or employer responsibility provisions. Treasury announced that it would provide one-year transition relief with respect to the information reporting requirements for insurance providers, the information reporting requirements for applicable employers, and the employer-shared responsi-

bility provisions. This does not affect the effective date of other Affordable Care Act provisions.

The Affordable Care Act is projected to increase by nearly 30 million the number of Americans with health coverage. The Administration is implementing this law to build on the progress already made toward better and more affordable coverage. We welcome the opportunity to further work with this Committee to achieve these objectives. Thank you, Chairman, and I look forward to answering your questions.

[The prepared statement of Mr. Iwry follows:]

EMBARGOED UNTIL 2:30 P.M. July 24, 2013

Written Testimony of J. Mark Iwry
Senior Advisor to the Secretary and
Deputy Assistant Secretary for Retirement and Health Policy
U.S. Department of the Treasury
Before the Senate Committee on Small Business and Entrepreneurship

July 24, 2013

Chairman Landrieu, Ranking Member Risch, and Members of the Committee, I appreciate the opportunity to discuss implementation of the provisions of the Affordable Care Act ("ACA") that relate to small businesses. The ACA provides numerous benefits to all Americans, including benefits for employees and owners of small businesses.

Benefits of the Affordable Care Act for Small Businesses

For years, many small businesses across America have struggled to provide health benefits to their employees. Small business owners often cannot afford to pay for specialized health insurance expertise and therefore are at a disadvantage in comparing different policies and choosing those that most efficiently provide benefits best suited to their employees. Additionally, it is estimated that small businesses pay more on average than large businesses for similar health insurance coverage.

The Affordable Care Act helps level the playing field by increasing the bargaining power of small businesses and lowering their costs. Small business owners will receive standardized information that will make it easy to compare insurance policies on an "apples to apples" basis. This will enable them to make choices they believe are right for their business and their employees. Also, beginning October 1, 2013, small businesses with 50 or fewer employees will be able to pool their buying power and reduce administrative costs by purchasing affordable insurance through the Small Business Health Options Program (SHOP).

In 2014, new market rules will ensure that premiums small employers pay for most health insurance plans will not vary based on the type of small business that purchases the coverage or the health status of the small business's employees. Under the Affordable Care Act, premiums will be allowed to vary only by age, tobacco use, family size, and geography. Small businesses no longer will be penalized due to the health status or gender of their employees, and insurers will face limits on charging additional premiums for older employees. These reforms will benefit both small businesses and their employees.

By making coverage more affordable, the Affordable Care Act will help encourage entrepreneurship. Among other things, the ACA will help increase individuals' incentives to start their own businesses and end the situation in which workers are reluctant to leave a job with health insurance for fear of being unable to find, or afford, health insurance on their own (often referred to as "job lock"). The ACA will also allow small businesses to compete more effectively with larger businesses to recruit and retain skilled workers by offering health coverage.

While the Affordable Care Act makes it easier for small businesses to offer health coverage if they choose to do so, the great majority of small businesses will not be required to offer coverage. Small businesses with fewer than 50 full-time employees are completely exempt from the law's employer responsibility provisions. That means about 96 percent of all firms in the U.S. are exempt from those requirements. Of larger small businesses with 50-199 employees, almost all already offer coverage.

Tax Credits for Small Businesses

To make health insurance more affordable for small businesses, the ACA also provides tax credits for many small businesses that offer coverage to their workers. The Congressional Budget Office has estimated that the tax credit will save small businesses around $14 billion over the current ten year budget window. Both for-profit and nonprofit organizations may qualify for the tax credit.

In order to be eligible for the credit, a small business must make uniform contributions on behalf of its employees of at least 50 percent of the cost of health insurance premiums. For taxable years beginning in 2010 through 2013, the credit has been available for any health insurance coverage purchased from an insurance company licensed under State law. For taxable years beginning after December 31, 2013, however, the credit is available only for health insurance purchased through a SHOP Health Insurance Marketplace (also known as an Affordable Insurance Exchange) and for a maximum coverage period of two additional consecutive taxable years.

A small business qualifies for the credit if it employs fewer than 25 full-time (or full-time equivalent) employees during the taxable year and if those employees have annual full-time equivalent wages that average less than $50,000 (indexed beginning in 2014). During 2010 through 2013, the maximum credit is 35 percent (25 percent for tax-exempt employers) of the small business's contributions to the premium. For 2014 and later years, the maximum credit percentage is 50 percent (35 percent for tax-exempts). For purposes of the tax credit, contributions that are taken into account may not exceed the amount the small business would have contributed had it paid the State average premium. The credit is phased out on a sliding scale between 10 and 25 full-time equivalent employees as well as between an average annual wage of $25,000 (indexed) and $50,000 (indexed).

Administrative guidance (Notice 2010-44 and Notice 2010-82) provides the rules for obtaining the credit through 2013. Guidance for obtaining the credit for years after 2013 is expected to be issued shortly.

The Administration's Budget for fiscal years 2013 and 2014 includes a proposal to expand the small business tax credit. Expanding eligibility for the credit and simplifying its operation would increase the utilization of the credit and encourage more small employers to provide health benefits to employees. The expanded credit would also provide an additional incentive for small employers to join a SHOP Health Insurance Marketplace, thereby broadening the risk pool. The proposal would expand the group of small businesses that are eligible for the credit to include small businesses with up to 50 full-time equivalent employees and would begin the phase-out at

20 (rather than 10) full-time equivalent employees. In addition, among other things, the proposal would change the coordination of the phase-outs based on average wage and the number of employees so as to provide a more gradual combined phase-out. As a result, the proposal would ensure that small businesses with fewer than 50 employees and an average wage of less than $50,000 would be eligible for the credit, even if they are nearing the end of both phase-outs.

Tax Credits for Individuals and Insurance Market Reforms

In addition to the small business tax credit available to small employers, the Affordable Care Act provides for a premium tax credit that will help about 20 million Americans afford health insurance on the new Health Insurance Marketplaces. Under the statute, open enrollment for insurance purchased through the Marketplaces will start October 1, 2013, with coverage beginning as soon as January 1, 2014.

The ACA also includes various insurance market reforms, which provide important protections for employees and other individuals. Thanks to those reforms, young adults up to age 26 are able to stay on their parents' health insurance plan; individuals are now able to receive many preventive services free of charge; insurance companies must spend at least 80 percent of their policyholders' premium dollars on health care and not overhead; insurance companies may no longer deny coverage to children for a pre-existing condition; and beginning in 2014, may no longer deny coverage for anyone with a pre-existing condition.

Employer Reporting and Employer Shared Responsibility Provisions

It is worth noting that the Treasury Department recently provided transition relief with respect to the employer reporting and employer shared responsibility provisions of the Affordable Care Act. These provisions affect only employers with 50 or more full-time workers (i.e., applicable large employers), which constitute only about 5 percent of all U.S. businesses. Accordingly, most businesses, and particularly most small businesses, are not affected by the employer reporting or employer responsibility provisions.

The Treasury Department announced on July 2 (followed by published formal guidance on July 9, see Notice 2013-45) that it would provide one-year transition relief (for 2014) with respect to three provisions of the ACA: (i) the information reporting requirements that apply to insurance companies, self-insuring employers, and certain other entities that provide minimum essential health coverage under section 6055 of the Internal Revenue Code (the Code); (ii) the information reporting requirements that apply to applicable large employers under section 6056 of the Code, and (iii) the employer shared responsibility provisions under section 4980H of the Code, which may apply if one or more full-time employees of an applicable large employer obtains a premium tax credit.

This transition relief does not affect employees' or other individuals' access to the premium tax credits available under the Affordable Care Act beginning in 2014 or the effective date of other ACA provisions, including the individual responsibility provisions, the insurance market reforms, and the various revenue provisions.

EMBARGOED UNTIL 2:30 P.M. July 24, 2013

Conclusion

The Affordable Care Act is projected to increase by nearly 30 million the number of Americans with health coverage. The Administration is implementing the ACA to build on the progress already made toward better and more affordable coverage. We welcome the opportunity to further work with this Committee to achieve these objectives. Thank you and I look forward to answering your questions.

Mark Iwry (pronounced "EVE-ree") is a Senior Advisor to the Secretary of the Treasury and is the Deputy Assistant Secretary for Retirement and Health Policy at the U.S. Treasury Department. In that role, he is heavily involved in retirement and savings policy and in the regulatory process relating to implementation of the Affordable Care Act.

Mark was previously a Nonresident Senior Fellow at the Brookings Institution, Of Counsel to the law firm of Sullivan & Cromwell LLP, a Principal of the Retirement Security Project, and Research Professor at Georgetown University. From 1995 to 2001, Mark was the Treasury Department's Benefits Tax Counsel, with responsibilities relating to tax policy and regulation with respect to qualified pension and 401(k) plans, employer-sponsored health plans, and other employee benefits.

Formerly a partner in the law firm of Covington & Burling, LLP, and chair of the D.C. Bar Employee Benefits Committee, Mark's books and articles include the co-edited volume (with William Gale and Peter Orszag), *Aging Gracefully: Ideas to Improve Retirement Security in America*. He is a Fellow of the American College of Employee Benefits Counsel and a member of the bar of the United States Supreme Court, and is listed in *Best Lawyers in America, Washington DC Super Lawyers, Who's Who*, etc. Mark is a graduate of Harvard College, Harvard Law School, and Harvard's Kennedy School of Government.

Chair LANDRIEU. Thank you. Mrs. Brooks-LaSure.

STATEMENT OF CHIQUITA BROOKS-LaSURE, DEPUTY DIRECTOR, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. BROOKS-LASURE. Chairwoman Landrieu, Ranking Member Risch, thank you very much for the opportunity to discuss the many benefits that the Affordable Care Act will provide for small businesses. Although many small businesses would like to offer their employees health benefits, they have faced many challenges. The way insurers have presented information may make it difficult for employers to comparison shop.

Small businesses employing women, older workers, or workers with chronic or high-cost illnesses have faced higher insurance rates in most states. Changes in the age, health status, or gender mix of employees can add to the unpredictability of increases in a small group's premiums. The Affordable Care Act will remove these obstacles and help small employers provide their employees with high quality affordable health care coverage.

On October 1st, 2013, the health insurance marketplaces will be open for business, giving Americans, including small businesses, a new way to shop for health insurance coverage. For small businesses the Small Business Health Options program, known as SHOP, will provide a new, streamlined way for small employers to offer health insurance to their employees. The SHOPs will offer the same level of benefits and coverage that have been available to larger employers while helping small employers better predict and control health care insurance expenses.

There are signs that competition created by the SHOPs is resulting in lower prices for consumers. The lowest cost silver plan available to small employers in 2014 in the six states with available data is estimated to be 18 percent less expensive, on average, than the average premium that small employers would be paying for a comparable plan before the passage of the Affordable Care Act.

The SHOPs will offer a single point of entry for small employers and their employees to apply for coverage, and, if eligible, the employer may qualify for a tax credit worth up to 50 percent of the employer's premium contribution. In addition, small businesses will be able to choose from among many plans by making side-by-side comparisons of health plans, their benefits, premiums, and quality, expanding options as well as increasing transparency and competition.

The SHOP employer and employee applications, models of which are already available online, are smart, dynamic tools that will ask an applicant only the questions relevant to establishing eligibility for that applicant based on his or her particular situation. Clear instructions will help applicants apply online and HealthCare.gov, the website for the Federally-facilitated SHOPs, also includes information about what number to call in order to get help by phone if needed. HealthCare.gov will also link to state-based SHOPs and the applications used by those SHOPs.

Both inside and outside the SHOPs, the Affordable Care Act also helps ensure that plans available to small businesses and their employees have a standard set of benefits and meet certain requirements. New market rules require that premiums for most health

insurance plans available to small employers will not vary based on what type of small business they cover or the health status of the business employees.

This means that the hardware store on Main Street will see similar premiums as the bakery down the street or a neighboring farmer. CMS is working closely with our partners at the Small Business Administration and the Department of Treasury to help educate and inform small businesses and their employees about the SHOPs, tax credits available to small businesses, recent insurance reforms, and other benefits of the Affordable Care Act.

In June of this year, CMS relaunched a new consumer focused HealthCare.gov website and the 24-hours a day consumer call center to help Americans prepare for open enrollment and to ultimately purchase affordable health care coverage.

To provide additional assistance to small businesses, CMS will open a SHOP call center next month. Until open enrollment begins, the call center will provide basic educational information about SHOPs for small employers. Beginning October 1st, the call center will provide customer support, including enrolling employers in insurance plans and helping them access the application and enrollment system.

Chair LANDRIEU. Please try to wrap up.

Ms. BROOKS-LASURE. The call center will assist agents, brokers, navigators, and marketplace assistors on behalf of small employers. We look forward to continuing to work with the Committee improve the health care options for American small businesses.

[The prepared statement of Ms. Brooks-LaSure follows:]

STATEMENT OF
CHIQUITA BROOKS-LASURE

DEPUTY DIRECTOR, POLICY & REGULATION
CENTER FOR CONSUMER INFORMATION
& INSURANCE OVERSIGHT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

IMPLEMENTATION OF THE AFFORDABLE CARE ACT:
UNDERSTANDING SMALL BUSINESS CONCERNS

BEFORE THE

U.S. SENATE COMMITTEE ON
SMALL BUSINESS & ENTREPRENEURSHIP

JULY 24, 2013

Statement of Chiquita Brooks-LaSure on

"Implementation of the Affordable Care Act: Understanding Small Business Concerns"

U.S. Senate Committee on Small Business and Entrepreneurship

July 24, 2013

Chairman Landrieu, Ranking Member Risch, thank you for the opportunity to discuss the many benefits that the Affordable Care Act will provide for small businesses. On October 1, 2013, the Health Insurance Marketplace will be open for business, providing Americans, including small businesses, with a new way to shop for health insurance coverage. For small businesses, the Small Business Health Options Program (SHOP) will provide a new, streamlined way for small employers to offer health insurance to their employees. The SHOPs are designed to offer the same level of benefits and coverage that has been available to larger employers, while helping small employers better predict and control health insurance expenses. There have already been signs that the Marketplaces will offer lower-cost plans than are currently available to small businesses today.

Although many small employers would like to offer their employees health benefits, they have faced many challenges. Historically, small businesses have been charged 18 percent more for the same benefits compared to large employers. It has been difficult for employers to comparison shop. Small businesses employing women or workers with chronic or high-cost illnesses, and other pre-existing conditions have faced higher insurance rates in most states. Changes in health status or gender mix of employees have added to the unpredictability of increases in a small group's premiums. The Affordable Care Act will remove these obstacles and help small employers provide their employees with high quality, affordable health care coverage.

Reforms are Already Helping to Make Insurance More Affordable and Comprehensive

The Affordable Care Act is already ensuring that small employers are getting better value for their premium dollar. Before the Affordable Care Act, Americans watched their premiums double over the previous decade, oftentimes without explanation or review. In an effort to slow

health care spending growth and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more for plans in the individual and small group markets, shedding light on arbitrary or unnecessary costs.

Since the rule on rate increases was implemented,[1] the number of requests for insurance premium increases of 10 percent or more plummeted from 75 percent to an estimated 14 percent. The average premium increase for all rates in 2012 was 30 percent below what it was in 2010. Available data suggest that this slowdown in rate increases is continuing into 2013.[2] Americans have saved an estimated $1 billion on their health insurance premiums thanks to rate review. Even when an insurer decides to increase rates, consumers are seeing lower rate increases than what the insurers initially requested. More than half of the requests for rate increases of 10 percent or more ultimately resulted in issuers imposing a lower rate increase than requested or no rate increase at all.

Furthermore, the rate review program works in conjunction with the 80/20 rule (or the Medical Loss Ratio rule),[3] which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care, and no more than 20 percent (15 percent in the large group market) on administrative costs (such as executive salaries and marketing) and profits. If they fail to do so, they must provide rebates to their customers. In 2012, the 77.8 million consumers in the three markets covered by this 80/20 rule saved an estimated $3.4 billion upfront on their premiums because of the 80/20 rule and other Affordable Care Act programs. Additionally, consumers will save $500 million in rebates, with 8.5 million enrollees due to receive an average rebate of approximately $100 per family.[4]

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[1] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf
[2] ASPE Research Brief: Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm
[3] MLR Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act
[4] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf

Moreover, insurance companies cannot rescind people's coverage because they made an unintentional mistake on their application[5] and cannot place lifetime limits on the dollar value of essential health benefits. Group health plans, group health insurance plans, and non-grandfathered individual health insurance policies also are restricted in the annual dollar limits they can place on essential health benefits, depending on the plan year. For plan or policy years beginning in 2014, group health plans, group health insurance plans, and non-grandfathered individual health insurance policies will be prohibited from imposing annual dollar limits on essential health benefits. This change will help ensure that Americans will no longer worry about hitting a an annual cap , which could force a consumer to either pay out of pocket for health care costs above the dollar limit or forgo necessary care.

Small Business Health Options Program (SHOP)

Beginning on October 1, 2013, many small employers will be able to choose from coverage options through the Small Business Health Options Program, or SHOP, for their employees for coverage beginning as soon as January 1, 2014. SHOPs in every state will offer a single point of entry for small employers and their employees to apply for coverage, and if eligible, the employer may qualify for a tax credit worth up to 50 percent of the employer's premium contribution.

In 2014 and 2015, in most states, the SHOPs will be open to small employers with 50 or fewer full-time equivalent employees. In 2016, the program will be open to businesses with 100 or fewer full-time equivalent employees, and states could choose to expand eligibility to businesses of that size before 2016. In 2014, the Federally-facilitated SHOPs will allow employers to choose one qualified health plan from a range of plans to offer their employees. Also in 2014, state-based SHOPs will have the flexibility to decide to give employers the option of allowing their employees to choose from a number of plans, or having employers offer their employees one qualified health plan that the employer chooses from among all the plans available in the market. In plan years beginning on or after January 1, 2015, all SHOPs must allow small businesses' employees the option to choose coverage from a number of plans.

[5] For an example see: http://www.healthcare.gov/law/features/rights/cancellations/index.html

New Market Rules Make Coverage More Affordable

For plan years beginning in 2014, new market rules will ensure that premiums for most health insurance plans available to small employers will not vary based on what type of small business they cover or the health status of the firm's employees. Premiums can only vary by age, tobacco use, family size, and geography. Small businesses will no longer be penalized due to the health status or gender of their employees, and insurers will face limits on charging additional premiums for older employees. These reforms will protect small businesses and their employees purchasing coverage both inside and outside of the SHOPs.

Small employers and their employees can be confident that health insurance plans will cover the important health care services they need. Most plans, including all plans in the SHOPs, must cover essential health benefits,[6] which include items and services in ten statutory benefit categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits must be equal in scope to a typical employer health plan. Also, these plans must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the average percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer could expect to be responsible for approximately 30 percent of the costs of the essential health benefits the plan covers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider participation, and other factors, will help consumers make more informed decisions.

Competition and Small Business Tax Credits Make Coverage More Affordable

There are signs that competition between plans is resulting in lower prices for consumers. The lowest cost silver plan available to small employers in 2014 in the six states with available data is estimated to be 18 percent less expensive, on average, than the average premium that small employers would be paying for a pre-Affordable Care Act silver plan trended forward.[7]

The Affordable Care Act created the Small Business Health Care Tax Credit to help small employers of lower wage workers afford a significant contribution towards workers' premiums.

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[6] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

[7] ASPE Issue Brief: Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20 Percent Lower than Expected, July 18, 2013

An employer may qualify for a tax credit if it has fewer than 25 full-time equivalent employees making an average of less than $50,000 a year. To qualify for the Small Business Health Care Tax Credit, an employer must pay at least 50 percent of the premium cost of employee-only (not family) coverage for each of its employees. Starting in 2014, the tax credit is worth up to 50 percent of the employer's contribution towards employees' premium costs (up to 35 percent for tax-exempt employers). The tax credit will help lower the cost of offering health care coverage.

Better Way to Shop for Coverage

When open enrollment in the SHOP begins on October 1, many small employers will find it much easier to find and compare plans, select the option that is best for their employees, and enroll in coverage. Today, many small group market applications are extremely text-heavy, with limited instructions crowded too closely together and limited sections to assist applicants navigating through enrollment forms. Additionally, many such applications require users to jump back and forth between sections to determine what information should be completed in each section, and for whom. They tend to be process-oriented applications that require repeated entry of individuals' names and information in response to questions. In addition, many small group applications today require consumers to fill out long health history information used for rating purposes.

The SHOP employer and employee applications, models of which are already available online, are smart, dynamic tools that will ask an applicant only the questions relevant to establishing eligibility for that applicant, based on his or her particular situation. For example, different questions are displayed for an employee depending on whether the employer has offered dependent coverage. Some questions will also be clearly marked as optional. Clear instructions will help applicants apply online, and the website for the Federally-facilitated SHOP, HealthCare.gov also includes information about the number to call in order to get help by phone, if needed. HealthCare.gov will also link to State-based SHOPs and the applications in use by those SHOPs.

In June of this year, CMS re-launched a new consumer-focused HealthCare.gov website and the 24-hours-a-day consumer call center to help Americans prepare for open enrollment and ultimately purchase affordable health care coverage. To provide additional assistance to small businesses, CMS will open a SHOP call center next month. Until open enrollment begins, the call center will provide basic educational information about the SHOP for small employers. Beginning October 1, the call center will provide customer service support, including enrolling employers in insurance plans, and helping them access the application and enrollment system. The call center will also assist agents, brokers, Navigators, and other Marketplace Assisters working on behalf of small employers. These new tools will help small businesses understand their choices and select the coverage that best suits their needs when open enrollment begins October 1. Additionally, agents and brokers will play a vital role in the SHOPs, as they do in the small group market today. Agents and brokers act as trusted counselors, providing service at the time of plan selection and enrollment and customer service throughout the year.

Conclusion

For too long, small business owners have struggled to keep up with the ever-rising cost of health insurance for their employees. The Affordable Care Act makes it easier for businesses to find better coverage options and builds on the employer-based insurance market already in place. The SHOP, combined with new insurance reforms and tax credits provided by the Affordable Care Act, will give employers new options to provide their employees with high quality, affordable health care coverage. The SHOP will allow employers to avoid the confusion that can currently come with looking for coverage, allowing them to make an apples-to-apples comparison between plans and apply using a streamlined application. I look forward to continuing to work with you to improve the health care options for America's small businesses.

Chiquita Brooks-LaSure

Deputy Director

Center for Consumer Information Insurance Oversight

Chiquita Brooks-LaSure is the Deputy Director for Policy and Regulation at the Center for Consumer Information and Insurance Oversight (CCIIO) at CMS/HHS. In this role, she oversees development and clearance of policy and regulations related to implementing private insurance reforms and Exchanges of the Affordable Care Act.

Prior to joining CCIIO, Chiquita was the Director of Coverage Policy in the Office of Health Reform (OHR) at HHS, where she was responsible for policies regarding the Exchanges and Medicaid coverage.

Before her work at OHR, she served on the Democratic staff of the Ways & Means Committee. Chiquita played an integral role in working on issues related to health care coverage, including Medicare Advantage and Part D and the passage of the Affordable Care Act.

Prior to joining the Committee, Chiquita was a Director at Avalere Health, a strategic advisory group that advises clients on health policy. From 1999 to 2003, she worked at the Office of Management and Budget where she advised OMB and White House policy officials on Medicaid and SCHIP waivers, the uninsured, and Medicaid reform.

Chiquita received her AB from Princeton University and her MPP from Georgetown University

Chair LANDRIEU. Thank you very much. Ms. Olafson, and please speak right into the mic.

Ms. OLAFSON. Thank you. Can you hear me?

Chair LANDRIEU. Yes.

STATEMENT OF MEREDITH K. OLAFSON, SENIOR POLICY ADVISOR TO THE ADMINISTRATOR, U.S. SMALL BUSINESS ADMINISTRATION

Ms. OLAFSON. Thank you, Chair Landrieu, Ranking Member Risch, and members of the Committee. I am pleased to be here today. America's 28 million small businesses are the backbone of our economy, creating two out of every three net new jobs and employing half of America's workforce. The U.S. Small Business Administration is committed to giving small business owners the resources they need to start and grow a business, including access to accurate, timely information about how the Affordable Care Act is opening up better health care options for small business owners and entrepreneurs.

Many small business owners consider their employees to be part of their family, and providing benefits such as health care is one important tool they have to help retain their talented workforce and remain competitive. The Affordable Care Act helps these entrepreneurs provide insurance through measures designed to help small business owners have the same purchasing power and options as larger businesses.

As my colleagues have mentioned, tax credits are also available for many small businesses to help cover up to 35 percent of the premium costs of health insurance. Hundreds of thousands of small business owners have already benefitted from these credits and the credits will rise to 50 percent in 2014. Also beginning in 2014, the Affordable Care Act will give self-employed entrepreneurs and small businesses, generally those with up to 50 employees, a better way to shop for insurance through the new individual and small employer marketplace.

And the majority of small businesses will not be affected by the employer-shared responsibility rules which take effect in 2015. In fact, businesses with fewer than 50 full-time or equivalent employees are not subject to these rules. That is about 96 percent of our businesses.

As the primary gateway for small business owners engaged with the Federal Government, the SBA is working closely with the Department of Health and Human Services, the Departments of Labor and Treasury, and others to ensure that small business owners know the facts about the Affordable Care Act. SBA is also partnering with HHS on the ground to leverage their expertise and connect them with small business owners across the country.

As part of our outreach efforts, SBA disseminates a weekly, a biweekly interactive health care blog, as well as a direct e-newsletter that reaches more than 1 million subscribers. We have also created robust online content at SBA.gov as well as Business.USA.gov. These two sites combined have more than 2 million visitors per month.

America's small business owners engage daily with SBA, HHS, IRS, and our other Federal partners through a variety of online

sites. Therefore, as part of our "no wrong door" approach to online engagement, Business.USA.gov is leading the Administration's efforts to provide comprehensive health care information and easy to use tools for businesses across these sites. This ensures that small business owners get the information they need no matter their point of online entry.

SBA has also developed a series of comprehensive small business webinar trainings for our staff, our extensive network of small business development centers, women's business centers, and SCORE, as well as staff from other Federal agencies. To date, we have trained more than 2,200 of these on the ground staff and partners so that they in turn can serve as resources for small businesses in their communities, and this training continues.

At the same time, we are working with our regional and local partners to better educate small businesses that are served by SBA's 68 district offices. Since February 2013, SBA has helped to lead over 350 events serving approximately 24,000 attendees. And just last week on July 18th, we launched a weekly Affordable Care Act webinar series in partnership with Small Business Majority. The goal of these webinars is to educate small business owners across the country and the webinars are open to all small businesses.

We have also worked to educate and train leaders and members of a number of national trade associations about the Affordable Care Act such as the International Franchise Association, the International Association of Plumbing and Mechanical Officials, and the International Bakers Association, as well as state organizations like the Louisiana Restaurant Association.

The Affordable Care Act allows small employers to offer coverage in a way that makes sense for their business and works for their bottom line. SBA is committed to leveraging our resources and Federal partnerships to ensure that small business owners have the facts and the resources they need to understand the law. Thank you.

[The prepared statement of Ms. Olafson follows:]

U.S SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

WRITTEN TESTIMONY OF

MEREDITH K. OLAFSON
U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

U.S. SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

JULY 24, 2013

Chair Landrieu, Ranking Member Risch and members of the Committee – I'm pleased to be here today.

America's 28 million small businesses are the backbone of our cconomy, creating two out of every three net new jobs and employing half of America's workforce. The U.S. Small Business Administration (SBA) is committed to giving small business owners the resources they need to start and grow a business-- including access to critical information about how the Affordable Care Act is opening up better health care options for small business owners and entrepreneurs.

Many small business owners consider their employees to be part of their family, and providing benefits such as health care is one important tool they have to help retain their talented workforce and compete for skilled employees. The Affordable Care Act helps these entrepreneurs provide insurance through measures designed to help small business owners have the same purchasing power and options as large businesses. Tax credits are also available for many small businesses to help cover up to 35% of the premium costs of employee insurance. Hundreds of thousands of small business owners have already benefited from these credits, which will rise to 50% in 2014.

Beginning in 2014, the Affordable Care Act gives self-employed entrepreneurs and small businesses with generally up to 50 employees a better way to shop for insurance through the new individual and small employer Health Insurance Marketplaces. And the majority of small businesses will not be affected by the new Employer Shared Responsibility rules which take effect in 2015. In fact, businesses with fewer than 50 full-time or equivalent employees are not subject to these rules – that's 96% of all businesses.

As the primary gateway for small business owners engaged with the federal government, SBA is working closely with the Department of Health and Human Services (HHS), Departments of Labor and Treasury, and others to ensure that small business owners know the facts about the Affordable Care Act. SBA is also partnering with HHS on the ground to leverage their expertise and connect them with small business owners across the country.

As part of our outreach efforts, SBA disseminates a bi-weekly, interactive health care blog as well as a direct e-newsletter that reaches more than one million subscribers. We've also created robust online

content at both SBA.gov and Business.USA.gov. The two sites combined have more than 2 million visitors per month.

America's small business owners engage daily with SBA, HHS, IRS and our other federal partners through a variety of online sites. Therefore, as part of a "no wrong door" approach to online engagement, Business.USA.gov is leading the Administration's efforts to provide comprehensive health care information and easy to use tools for businesses across these sites. This ensures that small businesses owners get the information they need, no matter their point of online entry.

SBA has also developed a series of comprehensive small business webinar trainings for our staff, our extensive network of Small Business Development Centers, Women's Business Centers, and SCORE, as well as staff from other federal agencies. To date, we've trained more than 2,200 of these "on-the-ground" staff and partners so that they in turn can serve as resources for small business in their communities.

At the same time, SBA is working with our regional and local partners to better educate small business owners served by our 68 district offices. Since February 2013, SBA has helped lead over 350 events, serving approximately 24,000 attendees. And on July 18, we launched a weekly Affordable Care Act webinar series in partnership with Small Business Majority to educate small business owners across the country. We've also worked with a number of national and state trade associations to educate their leaders and members about the Affordable Care Act.

The Affordable Care Act allows small employers to offer health coverage in a way that makes sense for their business and works for their bottom line. SBA is committed to leveraging our resources and federal partnerships to ensure that small business owners have the facts and resources they need to understand the law.

Thank you.

Meredith K. Olafson Bio

In her role as Senior Policy Advisor to the Administrator, Ms. Olafson is responsible for overseeing the U.S. Small Business Administration's education and outreach efforts around health care and the Affordable Care Act.

Previously, Ms. Olafson served as a Senior Policy Analyst in the Agency's Office of Entrepreneurial Development, where she worked on special initiatives involving entrepreneurship. Prior to that, Ms. Olafson served as an Attorney Advisor in the Agency's Office of General Counsel with a focus on employment and labor law matters.

Before joining the Agency, Ms. Olafson was an associate at Hunton & Williams LLP and Sonnenschein, Nath & Rosenthal, where she represented a diverse range of businesses in employment litigation at the federal and state level and provided advice and counsel on a range of employment-related matters. Ms. Olafson received her J.D. from Georgetown University Law Center and her B.A. from Northwestern University.

Chair LANDRIEU. Thank you very much. We will start with our first round of questioning. Let me put something into the record and then start my question to you, Ms. Brooks-LaSure, if I could. 96 percent, underscore, of all firms in the United States, which is almost 6 million firms, have fewer than 50 employees. They are exempt from any employer responsibility, correct?

Of the 5.8 million firms, do you know how many workers they employ? It is about 34 million. Does that sound right?

Ms. BROOKS-LASURE. Yes.

Chair LANDRIEU. In Louisiana, 67,000 small businesses have less than 50 employees. About 91 percent of all businesses in Louisiana are exempt from the requirements of this Act. 184,000 small businesses in our state have between 50 and 249. All the Senators can get access to the information from their states from the census, which is where I got this, and in Louisiana, 3,800 businesses only—that is a small number, it is a significant number, but relatively small—have between 50 and 249 employees.

So the point of this is that the vast majority of businesses, small businesses in America, do not have a mandate from the Affordable Care Act. So the implementation is happening really for businesses between 50 and above, and primarily between 50 and 249 employees. And that is what I want to ask about eventually.

But for right now, my first question is this. The ACA created health marketplaces that you all have described where individuals can shop for health insurance. These marketplaces, including the SHOP Act which you all just talked about, the SHOP provision, will increase the—the idea is for it to increase competition in the private market and give small businesses individual choices that they never had before.

How is HHS operating in states that choose not to set up their own exchanges? Because there have been some states that are busy cooperating and set up exchanges, others that have decided to sit on the sidelines. How is that happening? Chiquita, could you just talk for a minute about how small businesses are going to be helped in states that have not decided to engage in setting up exchanges?

Ms. BROOKS-LASURE. Absolutely. Thank you so much for the question. So in states that have chosen not to operate a state-based marketplace, we will be setting up a marketplace both for the individual market as well as for the SHOPs. In many of those states, they are still working with us to work to certify the qualified health plans. Those will be the private plans that are offering health insurance coverage.

And so, as part of our process right now, we are in the middle of reviewing the plans, working with the issuers to get plans certified. Starting on October 1st in every state where we are running the marketplace, individuals and small businesses will be able to go online, fill out an application. It takes about 15 minutes. And then they can choose a plan to offer to their employees.

Chair LANDRIEU. Now, you testified that in one of the states, and I do not know if you want to identify what it is—where you said the average of states that have cooperated and engaged in setting up these exchanges for small business, the rates have gone down

by 18 percent. Is that what you testified and could you elaborate, please?

Ms. BROOKS-LASURE. I would be happy to. So states have different rules about when they make data available, and six states have made data available about their——

Chair LANDRIEU. What states are those, please?

Ms. BROOKS-LASURE. I can get those for you. I do not have them, but we will get them for you for the record. And in those states, our research part of HHS did an analysis and looked at the silver plan that is being offered. That plan, when compared to an equivalent plan trended forward, before the Affordable Care Act, is 18 percent lower, and that report is on our website under the——

Chair LANDRIEU. And can you quickly, because I have just got a few minutes left, describe just quickly what a silver plan would look like?

Ms. BROOKS-LASURE. A silver plan means it is about—it is 70 percent. So it means that the plan itself pays about 70 percent of the cost when you go to the doctor, on average, and an individual would pay about 30 percent. So there would be likely a deductible and co-pays when you go to the doctor, and then an out-of-pocket cap.

Chair LANDRIEU. But it would be a fairly—would you describe it as a fairly generous, a silver plan, or how would you describe it——

Ms. BROOKS-LASURE. I would describe it as middle, silver. There is also bronze, which is a lower benefit, and we likely will see a lot of HSAs and high deductible plans. Silver is in the middle. Businesses will also be able to choose gold, which is 80 percent, which is the more generous benefit. And platinum. Those premiums will be higher.

Chair LANDRIEU. Okay. I am going to add one more minute and give the same to my ranking member. I would like to ask you, Ms. Olafson, because there have been a lot of questions from small businesses that I represent, and I am sure many members, they do not seem to be getting a lot of information about what is going on and there is some uncertainty.

You touched on this in your testimony, but can you describe in some more detail how you are obtaining and using information to get it out to small businesses, and explain a little bit more about what this "no wrong door" policy is?

Ms. OLAFSON. Absolutely. Thank you, Chair Landrieu. So SBA is taking, which I highlighted in my opening statement, a three-prong approach to outreach. You know, we want to make sure that we reach business owners in their communities through various mechanisms and tools.

So the three-prong approach, I mentioned online. You know, we disseminate the weekly interactive blog. We hear from a lot of businesses through that mechanism. And our e-newsletter is reaching more than 1 million subscribers. And then through SBA.gov as well as Business.USA.gov. Both of those sites together combined have more than 2 million visitors per month.

The "no wrong door" approach is, we want to make sure that no matter where a business owner is going, whether it is to our site or to HealthCare.gov, they are not falling through the cracks. So they are getting the same consistent information across sites. Busi-

ness.USA is working to leverage all of the content at those sites to provide information to business owners around the Affordable Care Act as well as——

Chair LANDRIEU. So if they cannot get this through their regular business associations, there are many options and you are trying to make that more public?

Ms. OLAFSON. Exactly.

Chair LANDRIEU. Thank you. I am going to turn this over now to Senator Risch, and add 1:41 to you.

Senator RISCH. Thank you, Madam Chairman. First of all, I am glad you cleared up the record. 96 percent of businesses, is that correct, are exempted from Obamacare?

Ms. BROOKS-LASURE. Exactly.

Senator RISCH. Is that what I am understanding? Chairman Landrieu asked you that question, is that right?

Ms. BROOKS-LASURE. She did.

Senator RISCH. I am assuming that the question and your answer is to indicate that those 96 percent are exempt is a good thing?

Ms. BROOKS-LASURE. Most small businesses are exempt, yes.

Senator RISCH. Well, if it is such a good thing, why do we not go the other 4 percent of the way and exempt all business, 100 percent of businesses, from Obamacare? That would be a great thing, would it not?

Ms. BROOKS-LASURE. The Treasury Department is responsible for overseeing employer responsibility. I will say, obviously, as part of the ACA, the idea is that both businesses, individuals have the responsibility to help provide coverage or to pay, because health care costs affect us all.

Senator RISCH. I am looking at—I am sorry.

Ms. OLAFSON. If I may?

Senator RISCH. Sure.

Ms. OLAFSON. For years, small business owners have been telling us that access to health care is one of their top concerns. They often have paid up to 18 percent more than their larger competitors for health care. The ACA is helping to level the playing field for small businesses. So the first thing we tell business owners is, Look at the facts and the opportunities around this law, the tax credits, the access to the affordable care markets, et cetera.

Senator RISCH. And by the way, I think that that particular provision of the law that allows the small businesses to pool was a good idea, and I think we probably would have gotten the bipartisan support to actually pass that here. Unfortunately, it was wrapped in 2,700 other pages that we did not particularly agree with. But the pooling seems to be a rational, reasonable idea that should be done.

One of the difficulties I have is that we keep getting reports that the cost of health care keeps going up, notwithstanding the fact that everybody was promised it would go down, notwithstanding the figures, Ms. LaSure, that you had. I am looking at a table that was produced by Society of Actuaries. Now, they are not beholden to the Administration like an agency is. They are not Republicans, they are not Democrats, they are not Conservatives or Liberals.

Their study shows that insurance premiums will go up quite substantially over the next few years. Senator Landrieu will be interested to hear that they are talking about a 28.6 percent increase in Louisiana. In New Hampshire, they are talking about a 36.8 percent increase. In North Dakota, they are talking about an increase of only 8.4 percent, so you are very fortunate there.

Massachusetts is the big winner. They get actually a decrease of about 12.8 percent. Senator Johnson, I have got bad news for you. It is an 80 percent increase in Wisconsin. So these numbers, although we are hearing these statistics that you are throwing out, that is not what we are hearing from the Society of Actuaries, and, it is not what we are hearing from the witnesses who are going to testify here today.

I hope you will stay around to hear the witnesses because you can look at the statistics all you want, but when you have live witnesses here who will tell you what is actually happening to their premiums, I think you will be interested.

Chair LANDRIEU. And I want you to identify for the record the document that you are reading from, and——

Senator RISCH. Yes. It was produced by the Society of Actuaries.

Chair LANDRIEU. What date?

Senator RISCH. Cannot give you the date.

Chair LANDRIEU. No date?

Senator RISCH. No date.

Chair LANDRIEU. Okay.

Senator RISCH. It is not 1932. It is a very recent study, Madam Chair.

Chair LANDRIEU. I would like to know the date for the record.

Senator RISCH. Thank you. We will get you that. Thank you, Madam Chairman. I yield back.

Chair LANDRIEU. Okay. Senator Shaheen.

Senator SHAHEEN. Yes, thank you, Madam Chair.

Chair LANDRIEU. Let me just say welcome to Senator Markey. This is your first meeting of the Small Business Committee. We would like to all welcome you to our Committee. Thank you for joining us today where the exchanges seem to be working fairly well. We are anxious to hear your perspective from Massachusetts. Senator Shaheen.

Senator SHAHEEN. Mr. Iwry, last month the Administration delayed the employer responsibility provision for a year, made the associated reporting requirements voluntary until 2015. I would like you to do two things, if you would. Could you answer who that employer responsibility provision applied to? I assume it was all business, not just large businesses. And also, can you talk about why the Treasury made that decision?

Mr. IWRY. Senator, I would be happy to. The employer responsibility provision applies to employers with 50 or more full-time employees, or full-time equivalents, and does not apply to employers with fewer than that number. The decision process was one that was thorough and conducted within the Treasury Department. As policy decisions are typically coordinated with the White House, this decision was also coordinated with the White House.

It stemmed from concerns that were expressed to Treasury and the Administration in general from the business community, in-

cluding small business and larger, about the need for more time for them to adapt and ramp up their systems for reporting; that is, collecting the information they would need in order to report, and then their systems were actually reporting that information to the Government and to the individuals.

They indicated that in order to smooth the path toward implementation, it would be far better if they had more time to adjust their systems to either adapt or develop systems, as the case may be.

And second, they expressed a concern that those reporting requirements were not as simple or streamlined as they might be, as businesses hoped we could make them, and they asked whether we could do our best to show the same kind of flexibility with respect to these reporting requirements, that is, the way Treasury applies and interprets them, that we did with respect to some of the employer responsibility provisions where we worked with the business community over an extended time, a lot of dialogue, to see how we could make the provisions, as applied on a regulatory level, as workable as possible consistent with the statute.

So we responded to those two concerns, Senator, by first, looking at them objectively and weighing whether they were sufficiently weighty to justify transition relief that people were asking for.

Senator SHAHEEN. And have you gotten feedback from business as the result of the decision to delay the employer responsibility provision?

Mr. IWRY. Yes, Senator Shaheen. We have received, indeed, business has provided feedback not in particular to us as opposed to publicly. The major business—many major business groups, including the U.S. Chamber of Commerce and the National Retail Federation, National Restaurant Association, others have indicated that they thought that the transition relief in response to the concerns that they had expressed, and many of them had expressed concerns not focused only on the reporting, but had asked for more time regarding employer responsibility generally.

With respect to reporting in particular, that drove our decision and the commended us for having listened and been flexible enough not to agree to postpone these provisions indefinitely, but simply to give them the transition relief that they asked for so they could adapt their systems and have as successful and smooth an implementation as possible.

Senator SHAHEEN. Thank you. My time is up.

Chair LANDRIEU. Senator Rubio.

Senator RUBIO. Thank you for holding this hearing, Madam Chair. Ms. LaSure, how are you? Good morning.

Ms. BROOKS-LASURE. Good.

Senator RUBIO. Afternoon. Feels like morning. I want to talk a little bit about the Small Business Health Options Program and how that is going. There is an article here from Forbes. It is an opinion piece dated July 8th of this year. And it writes as follows, and I want to know if this is true.

It said, Maryland, one of the first states to embrace Obamacare, announced in April that it would delay the launch of its Small Business Exchange by at least three months. A recent GAO report said that all 17 states that are building their own exchanges are

behind schedule, missing deadlines on 44 percent of the key activities needed to get them up and running. Is it true that 17 of the states that are building their own exchanges are behind schedule?

Ms. BROOKS-LASURE. I would say no to that. We are working very closely with the state-based marketplaces to make sure they are meeting their critical milestones. There are times where we adjust and make changes, but we are working very closely with the state-based marketplaces and expect them all to be up and running on October 1st.

Senator RUBIO. So you anticipate all the exchanges, including the Federal one, to be operational on October 1st of this year?

Ms. BROOKS-LASURE. Yes.

Senator RUBIO. Can you guarantee that?

Ms. BROOKS-LASURE. Of course I cannot.

Senator RUBIO. Okay.

Ms. BROOKS-LASURE. But we are working very hard to achieve that. We are working constantly, as I said, working with states. There may be, again, pieces where we take time and prioritize and may make some adjustments, but in terms of being open, the marketplaces will be open on——

Senator RUBIO. One of the concerns the article raises is that in some states this is—obviously, these exchanges are built on choice because the choice leads to competition and hopefully lower premiums. The article goes on to say that just one insurer signed up to provide coverage in Washington, in New Hampshire, and in North Carolina, and in Mississippi not a single insurance company signed up until recently. I think Humana finally stepped up.

Are we going to see multiple choices in each of these insurance marketplaces on October 1st?

Ms. BROOKS-LASURE. We have been very pleased in the Federally-facilitated marketplace with the interest from the issuer community. We have said there have been over 120 issuers that we are working on. Certification happens in September. That is when we finalize the final actual agreements, and so that is when we will be able to announce what all of the choices look like.

Senator RUBIO. How confident are you that every exchange out there, the 17 states, the 33 Federal ones, that all of them will offer multiple choices for patients?

Ms. BROOKS-LASURE. I am very confident that we will have choice. Again, this is——

Senator RUBIO. In all of them? In all of them?

Ms. BROOKS-LASURE [continuing]. I cannot speak to specific states, but I will also say, this is a voluntary engagement. This is based on the private sector, and so we are working with them, and private sector companies make choices. But we think this is a very attractive option for them and expect many issuers to participate.

Senator RUBIO. If you are a worker at a small business, can we guarantee that none of them will lose their existing coverage if they are happy with it?

Ms. BROOKS-LASURE. Well, in terms of what they are being offered, small employers will have additional options. Again, there are changes being made which benefit small employers, meaning that their insurance companies have requirements about what they need to offer for them.

Senator RUBIO. But the point being, one of the problems that was made in this law was if you have insurance and you are happy with it, you will get to keep it. Can we guarantee that due to this law, no one will lose coverage that they are happy with?

Ms. BROOKS-LASURE. People will make choices about what kind of coverage they choose.

Senator RUBIO. So we cannot guarantee it? In essence, there will be people that will lose their existing coverage that they are happy with because their employer will make a change as a result of the requirements of the law?

Ms. BROOKS-LASURE. I cannot answer that question.

Senator RUBIO. Okay. What about doctors? Can we ensure everyone that has a doctor that they are happy with that they are going to be put on a plan that includes that doctor in the network?

Ms. BROOKS-LASURE. Doctors in this country make choices about whether they want to participate. Again, we are working with issuers, issuers are working and needing to meet certain state and Federal requirements about network adequacy.

Senator RUBIO. So is it possible that someone who today has an existing relationship with a doctor that they are happy with will no longer be able to see that doctor because they are now going to be moved to a plan that that doctor is not part of the network?

Ms. BROOKS-LASURE. No one is moved to a plan. People make choices about what kind of coverage they choose.

Senator RUBIO. Well, their employer may make choices, right, as a result of the law's requirements?

Ms. BROOKS-LASURE. The employer makes choices, exactly.

Senator RUBIO. I know I am running out of time. Just real quick, Ms. Olafson, I wanted to ask you about the tax credit. According to the General Accounting Office, the participation on it has been less than anticipated. Is that not correct?

Ms. OLAFSON. So, you know, the tax credit is a significant part of the Affordable Care Act. I certainly have my colleagues here from Treasury to talk about the uptick on that, but we do know, as Chairwoman Landrieu said in her opening statement, that it is really targeted to those small business owners who most need help getting coverage.

We know that hundreds of thousands of business owners have already taken advantage of it and that the credits will rise in 2014 for those employers that are choosing to purchase coverage through SHOPs. So it is a critical part of this Act and we know that many of our businesses are taking advantage of it.

Chair LANDRIEU. Thank you. Senator Heitkamp.

Senator HEITKAMP. Ms. Brooks-LaSure, I have a quick question. If there was no Affordable Care Act, would there be any guarantee that an employee would be able to keep the coverage that they currently have if an employer made a different decision?

Ms. BROOKS-LASURE. No.

Senator HEITKAMP. If there were no Affordable Care Act, would there be any guarantee that the employer would continue to offer the same kind of coverage that he or she or it is currently offering?

Ms. BROOKS-LASURE. No.

Senator HEITKAMP. So a lot of this is about the choice. A lot of this is about whether, in fact, employers make a different choice to

go to a different plan and then whether employees make a choice to go to a different plan and whether the choice options have been broadened for those entities.

Can you tell us what percentage of American businesses plan on, at least in your estimation right now, maintaining the same coverage that they currently provide?

Ms. BROOKS-LASURE. All the evidence that we have, based on previous experience, the experience we have seen with Massachusetts in implementing their exchange, is that employers want to offer coverage and employer coverage increases. And so, we fully expect employers to continue to offer and hope that more small employers will now see opportunities to offer.

Senator HEITKAMP. Many of the—Ms. Chairman, many of the businesses that I talk to in North Dakota who have, over the years, offered great plans, plan on sticking with the great plans that they have, and that is certainly what Blue Cross and Blue Shield, which is the majority provider in our state, anticipates, that a lot of their corporate accounts will stay very, very similar.

And so, as we look, North Dakota is obviously a state where a lot of small businesses will not be subjected to the Affordable Care Act, if we want to use that word. And so, you know, the challenge in all of this, as we anticipate and we look forward to what the changes will be, is that we really do not know what choices people will make. There are a lot of assumptions, I think, on both sides about what those choices might be.

I guess, you know, delaying the mandate for an extra year will make the opportunity to collect additional information and maybe will make changes even more apparent. But I want to just use what remaining time I have to talk to Ms. Olafson.

One of the concerns that I have is small businesses that are not affiliated with a trade organization or an entity that may be like the Chamber of Commerce, do not necessarily have direct access, and that is key information. I encourage people to go out on Kaiser because I think that is a site that that has independent evaluation. People right now hear arguments on both sides. But I am curious, if Denver is a region that is affiliated with the Small Business Administration.

What are you hearing or what are you focusing on in terms of our opportunities to get the information out to our rural small businesses, our small manufacturers who may not otherwise have access to information?

Ms. OLAFSON. Thank you, Chairwoman—I am sorry—thank you, Senator. So as I said, we are leveraging all of the resources that are available to us. You know, many of our small businesses—and we know this from market research—do access information online, they coming to us, anyway, over 2 million visitors per month at our website.

But for those businesses that want or need sort of more direct on-the-ground resources, we are leveraging our 68 district offices. We have both trained those folks so they can serve as resources. We have trained our Women's Business Centers, our SCORE, our Small Business Development Centers, so that as our business owners come to us for counseling about access to capital, Government

contracting, they also know they can get current, accurate information about the health care law.

So we are trying to build out that network across the board, whether it is online, in person engagement, webinars, free webinars open to the small business community.

Senator HEITKAMP. Well, one of the concerns that I have is that where you saw in Medicare Part D a big public information campaign which was, in fact, funded by the Federal enactment, we do not see that in this situation. So it really is dependent on using available resources.

And I would suggest taking a look at non-traditional ways of getting information out and making sure that that information has a level of credibility, because one of the concerns that we have is that every time you turn around or every time I visit with folks, I am in the spot of having to say, That is not the way I understand it. Can I get back to you? Can I get information out there?

And so, some sites that are readily pointed to with some credibility I am frequently asked questions of could be enormously helpful.

Ms. OLAFSON. Absolutely, and that is critical. You know, we know that business owners are not going to make decisions based on misinformation. And so, our role—we really view our role as providing facts, cutting through the misinformation, and helping business owners make the decision that is best for their individual circumstances.

Chair LANDRIEU. Thank you, Senator Heitkamp. Let me just interject here that I really appreciate you pointing out that there were no guarantees before the ACA, there are very few guarantees after, but there are a few important guarantees. One of them is that there are going to be no lifetime caps come January on policies.

The other one that is—well, lifetime caps is now. The other is there will be no annual caps come January. And the other is that there is, pre-existing conditions are, you know, irrelevant now and that people—so there are some guarantees. But the guarantees that Senator Rubio asked about were doctors, which is a legitimate question, were not in place before or after the Affordable Care Act.

And just to clear the record, the Ranking Member submitted a document and I want to just make this clear, that we have gotten some more information about this, Senator Risch, and the study was published in March of 2013, according to this document that I am going to put into the record. It was an article written about it on April 18th.

The person that ran the study was Kenny Clan, who is the Chief Actuary at a Maryland-based CareFirst Blue Cross/Blue Shield. He is not independent. He works for a large insurance company. They are actuaries, but most of the actuaries work for insurance companies. And that is just the record. If you want to submit anything else, that is fine.

Chair LANDRIEU. Senator Johnson.

Senator JOHNSON. Thank you, Madam Chair. There actually was one guarantee that certainly sticks in my mind and that was President Obama repeatedly promised that if we passed the health care law, the average cost of a family plan would decline by $2,500 a

year by the end of his first term. In fact, it has increased by about $2,370 from 2009 to 2012. Is that correct, Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. Again, I do not believe so. For years, health insurance rates have been increasing faster than wages, and in the last few years, we have seen that it has slowed. I think it is very critical that when we look at these studies, that we are making apples to apples comparisons about the benefits.

Senator JOHNSON. What do you disagree with, though? That President Obama did not make that promise repeatedly?

Ms. BROOKS-LASURE. No, I am sorry. You had said that rates were going up——

Senator JOHNSON. Premiums for family plans are up almost $2,500, according to a Kaiser study, and we can submit that to the record.

Ms. BROOKS-LASURE. Okay. I guess what I wanted to make clear are two points. One, that rates have been going up over time. In the last few years, we have seen rates starting to slow. I believe the President described that this morning. And second, that it is important to compare apples to apples; that when talking about the cost of plans, it is important to compare what benefits were being offered in the original plan versus the future plans. So there may be——

Senator JOHNSON. Right now, we are comparing apples to apples because when the President made that promise, the average premium was somewhere around $13,000. Now it is over $15,000 for the same plan. So that is an apple to apple comparison. That is a promise. That is a guarantee that was broken.

Mr. Iwry, you talked about information that the businesses are not able to report to the Government. Specifically, what information, after three-and-a-half years of the implementation of this law, are they unable to comply with?

Mr. IWRY. Senator, the business community has told us that the information reporting requirements under the law——

Senator JOHNSON. Yes. What type of information? I want to know the type of information.

Mr. IWRY. That the information reporting requirements, which include the month-by-month determination of who are full-time employees of the employer, and whether they were offered affordable, minimum-value coverage by the employer, and related information to determine whether the employer responsibility provision is satisfied and whether the individuals have coverage from the employer or not, that that information was something that their systems could, with more time, more smoothly and readily provide.

They also did ask sir, and recognizing where your question is coming from, they did ask us whether we could simplify or streamline those information requirements consistent with the statute.

Senator JOHNSON. Here is some information that I am concerned that is not going to be gathered. Senator Shaheen talked about the delay in the employer mandate. I am concerned about the delay in basically a verification of income, verification of qualification for the subsidies, that that is just being waived for the first year of implementation.

So basically, people could self-report. Is the Treasury Department a little concerned about fraud in that waiver?

Mr. IWRY. Senator, the Treasury Department is not too concerned about the risk of fraud in connection with the verification provision that you are referring to because the people at HHS, the officials at the Centers for Medicare and Medicaid, have advised us that the verification adjustment, and I will defer to Ms. Brooks-LaSure to explain, that the adjustment for one year, for 2014, in the verification procedures is rather limited.

Ms. BROOKS-LASURE. So if I could just, Senator——

Senator JOHNSON. I want to know who in the end is going to verify those numbers. What agency within the Federal Government is going to verify the qualifications of individuals for subsidies?

Ms. BROOKS-LASURE. We start, and so, when someone comes to the marketplace, they go through a process that is determined whether they are eligible. We use data systems from the IRS, SSA, other systems, private insurance—a private system where we get data from employers. So we are verifying income.

We were never using the data that Treasury gets in terms of employer reporting because that data is available in 2015 for the first year and we need the data at the beginning of open enrollment. So on October 1st, we will start verifying whether people are eligible for tax credits.

Senator JOHNSON. So HHS will now have information from the IRS on an individual's income because of the Affordable Care Act. Now HHS has that very private income information.

Ms. BROOKS-LASURE. There are strict privacy standards.

Senator JOHNSON. Well, that gives me a lot of comfort.

Chair LANDRIEU. Thank you very much. Senator Enzi.

Senator ENZI. Thank you, Madam Chairman. Appreciate you holding this hearing. I am not only on the Small Business Committee. I am also on the Finance Committee and on the Health, Education, Labor, and Pensions Committee which handles this, so I have been to a number of hearings on it. And every time I go to one, I get a little more confused.

I can tell you that in all of the Committees, there is a whole lot more interest in what is going to happen, and that is because starting January 1st, all the Senators, all the Congressmen, and all of their staff are going to have to go on the exchange to get their insurance, and there are a lot of unanswered questions about that. So both sides of the aisle are rather intense on this exchange.

Some of the questions that they have asked is because we were told that it was beta tested, the exchange is beta tested already, so one of the people on the other side of the aisle asked, Who tested it and if they could have a list. And that is apparently not available.

Ms. BROOKS-LASURE. In terms of our testing, thank you, Senator, for the question, we are undergoing very rigorous testing. So we at HHS are testing with our Federal partners. That has been ongoing for the last year.

Senator ENZI. How do you write the program without having a basic plan defined? That is another question that has been asked in all three of these Committees.

Ms. BROOKS-LASURE. So I am not sure if I am understanding your question.

Senator ENZI. You give the silver plan as being 70 percent, gold 80 percent, and bronze. But what does that consist of?

Ms. BROOKS-LASURE. It is based on our standards and our regulation and then states are——

Senator ENZI. Can you send me the list of the exact things that are on that, not just the general ones like that?

Ms. BROOKS-LASURE. Certainly, but then plans are submitting that data to states. They are entering it into SURF and that is where the data is.

Senator ENZI. So far, nobody has provided us with that. Small businesses have complained that they have spent thousands of hours attending seminars to try and find out how they are going to be taken care of on, and, of course, now that has been put off for a year. But what they do not understand is what happens to their employees now if they do not offer the insurance, employees have to go into the exchange. But the amount that they used to subsidize will not be subsidizable tax-free anymore, the way we understand it.

But, Mr. Iwry, you raised something that was new to me, I guess. You talked about the full-time equivalency, I guess relating to the number of employees that an employer has. I thought it was just strictly full-time employees, not full-time equivalencies. Am I wrong?

Mr. IWRY. Senator Enzi, for purposes of determining whether an employer is one of the 96 or so percent that are not subject to this employer responsibility provision because they are below 50 employees in size, the statute provides for counting the full-time employees, as you say, plus counting the full-time equivalents.

So if I may answer with an example?

Senator ENZI. No, I do not need an example. I know what full-time equivalency means. I just had not——

Mr. IWRY. Yes.

Senator ENZI. That is going to be a surprise to a number of them, just as the 30 hours is a surprise. So actually, part-time is only 29 hours. If they hit that 30-hour mark, they are full-time. How come it is 30 hours? Forty hours has always been full-time. Thirty hours has always been part-time. A number of employers are pretty concerned about that number.

Mr. IWRY. Senator, I was not involved in the crafting of that particular provision that set the number at 30. My understanding is that one of the reasons that 30 was selected in the legislative process was that there was concern that employers not be induced unduly to reduce employees' hours from, for example, 40 to 39 if the level had been set at 40, and that because there is a lot of variation and diversity in practices among small business and larger business, that that might be a very easy thing for employers to do.

Whereas, while, of course an employer could reduce an employee's hours from 30 to 29, and there has been talk about that, because a majority of the full-time workers were, I think, thought to be working more than 30 hours, that that kind of gaming to avoid employer responsibility might be more difficult to do or less readily available with 30.

Senator ENZI. It is not working very well for you, I do not think, and it is not working well for the employers or the employees. I

know a lot of businesses that have—they have cut back to the 29, although there are a lot that cut back to the 30 thinking that would not be it. They are not aware of the full-time equivalency yet, so if they reduced two employees back to that, they still have one.

But the 29 versus 30 hours is very troublesome. I realize that is in the law. It is one of those things that people did not know until after they had passed out. Thank you, Madam Chair.

Chair LANDRIEU. Thank you, Senator. Senator Fischer and then we will get to Senator Vitter and then we are going to move to our second panel.

Senator FISCHER. Thank you, Madam Chair, and thank you, Ranking Member, for holding this hearing today. It is a vitally important hearing.

In Nebraska, small businesses represent 96.6 percent of all employers and they employ 50 percent of the private sector labor force. So the impact of the Affordable Care Act on this sector of my state's economy, not to mention the economy of our country, is of great concern to me. I had heard from many small business owners and employers who are not seeing the positive effects of the ACA. Hours are being reduced, fewer people are being hired, and small businesses are afraid to expand with this uncertainty that is facing them.

Ms. Brooks-LaSure, because of the Administration's delay of the requirement to provide employers with a choice of health plans, in your testimony you mentioned that the Federal SHOP Exchanges will allow—will allow—employers to choose one qualified health care plan to offer their employees.

I have read that the Administration cited "operational challenges" as the reason for this delay. Can you tell me what these challenges were?

Ms. BROOKS-LASURE. Sure. Thank you so much, Senator, for the question.

Senator FISCHER. And thank you all for being here. I appreciate it.

Ms. BROOKS-LASURE. During our comment process where we worked through our regulations, we sought comment on employee choice, which we certainly think of as a very important part of the SHOP. During that comment process, we did receive comments from a variety of stakeholders, and based on those comments, we learned that many issuers felt that they needed more time to develop the apparatus, basically, necessary to implement employee choice, and we were concerned about making sure that there were many options available in the SHOPs.

And so, as a result, we decided that for the Federally-facilitated marketplace, as were operating in many states across the country, we would wait one year before implementing employee choice because we thought more issuers would participate. And some states who are implementing state-based marketplaces are implementing employee choice this year.

Senator FISCHER. Do you think this one-year delay in implementation is going to make a difference, or are we going to be looking at another delay coming up?

Ms. BROOKS-LASURE. We are committed to 2015. That is what our regulations say. That is what we are working on. We just wanted to give all stakeholders more time because we want it to work well.

Senator FISCHER. Would it be fair to say that all stakeholders need more time and maybe we should have a delay for individuals as well as businesses?

Ms. BROOKS-LASURE. We have been working very hard throughout the implementation and the passage to really listen to stakeholders. We have given flexibility in many instances where we had administrative authority to do so. But we are fully prepared for the individual market October 1, and for SHOP for October 1.

Senator FISCHER. You mentioned earlier that the marketplaces will be open by October 1st. Did I hear you correctly on that?

Ms. BROOKS-LASURE. Yes.

Senator FISCHER. Can you tell me if they are going to be open in Nebraska by October 1st and where we are there? Because I know there is tremendous uncertainty in my state, and observing part of our legislative session back home this year, things are not settled.

Ms. BROOKS-LASURE. We are operating the Federally-facilitated marketplace in Nebraska. We are on track, as I mentioned. We are in the process of certifying plans now, working with them. Plans will start to see their data next month and start to be able to make sure it is correct. And then in September, we will sign issuer agreements and October 1, people will be able to see them and enroll.

Senator FISCHER. Thank you. Ms. Olafson, first of all, I want to let you know that I met with a number of the staff at the SBA in the Omaha metro area and had a great conversation with them recently. And so, I would thank you and thank them for being open for that.

Ms. OLAFSON. That is great to hear. Thank you, Senator.

Senator FISCHER. You acknowledged in your testimony that the SBA has devoted considerable time and resources to the promotion of the ACA through events such as Small Business Week and agency-funded resources such as this website. There is no line item to fund this. And so, can you tell me the amount and the origin of the funds that have been used to support these efforts?

Ms. OLAFSON. So as I mentioned earlier, SBA is leveraging all of the resources in our network, all the resources we have at our disposal to get the facts out to the small business community.

Senator FISCHER. Are you taking from other programs, you know, stealing from Peter to pay Paul so you can promote this?

Ms. OLAFSON. So again, we have a robust network within SBA of our counselors, for example, that are meeting every day with small business on a variety of issues. This is one of the most critical issues that our counselors are getting questions about and our staff, so we are building and leveraging those resources.

So that if a business owner is coming to us to talk about access to capital or health care, we can provide them with that information and those facts and tools to let them know where to go to get more information.

Senator FISCHER. If I could submit some questions to you, could you address just what programs are being affected by it, though?

Ms. OLAFSON. Certainly. We would be happy to talk with you.

Senator FISCHER. Okay. Thank you so much.

Chair LANDRIEU. Senator, we are going to try to move along. Let me ask you, did the State of Nebraska choose to set up an exchange or you are having to wait for the Federal Exchange?

Senator FISCHER. On the Federal.

Chair LANDRIEU. Senator Vitter, do you want to go? And then Senator Scott. And then we are going to have to move on to the second panel.

Senator VITTER. Thank you, Madam Chair, and I am eager to hear from the actual small businesses as well. I just want to briefly say, I share the concerns that have been expressed about this implementation. I think it is nothing short of a train wreck, and that is not my phrase. It is another member's.

I echo the feeling that if business is being given a reprieve for one year or more than individuals, families, middle class families, workers should be given the exact same treatment. And also, this is a completely unrelated issue, but it is an important Louisiana priority for both the Chair and me.

If the President has that administrative authority here, I would also ask him to use exactly the same authority and delay the implementation of completely unworkable flood insurance premiums under bigger waters, and I would specifically ask that. But again, I join the Chair in begin eager to hear from small businesses and I look forward to the second panel.

Chair LANDRIEU. Senator Scott.

Senator SCOTT. Thank you, Senator. I will make this a short question. Ms. Olafson, I believe there was a survey done by the NFIB earlier this year that found that the impact of the tax on providers, the $100 billion to tax, started, I think, next year. It starts at about $8 billion and it goes up over the years.

If the small business community is, in fact, the economic engine that we see of recent, their survey suggests that private sector employment should fall about 146,000 to 262,000 because of the new tax. How is the Small Business Administration going to respond and how do we help change that direction?

Ms. OLAFSON. So, thank you, Senator, for your question. You know, I think—and I cannot emphasize this enough. We have been hearing for years that access to affordable health care is one of the top concerns for business owners, and that as you have heard from many of us today, that often, historically, small businesses were paying as much as 18 percent more.

And so, we know that there are many mechanisms and reforms within this law that help to bring down costs for small business, including the rule that requires insurance companies to cover—to spend at least 80 percent of dollars on health care, and the rate review mechanisms.

As far as that particular provision you are talking about, I believe it is the health insurance assessment. I would certainly defer to my colleagues at Treasury for more nuanced information about that. But we know that—you know, we have been hearing this concern from the business community and the Affordable Care Act is helping to level the playing field for the first time for small businesses.

Senator SCOTT. I would just suggest that having owned a business, and I was an Allstate agent for the last 14 or 15 years in business ownership, I will tell you that the notion that the ACA is somehow going to create a more competitive environment is inconsistent with the reality faced by many of the businesses that I have been talking to, and I quote one specifically, a guy named Gary Chastain, who owns a bunch of Moe's franchises in Charleston, when you talk to him about talking to insurance agents about what they anticipate on the market looking like, he gets six different answers from six different agents.

So very consistently, the thing that seems to be most consistent about the ACA and its impact on small businesses is the lack of consistency that they are receiving. So I think we are in for a hard road as we see the inconsistencies of the Act, and its impact on businesses will be, I think, dire.

Ms. OLAFSON. Well, and part of the challenge is, you know, really to make sure that business owners understand the facts, because as I have said before, we talk to business owners every day. There is still a lot of misinformation. I mean, a lot of business owners still think that they may be impacted by something like share responsibility without realizing sort of what are the exact facts around that.

And that is our mission. You know, we are here to give that information to the hands of business owners, recognizing these are business decisions at the end of the day, but we need them to have the right information and the tools to make the best, most informed decision.

Senator SCOTT. I think the fact that the regulatory environment seems to be still in creation is a part of the challenge that many business owners face today as it relates to the ACA and the inability to understand what has not yet been filled in on the pages of the regulations, perhaps, provides a great opportunity for discontentment than does the lack of clarity going forward on the plans that will be available, though that in and of itself is still uncertain as well.

Mr. IWRY. Senator, may I?

Senator SCOTT. Chime in, yes, sir, absolutely.

Mr. IWRY. Treasury has issued a comprehensive proposed regulations on the employer responsibility provisions generally out of concern for the point you are making, that we do want small businesses and employers generally to have guidance that is clear and comprehensible and workable for them.

And, Senator, we had four rounds of guidance in writing at the sub-regulatory level and then written comments on those concepts from the small and large business community and all stakeholders who were interested in the public process, and it was tremendously useful to get that feedback from small and larger businesses in order to enable us to put rules out that would enable them to go ahead and make their own best decisions about how to comply.

Senator SCOTT. Yes, sir. I would say that I do not question the good intentions. There was some statement sometime about the road somewhere is paved with good intentions. I am not quite sure where that road leads, but I will tell you that from the folks—Senator Risch, you may know where that road leads.

Senator RISCH. I do.

Senator SCOTT. Well, we will talk about that later. What we have learned, however, is that when you talk to business owners about the implementation and the challenges that they face, I spoke with a CPA just yesterday at a small firm with about four or five employees. And their coverage is leaving South Carolina because of the inability to understand the path forward.

So the number of insurers available in states are becoming fewer insurers are available in states, not more, and I believe will cause more pressure on the rates in states. And so, you will see, in the end, higher rates. You will see the new health insurance tax, the HIT, coming into play which is only a pass-through down to employers that will help to pay for a part of their employees' premiums.

And so, the pressure on small businesses will only increase. But I think I am out of time.

Chair LANDRIEU. Yes, but thank you so much. I think it has been an excellent line of questioning and I think we have gotten some things very clear. As we go to the next panel, I want to just put some things into the record to clarify statements that were made, and if the Minority wants to put anything in addition to this record, because while we are all entitled to our opinion, as Chair of this Committee, I really would like to get some facts on the record about small business.

The Ranking Member referred to a study. I am going to put the entire study into the record. It is here. The date on it is clear. The study focused solely on claims and not actuarial premiums which consumers will be paying. Kristi Bohn, the actuary who worked on the study, acknowledged it did not attempt to estimate the effects of subsidies, insurance, insurer competition, or other factors that could offset the increases. I am going to put the entire study in the record and some articles that were written about it. People can make their own determinations.

[The information follows:]

Average Annual Premiums for Employer-Sponsored Insurance

Kaiser Family Foundation and Health Research & Educational Trust
Employer Health Benefits
Summary of Findings, Annual Surveys 2008 through 2012
http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/

Year	Average for family plan	Average for single plan
1999	5,742	2,270
2000	6,351	2,426
2001	7,053	2,650
2002	7,954	3,060
2003	9,068	3,383
2004	9,950	3,695
2005	10,880	4,024
2006	11,480	4,242
2007	12,106	4,479
2008	12,680	4,704
2009	13,375	4,824
2010	13,770	5,049
2011	15,073	5,429
2012	15,745	5,615
Amount Increased		
08 to 12	3,065	911
	24.17%	19.37%
09 to 12	2,370	791
	17.72%	16.40%
10 to 12	1,975	566
	14.34%	11.21%
11 to 12	672	186
	4.27%	3.31%

Sen. Johnson-
Kaiser Study

Summary of Findings

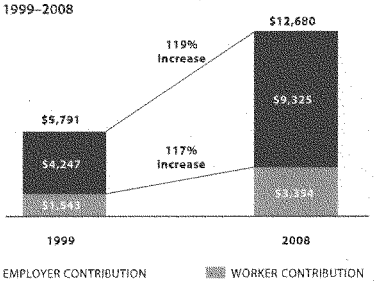
Employer-sponsored insurance is the leading source of health insurance, covering about 158 million nonelderly people in America.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers.

The key findings from the 2008 survey include increases in the average single and family premiums and an increase in the percentage of workers enrolled in high-deductible health plans with a savings option (HDHP/SO). Cost sharing for medical services has also increased in recent years. The percentage of employers sponsoring insurance and the percentage of workers covered by employer-sponsored insurance remained stable over the past year.

Fifty-four percent of firms offering health benefits offer at least one wellness program. Among large firms offering retiree health benefits, a large percentage report that some current workers would be eligible for health benefits when they retire.

EXHIBIT A

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999–2008



Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008.

HEALTH INSURANCE PREMIUMS

In 2008, the average annual premiums for employer-sponsored health insurance are $4,704 for single coverage and $12,680 for family coverage, up about 5% from the 2007 average premiums.[2] Since 1999, average premiums for family coverage have increased 119% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers). Premiums are higher in self-funded plans than fully insured plans for single and family coverage. Average premiums for HDHP/SOs are lower than the overall average for all plan types for both single and family coverage (Exhibit B).

As a result of factors such as benefit differences and geographical location, there is significant variation around the average annual premium (Exhibit C). For family coverage averaging $12,680, 18% of covered workers are in plans with an annual total premium greater than 120% of the average, and 20% of covered workers are in plans where premiums are less than 80% of the average.

About 80% of workers with single coverage and 93% of workers with family coverage contribute to the total premium for their coverage (Exhibit D). The average annual worker contributions for single and family coverage are $721 and $3,354,[3] respectively, which are not significantly different from the amounts reported in 2007. For single coverage, workers in small firms (3–199 workers) contribute less on average than workers in large firms (200 or more workers) ($624 vs. $769), but for family coverage, workers in small firms contribute significantly more than workers in large firms ($4,101 vs. $2,982). The average percentage of the premium paid by covered workers is 16% for single coverage and 27% for family coverage, similar to the percentages reported for the last several years. For single coverage, over one-fifth of workers pay greater than 25% of the total premium while another fifth make no contribution. For family coverage, 47% pay greater than 25% of the total premium and only 7% have no contribution.

The majority (58%) of covered workers are enrolled in preferred provider organizations (PPOs). Health maintenance organizations (HMOs) cover 20%, followed by point-of-service (POS) plans (12%), HDHP/SOs (8%), and conventional plans (2%).

EMPLOYEE COST SHARING

In addition to any premium contributions they may have, most covered workers face additional payments when they use health care services. Most (68%) workers in PPO plans have a general annual deductible for single coverage that must be met before all or

Summary of Findings

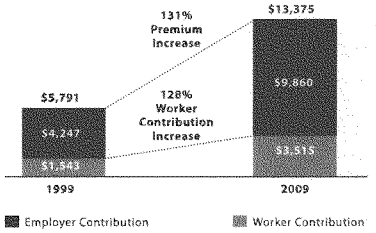
Employer-sponsored insurance is the leading source of health insurance, covering about 159 million nonelderly people in America.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the eleventh Kaiser/HRET survey and reflects health benefit information for 2009.

The key findings from the 2009 survey, conducted from January through May 2009, provide a mixed, but relatively stable story compared to 2008. In 2009, there was an increase in the average family premium, the percentage of covered workers with a deductible of $1,000 or more for single coverage, office visit copayments, and the percentage of large firms offering wellness programs. The average premium for single coverage did not significantly increase, breaking a long-standing trend.

The survey shows that many of the statistics related to health benefits remained relatively stable despite the severe economic downturn. This may indicate a strong commitment to maintaining workers' benefits, but several other factors may have contributed to this result as well. One is that the survey only collects information from firms that are still in business and cannot estimate the number of workers who lost coverage due to their company downsizing or closing. Another is that some firms may have made decisions about health benefits in advance of the plan year and may not have foreseen the full impact of the worsening economy on the firm. These firms may have made changes after they were surveyed or may make changes for the next plan year.

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 1999–2009



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2009.

HEALTH INSURANCE PREMIUMS

In 2009, the average annual premiums for employer-sponsored health insurance are $4,824 for single coverage and $13,375 for family coverage. Premiums for family coverage are 5% higher than last year ($12,680), but there was no statistically significant growth in the single premiums. Since 1999, average premiums for family coverage have increased 131% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B).

As a result of factors such as benefit differences and geographical location, there is significant variation around the average annual premium. Twenty percent of covered workers with family coverage are in plans with an annual total premium of at least $16,050 (120% of the average premium); 21% of covered workers are in plans where the family premium is less than $10,700 (80% of the average premium) (Exhibit C).

On average, covered workers contribute 17% of the total premium for single coverage and 27% for family coverage, similar to the last several years. The share of the premium workers contribute for coverage also varies considerably. For single coverage, 24% of workers pay more than 25% of the total premium while 18% make no contribution. Forty-five percent of workers with family coverage pay more than 25% of the total premium; only 6% make no contribution (Exhibit D). In terms of dollar amounts, the average annual worker contributions for single and family coverage are $779 and $3,515,[2] respectively, which are not significantly different from the amounts reported in 2008. For single coverage, workers in small firms (3–199 workers) contribute less on average than workers in large firms (200 or more workers) ($625 vs. $854), but for family coverage, workers in small firms contribute significantly more than workers in large firms ($4,204 vs. $3,182).

The majority (60%) of covered workers are enrolled in preferred provider organizations (PPOs). Health maintenance organizations (HMOs) cover 20%, followed by point-of-service (POS) plans (10%), HDHP/SOs (8%), and conventional plans (1%).

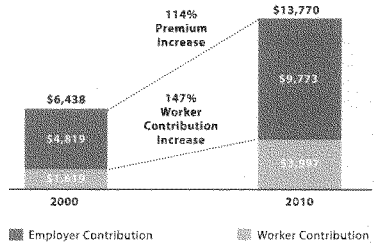
Summary of Findings

Employer-sponsored insurance is the leading source of health insurance, covering about 157 million nonelderly people in America.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the twelfth Kaiser/HRET survey and reflects health benefit information for 2010.

The key findings from the 2010 survey, conducted from January through May 2010, include increases in the average single and family premium as well as in the amount workers pay for coverage. About a quarter (27%) of covered workers have a deductible of at least $1,000 for single coverage, and a greater proportion of workers are enrolled in high-deductible health plans with a savings option (HDHP/SO) than in 2009. Firms responded that they increased cost sharing or reduced the scope of coverage, or increased the amount workers pay for insurance as a result of the economic downturn. The 2010 survey continues to track the percentage of firms offering wellness benefits or health risk assessments and also included questions on health plan quality indicators and benefit changes made as result of the Mental Health Parity and Addiction Equity Act.

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2000–2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000–2010.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

The average annual premiums for employer-sponsored health insurance in 2010 are $5,049 for single coverage and $13,770 for family coverage. Compared to 2009, premiums for single coverage are 5% higher ($4,824) and premiums for family coverage are 3% higher ($13,375). Since 2000, average premiums for family coverage have increased 114% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) ($13,250 vs. $14,038). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B). For PPOs, the most common plan type, the average family premium topped $14,000 annually in 2010.

As a result of factors such as benefit differences and geographical cost differences, there is significant variation around the average annual premium. Twenty percent of covered workers are in plans with an annual total premium for family coverage of at least $16,524 (120% of the average premium), while 19% of covered workers are in plans where the family premium is less than $11,016 (80% of the average premium) (Exhibit C).

In 2010, covered workers contributed a greater share of the total premium, a notable change from the steady share workers have paid on average over the last decade. Covered workers on average contribute 19% of the total premium for single coverage (up from 17% in 2009) and 30% for family coverage (up from 27% in 2009). As with total premiums, the premium shares contributed by workers vary considerably around these averages. For single coverage, 28% of workers pay more than 25% of the total premium while 16% make no contribution.

Fifty-one percent of workers with family coverage pay more than 25% of the total premium; only 5% make no contribution (Exhibit D).

Looking at dollar amounts, the average annual worker contributions are $899 for single coverage and $3,997 for family coverage, up from $779 and $3,515 respectively in 2009.[2] Workers in small firms (3–199 workers) contribute about the same amount for single coverage as workers in large firms (200 or more workers) ($865 vs. $917), but they contribute significantly more for family coverage ($4,665 vs. $3,652).

PLAN ENROLLMENT

The majority (58%) of covered workers are enrolled in preferred provider organizations (PPOs), followed by health maintenance organizations (HMOs) (19%), HDHP/SOs (13%), point-of-service (POS) plans (8%), and conventional plans (1%). Most notably, the percentage of covered workers in HDHP/SOs rose from 8% in 2009 to 13% in 2010.

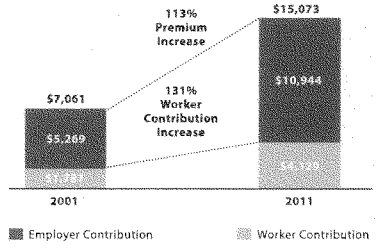
Summary of Findings

Employer-sponsored insurance is the leading source of health insurance, covering about 150 million nonelderly people in America.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the thirteenth Kaiser/HRET survey and reflects health benefit information for 2011.

The key findings from the 2011 survey, conducted from January through May 2011, include increases in the average single and family premiums, as well higher enrollment in high deductible health plans with savings options (HDHP/SOs). The 2011 survey includes new questions on the percentage of firms with grandfathered health plans, changes in benefits for preventive care, enrollment of adult children due to the new health reform law, and the use of stoploss coverage by firms with self-funded plans.

Exhibit A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2001–2011



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001–2011.

Health Insurance Premiums and Worker Contributions

The average annual premiums for employer-sponsored health insurance in 2011 are $5,429 for single coverage and $15,073 for family coverage. Compared to 2010, premiums for single coverage are 8% higher and premiums for family coverage are 9% higher. The 9% growth rate in family premiums for 2011 is significantly higher than the 3% growth rate in 2010.[2] Since 2001, average premiums for family coverage have increased 113% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) ($14,098 vs. $15,520). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B).

There is significant variation around the average annual premiums as a result of factors such as benefits, cost sharing, and geographic cost differences. Nineteen percent of covered workers are in plans with an annual total premium for family coverage of at least $18,087 (120% of the average family premium), while 21% of covered workers are in plans where the family premium is less than $12,058 (80% of the average premium) (Exhibit C).

Covered workers contribute on average 18% of the premium for single coverage and 28% of the premium for family coverage, similar to the percentages they contributed in 2010. Workers in small firms (3–199 workers) contribute a significantly lower average percentage for single coverage compared to workers in larger firms (15% vs. 19%), but a higher average percentage for family coverage (36% vs. 25%). As with total premiums, the share of the premium contributed by workers varies considerably around these averages. For single coverage, 59% of covered workers are in plans that require them to pay more than 0% but less than or equal to 25% of the total premium, and 3% are in plans that require more than 50% of the premium; 16% are in plans that require them to make no contribution. For family coverage, 47% of covered workers are in plans that require them to pay more than 0% but less than or equal to 25% of the total premium, and 15% are in plans that require more than 50% of the premium; only 6% are in plans that require no contribution (Exhibit D).

Looking at the dollar amounts that workers contribute, the average annual contributions in 2011 are $921 for single coverage and $4,129 for family coverage.[3] Neither amount is a statistically significant increase over the 2010 values. Workers in small firms (3–199 workers) have lower average contributions for single coverage than workers in larger firms ($762 vs. $996), and higher average contributions for family coverage ($4,946 vs. $3,755). Compared to the overall average contributions, workers in HDHP/SOs have lower average contributions for single coverage ($723 vs. $921), while workers in point of service (POS) plans have higher average contributions for family coverage ($5,333 vs. $4,129).

Summary of Findings

Employer-sponsored insurance is the leading source of health insurance in America, covering about 149 million nonelderly people.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the fourteenth Kaiser/HRET survey and reflects health benefit information for 2012.

The key findings from the survey, conducted from January through May 2012, include modest increases in the average single and family insurance premiums and little change in the premium contributions and cost sharing that workers face since last year. Enrollment in high deductible plans with a savings option, such as a health savings account or health reimbursement arrangement, did not increase significantly over the previous year for the first time since 2009. The share of workers in a grandfathered health plan decreased significantly from the previous year to 48% of covered workers. Approximately 2.9 million adult children who were previously not eligible for benefits now have health insurance coverage through their parents due to the Affordable Care Act. In addition, the 2012 survey includes questions on employer wellness programs, including the percentage of plans with financial rewards or penalties for completing health programs or achieving biometric targets.

Health Insurance Premiums and Worker Contributions

The average annual premiums for employer-sponsored health insurance in 2012 are $5,615 for single coverage and $15,745 for family coverage. Compared to 2011, the average premium for single coverage ($5,429) is 3% higher and the average premium for family coverage ($15,073) is 4% higher. Since 2002, average premiums for family coverage have increased 97% (Exhibit A). The growth in premiums has outpaced increases in both workers' wages (1.7% since 2011 and 33% since 2002) and inflation (2.3% since 2011 and 28% since 2002).[2]

The average premium for family coverage is lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) ($15,253 vs. $15,980). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B), at $4,928 and $14,129, respectively. Average single and family premiums are higher in the Northeast and lower in the South when compared to the other regions.

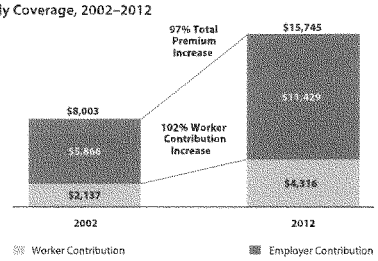
There is significant variation in the average annual premiums as a result of factors such as benefits, cost sharing, and geographical cost differences. Nineteen percent of covered workers are in plans with an annual total premium for family coverage of at least $18,894 (120% of the average family premium), while 20% of covered workers are in plans where the family premium is less than $12,596 (less than 80% of the average family premium). The distribution is similar around the average single premium (Exhibit C).

Covered workers contribute on average 18% of the premium for single coverage and 28% of the premium for family coverage, the same percentages they contributed in 2011 and relatively unchanged over the past decade. Workers in small firms (3–199 workers) contribute a lower average percentage for single coverage compared to workers in larger firms (16% vs. 18%), but a higher average percentage for family coverage (35% vs. 25%).

As with total premiums, the share of the premium contributed by workers varies considerably around these averages. For single coverage, 61% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 2% are in plans that require a contribution of more than half of the premium; while 16% are in plans that require no contribution at all. For family coverage, 43% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 14% are in plans that require more than half of the premium; only 6% are in plans that require no contribution for family coverage (Exhibit D).

Exhibit A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2002–2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002–2012.

Chair LANDRIEU. Secondly, I am going to refer to something that Senator Scott referred to. He talked about an NFIB study. We have some information about that I am going to submit. It says that the NFIB, the study that he referred to, was funded by the Group for Health Insurance Industry that worked on the repeal of the Affordable Care Act.

[The information follows:]

The Individual Mandate in Perspective

Timely Analysis of Immediate Health Policy Issues

March 2012

Linda J. Blumberg, Matthew Buettgens, Judy Feder

Researchers find small number of people will be affected by mandate, but large benefit for population and stability of insurance markets.

The "individual mandate"—the requirement that individuals either have health insurance coverage or pay a fine—is both the best known and the least popular component of the Affordable Care Act (ACA).[1] That people know about the mandate—and may even worry about it—is not surprising, given both the heated political controversy and the constitutional challenge surrounding this provision of the law. What may be surprising, however, is that if the ACA were in effect today, 94 percent of the total population (93 percent of the nonelderly population) or 250.3 million people out of 268.8 million nonelderly people—would not face a requirement to *newly purchase* insurance or pay a fine.

In this brief we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the number and share of Americans potentially subject to the mandate, identify their insurance status absent the ACA, and simulate eligibility for Medicaid and exchange-based premium and cost-sharing subsidies.[2] To allow the most direct comparison of postreform coverage with coverage absent reform, our analysis treats the provisions of the ACA as if fully implemented in 2011. The table presents the results of this analysis—with estimates of the population exempt from the mandate; the population potentially affected by the mandate, but already covered by insurance of some type; and the remaining population required to newly purchase coverage or pay a fine.

Starting from the top, our analysis shows that if the ACA were fully in effect in 2011, 87.4 million nonelderly Americans—33 percent of the population under age 65 would be explicitly exempt from the individual responsibility requirement. These are people whose incomes fall below the tax filing threshold, those for whom the direct premium of the lowest cost available plan exceeds 8 percent of family income,[3] and undocumented immigrants. (Also exempt from the mandate, but beyond our capacity to estimate, are people found to have other economic hardship or religious objections, Native Americans, those without coverage for less than three months, and incarcerated individuals.) Almost three-quarters of the exempt population already have health insurance coverage of some type today; a little more than one-quarter is uninsured.

Of the remaining 181 million Americans under the age of 65 who are subject to the mandate, 86 percent are estimated to have health insurance without reform. HIPSM simulates that 95 percent of those with some type of insurance coverage (employer, nongroup, public) without reform will have the same type of coverage under the ACA (data not shown). Virtually all of the remaining 5 percent will obtain coverage through a different route under reform than they do today (e.g., some of those with nongroup coverage today will get an employer offer of coverage under reform, and will take that up instead of buying nongroup, and vice versa). In short, the vast majority of those potentially subject to the individual mandate have coverage today and will not obtain a different type of coverage postreform.

Forty-three percent of the population potentially subject to the individual responsibility requirement receive coverage through large employers; 12 percent receive coverage through small employers; and 7 percent have employer-based coverage from an unobserved source (most commonly a family member living in another household or a previous employer); almost all of these people will continue to obtain their coverage through the same route once the reforms are fully in place. Five percent purchase coverage in the nongroup market, and 17 percent have coverage through a public program (e.g., Medicaid, Children's Health Insurance Program (CHIP), military); again, almost all will continue to do so once the reforms are fully in place. Although those already covered by nongroup or small group coverage will not be newly purchasing coverage under the reforms, some will have their coverage broadened somewhat so that it satisfies the ACA's minimum or "essential health benefits" requirements.

About 26.3 million Americans who are currently uninsured will be required to newly obtain coverage or pay a fine. In this group, 8.1 million people will be eligible to receive free or close-to-free insurance through Medicaid or CHIP and can avoid the mandate penalties if they do so; hence our finding that 18.2 million Americans (6 percent of the total population, 7 percent of the nonelderly population) will be required to newly

purchase coverage or face a penalty. Of that 18.2 million, 10.9 million people will be eligible to receive subsidies toward private insurance premiums in the newly established health insurance exchanges, but will have to make partial contributions toward their coverage. About 7.3 million people—2 percent of the total population (3 percent of the population under age 65)—are not offered any financial assistance under the ACA and will be subject to penalties if they do not obtain coverage.

While the number of people who will be required to newly purchase coverage or pay a penalty is small compared with the total population, the individual responsibility requirement will still make an important difference in the premium levels and long-term stability of the nongroup and small group insurance markets under the ACA. Almost 11 million people uninsured without reform and subject to the mandate will be eligible to purchase subsidized nongroup coverage in order to comply with the coverage requirement; and many of the 7 million not eligible for subsidies will also comply by purchasing coverage in the nongroup market, because they will not have access to employer-sponsored insurance (ESI). The nongroup market now covers about 14 million people, so several million additional enrollees brought in by the coverage requirement will change premiums in the market noticeably. In addition, the consumer protections introduced by the ACA, which will guarantee issue of insurance products and prohibit premium variations due to health status and claims experience, could lead some of those currently healthy and insured in these markets to leave them in the absence of the coverage requirement. By encouraging the currently insured healthier individuals to stay in these markets and attracting newly insured healthy individuals into them as well, the individual responsibility requirement leads to lower premiums and more stable insurance markets than would be the case without it. We find that premiums in the nongroup market would be 10 to 20 percent higher on average without the individual coverage requirement.[4]

The Individual Responsibility Requirement*

	Number of People (millions)	% of Subgroup	% of Nonelderly	% of Total Population
Total Nonelderly	268.8	--	100%	87%
Number Exempt from Individual Responsibility Requirement, Regardless of Postreform Coverage Decision	**87.4**	**100%**	**33%**	**28%**
Coverage in Baseline	**63.4**	**73%**	**24%**	**20%**
Large Firm ESI	20.4	23%	8%	7%
Small Firm ESI	5.3	6%	2%	2%
Unknown Firm Size ESI	10.9	12%	4%	4%
Non-Group	4.9	6%	2%	2%
Public	22.0	25%	8%	7%
Uninsured	**24.0**	**27%**	**9%**	**8%**
Undocumented Immigrants	7.3	8%	3%	2%
Income Below Tax Filing Threshold	14.3	16%	5%	5%
No Access to Affordable Coverage	2.4	3%	1%	1%
Number Potentially Subject to Individual Responsibility Requirement if Uninsured	**181.4**	**100%**	**67%**	**59%**
Coverage in Baseline	**155.1**	**86%**	**58%**	**50%**
Large Firm ESI	78.3	43%	29%	25%
Small Firm ESI	22.6	12%	8%	7%
Unknown Firm Size ESI	13.0	7%	5%	4%
Non-Group	9.6	5%	4%	3%
Public	31.6	17%	12%	10%
Uninsured	**26.3**	**14%**	**10%**	**8%**
Eligible for Medicaid Under Reform	8.1	4%	3%	3%
Eligible for Exchange Subsidies Under Reform	*10.9*	*6%*	*4%*	*4%*
Access to Affordable Unsubsidized Coverage	*7.3*	*4%*	*3%*	*2%*

Source: Urban Institute analysis, HIPSM 2011.

*Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Endnotes

1. Kaiser Family Foundation. Health Tracking Poll, March 2012. http://www.kff.org/kaiserpolls/upload/8285-F.pdf.
2. HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. For more information on HIPSM and a list of recent publications using the model, see http://www.urban.org/uploadedpdf/412154-HealthMicrosimulationCapabilities.pdf.
3. Here we assume that dependents without access to a family premium (either through employer-based coverage or the exchange) whose direct cost to the family is less than or equal to 8 percent of income will not be subject to a penalty for being uninsured. This is an interpretation consistent with the spirit of the Notice of Proposed Rulemaking. See: US Department of the Treasury, "Health insurance tax credit," Federal Register 2011; 76(159): 50931-49.
4. For a discussion of these results and other effects of eliminating the coverage requirement, see Matthew Buettgens and Caitlin Carroll, "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care" (Washington, DC: The Urban Institute, 2012). http://www.urban.org/health_policy/url.cfm?ID=412480.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees or its funders.

About the Authors and Acknowledgments

Linda J. Blumberg is a senior fellow, Matthew Buettgens is a senior research associate, and Judy Feder is an Urban Institute Fellow in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors would like to thank Jeremy Roth for research assistance and John Holahan for helpful comments and suggestions.

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Chair LANDRIEU. And then thirdly, this urban study that I referred to, which is the average business with fewer than 50 employees, if they choose to offer coverage, would find cost per person reduced by 7.3 percent. I want to put into the record, this was done by four health economists, Linda Bloomberg, Matthew Buettgens, Judy Feder, and John Holahan, and that general spending as a group was reduced by 1.4 percent.

[The information follows:]

-------- Original Message --------

BACKGROUND MEMO: FACTS ABOUT THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

The National Federation of Independent Business (NFIB) presents itself as a non-partisan, member-driven organization that represents small business views. But the facts about NFIB tell a different story:

NFIB Took Secret Money from the Health Insurance Industry in 2011 and Set Up a Group to Advance Insurers' Health Care Agenda Using Small Business as the "Front Man":

National Journal broke the story in May 2013 that NFIB accepted a secret contribution of $850,000 in 2011 from America's Health Insurance Plans (AHIP), the leading lobby group for the health insurance industry, to work for repeal of a fee on health insurers in the Affordable Care Act. This secret contribution – the second largest contribution NFIB received in 2011 – makes NFIB's "Stop the HIT" coalition, a group it set up to lobby for repeal of the health insurer fee in the name of small businesses, look like a front group for the health insurance industry. *Bloomberg Businessweek* likened the AHIP-NFIB dealings to "message-laundering," concluding: "It's legal for the money to flow anonymously from the insurance lobby to the NFIB... But it's something that the public – and Congress – should keep in mind when evaluating the NFIB's claims." Former insurance industry executive Wendell Potter wrote: "NFIB is a nonprofit that calls itself the voice of small business but which I know from my days in the insurance industry has often been a voice for my former bosses."

NFIB Took Millions from Karl Rove's Crossroads GPS, Conservative Conduit Group "Donors Trust," and Conservative Funder Bradley Foundation in 2010 as it Launched its Lawsuit Against ObamaCare:

In 2010, as the NFIB launched the lawsuit against ObamaCare that eventually reached the U.S. Supreme Court, the group accepted a $3.7 million gift from Crossroads GPS, a political organization affiliated with Republican political operative Karl Rove that overwhelmingly endorses and financially supports Republican candidates.[1] According to data compiled by the Center for Responsive Politics, in 2010 NFIB's Small Business Legal Center received $1.15 million from conservative conduit group Donors Trust, a major contributor to the Koch brothers' Americans for Prosperity Foundation. The NFIB's legal arm also received a $100,000 contribution from the conservative Lynde and Harry Bradley Foundation in 2010, explicitly marked in the Bradley Foundation's IRS filings as intended "to support health-care litigation efforts." The Bradley Foundation gave to a range of conservative groups in 2010, including $500,000 to Americans for Prosperity Foundation and $95,000 to ALEC.

NFIB's Political Giving Puts it in the Top Three Most Partisan Supporters of Republican Candidates Among OpenSecrets.org "Heavy Hitters," Ahead of Koch Industries and the National Rifle Association:

In nine of the last ten election cycles, NFIB has given 90 percent or more of its political contributions to Republican candidates. In the 2012 election cycle, it gave $670,543 to Republican candidates and $11,000 to Democratic candidates, a 98 percent to 2 percent split.[2] On the Center for Responsive Politics' "Heavy Hitters" list of top all-time political donors since 1989, NFIB ranked third in percentage of contributions given to Republican candidates (93 percent), even more lopsided than Koch Industries (91 percent), Exxon Mobil (86 percent), and the National Rifle Association (82 percent).[3] In contrast, independent polling has found small businesses owners quite evenly divided politically (one poll found 33 percent identify as Republicans, 32 percent as Democrats, and 29 percent as Independent).[4]

In the 2012 Elections, NFIB Made Over $4 Million in Independent Expenditures; Every Dollar Either Supported Republicans or Opposed Democrats:

In the 2012 election cycle, NFIB and its controlled entities spent a total of $4,063,021 influencing elections independently of candidates. Every dollar of its independent expenditures was spent either in support of Republican candidates ($2,583,943) or against Democratic candidates ($1,479,078).[5]

For more information, visit: www.nfibexposed.org

[1] Dan Eggen, Clash over financial disclosure escalates, spilling into presidential race, *The Washington Post*, June 23, 2012.
[2] Center for Responsive Politics, Heavy Hitters: National Federation of Independent Business, *OpenSecrets.org*.
[3] Center for Responsive Politics, Heavy Hitters: Top All-Time Donors, 1989-2012, *OpenSecrets.org*.
[4] Greg Robb Mandelbaum, Whom Does the N.F.I.B. Represent (Besides Its Members)? *The New York Times*, August 26, 2009.
[5] Center for Responsive Politics, National Fedn of Independent Business, Outside Spending Summary 2012, *OpenSecrets.org*.

Chair LANDRIEU. Now, if there is anything that you want to put into the record before we move to the next panel, Senator Risch?

Senator RISCH. Not at this point.

Chair LANDRIEU. Okay. Thank you all very much and we will go to the second panel. Senator Johnson, if you will permit the Kaiser study, to put your Kaiser study reference in the record, please, the entirety of it.

Now, members, I think we are going to have a vote at 4:30 or 5:00, so I am going to try to move this along as quickly as I can. I do want to give everybody an opportunity for questions, so we may just do three minutes, but let us see. We have a large panel that I am happy to hear because these are small business owners.

If we could move as quickly as we can just because our time is getting short, I would appreciate it. So let me begin. We have six distinguished witnesses joining us for today's second panel. Thank you all for being here today.

Let me start by just referencing and introducing Mr. Lawrence Katz. Senator Vitter will do a broader introduction in a minute. But he is from our home State of Louisiana. He is the owner of Dot's Diner with six locations in Louisiana. He is the President of the City Park, incoming President of City Park Board. I welcome him. I am going to turn it over to Senator Vitter for a brief introduction.

Senator VITTER. Thank you, Madam Chair. First I want to recognize the testimony of another of our constituents, Hugh Raetzsch. He is not here, but his testimony is being passed out to members. Hugh is President of the Lyons Speciality Company in Port Allen, Louisiana, and his testimony not only represents his personal experiences as a small business owner, but also his experiences serving as the Chairman of the American Wholesale Marketers Association.

And then, Madam Chair, as you said, I also certainly want to welcome, recognize, and introduce Larry Katz, the Founder and President of a great small business in Louisiana, Dot's Diner. And I think we will also see Larry's testimony goes right to the bottom line for small business, and it is very compelling.

Larry and Dot's Diner are true Louisiana success stories. Seventeen years ago, he took his life savings and opening his first Dot's Diner restaurant, a small diner with about 20 seats. Through hard work and determination, Larry's business has grown to six locations employing about 85 employees, of which 65 are full-term.

Through this expansion of the business, Larry has received numerous awards, including Best Diner in New Orleans and Best Value in New Orleans. His experience and the threats he now faces in terms of increased costs and mandates under Obamacare are exactly what is facing millions of small businesses throughout Louisiana and around the country.

Chair LANDRIEU. David, try to make it brief.

Senator VITTER. And so, I really appreciate his sharing his experience because it is better than any study, better than any press report. It really goes to the bottom line of what this means to small business. So thank you, Larry, for being here.

Chair LANDRIEU. I would like to introduce Jim Houser. Mr. Houser opened Hawthorne Auto Clinic 30 years ago. Hawthorne

Auto Clinic offers full health care for all 12 full-time employees and their families. He also serves on the Oregon Individual Employer Consumer Advisory Committee and he will share some of his story with us today.

We are also joined by Jamal Lee, owner of Breasia Studios and Audio, Lighting and Video Production Company in Laurel, Maryland. Mr. Lee is going to share with us a heart-wrenching story about his wife and business partner of 30 years, suffered from a life-threatening illness, and how the Affordable Care Act has affected their business.

Our next witness is Nancy Clark, a small business owner from New Hampshire. I will now turn it over to Senator Shaheen to introduce Ms. Clark.

Senator SHAHEEN. Thank you, Madam Chair. We are very delighted to have Nancy Clark, who is from North Conway, New Hampshire, here today to testify at this hearing. Nancy is the owner and president of the Glen Group, which is a full-service advertising agency in a small town in rural New Hampshire. The company employs nine employees in North Conway and they all receive health insurance from the company, which has benefitted from the premium health care tax credit in the Affordable Care Act.

In addition to her experience as a small business owner, Nancy brings a unique perspective because she is a member of the Health Exchange Advisory Board in New Hampshire. She is also a board member of the New Hampshire Business and Industry Association where she chairs a health care committee and served on the Executive Committee of the Mount Washington Valley Economic Council. So we are delighted to have you here and I look forward to hearing your perspective and the perspective of everyone who is on the panel. Thank you.

Chair LANDRIEU. Kevin Settles joins us here today from Idaho. Mr. Settles is a small business owner who was appointed by Governor Otter to serve on Idaho's Exchange. I will now turn it over to my Ranking Member, Senator Risch, to do a further introduction.

Senator RISCH. Thank you, Madam Chairman. We are glad to have Kevin Settles here with us—Kevin, we are glad to have you here. Kevin owns Bardenay Restaurant and Distillery with locations in Boise, Eagle, and Coeur d'Alene, Idaho. He has been written up in USA Today, Wall Street Journal, many other publications. He has been on TV. In 2011, he was named the Idaho Restauranteur of the Year.

More importantly than all of that, or at least equally as important with all of that, he is a member of numerous organizations dealing with small businesses. He is also a Commissioner for the Idaho Human Rights Commission, and a Board member for the Idaho Health Insurance Exchange that is attempting to make this monstrosity work. We thank you for your service in Idaho.

Mr. Settles is angry. I am just really disappointed that the representatives of the Treasury Department, the Department of Health and Human Services, and the Small Business Administration, who just gave us all these glowing stories about how wonderful Obamacare is, could not stick around for just a few minutes to

hear that that is all baloney and how this is actually working on the ground. Kevin, thank you for coming, and I know you are going to be very candid with us about your thoughts on this.

Chair LANDRIEU. And our final witness today is William Dennis. Mr. Dennis is currently a Senior Research Fellow with the National Federation of Independent Business Research Foundation in Washington. As part of that employment, he spent five years as a staff member for the U.S. House of Representatives. And what member was that, Mr. Dennis?

Mr. DENNIS. Vernon Thomson from Wisconsin.

Chair LANDRIEU. Great. Ms. Clark, why do we not go ahead and start with you? And if we could try to limit your opening remarks to four minutes each? You can submit it to the record. If you could summarize your remarks so we can really get our questions in?

STATEMENT OF NANCY CLARK, PRESIDENT, GLEN GROUP, INC.

Ms. CLARK. Sure. Thank you very much for the opportunity to be here. I can tell you, I am part of the 96 percent. I am the 96 percent that has benefitted from the Affordable Care Act. I have nine employees. I am currently recruiting for two more, which is fantastic, and I have long been an advocate of the improvement in our health care system, because as a small business owner, I really believe that a healthy workforce is a more productive workforce.

And that helps me ensure the success of my business and allows me to continue to retain jobs and create new jobs. I absolutely believe that health care should be a right, not a privilege.

So I instituted a health care plan when I bought my business in 1997 and have never, ever considered not offering that, even in the darkest hours of the recession, and my industry like many others got hit pretty hard. When we literally had to turn down the heat and shut off the lights, health care was never, ever on the chopping block.

And it is a big expense for me. That is a struggle. Short of payroll, it is my second largest expense. But the good news this year, after seeing six years of rising premiums, my premiums actually went down for every single employee including the family plans. So that, to me, is a really nice step in the right direction.

And I am a supporter of the Affordable Care Act because I believe it is a step towards a solution. It is a proactive step towards no matter what side of the aisle you are on, it is a step towards fixing the health care system in our country. And what matters most to me is that we are moving forward. We are taking these steps forward and we are continuing to provide a mechanism so that small employers can offer health care.

And I have taken advantage of the tax credit ever since its inception three years ago. Now, it has been about $1,100 each year, which is not meaningful to a lot of businesses, but it is to mine. And it is meaningful to me for two reasons. One, because we had a rough few years, and so it has contributed to the bottom line of my business. We are not quite break-even yet, but we will be in 2013.

And secondly, as I mentioned just a minute ago, it is meaningful because it truly helps businesses where it matters most, in our bot-

tom line. But thirdly, I hope once I break even that I can give it back to my employees, which I believe was the intent of the tax credit, that I can help offset some of their expenses.

So I am very pleased that I was appointed to the Health Exchange Advisory Board in New Hampshire, both as a small business member, but also I was appointed as a consumer member. And we have this diverse great group of people on that Board and we are all committed to implementing the exchange component of the Affordable Care Act.

So I am delighted to be a voice at that table and to encourage those initiatives to improve our health care in the U.S. So thank you so much for your time today. I do really look forward to answering questions you might have as a real business, boots-on-the-ground owner in the store. So thank you very much for your time.

[The prepared statement of Ms. Clark follows:]

Implementation of the Affordable Care Act: Understanding Small Business Concerns
Wednesday, July 24, 2013

Testimony of
Nancy Clark

I own a small business in New Hampshire, employing 9 people and currently recruiting for two additional positions. I have long been an advocate for an improvement in our healthcare system because as a small business owner, I believe that health care should be a right, not a privilege. A healthy workforce is a more productive workforce...which helps to ensure the success of my business, which in turn, retains and creates new jobs.

I instituted a healthcare plan when I bought my business in 1997, and have never considered not offering it. Even during the darkest days of the recession, when we turned down the heat and shut off lights to save money, health care was never ever on the chopping block. I am a supporter of the ACA because I believe it is a step towards a solution in fixing our healthcare system. It is a huge step forward To me, it doesn't matter what side of the aisle you are on....what matters is that we are taking steps forward, that we are doing something meaningful to offset the cost of healthcare and insure that we have a mechanism to provide healthcare.

I have taken advantage of the tax credit each year since its inception - my tax credit has averaged $1100 a year, which for many businesses is not much, but for me it is very meaningful for two reasons. 1) I'm able to put that towards my bottom line because we aren't quite break even yet, and 2) It is a real and genuine step towards encouraging more businesses like mine to offer health care...it truly helps small businesses where it matters most - our bottom line.

I am also pleased to have been appointed to the Health Exchange Advisory Board in NH, as both a small business member and a consumer. We have a diverse and positive group of people on this board, who are committed to implementing this component of the Affordable Care Act. I'm delighted to be a voice at that table to support and encourage initiatives to improve access to health care in the U.S.

Thank you for your time today, and I look forward to answering any questions you may have.

Bio of Nancy Clark

Nancy Clark is owner/president of Glen Group, Inc., a full service advertising agency in New Hampshire. In addition to her agency experience working with many of the agency's business and healthcare clients, Nancy is a member of the Health Exchange Advisory Board in NH, is currently a NH Business and Industry Association board member and executive committee member of the Mt. Washington Valley Economic Council. As a member of the NH BIA board, she chairs a healthcare committee as part of the association's strategic planning process. She is an EMT affiliated with local ambulance service, and she & her husband, Rob, are licensed emergency foster care parents. As the mother of 4 active boys, she often says that she is a "frequent flyer" consumer of the health care system. A graduate of Long Island University, with a B.A. in Communications/Journalism, Nancy frequently lectures on business, marketing and finance.

Chair LANDRIEU. Thank you, Mrs. Clark. Mr. Lee.

STATEMENT OF JAMAL LEE, DIRECTOR AND CHIEF ENGINEER, BREASIA STUDIOS, LLC

Mr. LEE. Okay. Thank you so much. Thank you so much, Chair Landrieu and Ranking Member Risch, as well as the Committee members. It is an honor and a pleasure to be a part of this. This is an opportunity that allows us to speak our words about very serious issues, this particular issue.

So my name is Jamal Lee and I am the owner of Breasia Productions. We are an audio, lighting, and video streaming production company in Laurel, Maryland. I also sit on the Network Council for the Small Business Majority. The Small Business Majority is a national small business advocacy organization that works to find solutions for the larger problems that smaller businesses face today.

I volunteer my time and entrepreneurial expertise to help the Small Business Majority find pragmatic solutions to many issues concerning small businesses today. That is kind of what I wanted to talk about today.

I started my career in movie production in movies like Runaway Bride and Wedding Crashers, and I worked my way up to be the head audio producer and engineer for the Washington Nationals baseball team, and then I eventually opened up Breasia Productions, which has been enormously successful at this point.

Although Breasia Productions has gained a lot of recognition in regard to the kind of work that we do for the MEs and the inaugural galas and things of that nature, a feature on Oprah Winfrey and that sort of thing. But as a new business owner, I knew I could not afford $400 to $600 in premiums for health care for my employees. With great regret, I chose against, at the time, having health insurance because the prices were astronomical, in my opinion. In fact, I did not have coverage since college in my mid-20s or early 20s.

When I needed a medical procedure done, I actually left the country and flew to a neighboring country to have my procedures completed. And I would vacation and I would shop and I would dine and I would have the procedures done and it would still be less, the whole trip would be less than what I would pay for the procedure here in my own backyard. That is a hard pill to swallow for me because I am a patriotic and I love my country. I believe we live in the best country on the planet.

I considered it a blessing to learn of Governor O'Malley's Working Family and Small Business Health Care Coverage Act of 2007. I was eligible for the small business grant that helped me to make health insurance more affordable, and I am fortunate to live in Maryland. Maryland is a state that has made small business coverage a priority.

Beyond this, for me, it is very personal, this entire issue because of my business manager, Nailah Govern. She fell ill last year and she needed emergency surgery, and I found her face down on the floor and she was gasping for air. In fact, she was dying.

The doctor said that if I had not rushed her to the hospital when we had gotten her there, that she would not be with us. Without the Affordable Care Act, she would have been, I believe, shifted

around from medical system to medical system receiving—not receiving the immediate treatment that I believe she required at the moment.

Because of that support of the affordable health care, today she is with me and I actually made her my wife. I think she had to marry me because I saved her life.

So in all that to say, I really appreciate the time that we have here today. Ask any questions. We are right in the midst of the firing squad, if you will, and it is difficult, but we are here to help grow the economy and build our workforce, and I believe that we are the backbone of the economy right now. So we really need the assistance of what we have in place. Thanks.

[The prepared statement of Mr. Lee follows:]

STATEMENT FOR THE RECORD

BEFORE THE SENATE SMALL BUSINESS AND ENTREPRENEURSHIP COMMITTEE

ON

SMALL BUSINESSES AND HEALTHCARE

JULY 24, 2013

JAMAL LEE
OWNER
BREASIA STUDIOS

Good morning, Chair Landrieu, Ranking Member Risch and members of the committee.

My name is Jamal Lee, I'm the owner of Breasia Studios, an audio, lighting, and video production company in Laurel, Maryland. I'm also a member of Small Business Majority's Network Council. Small Business Majority is a national small business advocacy organization that works to find solutions to the biggest problems facing small businesses today. As a network council member, I volunteer my time aud entrepreneurial expertise to help Small Business Majority find pragmatic solutions to many of those problems—one of which is the risiug cost of health insurance. That's what I'd like to talk to you about today.

I started my career working lighting on various movie sets and concerts, eventually becoming the audio producer for the Washington Nationals. In 2005, I Breasia Studios in my mother's Baltimore, Maryland basement. I worked hard and we did well, and it wasn't long before we moved to a space in Laurel that could accommodate new equipment and added employees.

Although Breasia Studios was gaining recognition, there was still one major obstacle to overcome: health insurance. As a new business owner, I knew I couldn't afford to provide healthcare to my employees. In fact, I didn't even have insurance and hadn't since I was in my 20s. In order to have any procedures done I chose to leave the country because it was too expensive here in America.

Luckily, I discovered that, thanks to the Governor's Working Families and Small Business Health Coverage Act of 2007, I was eligible for a small business grant that helped make health insurance more affordable. I'm lucky enough to live in Maryland, a state that has made small business coverage a priority, but I strongly believe affordable healthcare should be accessible for everyone. The Affordable Care Act, especially the small business provisions, will help me to continue to provide coverage for my employees. In fact, I've already received a healthcare tax credit thauks to the new law.

What's more, my wife and business partner, Nailah Gobern, almost died in December 2011. I actually found her lying on the floor gasping for air. I don't want to think about what could have happened if she didn't have the coverage that has been made available through the recent adjustments in the law.

Without the Affordable Care Act, she would have just been sbifted around through the medical system and probably not have received the treatment that she needed. She almost died as it was.

I always wanted health insurance and being self-employed we couldn't afford it. We don't want to go back to that. I'm looking forward to full implementation of the Affordable Care Act next year when our state exchange opens and additional cost containment provisions go into effect. I may finally start to have the certainty and stability I need when it comes to health insurance premiums and choices of plans.

Benefits of the ACA for my small business

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

There have been objections from small business owners about this law, but I believe that that discontent is largely based on misinformation and myths. One myth I hear all the time is that small businesses will go out of business because they'll be required to provide costly health insurance to their employees. That's just not the case. Lets look at the numbers: 96% of all businesses in this country have fewer than 50 full-time employees, which means they won't be required to offer insurance at all. Of the 4% who do have more than 50 employees, 96% of them already offer insurance. So, that leaves 0.02% of small businesses that have more than 50 full-time employees and don't offer insurance that will be impacted. That's a very small segment of our community.

Going back to the majority of small businesses, I'm one of those employers with fewer than 50 full-time-equivalent employees. Starting next year, I'll be able to use our state small business health insurance exchange to purchase coverage. This is huge. In Maryland, we don't have a lot of choice in insurance providers. In fact, we only have three. The Small Business Health Options (SHOP) exchange will allow business owners like me to pool our buying power when purchasing insurance. With a larger pool of businesses, ideally we will have more insurers offering coverage, and therefore more options to choose from. Presumably, this will make the market more competitive and I expect prices to come down as a result. Simply knowing I'll be able to shop for other plans as insurers change and costs fluctuate makes me feel more secure.

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

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

Conclusion

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

Thank you for giving me the opportunity to address the committee today.

Jamal Lee started his career by working lighting on various movie sets and concerts, eventually becoming the audio producer for the Washington Nationals. He has also worked the Technical Emmys featuring Oprah. In 2005, Jamal's strong entrepreneurial spirit led him to create his own recording and production studio. He knew the 9 to 5 life wasn't for him, and after getting his feet wet in sound production, Jamal set up Breasia Studios in his mother's Baltimore, Maryland basement. Despite humble beginnings, the studio grew quickly. It wasn't long before Jamal moved to a space in Laurel that could accommodate new equipment and added employees—who were becoming a necessary part of his business. With a growing number of clients based in Washington, D.C., Breasia Studios continues to flourish.

Chair LANDRIEU. Thank you, Mr. Lee. To make this more fair, you all sat sort of pro and con. I am going to go to Mr. Settles and then come back. So, Mr. Settles, please proceed.

STATEMENT OF KEVIN SETTLES, PRESIDENT AND CEO, BARDENAY RESTAURANT & DISTILLERY

Mr. SETTLES. Chairwoman Landrieu and Ranking Member Risch, members of the Committee, I would like to thank you for your time today. My testimony today will focus on some of the issues that my company has been struggling with while trying to understand the health care law. I want to ensure that my company, Bardenay, is fully compliant with the law while remaining healthy and vibrant.

These issues are the definition of a full-time employee; (2) employee classifications, and that is full-time, part-time, variable hours, seasonal; (3) auto-enrollment; and (4) non-discrimination rules. After more than three years, there is still a tremendous amount of uncertainty surrounding the laws. This uncertainly has been a key factor in extending the longest time period without expansion in all my years as an independent businessman.

Bardenay is operated for the long run. We do not make long-term commitments to unmanageable expenses, and we cannot know how to manage for PPACA until all of its rules are known. While the law's definition of a full-time employee of 30 hours has been published for some time now, how it actually applies to my operation is trickier to calculate.

My restaurants are very busy places and it takes a well-trained staff of restaurant professionals to make them run. We are also very much affected by the seasons. The number of people it takes to run my restaurants in the winter is much lower than in the summer. While we do hire some people to work just through the summer, we have many more that want to work year-around, but vary the hours that they work to fit the seasons.

This is where the Federally defined classifications of full-time, variable hour, and seasonal come into play. These rules will affect our ability to allow our employees to have the variable hour schedules that they find so attractive. The hours they work are often based upon their needs. Maybe they are returning to college. We have a lot of parents who are splitting child care duties.

This is the freedom that has caused a number of my employees to decline health insurance because to get it through my company, you have to work a fixed schedule and that does not fit their lifestyle. And in our industry, lifestyle is a critical factor in attracting employees. It is our ability to use the work schedules to determine—pardon me.

Our ability to use it when determining work schedules is diminished under the law. With the significant added cost to insurance and penalties for not offering it, we cannot let them inadvertently slip between part-time and full-time. Since many of our employees like to work about 30 hours a week, their schedules will have to be managed very closely.

When it comes to auto enrollment, this is the specific provision that has stopped me from looking at expanding. While I now know that we are exempt from it for now, it is the uncertainty regarding how this rule would be applied, combined with not knowing what

a policy is going to cost, that has stopped me from looking into expansion.

As an employer, life gets a lot more complex when you pass 50 full-time equivalents in employees. I have discussed this issue with the CEOs of the three largest health insurance providers in Idaho and they have confirmed that you need to be covering at least 400 employees to get the best rates.

For now, Bardenay is subject to the requirements to offer coverage under the health care law, but we do not qualify for the best rates and yet, we are too large to take advantage of the Exchanges that are being set up.

When it comes to the non-discrimination rules, I have to be careful that I do not offer a better policy to my CFO, who has an M.B.A., than I do to any other employee. Today's restaurants are very sophisticated businesses and its employees must have a variety of skill sets for it to succeed.

Restaurants are the place where many people learn to work. Our staff varies from young people, working their first job, to industry veterans with college degrees. I need to ensure that I can retain my highly skilled staff by providing them with the benefits that they expect.

To meet the law's requirements, we may end up asking participating employees to contribute financially. The law allows for this and sets out the terms for calculating the maximum employee contribution. The danger is that we need a certain percentage of the eligible employees to participate or the carrier will decline to bind coverage. In Idaho, that rate is generally 75 percent to 80 percent of the eligible people that will have to participate.

Since the law has passed, Bardenay has thrived, yet we have been conservative in our actions. We have sat on the sidelines and worked on our internal system so that we are ready to grow if that still seems prudent once we know the full impact of the law.

Chair LANDRIEU. Can you try to wrap up, Mr. Settles?

Mr. SETTLES. In closing, I would like to state that I am not against offering health care coverage. We have offered it to our salaried staff since shortly before we opened and we picked up 100 percent of the cost. Since the health care law has passed, the cost of that policy has doubled, and it would have gone up higher except we have allowed the deductible to triple—actually, it has gone up fourfold.

So that kind of price increase is not sustainable. More than three years after the law's enactment, we still do not know if it will make it easier for employers like me to cover more employees or not, and we do not know—for those of us with the goal of growing a business, and the thing has just gotten much more complex. Thank you.

[The prepared statement of Mr. Settles follows:]

Statement
On behalf of the
National Restaurant Association

HEARING: IMPLEMENTATION OF THE AFFORDABLE CARE ACT: UNDERSTANDING SMALL BUSINESS CONCERNS

BEFORE: COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP
U.S. SENATE

BY: KEVIN SETTLES
PRESIDENT AND CEO
BARDENAY RESTAURANT & DISTILLERY

DATE: JULY 24, 2013

Statement for the hearing
"Implementation of the Affordable Care Act:
Understanding Small Business Concerns"

Before the

Committee on Small Business and Entrepreneurship,
U.S. Senate

By
Kevin Settles,
President and CEO,
Bardenay Restaurant & Distillery

On behalf of the
National Restaurant Association

July 24, 2013

Chairwoman Landrieu, Ranking member Risch, and members of the Senate Committee on Small Business and Entrepreneurship; thank you for the opportunity to testify today on the Affordable Care Act's implementation and the concerns of small businesses like mine.

My name is Kevin Settles and I own and operate Bardenay Restaurants & Distilleries with three locations: Boise, Eagle and Coeur d'Alene, Idaho. I'm honored to share the perspective of my company and the National Restaurant Association, where I serve on the organization's Board of Directors.

I have spent a lot of time studying the impacts of this law on my business and was appointed by Governor C.L. "Butch" Otter to Idaho's Health Insurance Exchange Board as one of four small employer business interests.

Today, my testimony will focus on some of the issues that my company has been struggling with while trying to understand the health care law. I want to ensure that Bardenay is fully compliant with the law, while remaining healthy and vibrant. These issues are:

- The definition of a full-time employee;
- Employee Classifications – such as full time, part time, variable hour and seasonal;
- The determination of who is a small or large employer;
- Auto Enrollment;

- Non-discrimination rules;
- Employer reporting;
- Communicating with employees; and
- Policy costs.

Even after more than three years, there is still a tremendous amount of uncertainty, which has been a key factor in extending what for me is the longest time period without expansion in my years as an independent businessman. Bardenay is operated for the long run, which means that we do not make long-term commitments to unmanageable expenses. One can only manage the law's effects once all of the rules are known.

BARNENAY RESTAURANT & DISTILLERY

Bardenay Restaurant and Distillery is a cornerstone of Idaho's restaurant and bar industry, with three locations that capture the spirit of Idaho and the Northwest. Employing about 200 people, Bardenay is a small business with a goal of being the employer of choice in our industry.

As the nation's first restaurant distillery, Bardenay has set an industry precedent as the full service restaurant and bar with the ability to create handcrafted liquor on-site. We made history on April 25, 2000, when we served the first cocktail to included spirits distilled in a restaurant in the U.S.

THE RESTAURANT AND FOODSERVICE INDUSTRY

The National Restaurant Association is the leading trade association for the restaurant and foodservice industry. Its mission is to help members like me establish customer loyalty, build rewarding careers, and achieve financial success. The industry is comprised of 980,000 restaurant and foodservice outlets employing 13.1 million people who serve 130 million guests daily. Restaurants are job-creators. While small businesses comprise the majority of restaurants, the industry as a whole is the nation's second-largest private-sector employer, employing about ten percent of the U.S. workforce.[1]

The unique characteristics of our workforce create compliance challenges for restaurant and foodservice operators within this law. It's difficult for restaurants to determine how the law impacts them and what they must do to comply. Many of the determinations employers must make to figure out how the law impacts them – for example the applicable large employer calculation – are much more complicated for restaurants than for other businesses that have more stable workforces with less turnover.

[1] *2013 Restaurant Industry Forecast.*

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

Business owners crave certainty, because it enables us to plan for the future and make decisions that benefit our employees, customers, and communities. One of the most difficult things to predict about the impact of this law is the choices employees will make.

> Will they accept restaurant operators' offers of minimum essential coverage more than they do today?
>
> Will our young workforce choose to pay the individual mandate tax penalty instead of accepting the employer's offer of coverage in 2015, 2016 and beyond?
>
> Will exchange coverage be less expensive than what our operators can afford to offer under the law?

With the younger, healthier population of the workforce, we may find that more team members will favor the tax penalty because it is less expensive than employer-sponsored coverage. This provides less certainty for employers to predictively model.

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

Since the law was enacted in 2010, the National Restaurant Association has taken steps to educate America's restaurants about the requirements of the law and the details of the Federal agencies' guidance and regulations. Through the National Restaurant Association Health Care Knowledge Center website (Restaurant.org/healthcare), we offer one place where restaurant operators of every size can go to better understand the law's requirements and determine its impact on their employees and businesses.

The National Restaurant Association has actively participated in the regulatory process, from the beginning, to ensure that the implementing regulations and Federal agencies' guidance consider the implications for businesses that are not just one type or size. As co-leaders of the Employers for Flexibility in Health Care (E-Flex) coalition, we have partnered with other businesses and organizations with similar workforce characteristics. Together we advocate for

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[2] Bureau of Labor Statistics, U.S. Department of Labor.
[3] *2013 Restaurant Industry Forecast.*

greater flexibility and options within the implementing regulations, especially for those that employ many part-time, seasonal, or temporary employees.

The overarching challenge restaurant and foodservice operators face in complying with the law is to first understand its complicated and interwoven requirements. By far, the definition of "full-time employee" under the law poses the greatest challenge. It does not reflect current workforce practices and could have a detrimental impact on a restaurant operator's ability to offer flexible schedules for his or her employees.

In addition, the applicable large employer determination is too complex. It stifles smaller employers' ability to manage their workforces, expand their businesses and prepare to offer health care coverage. Finally, the automatic enrollment provision could cause financial hardship and greater confusion about the law for some employees, without increasing their access to coverage.

All of these factors combine to complicate what a restaurant and foodservice operator must consider when adapting their business to comply with the law.

APPLICABLE LARGE EMPLOYER DETERMINATION

To determine the law's impact on a restaurant, the employer must first determine if they are considered small or large under the definitions of the law. The statute prescribes a very specific calculation that must be used by employers to determine if they are an applicable large employer and hence subject to the Shared Responsibility for Employers and Employer Reporting provisions. Due to the structure of many restaurant companies, determining the employer may be more complicated than expected.

Aggregation rules in the law require employers to apply the long-standing Common Control Clause[4] in the Internal Revenue Code (Tax Code) to determine if they are considered one or multiple employers for the purposes of the health care law. These rules have been part of the Tax Code for years, but this is the first time that many restaurateurs, especially smaller operators, have had to understand how these complicated regulations apply to their businesses. The Treasury Department has not issued, nor to our knowledge plans to issue, guidance to help smaller operators understand how these rules apply to them. Restaurant and food service operators are forced to hire expensive tax advisors to determine how the complicated rules and regulations associated with this section of the Tax Code apply to their specific situations. Often, entrepreneurs own multiple restaurant entities with various partners. Though these restaurateurs consider each operation to be a separate small business, many are discovering that, for the purposes of the health care law, all of the businesses can be considered one employer due to common ownership.

[4] Internal Revenue Code, §414 (b),(c),(m),(o).

Once a restaurant or foodservice operator determines what entities are considered a single employer, they must determine their applicable large employer status annually. For some restaurants, like Bardenay, it is clear that we have more than 50 full-time equivalent (FTE) employees employed on business days in a calendar year. However, many small businesses will have to complete this calculation annually to determine their responsibilities under the law. That is not so easy given the number of employees' hours of service that must be tracked due to the labor intensive nature of the business.

Unfortunately, operators on the cusp of 50 full-time equivalent employees are struggling to understand how to complete this complicated calculation each year. An employer must consider each employee's hours of service in all 12 calendar months each year. Immediately after they achieve this cumbersome calculation at the end of the year, they must begin to offer coverage January 1st.

Smaller restaurant and foodservice operators need clarification on when such employers must offer coverage in future years. Will small businesses just reaching the applicable large employer threshold on December 31, 2015, for example, be able to offer coverage a day later on January 1, 2016? Currently, the law does not allow any time to shop for coverage or conduct open enrollment once a small employer determines they are now a large employer. Congress should allow small businesses an administrative period between determining large employer status and offer of coverage, before it creates further confusion, especially in the second year of implementation and beyond.

The applicable large employer determination is complicated. Employers must determine all employees' hours of service each calendar month, calculate the number of FTEs per month, and finally average each month over a full calendar year to determine the employer's status for the following year. The calculation is as follows:

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

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

This annual determination is administratively burdensome, especially for those employers just above or below the 50 FTE threshold who must most closely monitor their status – most likely smaller businesses. Many restaurant operators rely on third-party vendors to develop technology or solutions to help them comply with these types of requirements but, in addition to the added costs and time this requires, vendors are backlogged and solutions are not easily accessible at this time.

Congress should simplify this calculation and help small businesses more easily determine their status under the law. A more workable definition of large employer is needed as the current calculation stifles smaller employers' ability to manage their workforces, plan to expand their businesses, and prepare to provide health coverage.

OFFERING COVERAGE TO FULL-TIME EMPLOYEES

The health care law requires employers subject to the Shared Responsibility for Employers provision to offer a certain level of coverage to their full-time employees and their dependents, or face potential penalties. The statute defines a full-time employee as someone who averages 30 hours a week in any given month.

This 30-hour threshold is not based on existing laws or traditional business practices. In fact, the Fair Labor Standards Act does not define full-time employment. It simply requires employers to pay overtime when nonexempt employees work more than a 40-hour workweek. As a result, 40 hours per week is generally considered full-time in many U.S. industries. In the restaurant and foodservice industry, operators have traditionally used a 40-hour definition of full-time. Adopting such a definition in this law would also provide employers the flexibility to comply with the law in a way that best fits their workforce and business models.

Compliance based on a 30-hour a week definition is further complicated by the fact that, for restaurant and foodservice operators who are applicable large employers, it is not easy to predict which hourly staff might work 30 hours a week on average and which will not. Hourly employees are scheduled for more or less hours depending on several factors, including customer traffic flows.

One reason so many Americans are drawn to restaurant jobs is the flexibility to change your hours to suit your own personal needs. However, under this law, for the first time, the federal government has drawn a bright line as to who is considered full-time and who is considered part-time. As a result, employers with variable workforces and flexible scheduling must alter their practices and be very deliberate about scheduling hours. The reason being that the law imposes a greater financial impact than before in the form of potential liability for employer penalties if employees who work full-time hours are not offered coverage. If the definition is not changed to align with workforce patterns, the flexibility so many employees value will no longer be as widely available in the industry. This could result in significant structural changes to our labor market.

At Bardenay, we have redefined who is a full-time employee because of the definition within this law. And it will have an impact on my employees' ability to pick up extra hours when they would like them. We will be requiring full time employees to work a full 40 hours. At the rates we are currently paying for insurance, our costs per employee that we provide insurance to will increase by over $3.00 per hour. To ensure that we obtain maximum value for this benefit, we have already set up our scheduling program to alert us when an employee is close to crossing over from the variable classification to full time.

The National Restaurant Association supports efforts, such as Senators Susan Collins' and Joe Donnelly's bipartisan bill S. 1188, and Congressman Todd Young's bill H.R. 2575, that would define a full-time employee under the Affordable Care Act as someone working 40 hours or more a week.

We appreciate that the Treasury Department, in its January 2nd proposed rule, recognized that it may be difficult for applicable large employers to determine employees' status as full-time or part-time on a monthly basis, causing employee churn between employer coverage and the exchange or other programs. Such coverage instability is not in our employees' best interests. We are pleased that the Lookback Measurement Method is an option that applicable large employers may use.

While the Lookback Measurement Method's implementing rules are complex, it could be helpful for both employers and employees. Employers will be better able to predict costs and accurately offer coverage to employees as required. Employees whose hours fluctuate (variable hour and seasonal employees) have the peace of mind of knowing that if their hours do decrease from one month to the next, coverage will not be cut short before the end of their stability period.

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

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

Minimum value is generally understood to be a 60 percent actuarial test; a measure of the richness of the plan's offered benefits. This is a critical test for employers especially relating to what the employer's group health plan covers and hence what the premium cost will be in 2014. Business owners strive for certainty, and that means the ability to plan for their future costs. Employers are eager to know what their premium costs will be under the new law. Minimum value is necessary to determining that information.

On February 25, 2013 the Health and Human Services Department included the Minimum Value Calculator, one of the acceptable methods to determine a plan's value, in its Final Rule: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Minimum value can now be determined using this calculator or other options, but it is still difficult to anticipate premium costs this far in advance.

Why? Rates are not usually available until a few months before the employer's plan year begins because insurance companies provide quotes based on the most current data with the greatest amount of claims history. This gives operators a short timeframe to budget and make business decisions in advance of the new plan year. Restaurant operators are eager to see premiums for 2014 and better evaluate the impact and costs associated with the employer requirements for voluntary compliance and then full implementation in 2015.

I employ about 200 people with 60-90 of them full-time employees, depending on the season. We currently provide insurance to our full time, salaried staff. Since the health care law passed, the cost of that insurance has doubled and our deductible has gone from $500 to $2,000. This policy renews September 1 and our initial quote was for it to go up another 11% this year. No other cost has ever increased at this rate, not even close.

Insurance has been offered to key hourly employees in the past. Their flexible hours and freedom that affords has caused them to decline our offer of coverage as it would require a fixed schedule. What many do not realize, is that some employees are not looking to restaurants to offer them health care coverage. That is their personal choice. They have the hours they need to work and live the lifestyle they choose. The problem is that under this law, with the significant added cost of insurance or penalties, we cannot let them inadvertently fluctuate between part-time and full-time.

The cost of health care coverage has long been a major concern for restaurant and foodservice operators. Many of us are subject to the requirement to offer coverage under the law, but are not large enough to qualify for large group rates, yet too large to use the Exchanges being set up for small employers. I have discussed the issue with the CEO's of the three largest insurers in Idaho and they confirmed that employers sitting between 50 and 400 employees are in the least desirable position in regards to the health care law.

To help us manage this new cost, we may end up asking participating employees to contribute financially. The law allows for this and sets out terms for calculating the maximum employee contribution. The danger is that we need a certain percentage of eligible employees to participate or the carrier will decline to bind coverage. In Idaho, that participation rate is generally 75 to 80 percent. Ask our employees to contribute too much so they decline coverage

and we could find ourselves unable to purchase the insurance that will soon be required by law. The Department of Health and Human Services recently issued a proposed rule[5] which clarified that guaranteed availability and renewability apply in the individual, small group *and* large group markets. If the rule is finalized with this language, it should mean that participation rate restrictions will not be allowed for businesses purchasing group health plans like me, but it may also increase premiums.

In addition, Idaho's exchange will impose a 2.5 percent fee on each policy sold within the exchange. Since all policies in the state, whether sold on or off the exchange, must be sold for the same rate, that fee will be applied to all policies. This means that even though my company cannot utilize the Exchange, the policy costs will be higher due to it.

Speaking of cost, employers must also ensure at least one of their plans is affordable to their full-time employees or face potential penalties. A full-time employee's contribution toward the cost of the premium for single-only coverage cannot be more than 9.5 percent of their household income to be considered affordable. Employers will not know household income – which the statute specifies as the general standard – nor do they want to know this information for privacy reasons. Hence, they needed a way to estimate before a plan is offered if it will be affordable to employees or potentially trigger an employer penalty.

What employers do know are the wages they pay their employees. Almost always, employees' wages will be a stricter test than household income. Employers are begrudgingly willing to accept a stricter test in the form of wages so that they know they are complying with the law and are provided protection from penalty under a safe harbor. The Treasury Department's proposed rule allows employers to use one of three Affordability Safe Harbors based on Form W-2 wages, Rate of Pay or Federal Poverty Line. The option of utilizing these methods will be helpful to employers as they determine at what level to set contribution rates and their ability to continue to offer coverage to their employees.

I believe that Bardenay will have to go by percentage of pay rate even though that will end up as a variable amount. Even though many of my employees have been with us long enough for us to use the income from company issued W-2's, if their hours are less and we do not adjust, we could be penalized.

The law speaks to affordability for employees but is silent regarding whether the coverage required to comply with the Shared Responsibility for Employers section of the law is affordable to employers. As restaurant and foodservice operators implement this law, considering all of the interlocking provisions, some will be faced with difficult business decisions – between offering coverage they cannot afford with a finite dollar for benefits, and paying a penalty – an option they do not want to take, but that is equally unaffordable to them as well.

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[5] Centers for Medicaid and Medicare Services, Department of Health and Human Services, Proposed Rule: Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards (CMS-9957-P), June 19, 2013.

We encourage policymakers to address the cost of coverage so that the employer-sponsored system of health care coverage will be maintained, and businesses aren't forced to choose between plans they cannot afford and penalties they cannot afford.

AUTOMATIC ENROLLMENT REQUIREMENT

Applicable large employers who employ 200 or more full-time employees are also subject to the Automatic Enrollment provision of the law. This duplicative mandate requires these employers to enroll new and current full-time employees in their lowest cost plan if the employees have not opted out of the coverage.

This provision also interacts with the prohibition on waiting periods longer than 90 days and effectively means that on the 91st day, employers must enroll a new full-time hire in their lowest cost plan if the employee does not opt out by that deadline. Employee premium contributions will begin to be collected.

I share the concern many of my restaurant industry colleagues that this could cause financial hardship and greater confusion about the law, especially for our young employees. Since 43 percent of restaurant employees are under age 26, and therefore more likely to change jobs frequently or enroll in their parents' plans, many are likely to inadvertently miss opt-out deadlines and will be automatically enrolled in their employer's health plan. This would cause significant, unexpected and, most importantly, unnecessary financial hardship.

Automatically enrolling an employee and then shortly thereafter removing them from the plan when the employee opts out increases costs without increasing our employee's access to coverage as the law intended. Since the health care law's employer Shared Responsibility provision already subjects large employers to potential penalties if they fail to offer affordable health care coverage to full-time employees and their dependents, the auto-enrollment mandate is redundant. It adds a layer of bureaucracy and, burdens businesses without increasing employees' access to coverage.

Some compare automatically enrolling employees in health benefit plans to automatically enrolling them in a 401(k) plan, but this isn't a good parallel. The financial contribution associated with health benefits can be much larger, for example: 9.5 percent of household income toward the cost of the premium for employees of applicable large employers versus an average 3 percent automatic 401(k) contribution.[6] The financial burden on employees of automatic enrollment in health benefit plans would be much greater than that of 401(k) plans. Additionally, 401(k) rules allow employees to access their contributions when they opt out of automatic enrollment; however, health benefit premium contributions cannot be retrieved.

[6] "Disparities in Automatic Enrollment Availability," Bureau of Labor Statistics, August 2010.

Restaurateurs will educate their employees about how this provision impacts them, but if an employee misses the 90-day opt out deadline, a premium contribution is a significant amount of money, which can be a serious financial burden. Since the same full-time employees must be offered coverage by the same employers subject to the Automatic Enrollment provision and the Shared Responsibility for Employer provisions, we believe the automatic provision is unnecessary and should be eliminated.

The National Restaurant Association supports H.R. 1254, legislation introduced by Congressman Richard Hudson, together with Congressman Robert Pittenger, that would eliminate the automatic enrollment requirement that could hurt both employees and employers.

While I now know that we are exempt from Auto Enrollment until I expand, it was the uncertainty regarding how this rule would be applied, combined with not knowing what a policy would cost, that has stopped me from looking into expansion. As an employer, life gets more complex when you pass 50 FTE's and you do not gain a cost advantage due to size until you exceed 400 FTE's.

NONDISCRIMINATION RULES NOW WILL APPLY TO FULLY-INSURED PLANS

The health care law applies the nondiscrimination rules that currently apply to self-funded plans to fully-insured plans in the future. These rules state that a plan cannot offer benefits in favor of their highly-compensated individuals over other employees. This rule is not in effect as the Treasury Department has put implementation on hold until further guidance has been issued in this complex area. Under the law, these rules apply to all insured plans, regardless of where they are offered by an applicable large employer or a small business. I am watching this rule closely as it could impact what future plan offerings and compliance with the law.

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

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

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

With the new non-discrimination rules set to apply to group health plans like the ones I purchase, I must be careful not to offer a better policy to my CFO with an MBA than I do to any other employee. Today's restaurants are very sophisticated business and its employees must

have a variety of skill sets for it to succeed. While Restaurants are still the place where many people learn to work, our staff varies from young people without much work experience or those with a troubled past to people with college degrees. I need to ensure that I can retain my highly skilled staff while not breaking the bank. To avoid this, we may end up asking participating employees to contribute financially.

APPLICABLE LARGE EMPLOYER REPORTING REQUIREMENTS

The employer reporting requirements are a key area of implementation for employers: the required information reporting under Tax Code §6055 and §6056 from the Internal Revenue Service and the Treasury Department. These employer reporting requirements are a critical link in the chain of the law's implementation. They represent what could be a significant employer administrative burden and compliance cost.

The Administration's July 2nd announcement and subsequent July 9th IRS Notice 2013-45 provides transition relief and voluntary compliance in 2014 for the Employer Reporting requirements under Tax Code Sections 6055 and 6056, and hence the Employer Shared Responsibility requirements under Tax Code Section 4980H.

The restaurant and foodservice industry welcomes this transition relief after asking the Administration and Congress for more time to receive, understand, and comply with the complex implementing regulations for Employer Reporting under Sections 6055 and 6056. As early as October 2011, the National Restaurant Association, as part of the E-Flex coalition, submitted comments to the Administration requesting transition relief and time to implement the reporting requirements under Tax Code Sections 6055 and 6056 once the rules were issued. The proposed rule from the Treasury Department concerning Tax Code Section 4980H was published in the *Federal Register* on January 2, 2013 to implement the employer mandate, but employers have been waiting for the also critical proposed rules on Tax Code Sections 6055 and 6056.

Employers need the rules for these reporting requirements to set up the systems that will track data on each full-time employee and their dependents to then report this data to the IRS annually. While the first report was not originally required to be submitted to the IRS until January 31, 2015, six months (July-Dec 2013) was too short a time frame for employers to receive the rule, set up systems or engage vendors to develop information technology systems that would begin tracking the necessary data as of January 1, 2014.

We welcome the transition relief and await the proposed rule on Tax Code Sections 6055 and 6056 that the Administration stated it plans to issue later this summer.[7] Regarding those rules, of particular concern is the flow of information and the timing of reporting employers must make to multiple levels and layers of government. Streamlining employer reporting will help

[7] "Continuing to Implement the ACA in a Careful, Thoughtful Manner," Mark Mazur, Treasury Notes Blog, July 2, 2013: http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx

ease employer administrative burden and simplify the process. The restaurant and foodservice industry, along with other employer groups, have advocated for a single, annual reporting process by employers to the Treasury Department each January 31st that would provide prospective general plan information and wage information for the affordability safe harbors, as well as retrospective reporting as required by Tax Code Section 6056 on individual full-time employees and their dependents.

While my comments revolve around the unknowns of this law, there is one certainty; the workload in accounting will go up, significantly. To minimize the impact, we have increased the required skillset for office assistants – they must have experience in accounting – and are working with our timekeeping and accounting software provider to try to make reporting as easy as possible. Possibly the most positive aspect of transition relief is the added time to understand the required reports and I urge that the Treasury Department release the proposed rule as soon as possible.

COMMUNICATING THE LAW'S IMPACT TO OUR EMPLOYEES

I have made a concerted effort to educate not only myself, but my staff. If the people responsible for implementing the law cannot launch it in time due to its complexity, how can anyone else possibly understand it. My staff is as informed as they can be with the information available. They know that some may benefit and some may not but they all know that everyone will pay at least something for this law.

CONCLUSION

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

Congress must address key definitions in the law: The law should more accurately reflect restaurant and foodservice operators' needs – and our employees' desire for flexible hours.

We ask you to simplify the applicable large employer determination and remove the unnecessary burdens on small businesses, who must closely track their status from year-to-year.

And we ask you to eliminate the duplicative automatic enrollment provision, as it has the potential to confuse and financially harm employees while burdening employers, without increasing employee's access to coverage.

In closing, I would like to state that I am not against offering health care insurance to my employees. I have been able to provide insurance for employees that have had serious illnesses and that is very satisfying. When discussions about the law started, I thought great, the U.S. has the largest economy in the world and we spend 9% more of our gross domestic production than

any other country on healthcare, find the money in there. More than three years after its enactment, we still do not know what will happen. What I do know is that for those of us with a goal of growing a business, things have gotten much more complex.

Thank you again for the opportunity to testify before you today regarding small business concerns as we implement the health care law.

This law is one of the most significant requirements our industry has had to comply with that most any can remember. While we appreciate the transition relief, giving us the opportunity to receive and understand the rules and then implement them, the industry still faces challenges only Congress can address: the definition of full-time employee, the determination of who is an applicable large employer under the law, and the elimination of the automatic enrollment provision.

We are both proud and grateful for the responsibility of serving America's communities – creating jobs, boosting the economy, and serving our customers. We are committed to working with Congress to find solutions that foster job growth and truly benefit the communities we serve.

Bio of Kevin Settles

Kevin Settles owns and operates the successful Bardenay restaurant & distillery operations with location in Boise, Eagle and Coeur d'Alene, ID. He and his businesses have earned nationwide recognition in the Wall Street Journal, USA Today, Fortune, Forbes, Inc., Market Watch, National Public Radio and Modern Marvels, an A&E Television Network show on the History Channel. In 2011, he was named Idaho Restaurateur of the year.

Kevin is a member of the National Restaurant Associations Board of Directors, Past President of the Idaho Lodging and Restaurant Associations Board of Directors, Secretary of the Bogus Basin Recreational Association Board of Directors, a Commissioner for the Idaho Human Rights Commission and a Board Member for the Idaho Health Insurance Exchange.

Chair LANDRIEU. Thank you.
Mr. Katz.

STATEMENT OF LAWRENCE K. KATZ, PRESIDENT AND CEO, JOMAR CAFÉ, INC., DBA DOT'S DINER

Mr. KATZ. Good afternoon, Madam Chair Landrieu, Ranking Member Risch, and the other distinguished members of the Committee. My name is Larry Katz and I am the owner of the Dot's Diner Restaurant Group based in Metairie, Louisiana. I would like to thank Senator Vitter for his invitation to appear today.

While there is no question that the Federal Government needs to reform and strengthen our health care system, I believe that the law as currently written will negatively impact job growth, start-up expansions, and raise prices, not just of health care, but of all products and services that we buy.

It certainly has had a direct effect on my company, and I anticipate it will leave me in a position of being less competitive than other local restaurants going forward. I will detail these observations, but first of all let me tell you a short history of Dot's and me.

After college, I moved to New Orleans and took a job with a clothing manufacturer, eventually becoming President. In 1996, the company was sold. Not wanting to continue with the new concern, my dream was to own my own company. I cashed in my whole life insurance, calculated credit card availability, and emptied my entire savings into my dream.

With less than $200,000, I opened the first Dot's Diner Restaurant. Well, fast-forward 12 months. I had stopped sleeping, was down to less than $10,000 in savings, and at that point, I had just a few options. Second-mortgage our home or declare bankruptcy. The third option of admitting to my wife that I had made a mistake was off the table.

By the grace of God, perseverance, and some good luck, we broke even that week. It was in April 1997 and I can remember the day like it was yesterday. The following week we made a few hundred dollars and the tide had been turned. Today I own six diners, employ 85 people, and I am proud that I constantly get calls from landlords asking us to consider opening a store in their area.

We offer paid holidays, vacation, dental, vision, term life, and health insurance. We currently employ 65 FTEs and, thus, will not be able to benefit for most of the subsidies and tax credits offered to similar companies under the ACA. And in addition to not benefitting, we will be hurt by virtue of being over the 50 employee limit.

Smaller restaurant companies will now have their employees covered by the Exchanges at little or no cost to them, while larger companies generally offer health insurance and will not be impacted as much. Well, we are caught in this unintended donut hole and, thus, will be saddled with the options of either dropping our current health insurance plans and pay the penalty, or cover 100 percent of our employees and incur its result in much higher cost.

While I have, unfortunately, made the decision to quit offering coverage as soon as the employer mandate kicks in. As the penalty, while huge, is less than the cost of offering the required coverage

to all of our employees. So beginning January 1, 2015, my employees and I will become part of the Federal system and the company will be saddled with a $70,000 after tax penalty. At inception, I will be forced to raise my prices between 2 and 3 percent to cover these expenses.

The biggest issue to me, though, is the two major business decisions I am facing. One option is either selling or closing the two least profitable diners. This action would jettison 12 FTEs. At that point, I would juggle the hours of the remaining employees to get us under the 50-person limit. And sadly, I have made the calculation that the corporation would be better off if I were to do exactly this, as the penalty owed would be less than the profit I would lose if I were to close them.

So is it not a shameful position to be put into? I, the business owner, am now forced to put 16 people out of work just to save himself from the negative effects of the ACA. Fearful of the future, I am also currently in the process of having Dot's valued and will consider selling the entire company based on what I learn from this evaluation.

So after 17 years, the first few facing bankruptcy, the next eight investing 100 percent of our profits back into the company to fuel growth, I now strongly am considering getting rid of my life's work and dream. As to expansion, that option is off the table. I want no part of adding employees over the 50-person limit.

I recently went to look at a new restaurant location. The rent, the demographics would be perfect. My instincts tell me that it would be our best location, and with all that, I decided not to open a restaurant there. Why? Because I determined that the prospect of adding 15 more employees and permanently assuring myself of being over the 50-person employee limit would be more harmful than the profits I might gain from opening the diner.

So in conclusion, with all the benefits that one side of this Committee truly believes will happen, I wanted to point out the very real side effects to this Act, the loss of jobs, the raising of prices, no expansion, and the forcing of employees into the Federal Exchanges. Thank you all for the opportunity today to speak about this critical issue facing our country and its small businesses.

[The prepared statement of Mr. Katz follows:]

Written Testimony
Of

Mr. Lawrence K. "Larry" Katz
President & CEO, Dots Diner

Before the
U.S. Senate Committee on Small Business and Entrepreneurship
Wednesday, July 24, 2013

Good afternoon Madam Chair Landrieu, Ranking Member Risch and the other distinguished members of the Committee. My name is Larry Katz and I am the owner of the Dots Diner restaurant group, based in Metairie, Louisiana. I would like to thank Senator Vitter for his invitation to appear today to allow me to share my concerns of how the Affordable Care Act will negatively impact my business and equally as importantly, negatively effect its' employees.

While there is no question that the federal government needs to reform and strengthen our health care system, I believe that the law as currently written will negatively impact job growth, startups & expansions and raise prices, not just of health care, but of all products and services that we buy. It certainly has had a direct effect on my company and I anticipate it will leave me in a position of being less competitive with other local restaurants going forward.

I will detail these observations, but first allow me to tell you a short history of Dots Diner and me.

After graduating from college, I moved to New Orleans and took a job with a clothing manufacturer, eventually becoming president. In 1996, the company was sold.

Not wanting to continue with the new concern, my dream was to own my own company. I cashed in my Whole Life insurance, calculated credit card availability and emptied my life savings into my dream. With less than $200,000.00, I opened the first Dots Diner restaurant.

Fast forward 12 months: I had stopped sleeping and was down to less than $10,000.00 in savings. At that point, I considered two options: 2nd mortgage our home or declaring bankruptcy. The third option, of admitting to my wife that I had made a mistake, was off the table.

Well, by the grace of God, perseverance and some good luck, we broke even that week. It was in April 1997 and I can remember that day like it was yesterday. The following week, we made a few hundred dollars and the tide had been turned.

Today, I own 6 Diners, employ 85 people and I am proud that we constantly get calls from landlords asking us to consider opening a store in their area.

We have paid holidays, vacation, dental, vision, term life and health insurance. We currently employ 65 FTE's and thus, will not be able to benefit from most of the subsidies and tax credits offered to smaller companies under the ACA.

In addition to not benefiting, we will be hurt by being over the 50 employee limit. Smaller restaurant companies will now have their employees covered by the National Exchanges at no costs to them, while larger companies generally offer health insurance and will not be impacted as much. We are caught in this unintended donut hole. And thus, will be saddled with the options of either dropping our current health insurance plans and pay the penalty, or cover 100% of our employees and incur its resultant much higher costs.

I have unfortunately made the decision to quit offering coverage as soon as the employer mandate kicks in, as the penalty, while huge, is less than the costs of offering the required coverage to all of our employees. So, beginning January 1, 2015, my employees and I will become a part of the federal system and the company will be saddled with a $70,000.00 after tax penalty. At inception I will be forced to raise my prices between 2-3% to cover these added expenses.

The biggest issue to me is the two major business decisions I am facing. One option is either selling or closing the two least profitable diners. This action would jettison 12 FTE's. At that point I would juggle the hours of the remaining employees to get us under the 50 person limit. Sadly, I have made the calculation that the corporation would be better off if I were to do exactly this, as the resultant penalty would be less than the profit I would lose if I were to close them.

So, isn't it a shameful position to be put into? I, the business owner, am now forced to put 16 people out of work just to save himself from the negative effects of the ACA.

Fearful of the future, I also currently am in the process of having Dots valued and will consider selling the entire company based on what I learn from this evaluation. So after 17 years, the first few facing bankruptcy, the next eight investing 100% of our profits back into the company to fuel growth, I now am strongly considering getting rid of my life's work and dream.

As to expansion; that option is off the table. I want no part of adding employees over the 50 person limit. I recently went to look at a possible new restaurant location. The rent, location and the demos would be perfect. My instinct tells me that it would be our best location. With all that, I decided not to open a restaurant there. Why? Because, I determined that the prospect of adding 15 more employees and permanently assuring myself of being over the 50 person employee limit would be more harmful than the profits I might gain from opening the diner.

So, in conclusion, with all the benefits that one side of this committee truly believes will happen, I wanted to point out the very real side effects to this act; the loss of jobs, the raising of prices, no expansion and the forcing of employees into the Federal exchanges.

Thank you all for the opportunity to speak today about this critical issue facing our country and its small businesses.

Bio of Lawrence ("Larry") K. Katz

Lawrence K. "Larry" Katz graduated from Ohio University in 1977 with a BSC. He worked for 19 years in the Clothing manufacturing business prior to founding the Dots Diner group of restaurants in 1996. Starting with one twenty seat diner, he has grown the chain into a modern day New Orleans institution with six diners, four of which are open around the clock, Dots employs 85 people and serves thousands of hungry patrons each day. Dots Diner has consistently been honored as one of the "Best Diners in New Orleans" and also been voted the "Best Value in New Orleans" numerous times.

Mr. Katz is very active in the local community. He is a cofounder of the Jefferson Chamber of Commerce and Jefferson Dollars for Scholars. Larry is a Past Chairman of the Chamber of Commerce in East Jefferson and he currently serves on the Board of Directors of the Louisiana Lottery Corporation, New Orleans City Park, Greater New Orleans Expressway Commission and WYES-TV. He also recently served as past chair of the Malcolm Baldrige National Quality Award Board of Overseers and as the Small business representative to the US Travel and Tourism Advisory Board.

Chair LANDRIEU. Thank you, Mr. Katz. Mr. Houser.

STATEMENT OF JIM HOUSER, OWNER, HAWTHORNE AUTO CLINIC, INC.

Mr. HOUSER. Thank you, Chair Landrieu, Ranking Member Risch, and esteemed Senators. My name is Jim Houser. I am an ASC certified master automotive technician and co-owner of Hawthorne Auto Clinic of Portland, Oregon. I am also co-Chair of the Main Street Alliance of Oregon, and a member of the Executive Committee of the Main Street Alliance National Network, a nationwide network of state and locally-based small business groups.

When my wife and I opened Hawthorne Auto Clinic 30 years ago, we made the commitment to offer those who worked with us a good benefits package, including comprehensive health insurance. We are in a high skill field where being able to offer good benefits to keep good people is very important. We would not want our best customers to even think of going anywhere else, and the same holds true for our staff.

The business case for our decision to offer full health insurance coverage is underscored by the fact that the average tenure of our full-time staff is now almost 20 years. Plus, we are an aging profession. These factors make health care coverage critically important for the success of our business.

Before the Affordable Care Act, in many ways, the health care cost dilemma for our business resembled the case of the proverbial frog in the pot of cold water gradually heated. By 2009, health care costs for our nine full-time employees and their families had doubled in just eight years, to equal over 20 percent of payroll. That year we paid over $100,000 for our insurance coverage. This increase far exceeded increases for any other business cost and was not possible to pass on to our customers.

Clearly, we could not cut our employees' pay by passing the cost on to them and still expect to retain the loyalty we had earned over the past many years, so we kept paying even as rates rose rapidly, often by double digits, from one year to the next.

Now, however, we have seen a reversal of the trend of skyrocketing rates that we had absorbed from 2000 to 2010. In 2011, and again in 2012, for the first time in my memory, our health insurance premiums actually declined and by over 3 percent.

In Oregon, 22 different insurance carriers have applied to and been accepted by Cover Oregon. That is our Exchange. And many of these carriers have already lowered their premium requests in order to match the competition created by our new Exchange. I have the privilege of serving on the Consumer Advisory Committee of Cover Oregon and I am proud that we are setting an example for how the Affordable Care Act, when fully implemented, can help small businesses and consumers afford quality coverage.

Rate review rules are giving states new tools to protect small businesses and other insurance customers from unreasonable rate increases. United Health customers save $274 per person when the Oregon Insurance Commission knocked back their 16 percent proposed increase to 10 percent. The 80/20 Rule is ensuring that small businesses get real value for our premium dollars.

Requiring insurers to issue rebate checks when they fail to spend at least 80 percent of premiums on medical care, has returned millions of dollars to consumers throughout the country in the form of lower premiums and rebates. In Oregon, Regents had to return $499 per rate payer.

Thanks to the law's small business health care tax credit, our business received a credit of $12,900. The Kaiser Family Foundation reports that the percentage of employers with between three and nine employees offering health care coverage has risen from 46 percent in 2009 to 59 percent in 2010, in part due to the small business tax credit.

Here is the bottom line. The Affordable Care Act has been like a time machine for our small business. Insurance premium decreases, combined with the small business tax credit, have rolled our health care costs to what we were paying in 2007. Our customers have been returning, our business has been slowly recovering from the recession, health insurance pricing certainty has now enabled us to add two more full-time employees, including an Afghanistan war vet, an almost 25 percent increase in our prior staffing.

We cannot go backward, we must go forward, and thank you very much.

[The prepared statement of Mr. Houser follows:]

Implementation of the Affordable Care Act: Understanding Small Business Concerns

Statement on Behalf of the Main Street Alliance

By

Jim Houser

Co-owner, Hawthorne Auto Clinic, Portland, Oregon

Co-Chair, Main Street Alliance of Oregon

United States Senate

Committee on Small Business and Entrepreneurship

July 24, 2013

Good afternoon, Chair Landrieu, Ranking Member Risch, and esteemed Senators. My name is Jim Houser and I am an ASE Certified Master Automotive Technician and co-owner of Hawthorne Auto Clinic in Portland, Oregon. I am also co-chair of the Main Street Alliance of Oregon and a member of the executive committee of the Main Street Alliance national network, a nationwide network of state and locally based small business groups that works to provide small business owners a voice on the most pressing public policy issues facing our businesses and our local economies.

When my wife, Liz Dally, also a Certified Master Technician, and I opened Hawthorne Auto Clinic 30 years ago, we made the commitment to offer those who worked with us a good benefits package, including comprehensive health insurance.

Health care is a major issue for small businesses like ours, and especially for those of us in the auto repair industry. We're in a high-skill field where being able to offer good benefits to keep good people is very important. In the same way that we wouldn't want our best customers to even think of going anywhere else, the same holds true for our staff. The business case for our decision to offer full health coverage is underscored by the fact that the average tenure for our Full-Time staff is now almost 20 years. Plus, we're an aging profession. These factors make health care coverage critically important for the success of our business.

Of the 49 million Americans living without health coverage (up from 40 million in 2000), an outsized majority -- about 60 percent -- work for small businesses, according to the nonprofit Employee Benefit Research Institute. Millions of small businesses together power the American economy. During economic crises, like the Great Recession we still struggle with, these businesses operate close to the margin, or don't survive at all. But their innovation and entrepreneurship put them in the lead in helping our economy recover.

For American small businesses, health care has been an unrelenting headache, with:

- Small businesses' health care costs growing 129% since 2000,
- Workers in small businesses paying an average of 18% more for premiums than those with larger firms, and
- Administrative costs eating up two and half times more of their premiums than larger businesses pay.

In many ways the health care cost dilemma for our business resembled the case of the proverbial frog in the pot of cold water gradually heated. By 2009, health care costs for our 9 full-time employees and their families had doubled in just 8 years to equal over 20% of payroll. That year, we paid over $100,000 for our health insurance coverage. This increase far exceeded increases for any other of our business costs, and was not possible to pass on to our customers. But clearly we couldn't cut our employees' pay by passing the costs on to them and still expect to retain the

loyalty we had earned over the past many years. So we kept paying even as rates rose rapidly, often by double digits from one year to the next.

Now, I know some insurance lobbyists claim the new health care law is driving up premiums. But that claim just doesn't pass inspection. It's not what we're observing in states that are assertively implementing the new law and taking advantage of opportunities to put downward pressure on premiums. And it's not my own experience, either – in fact, my experience is the opposite.

Consider my home state of Oregon, where twenty-two different insurance carriers have applied to and been accepted by Cover Oregon (the name of our state exchange) and many of these carriers have already lowered their premium requests in order to match the competition created by our new health insurance exchange.

Our neighbor to the south, California, has witnessed lower than expected insurance rates and robust health plan participation where Covered California has been able to negotiate with insurers to keep rates for individual health plans to no more than 2% above the rate small businesses pay now.

As for my own experience, we've already seen a reversal of the trend of skyrocketing rates we had to absorb from 2000 to 2010. In 2011, for the first time in my memory, our health insurance premiums actually *declined*, and by over 3%. You might think this was a fluke, but it wasn't: when 2012 rolled around, our premiums declined another 3%.

These decreases are due in part to provisions in the new health care law requiring insurers to cover preventative services with no deductibles or copays. As my mechanics will tell you, our customers who have us regularly perform preventative maintenance on their vehicles rarely get towed in for unanticipated, expensive repairs. It is much more cost effective for a health care provider to spend $200 on a preventative procedure like getting a patient's blood pressure under control than to spend $50,000 for the ER response to a stroke.

The Affordable Care Act, the ACA, has also allowed our 25-year-old under-employed daughter to rejoin our health plan, sharing our health care risk over a larger, healthier pool of enrollees.

The ACA is working for small business. The Kaiser Family Foundation reports that the percentage of employers with between three and nine employees offering health coverage has risen from 46 percent in 2009 to 59 percent in 2010– in part due to the ACA's small business tax credits. And, the Urban Institute estimates that small employers will pay 7.9% less for health insurance by 2019 as a result of the ACA.

Thanks to the Affordable Care Act, this is what American small businesses have to look forward to in the next few years:

- Small business health insurance tax credits. Our business received a tax credit of $12,903. That, combined with lower rates, has rolled our rates back to what they were six years ago.
- Health insurance marketplaces with more choices and more bargaining power for small businesses and individuals. It is predicted that as many as 970,000 people will enroll in Oregon's new health insurance exchange (Cover Oregon) by 2016. I have had the privilege of serving on the Consumer Advisory Committee of Cover Oregon, and I'm pleased that we are setting an example for how the Affordable Care Act, when fully implemented, can help small businesses and consumers afford quality coverage.
- Rate review rules that give states new tools to protect small businesses and other insurance customers from unreasonable rate increases. Oregon's rate review process has dramatically cut the rates carriers were proposing for individuals and small businesses. Regence customers saved $12.5 million, or over $200 per person, when the state cut back Regence's proposed 22.1% increase to 12.8%. United HealthCare customers saved $274 per person when the state knocked back their 16.8% proposed increase to 10%.
- The "80/20 Rule" that ensures that small businesses get real value for our premium dollars. Requiring insures to issue rebate checks when they fail to spend at least 80 percent of premiums on medical care has returned millions of dollars throughout the country, in the form of both lower premiums and rebates. In Oregon, Regence had to return $499 per rate payer.

Small businesses are the economic engine of this country and we, and our employees, will bear the fruit of the Affordable Care Act or bear the brunt of any attempts to weaken our new health care reforms. The ACA has been like a time machine for our small business. Insurance premium decreases, combined with the Small Business Tax Credit, have rolled our health care costs back to what we were paying in 2007. Our customers have been returning and our business has been slowly recovering from the Great Recession. Health insurance pricing certainty has now enabled us to add two more Full-Time employees (including an Afghanistan War vet), an almost 25% increase in our prior staffing level.

Before I conclude, I would like to say a brief word about both opportunities to strengthen the law as well as politically motivated efforts to undermine it.

There are provisions of the law which can and ought to be strengthened. Limits placed on eligibility for the small business tax credit have resulted in too few firms being able to take advantage of this benefit like our business has. I commend Senator Begich for including measures to expand and simplify this tax credit in recently introduced legislation.

There has been much discussion of the employer shared responsibility provision of the Affordable Care Act, and the Administration's recent decision to delay it. I would like to point out that the argument that this provision will have negative consequences on small business has been grossly exaggerated, while its benefits have been largely ignored.

- First, it simply must be emphasized that employer shared responsibility rules do not apply to a business with under 50 employees. This means that over 95% of businesses in this country will not be affected by this provision of the law. Among the small fraction of firms with 50 or more employees, 94% of these firms already provide health insurance. So this provision will affect a very small percentage of all firms – and an even smaller percentage of true, Main Street small businesses.
- Second, allow me to observe that embedded in the premiums that our business – and indeed everyone with insurance – pays is a "hidden tax" to pay for uncompensated care provided to the employees of other businesses who fail to provide insurance. How is it fair for small business owners like myself to subsidize the costs of businesses that, though they are much larger than mine, fail to take responsibility for offering insurance to full-time employees? The employer responsibility provision helps to level the playing field. The short delay of this provision for practical implementation reasons should not be used as an excuse to erode the law's premise of shared responsibility.

It is frustrating for small business owners to witness so much attention inside the beltway being paid to rehashing old political debates about the law, and not enough to educating small business owners about how to take advantage of the law's significant benefits or working collaboratively on practical ways to strengthen those benefits. Nevertheless, I have optimism that this kind of collaboration is possible from my experience serving on the Consumer Advisory Committee for our state's exchange, which is co-chaired by NFIB of Oregon's Vice-Chair and a fellow small business owner.

In closing, if American small businesses are to lead our country back to prosperity, Congress will need to continue to work to get control of skyrocketing health care costs. Small businesses need customers who have the family-wage jobs and income to afford our goods and services, and small businesses need to be able to control our health care costs so we can hire the workers necessary to grow our economy. To accomplish these goals we must strengthen, not weaken, provisions of the Patient Protection and Affordable Care Act.

Thank you for considering my remarks.

Bio of Jim Houser

* Along with wife, Liz Dally, Jim opened Hawthorne Auto Clinic 30 years ago.
* Hawthorne Auto Clinic offers full health care coverage for all 12 full-time employees and their families. (Proportional for part-time)
* Jim is co-chair of the Main Street Alliance of Oregon, a network of small business owners (now over 1400 state wide) that works to provide small businesses a voice on the most pressing public policy issues of Oregon.
* In 2009 Jim traveled to Washington, DC with other Oregon small business owners to meet with Oregon's congressional delegation, share his business's story, and discuss provisions to include in health reform to meet the needs of small businesses.
* Jim hosted health care events at his business with members of the Oregon congressional delegation.
* Jim's business, along with over 4 million other small businesses, now qualifies for the new health premium tax credit in the Affordable Care Act
* In September 2010 Jim was invited to join an informal gathering with President Obama commemorating the 6-month anniversary of the ACA.
* Jim was invited by First Lady Michele Obama to the 2011 State of the Union Address, and was recognized by President Obama for his business's commitment to providing health insurance for his employees.
* Jim serves on the Cover Oregon (health exchange) Individual and Employer Consumer Advisory Committee, providing input on exchange development from a small business perspective.
* During the recent Oregon legislative session, Jim testified about health care before legislative committees, preparing and presenting detailed testimony on key decisions to be made in the structure and functions of the health insurance exchange in order to ensure that it meets the needs of small businesses.
* In addition to his personal experience as a business owner, from 1983 to its demise in 2002, Jim was a member of GO Garage Parts, Inc., an automotive parts buying and member services cooperative, which administered health insurance for over 200 small automotive service business members. As Board Chair from 1989 to 2002, Jim helped increase GO Garage membership, including in its health insurance plans, by over 50%.

Chair LANDRIEU. Thank you. Mr. Dennis.

STATEMENT OF WILLIAM J. DENNIS, JR., SENIOR RESEARCH FELLOW, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. DENNIS. Thank you, Madam Chairman, Senator Risch, members of the Committee. On July 2nd, the Administration announced a one-year delay in the reporting requirements of the employer mandate, and hence, the mandate itself. I think the first small business reaction was one of relief. Small businesses were pleased because there has been so little specific information from which to make concrete business decisions.

The law is complex. There are many non-decisions, important provisions of the law on which there has been no guidance, no regulations. And the communication has been terrible, quite frankly, for the small business population.

But there was a second reaction and that second reaction was that nothing has happened. The substance has not changed. The lack of confidence, which is continuing to dampen economic output, in part caused by the uncertainty surrounding ACA, has not changed either. So small business continues with minimal hiring, minimal investment, and not performing particularly well economically.

The one thing the delay did was provide an opportunity to assess the problems and make revisions to the Act itself, and I hope you will take the opportunity to think about some of these things. I have listed just five potential issues. Some of the gentlemen here have also listed some as well. I do not want to repeat, so let me just say first, the definition of full-time, part-time is an obvious issue, both for employers large and small, and employees as well as employers.

I also have some questions about Section 6055 and Section 6056, reporting requirements that Mr. Iwry made some comments about. There have never been any rules put forward on these sections, but the law lays out substantial reporting requirements. Clearly, those that must offer are covered by the mandate.

However, we also think that small employers who are not covered are going to have substantial reporting requirements because the information they have is necessary for some other parts of the Act. So if someone else is going to provide the information, fine. We will be more than happy. But I will believe it when I see it.

Business aggregation rules. I think this is the sleeper. Few know about them. The issue is what is a single business, and in a sense, it is quite simple. If I own a business here and if I own a business there, I just add up the employees for purposes of ACA. If I am over 50, I have to offer.

The problem is that there are many businesses that have multiple owners and many owners have multiple businesses. So that leaves us to the tender mercies of the ERISA rules, and the ERISA rules are some of the most complex we have, requiring very fine interpretations by employee benefit specialists. I do not know where small business owners are going to get advice from that.

We have the $100 billion HIT tax. If you can believe it or not, this was an idea to make insurers pay for extra business that was

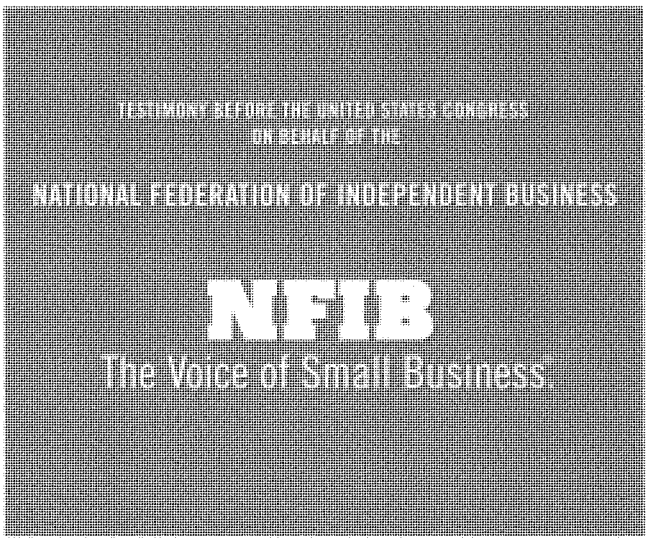
generated by ACA. The practical effect, however, is to pass those costs on to those in the small group market. Now, do not trust me. The Joint Tax Committee, the CBO, and most economists will tell you that.

We tax only those offering small firms, precisely the firms that we want to encourage. Precisely the behavior we want to encourage we are taxing.

Chair LANDRIEU. Try to wrap up, please.

Mr. DENNIS. Okay. In essence, the primary issue about this is cost, and I am sure we will talk a little bit about health insurance cost and how we get to it as we proceed in the discussion. Coost clearly remains a problem. Thank you.

[The prepared statement of Mr. Dennis follows:]



Testimony of

Mr. William J. Dennis, Jr.

before the

Senate Committee on Small Business & Entrepreneurship

on the subject of

the Implementation of the Affordable Care Act:
Understanding Small Business Concerns

on the date of

July 24, 2013

Chairwoman Landrieu, Ranking Member Risch, and Members of the Committee, thank you for the opportunity to present NFIB views on the current state of the Affordable Care Act (ACA), and offer suggestions to improve the current condition of the law and its implementation.

On July 2, the Administration surreptitiously announced postponement of: (i) the information reporting requirements that apply to insurance companies, self-insuring employers, and certain other entities that provide minimum essential health coverage under section 6055 of the Internal Revenue Code (the "Code"); (ii) the information reporting requirements that apply to applicable large employers under section 6056 of the Code, and (iii) the employer shared responsibility provisions under section 4980H of the Code.[1],[2] Effectively, the Administration had failed to produce regulations implementing certain data collection provisions of the Affordable Care Act, thereby effectively rendering the so-called employer mandate provisions of the Act temporarily unenforceable, and hence moot. The reprieve is to last one year.

All communication NFIB has had to date with its members and other small business owners indicates that this Administration decision was well-received. Small-business owners seemed relieved. The reason is that the reprieve gives them another year to obtain the specific information necessary to translate the glowing generalities that pass for a communications program into the explicit facts that allow them to make business decisions. Quite frankly, the Administration's communication with small-business owners about ACA requirements has been terrible. But in fairness to those charged with that portion of the program, it is very difficult to communicate the content of a "no decision".

The Administration indicated that it would provide further guidance in the next few weeks.[3] One can only hope that that the guidance will be clear, specific, and soon. Unless the Administration acts shortly, we may be looking at the same situation next year at this time.

I do not need to remind Members of this Committee that getting useful and correct information to five and one-million small employers let another one-half million starting every year is no modest task. They typically do not paw through the *Federal Register* or Treasury blogs in their limited spare time. Small employers are most likely to discover what government requires of them through trusted secondary channels.[4] Those channels include accountants and lawyers, other affected business owners, and trade websites. A necessary process is therefore "teaching the teachers" before understanding and compliance can be expected from the population. The key points of contacts must first understand what the ACA requires, not in generalities, but in specifics. (They now are simply passing on the contents of no decisions.) Only then can they pass useful information to their colleagues and clients.

Some might suggest that the Internal Revenue Service (IRS) or some other agency of government simply send notices to all affected taxpayers containing compliance instructions (once they have been developed) and all would be satisfied. Indeed, wide dissemination of that nature would be helpful. But

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[1] Mark J. Mazur, "Continuing to Implement the ACA in a Careful, Thoughtful Manner," blog post, July 2, 2013. www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner Accessed 7/5/2013.

[2] Testimony of J. Mark Iwry, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy, U.S. Department of the Treasury, Before the Subcommittee on Health, House Committee on Ways and Means Committee, July 17, 2013.

[3] Mazur, op. cit.; Iwry, op. cit.

[4] Regulation, *Natianal Small Business Poll*, (ed.) William J. Dennis, Jr., NFIB Research Foundation, Vol. 12, Iss. 6, 2012.

don't expect immediate awareness and knowledge as a result. Despite broad outreach by the IRS,[5] including mailing over four million post cards about the small-business health insurance tax credit in 2011,[6] only about half of eligible small businesses were even aware of the credit shortly thereafter,[7] let alone familiar enough to know if they were eligible.

Relief is the initial reaction of affected small-business owners from the one-year delay in the employer mandate. The second reaction is a bit different. It is recognition that, despite the reprieve, nothing has fundamentally changed, both in terms of the law per se and the general lack of confidence, in part stemming from the ACA, that dampens economic growth. Small business continues to be in an economic holding pattern.[8] Economic activity remains tepid. Plans to invest and hire remain low by historical standards (last 40 years). Nothing on the horizon portends an abrupt positive change, including the one-year delay. Moreover, the current postponement of the employer mandate exacerbates questions in light of prior delays, such as delay of competition within most SHOP exchanges, about the ability of this Administration or any Administration, to implement and administer ACA in any type of cost-effective and fair manner.

Hopefully, the Congress will use the reprieve to recognize some of the problems it has created in the Affordable Care Act and make reasonable efforts to change them. You would not only help small business, but the people attempting to implement the Act. I list below just five examples of needed changes, specifically focused on small business: 1. definition of part-time employee - the 30/35 hour question, 2. Section 6055 and Section 6056 record-keeping rules, 3. business aggregation rules, 4. the HIT tax, and 5. the mandate per se. Let me briefly address each.

1. *Definition of "Part-Time Employee"*

Employers with more than 50 employees must offer coverage to full-time employees or pay a penalty; the same does not apply to part-time employees. These employers may choose to offer part-time employees health insurance or not. The ACA defines a full-time employee as working 30 hours or more a week. The Bureau of Labor Statistics (BLS) classifies full-time employees as working 35 hours a week or more and part-time employees as 1 – 34 hours per week.[9] That is also common use of the terms in the private sector, although some place the division at 40 hours. The federal government in the Fair Labor Standards Act even makes it policy to require additional compensation (overtime pay) only after 40 hours.

The ACA's differential classification has already caused employers to start juggling hiring practices and forcing the hours of many employees to fall beneath the 30 hour standard.[10] We have seen employers reduce or announce reduction in hours to escape the mandate, and not just small employers as illustrated by the actions of the Commonwealth of Virginia[11] and some colleges.[12] This is not simply an

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[5] Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity, Government Accountability Office (GAO-12-549), May 2012, p. 16.

[6] http://www.irs.gov/pub/irs-news/health_care_postcard_notice.pdf Accessed 7/8/2013

[7] Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity, op. cit.

[8] Small Business Economic Trends, (ed.) William C. Dunkelberg and Holly Wade, NFIB Research Foundation, series.

[9] http://www.bls.gov/cps/lfcharacteristics.htm#fullpart Accessed 7/8/2013

[10] Obamacare Putting Millions of Part-time Workers at Risk of Seeing Cut Hours: Study, Huffington Post, July 9, 2013. http://www.huffingtonpost.com/2013/05/07/part-time-workers-obamacare_n_3210321.html Accessed 7/9/2013

[11] Bill Sizemore, "Va. workers' part-time hours capped due to health law," PilotOnline.com, Feb. 8, 2013. http://hamptonroads.com/2013/02/state-workers-parttime-hours-capped-due-health-law Accessed 7/8/2013.

[12] Colleen Flaherty, "So Close Yet So Far," Inside Higher Ed., Nov. 20, 2012, www.insidehighered.com/news/2012/11/20/college-cuts-adjuncts-hours-avoid-affordable-care-act-costs Accessed 7/8/2013.

administrative and cost issue for offering employers, large and small, but an income issue for employees who would like to work more hours for an employer, but are now effectively barred from doing so. While it is too early to claim definitive evidence of an impact from the ACA definition,[13] one must note that the only net new employment (seasonally adjusted) this year (January – June) has been part-time, with the trend exacerbated in June.[14]

2. *Sections 6055 and 6056 Paperwork*

Postponement of the employer mandate was technically a delay in the promulgation of the paperwork/ reporting in Sections 6055 and 6056 of the Act. Those provisions require among other things a listing of the names and addresses, etc., of employees and the firm's offer/lack thereof of "adequate and affordable" health insurance. A major purpose of the list is for the government to determine which firms pay what penalty, if any, for failure to offer, and which employees pay what penalty, if any, for failure to carry the mandated insurance. The information from these reports appear critical to enforcement on both businesses and individuals.

I need not reiterate here small-business owners' absolute distain for paperwork and record-keeping. However, in the current context, they have two principal concerns regarding these two sections of ACA, and their implementing rules which have yet to be proposed. The first is who is covered? The second is what paperwork and reporting will be required?

Section 6056 covers those businesses required to offer, including small businesses with 50 employees or more. These enterprises automatically incur the new reporting burden, whatever it eventually is. However, the fate of offering small businesses with fewer than 50 employees is less clear, while it is even murkier for non-offering businesses employing fewer than 50.

The Administration in testimony before the Health Subcommittee of the House Ways and Means Committee referred to information reporting requirements that apply to insurance companies, self-insuring employers, and *certain other entities* (italics added) that provide minimum essential health coverage.[15] Section 6055(b)(2)(C) refers to the small group market offered through an exchange and the small business tax credit. Further, without reports on employees and offers of "adequate and affordable" insurance, government has no way of knowing which employees are potentially liable for penalties as well as their eligibility for subsidies in the exchange. NFIB interprets these factors collectively to mean that small businesses (fewer than 50 employees) offering employee health insurance must report, though the Administration's witness at the Ways and Means hearing referred to many groups except small business.[16]

Statute language would seem to exclude reporting by non-offering small employers. The only possible motivation to require this group to report would be to demonstrate that the employee has no

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[13] The Labor Center at the University of California-Berkeley estimates from *Current Population Survey* data (March, 2010-2012) that 8.9 percent of employees have jobs working 30-36 hours per week. However, the authors consider about 3.1 percent (2.3 million) vulnerable to work reduction because they are below 400 percent of the Federal Poverty Level and do not have insurance through their own employer. These data apply only to firms with 100 or more employees. The number would rise in absolute, if not in percentage, terms by including small employers. See, David Graham-Squire and Ken Jacobs, Data Brief – Which workers are most at risk of reduced hours under the Affordable Care Act?, February, 2013. http://laborcenter.berkeley.edu/press/coverage_reduced_hours_aca13.shtml. Accessed 7/16/2013.

[14] http://www.bls.gov/web/empsit/cpseea06.pdf Accessed 7/19/13.

[15] Iwry, op. cit.

[16] Iwry, op.cit.

employment-based insurance and therefore has not refused an employer's offer. This would appear a stretch thereby allowing us to assume that the reporting requirements do *not* apply to these employers.

The second issue is the paperwork/reporting that IRS will require. As a general rule, the less paper and the less frequent the better. Additionally, it would be helpful to piggy-back on existing paperwork to the extent possible. An extension of the W-2 filing is the obvious candidate. The names, addresses, and TIN's of all employees are already part of that filing. The statute also requires 6055 and 6056 reports to be filed by January 31, the same date W-2's are to be mailed to employees. There is also already a small, but new requirement on the W-2 pertaining to health insurance (implementation temporarily postponed for businesses with fewer than 250 employees). The issue that is not clear is whether the added ACA reporting requirements piggy-backed on the W-2 is too much at one time. We have no current information to assist with that question.

Small employers will not be happy whenever the IRS promulgates its ACA paperwork requirements. Businesses of all sizes will have to make adjustments to the way they maintain records. Reprogramming computers and/or purchasing new software will be additional costs. But the longer the lead time (assuming rational requirements), the easier it will be for everyone concerned. So, moving forward on these requirements with all deliberate speed, at least to the extent of offering insights about what will be demanded, seem warranted.

3. *Business Aggregation Rules*

The *New York Times* recently carried an article about a small business owner in Maryland struggling to find the right mix of full- and part-time employees to crawl under ACA's 50 employee employer mandate level.[17] The business apparently could not survive if it were compelled to offer employees health insurance or pay a fine. The owner thought he had found a formula. But in an almost throw-away line, the article mentioned that the owner and his family obtained their health insurance through a much smaller business they owned across the street. It apparently did not occur to either the business owner or the *Times* reporter that the owner was likely subject to the business aggregation rules, and therefore was likely to have more than 50 employees under ACA, despite his view to the contrary.

The business aggregation rules define a single business unit in instances where a firm may have different locations or operating units. For example, if John Doe owns a retail store in Virginia with 35 full-time employees and a repair shop in Maryland with 15 full-time employees, the firm is a single business with 50 employees for purposes of ACA. The rules' presumed purpose is to prohibit small employers from subdividing their firms into multiple parts in order to avoid the mandate. The provision appears unknown to most owners and is likely to trip up many small-business owners due to its opacity, the number of firms potentially affected, and its complexity.

An aggregation rule might work if the world consisted of individual small employers owning individual small firms, such as the example cited above.[18] But the world consists of many single firms with multiple

[17] Abby Goodnough, "At Restaurant Delay is Help on Health Law," *New York Times*, July 9, 2013, http://mobile.nytimes.com/2013/07/10/us/at-restaurant-delay-is-help-on-health-law.html?pagewanted=2. Accessed 7/11/2013.

[18] Opinion has been voiced that ACA impacts only about 3-4 percent of small businesses. That number is apparently derived from the proportion of employers who have 50 employees or more. However, that opinion is misinformed. Small offering firms will be directly impacted by ACA's reporting requirements. A substantial, but unknown, number will also be impacted by the business aggregation rules. Others have been impacted by required changes in the benefits that must be included in the health plans they offer (or would have offered). All are supposed to provide employees information about the exchanges.

owners and many single owners with multiple firms. For example, just 35 percent of small businesses employing 20 or more people have a single owner (counting a husband/wife combination as a single person).[19] Reverse the situation and one finds that 39 percent of people owning a small business with 20 or more employees also hold a 10 percent or more share in at least one other venture, separate and distinct from the enterprise about which they were initially interviewed. Adding to the complication is the degree of control owners have over each business. For example, 70 percent who have family member owners indicate that these family member/owners actively participate in the firm's critical decisions.[20] At the same time, owners are likely to participate in the critical decisions of a second firm they own, though they are somewhat less likely to participate in the critical decisions of a third firm that they own.[21]

The rules proposed to handle these complexities and determine the meaning of a single business entity are ERISA rules. The practical problem is that ERISA rules are intricate, meant for interpretation by legal specialists in employment benefits law, not for the general public or even for attorneys generally. That means that perhaps as many as 100,000 small businesses should have an interpretation from a specialist in benefits law to be confident about his or her status. That is not likely to happen.

4. *HIT Tax*

The ACA included as one of its revenue raisers an annual "fee" on insurer beginnings in 2014. The "fee", a euphemism for tax, is substantial. It is designed to collect over $100 billion in the next ten years. A predetermined amount of revenue will be collected each year: $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion or more annually in years 2018 and beyond. The tax is not only large, but astonishingly discriminatory. The tax formally falls on the sale of fully-insured health plans, hence the name HIT tax, which means it falls on plans sold in the small group market, a market consisting of business owners having fewer than 50 employees. As a result, the HIT Tax targets *only* small-business owners who offer, a behavior that ACA specifically, and health policy generally, intends to encourage.

The critical point is that this tax, ostensibly an industry fee targeted at health insurers, will ultimately be shifted. The Congressional Budget Office (CBO) explicitly asserted that this tax/fee/surcharge "would be largely passed through to consumers in the form of higher premiums for private coverage."[22] A March 2011 report by former Congressional Budget Office Director Douglas Holtz-Eakin concurred in that view[23] as did the Joint Committee on Taxation (JCT) in a letter to Senator Jon Kyl dated June 3rd, 2011.[24] The JCT estimates the HIT tax would raise premiums offered by covered entities by 2.0 percent to 2.5 percent[25] and the Holtz-Eakin by as much as 3 percent, a price increase that cumulatively amounts to nearly $5,000 per family over the current decade.[26]

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[19] Business Structure, *National Small Business Poll*, (ed.) William J. Dennis, Jr., NFIB Research Foundation, Vol. 4, Iss. 7, 2004.
[20] Businesses Within Families, *National Small Business Poll*, (ed.) William J. Dennis, Jr., NFIB Research Foundation, Vol. 12, Iss. 4, 2012.
[21] Ibid.
[22] An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, Congressional Budget Office, November 30, 2009, pp. 15-16.
[23] Holtz-Eakin, Douglas, "Higher Costs and the Affordable Care Act: The Case of the Premium Tax," American Action Forum , March 9, 2011.
[24] Barthold, Thomas A., letter to Senator Jon Kyl, Joint Committee on Taxation, Washington, DC, June 3, 2011.
[25] Ibid.
[26] Holtz-Eakin, op. cit.

The NFIB Research Foundation modeled the impact of the HIT tax earlier this year to determine its broad economic effects.[27] Simulations were run using various assumed health insurance inflation rates. Depending on the assumed inflation rate, the HIT tax is forecast to reduce private sector employment by between 146,000 and 262,000 jobs in 2022. Approximately 59 percent of the jobs lost would be in small firms. We could not estimate the impact on health insurance offers that result from the higher premiums.

5. *The Employer Mandate Per Se*

The employer mandate has been effectively postponed. So, to come full-circle, it is fair to ask why it exists at all. If it is simply a means to raise revenue, most would not consider it good tax policy. But if it is a means to increase health insurance coverage, it is creating huge dislocations and considerable costs for little if any return. Ninety-eight (98) percent of employers with more than 200 employees currently offer health insurance; about 60 percent under 50 employees do, including half among the 3-9 employee group.[28] Small-employers, who have much lower rates of coverage, are not required to offer. Thus, the mandate adds a minimal number of people to the covered population. A recent paper from the Urban Institute[29]estimated that postponement of the mandate would impact only about one million people (out of about 160 million). The Congressional Budget Office (CBO) has not yet made a direct estimate, but interpreting their net numbers yields an estimate of about two million.[30] Unless one assumes that large employers would soon start massively dumping of their health plans, coverage is largely unaffected by elimination of the employer mandate.[31]

The current tie between health insurance and employment arose from a quirk of historical circumstance, not from a rational policy decision about health. The ACA freezes that quirk and continues to lock health insurance to employment. But, the future is another direction, a direction with greater flexibility, one in which individuals have their own insurance and carry it with them from job to job and in and out of employment. The ACA's employer mandate therefore is in sum a strike against a rational future.

Reflection

Small-business owners became interested in health years ago due to the rapid increase in health insurance costs,[32] costs that they recognized were rising unsustainably even when others did not. What will happen to small business rates? Some will likely benefit; some likely will not. Everyone will have an example that aligns with their expectations. But the real issue is what will be the rate trend for small employers overall.

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[27] Michael J. Chow, "Effects of the PPACA Health Insurance Premium Tax on Small Businesses and Their Employees: An Update," NFIB Research Foundation, March 19, 2013, http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/health-insurance-tax-study-nfib-2013-03.pdf. Accessed 7/20/13.

[28] Kaiser Family Foundation, 2012 Employer Health Benefits Survey, September, 2012. http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf Accessed 7/20/2013.

[29] Linda J. Blumberg, John Holahan, and Mathew Beuttgens, "It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate," Urban Institute, July 15, 2013, endnote 16. http://www.urban.org/publications/412865.html. Accessed 7/16/2013.

[30] CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance, Congressional Budget Office, March, 2012.

[31] Blumberg, et. al., op. cit.

[32] Holly Wade, Small Business Problems and Priorities, NFIB Research Foundation, August 2012, Table 5. http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/small-business-problems-priorities-2012-nfib.pdf. Accessed 7/20/2013.

The small business health insurance tax credit has been put forward as one way the ACA will help owners with health insurance costs. While "free money" is always welcome, the credit is essentially a windfall (rather than an incentive) for eligible small business owners and a "bait and switch" for those who actually use it as incentive. The credit was touted as a good deal for four million eligible small businesses.[33] But after reading the fine print, the number eligible was actually 244,094 for the full credit and 1,165,505 for a partial credit.[34] The GAO confirmed the credit's minimal use and identified several reasons for it, including the perfectly reasonable requirement that one had to purchase health insurance before attaining eligibility.[35] But, the credit pretty much became a bait and switch. Announcements about the credit forgot to mention that it is temporary. It is available for two years once SHOP exchange opens. Thus, the owner gets the credit once he or she committed to purchase health insurance. The unspoken caveat is that once ensnarled, it will be very difficult to drop it should circumstances warrant. The IRS Web page touting the credit, for example, explains the benefits in some detail, but fails to mention that it expires.[36] The credit will be helpful to some small businesses, despite its inherent problems, and that is welcome. But as a serious attempt to alleviate small-business owners' health insurance costs, it is a bit of a farce.

Conclusion

The postponement of the employer mandate has been helpful to small employers. It gives them breathing space to be able to determine what is required of them under the ACA. But it has also been helpful in another respect: it has given all parties a chance to reflect on the shortcomings of the law as enacted. While we may disagree on the severity of those shortcomings and precisely what they are, I know of no one who argues that improvements cannot be made. This hearing provides a good place to identify the needed improvements that directly impact small business.

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[33] http://www.whitehouse.gov/health-care-meeting/questions/small-business-6. Accessed 7/20/2013.

[34] William J. Dennis, Jr., Small Business and Health Insurance: One Year After Enactment of PPACA, NFIB Research Foundation, July, 2011.

[35] Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity, op. cit.

[36] http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers. Accessed 7/18/13.

Bio of WILLIAM J. DENNIS, JR.

William J. (Denny) Dennis, Jr. is currently a Senior Research Fellow at the NFIB Research Foundation in Washington, D.C., and directs its activities. He has been employed since 1976 in various research capacities by the National Federation of Independent Business (NFIB), the nation's largest small business trade association. Prior to his employment at NFIB, Dennis spent over five years as a professional staff member in the U.S. House of Representatives.

Dennis is founder and editor of the National Small Business Poll (2001-), member of the National Advisory Committee of The State of the USA project (formerly, the Key National Indicators Initiative (2003 - 2009), and member of the International Reference Group, Swedish Entrepreneurship Forum (formerly Swedish Foundation for Small Business Research) (1997 -). He is a former President of the International Council for Small Business (1996 – 97) and Vice-President for Research and Publications (1993 – 95); Team Leader for Entrepreneurship Research Consortium, (1996 – 2002), co-author of Small Business Economic Trends, (1986 – 2000), a member of the Business Research Advisory Committee, U.S. Bureau of Labor Statistics (1982 - 2007), and, member of two panels for the National Academies of Science (High Schools and the Changing Workplace, and the Mathematical Sciences Education Board).

Dennis received the Academy of Management's (entrepreneurship division) Advocate Award for outstanding contributions to the field of entrepreneurship (2006) and the U.S. Small Business Administration's Special Advocacy Award for Research (1998). He was named a Wilford White Fellow by the International Council for Small Business (2000) and a Justin Longenecker Fellow by the United States Association for Small Business and Entrepreneurship (1989).

In 2010, Dennis was named a senior scholar at the Center for Entrepreneurial Excellence (CFEE) at The George Washington University. A year later, he was appointed to the Commonwealth of Virginia's Board of Professional and Occupational Regulation.

Dennis has published in the major academic small business and entrepreneurship journals, and was assigned to write the Senior Scholar's paper on entrepreneurship and public policy for the United States Association for Small Business and Entrepreneurship (2005). He has also testified on policy issues before a variety of committees in the U.S. House of Representative and the U.S. Senate as well as before state legislative bodies. His principal research interest lies in smaller firms and public policy.

Chair LANDRIEU. Thank you all very much. There still have not been votes that have been called. I intend to try to keep this hearing open at least until 5:00 or 5:15, if that is okay with the members. We are just going to go through a round of questioning three to four minutes each and we will try to do the best we can.

Mr. Katz, let me start with you. I really, really appreciate the story of which you have built your business, and as I opened my—I mean, the risk that you took to open your business and the success of your business in Louisiana, we are very blessed to have so many people like you in our state that are working hard.

When I opened this hearing, I called out specifically that you would be, I think, in this group of businesses in Louisiana. There are 67,000 small businesses with fewer than 50 people that will not be affected at all. You referred to those in your testimony. And then there are 3,800 businesses, yours included, that have between 50 and 249 employees, and you fall in that group.

Now, you testified that you did provide health insurance to your—and dental and vision. I read your testimony. Did you provide before the Health Insurance Act, insurance for all your employees or just a portion of your employees?

Mr. KATZ. We offer it, Senator.

Chair LANDRIEU. You offered it before the Affordable Care Act?

Mr. KATZ. Some of the benefits we pay for. The health insurance is the employees' options.

Chair LANDRIEU. So try to clarify that.

Mr. KATZ. Sure.

Chair LANDRIEU. You did not provide health insurance for your employees before?

Mr. KATZ. We do not pay 100 percent of it. The ones who elect to take it pay about a third. We pay two-thirds.

Chair LANDRIEU. Okay. So for those that chose to pay it, they paid a third and you paid two-thirds——

Mr. KATZ. Correct.

Chair LANDRIEU. [continuing]. Before the Affordable Care Act. And what percentage of your workers chose to participate?

Mr. KATZ. Of the eligible workers, today it is about 50 percent.

Chair LANDRIEU. So 50 percent did not, for whatever reasons. They did not think they could afford it?

Mr. KATZ. Some were covered by their spouse.

Chair LANDRIEU. Some were covered by their spouse, et cetera, et cetera.

Mr. KATZ. Either they could not afford it.

Chair LANDRIEU. I want to acknowledge that even as the ACA passed, I had some, you know, serious concerns about the group of companies like yours that would get caught. It is a small number, but it is an important number, between 50 and 240. As you said, the larger companies can take advantage of the lower rates for groups. The smaller companies will be able to pool their assets through the Exchange. And then companies like yours will have a challenge.

So I am going to really read the testimony that you have submitted to this and see if we can come up with some solutions to help you all, because we most certainly do not want businesses to

close, we want businesses to expand, and we want to be very focused on some of the issues that you raised.

Mr. Settles, let me ask you this. You did testify sort of in opposition to the bill. I want to just be clear that in your testimony, though, you did serve on the Idaho Health Care Law. You did advocate for the creation of the Exchange. Have you changed your position or could you try to clarify that for me?

Mr. SETTLES. Chairman Landrieu——

Chair LANDRIEU. You advocated for the creation of the Exchange?

Mr. SETTLES. I did. You know, historically, Idaho has had some of the lowest health care rates in the Nation, and so it did not make any sense to me to let an organization that had much higher average rates take over our state system. So I was very involved in the Governor's task force that looked into this. Although we still, we lose a lot of control, we are able to make a few decisions that we think can help us drive down the cost.

An example of that is that—there are fewer participating in the Federal Exchange, there is a 3.5 percent fee that is attached to all policies to help cover that, and they are not just the policies in the Exchange because all policies have to be priced the same in and out of the Exchange. In Idaho, we set that at 1.5 percent and we are hoping we can drive it lower.

Chair LANDRIEU. So by setting up your own Exchange as opposed to sitting on the sidelines and letting the Federal Government do it, you were able to drive down cost?

Mr. SETTLES. Absolutely. You know, you have people that are saying, Well, we are just going to kill this thing, but I am a business owner that has a significant out-of-pocket cost as this thing goes forward, and I cannot just stand back and say, I am going to kill it. I am going to be there to try and minimize the cost and take——

Chair LANDRIEU. And try to make it work? And I think that is admirable. How many employees do you have?

Mr. SETTLES. We issue about 200 paychecks every pay period, but about 60 of those would be considered full-time under the law.

Chair LANDRIEU. Okay. My time has expired. Senator Risch.

Senator RISCH. Thank you. First of all, Mr. Katz, your story is compelling. I cannot apologize for the Federal Government. If I could, I would. We could have killed that bill with one vote in this body. One vote would have stopped that bill from becoming law and you would not have had to have been in the position that you are in. It is really heartbreaking to hear what you went through living the American dream and now winding up in the position that you are in.

Mr. Settles, so that we do not leave any question about this, there was a dynamic argument in Idaho whether or not to adopt the state Exchange, is that right?

Mr. SETTLES. Oh, it was ugly, very dynamic.

Senator RISCH. Even the people that voted for it did not really want it, but the Federal Government told them, they said, "Do you want to be shot or do you want to be hung, either way, you are going to have an Exchange." Is that a fair way to look at it?

Mr. SETTLES. You know, it was the Supreme Court ruling when you finally heard a lot of people say, Okay, we do not like this, we are going to plug our nose and vote for it.

Senator RISCH. Do what we have to do to——

Mr. SETTLES. Yes.

Senator RISCH [continuing]. To cut our losses. People in Idaho were pretty happy, were they not, with what they had compared to what they are facing now. Is that a fair statement?

Mr. SETTLES. You know, like I said, historically, mandates are what make a policy more expensive. Our neighboring state has over 100-something mandates added to their policies, things that have to be covered. We had four total. That is about as low as you can get. So under health care now, we have to add some things that were not in. Every policy in our state is going to have a component for pediatric dental. I have not had a baby tooth for years. But it is built into the cost of all policies. So those are the kind of things that we really want to try and have some control over.

Senator RISCH. And this business about being able to keep your policy if you like your policy, that is all out the window.

Mr. SETTLES. Well——

Senator RISCH. That was a joke, I guess, at the time it was promoted.

Mr. SETTLES. I actually asked the CEOs of two of our largest carriers. The day before I flew out here we were in a meeting for the Health Exchange Board. They actually have a fair number of clients that have the Legacy policies. For me, the first year it passed I was looking at a 50 percent increase if I did not do something. So I gave up the right to have a Legacy policy.

What is the advantage of having a Legacy policy if you are going to be subject to those kinds of price increases every year?

Senator RISCH. I am told that with the Exchange being set up, there are some issues with choice, that there is only going to be one choice of plan. Am I right or am I wrong on that?

Mr. SETTLES. You know, I think that our carriers are going to be very competitive getting into the market, and the choice part, there is a component under the law that allows Exchanges to be set up so an employer could allow their employees to choose a certain metal plan, silver plan, but from different carriers.

I am not sure I really see the value of that. It is called dis-aggregation and it is one of the first things that was backed away from the Federal Exchanges because it is so hard to manage, because then all of a sudden you start to figure out, how does the money get from the person paying the policy to the insurer?

Does it start to have to flow through our health Exchange? And if our health Exchange actually has to start collecting premiums, it becomes a much bigger monster.

Senator RISCH. Mr. Settles, on behalf of all Idahoans, thank you for trying to diminish the tremendous damage that has been done by this law. Thank you very much. I yield back my time.

Chair LANDRIEU. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chair. Mr. Settles, I was interested in your comment about pediatric dental coverage because I do not have any baby teeth either, but my grandchildren sure have a lot. So I assume that the policy you are referring to

would require coverage for children as opposed to adults, but that everybody might be paying towards that.

Mr. SETTLES. When they start to—when they calculate what they want to charge for a plan, they have to figure out all their potential costs, and because of the—the plans have to be like-like inside and out of the Exchange, et cetera, the discussion has been, Well, this plan has to have pediatric dental, so we have got to bury it in there. If this plan has to cost the same, then it has to be in all policies.

And so, maybe they will drive down the ultimate rate for pediatric, but everybody picks it up. It is just like the 3.5 percent. You are paying to support the health care Exchange whether you can use it or not.

Senator SHAHEEN [presiding]. You know, listening to the panel, it really struck me that this is a law that is working very well for some people, to the extent that it has been implemented to date, and for other people it is not working very well. Mr. Settles and Mr. Katz, I can tell you that many of the concerns you have raised I have heard from small business people, particularly in the hospitality industry in New Hampshire.

I guess my hope is that we can look at what is not working very well and try and address that in a way that is much more positive, but recognize that the system that we had sure was not working for an awful lot of people. It was not working in terms of coverage and it was not working in terms of cost. In a lot of places, it was not working in terms of quality either.

So that is certainly my hope going forward and that is what I intend to work on. But let me go back to you, Nancy, and I wonder if you could talk about the—you talked a little bit about this in your statement, but the challenge of health care costs in general as a small business. What other options, in the absence of ACA or some other option to address health care costs, how you would try and control that and whether you would be able to stay competitive without some way to control health care costs.

Ms. CLARK. I can—I would control my expenses other ways. I have no—I had no control over health care costs at all. It was a necessary evil to doing business. So that is why I was delighted that my premiums went down this year. But in order for me to be competitive as a professional industry in rural New Hampshire, I have to offer that as a benefit, likewise I offer 401(k) as well.

But I control other expenses, not health care, but as I said, this year, and I am positive about the Exchange offering more choice down the road. Thank you.

Senator SHAHEEN. And can you talk a little bit about—because the earlier panel talked about some of the efforts under way to make sure that businesses know about what is in the health care law and how to take advantage of what can be helpful and how to understand other requirements. Can you talk about how you learned about the tax credit and how hard that was to implement?

Ms. CLARK. How I learned about the tax credit is because I am so involved in health care and fixing the health care system. And I have an accountant who does my taxes, so it is not at all hard to implement, for him at all, and if it was hard for him, I would have moved to a different accountant. So we hire experts. I hire

people that are smarter than me. So yeah, it has not been an issue at all.

Senator SHAHEEN. Thank you. Thank you, Madam Chair. Senator Vitter.

Senator VITTER. Thank you. Thank you again, Mr. Katz. I think your testimony went right to the bottom line of a lot of small businesses. I would like to ask you to summarize what you went over in terms of the unfortunate cut-backs, sales, a possible closing two restaurants you are facing.

And then spend more time, focus on a different category. If these impediments and costs did not face you, absent the Obamacare law, what would you probably be doing in terms of opportunities, in terms of the new location you described, et cetera.

Mr. KATZ. Well, I think along with Mr. Settles, I would be aggressively expanding at this point, Senator. Part of the problem is the cost. The other problem is the uncertainty, and we just do not know. And the issue—my concern today is, I almost think it is a house of cards, because we know the penalty is going to be $2,000, but it is irrational to think that it is going to remain that.

And so, if I have to put my faith in myself to keep me in business or the Federal Government to not set rates to put me out of business, I am going to make my own decisions. And so, we have talked about it a little bit, but the global issue to me is, I never—I grew up thinking to be in the 96th percentile was good and the 4th percentile was bad, and I never knew how true that was until I have heard today, because I really want to get into the 96th percentile and get out of the 4th.

Chair LANDRIEU. [presiding]. I would like to help you.

Mr. KATZ. And whether, if it cannot be done away with, whether that is increasing the definition of what a full-time employee is, maybe expanding to help some of these small businesses. The biggest issue to me is what I am faced with. You get the 48 or 49 people, do you want to go any higher? Do you want to hire anyone? Do you want to open another business? And you have got to have an awfully profitable business in order to say yes to that question.

So my 15 or 16 employees, it is a crime, but that is going to happen tens of thousands of times. There are lots of people like me making these same decisions today, and that is my biggest concern, is what is going to happen going forward.

Senator VITTER. Thank you. That is all I have. Thank you.

Chair LANDRIEU. Senator Rubio.

Senator RUBIO. Thank you. Mr. Katz, I, too, am inspired by your story. It really is the epitome of what it means to succeed in America. This story is amazing. So you basically cashed out your life insurance, you took out your credit card availability, you emptied your life savings, and with that, you opened these restaurants and then you struggled at the beginning to make it. But today, you own six diners, you employ 85 people, 65 of them full-time, right?

Mr. KATZ. Correct.

Senator RUBIO. And you offer them today paid holidays, vacation, dental, vision, term life, and health insurance?

Mr. KATZ. Correct.

Senator RUBIO. Is it correct to say your employees are happy with that coverage that they are getting?

Mr. KATZ. I think so. We have very low turn-over for our industry.

Chair LANDRIEU. It is 50 percent that have it. You offer it, but 50 percent have it.

Mr. KATZ. Correct, correct.

Chair LANDRIEU. But the other 50 percent do not.

Mr. KATZ. Well, most of them are ineligible because of the hour requirement, Senator.

Chair LANDRIEU. But they do not have—50 percent of your employees have it, 50 person do not.

Mr. KATZ. Yes. I would think a percentage of those do. Some of are covered by Medicaid. Some have other ways, through their spouses, of having coverage.

Chair LANDRIEU. But they do not have your coverage.

Mr. KATZ. They do not have my coverage, that is correct.

Senator RUBIO. But the point is, you have a large number of employees that are currently covered by health insurance and are happy with that insurance?

Mr. KATZ. Correct.

Senator RUBIO. Okay. When the mandate kicks in, what are you going to do with that insurance?

Mr. KATZ. Day one, I am going to have to drop it.

Senator RUBIO. Okay. So is it fair to say that these employees that now have coverage and are happy with it are no longer going to have that coverage?

Mr. KATZ. Not through our company, correct.

Senator RUBIO. Earlier I heard statements made that that would be a choice, that people would make that choice. So let me ask you, were it not for Obamacare, would you have made that choice?

Mr. KATZ. No. We would have continued it.

Senator RUBIO. You have also discussed in your testimony, in your written testimony that I have read, about some of the decisions you are going to have to make. You described that one of your options is that you may have to close or sell two of your diners, right?

Mr. KATZ. Correct.

Senator RUBIO. Is that because of Obamacare?

Mr. KATZ. Correct.

Senator RUBIO. How many people would that—how many people will lose their jobs if you have to make that decision?

Mr. KATZ. Sixteen FTEs will get me to 49 and that is apparently the magic number.

Senator RUBIO. So 16 people may lose their jobs if you have to make——

Mr. KATZ. Slightly more than that because some of those are going to be part-time people.

Senator RUBIO. So is it fair to say that 16 people could potentially lose their jobs because of Obamacare?

Mr. KATZ. Well, it is not just fair. It is an accurate statement, sir.

Senator RUBIO. And you also, like most businesses, would like to grow, right?

Mr. KATZ. Correct.

Senator RUBIO. In fact, you have identified a location that you may want to expand to, right?

Mr. KATZ. Correct.

Senator RUBIO. And everything you know about your business tells you, I should expand, this is exactly the right location?

Mr. KATZ. Correct.

Senator RUBIO. Are you going to do that?

Mr. KATZ. No, sir.

Senator RUBIO. Why?

Mr. KATZ. Because that will permanently—if I add 15 people, the after-tax penalty is going to be $30,000. So you are looking at roughly $42,000, $45,000 in profit that is going to go to that. I am looking at—my gut tells me it will be good. It could be unsuccessful. But the least, it might make us $40,000, $50,000.

So I am looking at the option. Do I want to open a restaurant, invest a half million dollars or more to make $50,000, $60,000, $70,000 knowing that almost 50 of that is going to go to the Federal Government? So the odds are not in my favor.

Senator RUBIO. If you open that new restaurant, how many new people would you hire?

Mr. KATZ. Fifteen to 20 people, at least 15 FTEs.

Senator RUBIO. Okay. So there is a new business that is not going to open at least because of Obamacare?

Mr. KATZ. Correct.

Senator RUBIO. And there are 15 or 16 people that are potentially unemployed today or looking for a job that will not be able to find one because of Obamacare?

Mr. KATZ. Correct.

Senator RUBIO. There are 15 or 16 jobs that are not going to be created because of Obamacare?

Mr. KATZ. Correct.

Senator RUBIO. Had it not been for Obamacare, you would have probably created those jobs?

Mr. KATZ. Yes, Senator.

Senator RUBIO. Okay. Thank you.

Chair LANDRIEU. Thank you, Senator Rubio. I would just mention that there are three other businesses that are expanding because of the Affordable Care Act, one that is decreasing, and Mr. Settles, we are not sure what you are doing, but you are just trying to make it work in Idaho, and Mr. Dennis, you are opposed to it completely.

This has been a very, very instructive panel and I really do appreciate all the witnesses here testifying.

Senator RISCH. Madam Chairman, to comment——

Chair LANDRIEU. Could I finish, please? I really appreciate all the businesses that have testified, you know, how it is affecting you positively, how it is affecting you negatively. It is a debate that is continuing to go on in this Congress.

As the Chair of this Committee, I really hope that we can continue to improve on a law that will provide, hopefully, affordable insurance for every family and every business with the shared responsibility for individuals, for business, and for the Government. So I thank you all very much. Senator Risch.

Senator RISCH. Madam Chairman, you know, I think it is a shame and really an embarrassment for the United States of America when the Federal Government passes laws that create winners and losers in the marketplace. It ought to be governed by the marketplace. It ought to be free people. It ought to be Americans that decide this, not the Federal Government doing this.

I am glad to hear that you want to help do something about this. You can help us move this to where we do no harm. Let us go back to what we had, which does not do the harm that has been described by these people here. The situation in America today is that it is just disgusting that the Federal Government having botched this as badly as it has. And we are going to work at it.

Thank you all for what you do in the free enterprise system. God bless you and keep up the good work.

Chair LANDRIEU. Thank you, Senator Risch, but we are not going to go back to the time before people had affordable insurance, and there are many businesses that are growing and expanding their employment because of this Act. There are some glitches that need to be fixed. There are some, probably, good ideas. Mr. Katz suggested a few. We are going to follow up with you to see how that is done.

We will not go back to a time when businesses cannot afford insurance and cannot grow because of it, or lose their coverage because they get sick or they have a disabled child and their whole firm loses coverage because one child is born with Down's Syndrome. I can assure you we are not going back. Thank you.

Senator RISCH. Madam Chairman, I sincerely hope you can fix this mess.

Chair LANDRIEU. The record is closed.

[Whereupon, at 4:58 p.m., the Committee was adjourned.]

APPENDIX MATERIAL SUBMITTED

Summary of Testimony- Larry Katz
Founder and Owner of Dots Diner

Lawrence K. "Larry" Katz is testifying on Dots Diner at the invitation of Senator Vitter. Katz currently serves as vice chairman of the Lake Pontchartrain Causeway Commission, and on the boards of City Park, WYES television and the Pelican State Pachyderm Club. He also has served as chairman of the East Jefferson Council of the Chamber of Commerce and has volunteered with Jefferson Dollars for Scholars. Katz is on the Jefferson Parish Planning Advisory Board, the Jefferson Parish Long Range Planning Committee and the Jefferson Parish Charter Advisory Committee. He has donated a combined total of $6,657 to David Vitter, Bill Cassidy, and other republican members from Louisiana.

Background on Company

- Katz owns 6 Diners and employs 85 people.
- They currently have 65 full time equivalents (FTE). Therefore he will be caught in the "over 50 employee limit." Beginning January 1, 2015, he will pay the $70,000 penalty which he will make up a 2-3% to cover these added expenses.
- With less than $200,000.00, Larry opened the first Dots Diner restaurant. In 12 months, he was down to less than $10,000.00 in savings. At that point, he considered two options: 2nd mortgage his home or declaring bankruptcy.
- Finally he broke even and the following week, he made a few hundred dollars and the tide had been turned.

Summary of Testimony

- Katz successfully owns and operates 6 diners in the Greater New Orleans Area with plans to open a seventh location.
- His diners employ over 50 FTEs, and he cannot take advantage of the tax credits for small companies under the ACA.
- He faces the decision of limiting his expansion and shuttering two of his six diners or paying the penalty, which he estimates will raise his food prices 3 percent.
- He is also having his company valued so that he has the option of selling the Dot's Diners; this is an option he would not have considered if the ACA was not going to cost his company so much starting in 2015.

Larry Katz Conclusions

- Katz recommends full repeal of the Affordable Care Act. His testimony is meant to provide a real world example of the consequences of the law as it is written.
- He would like to be able to take advantage of the tax credits if available to him without limiting the options for growth of his diners.
- He believes that the impacts of this law as written hurt small businesses and creates conditions for the loss of jobs, the raising of prices, and the forcing of employees into the Federal exchanges.

Post-Hearing Questions for the Record
"Implementation of the Affordable Care Act: Understanding Small Business Concerns"
July 24, 2013

Questions for Ms. Olafson:

From Ranking Member Risch
Ms. Olafson, you mentioned that the SBA is building and leveraging resources to promote the ACA, through events and other agency-funded resources such as its website, health care blog, webinar trainings, and e-newsletter. **Can you share the amount and origin of funds that have been used to support each of these efforts? If these efforts have been undertaken in partnership or co-sponsorship with outside entities, can you please provide documentation of such relationship(s) (i.e. co-sponsorship agreements, contracts, etc.)? Have you been instructed to oversee the SBA's efforts on educating small businesses about the law? If so, could you please explain what specifically you have been tasked with? Finally, could you provide a list of all SBA employees or contractors who perform each of these outreach efforts, including their grade or salary?**

Answer:
SBA is working with a range of entities and stakeholders across the country to help small businesses better prepare for the implementation of the Affordable Care Act. This includes working with our federal agency partners, our network of business counselors, community organizations, trade groups, and other small business stakeholders to help educate small businesses about the Affordable Care Act and the benefits available under the law.

SBA is using its Salaries and Expenses operating account to fund the small business ACA educational efforts, which include online outreach as well as train-the-trainers and in person assistance. SBA does not separately track the amount of employee time used in engaging in ACA educational efforts in its annual Cost Allocation Survey. Health care efforts and activity are not collected by SBA on Entrepreneurial Development Management Information System or other SBA information collections. We understand that these educational efforts generally involve minimal use of time for most SBA employees.

SBA has entered into one co-sponsorship agreement with Small Business Majority to co-sponsor weekly small business webinars providing educational information on what the Affordable Care Act means for small business owners. These no-cost webinars have been offered every Thursday since July 18, 2013 and are open to all small business owners across the country. A signed copy of the co-sponsorship agreement is attached.

The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury are the primary Federal agencies tasked with implementation of the ACA. However, as you know, ACA implementation raises many issues of interest to small business. Some of these were discussed in the recent CRS Report: The Affordable Care Act and Small Business: Economic Issues, is available at http://www.fas.org/sgp/crs/misc/R43181.pdf.

My role as Senior Policy Advisor to the Administrator includes coordinating the Agency's education and outreach efforts on the Affordable Care Act. In this capacity, I perform a variety of tasks, including providing program advice and assistance to agency management and SBA employees on what the ACA means to small business, participating in interagency meetings, and working with a range of stakeholder groups. Other SBA employees are providing minimal staff time in support of the educational efforts, such as responding to questions from stakeholders during counseling sessions and participoting in voluntary training events.

Ms. Olafson, in your testimony, you assert that "hundreds of thousands" of small businesses have already benefitted from small business tax credits that provide up to 35 percent of premium costs of health insurance, otherwise known as the small business health tax credit. Although originally estimated that 1.4 to four million small businesses would be eligible for the credit, GAO reports that in the tax year 2010, only 170,300 small businesses actually claimed it, with only 28,100 claiming the full credit. **Where did you receive this "hundreds of thousands" figure that you cited? Could you provide the precise number of small businesses that have claimed the full credit?**

Answer:
The Affordable Care Act helps level the playing field for small businesses, expanding their bargaining power and their ability to offer the kind of benefit packages that attract and retain top-quality workers. Through the Affordable Care Act, small businesses have had access to historic tax credits since 2010. The GAO estimate pertains to tax year 2010 alone. Since then, additional employers have claimed the credit. According to the Department of Treasury, the Agency responsible for implementing the Small Business Health Care Tax Credit, roughly 200,000 employers have claimed the credit each year.

From Senator Deb Fischer
During our conversation at last week's hearing, you mentioned that the Small Business Administration is leveraging all the resources in its network and at its disposal to get the facts about the ACA to the small business community. While I understand the SBA's intent to answer questions asked of it by small businesses which are rightfully concerned by this law, **what is the provision of law which authorizes the SBA to promote and provide materials about the ACA? Will you provide me with the list of SBA programs and accounts which are being used as part of this effort? Finally, what is the amount of resources being used by the SBA to dispense information about the ACA which would have otherwise been used for another purpose?**

Answer:

The Small Business Act, Section 8(b)(1)(a), provides the Administrator with the authority to provide information to small businesses related to their management, financial, and operational concerns. In addition, the mission of the SBA is to counsel, assist and protect the interests of small business, and we are working every day to help educate small business owners about a range of issues—from accessing the loans that can help them start a business, to helping them tap into the federal supply chain. This includes informing business owners on ways the Affordable Care Act may benefit and impact their business.

Several SBA resource partners are providing educational counseling and training on ACA related issues, including Small Business Development Centers, Women's Business Centers, Veterans Business Opportunity Centers, and SCORE. The funding for these programs are in SBA's Salaries and Expenses appropriation account. SBA is also leveraging the expertise of its Regional and District Offices as well as its web and social media team to help educate small businesses on ACA.

As stated previously, SBA does not track employee time expended on ACA educational efforts in its annual Cost Allocation Survey. Generally, SBA's ACA education and outreach activities involve a minimal use of employee time. SBA does have on staff a Senior Policy Advisor to the Administrator, who is primarily devoted to ACA educational efforts. The educational effort undertaken by SBA is similar to previous Agency efforts to assist small businesses with key issues that are relevant to the small business community, such as Y2K in 2000 and various small business tax changes in the past. The appropriation account that SBA uses to pay for all non-credit activities is Salaries and Expenses (73-0100).

COSPONSORSHIP AGREEMENT

between

U.S. Small Business Administration
Office of Communications & Public Liaison
and

Small Business Majority
1101 14th Street, NW, Suite 1001
Washington, DC 20005

Authorization No: 13-2110-118

1. Parties
This cosponsorship agreement ("Agreement") is between the U.S. Small Business Administration ("SBA") and the following cosponsor(s) (individually a "Cosponsor" or collectively the "Cosponsors"):

Small Business Majority (SBM)
1101 14th Street, NW, Suite 1001
Washington, DC 20005
Description of Cosponsor: Small Business Majority is a 501(c)(3) non-profit entity founded and run by small business owners to focus on solving the biggest problems facing small businesses today.

2. Purpose
The purpose of this Agreement is to describe the rights and responsibilities of each Cosponsor regarding the activity described below pursuant to SBA's cosponsorship authority, 15 U.S.C. section 633(h) and 13 C.F.R. Part 106. The Agreement encompasses this document, all Attachments and applicable laws and regulations. Except as properly amended, this Agreement is the final and complete agreement of the Cosponsors. It does not authorize the expenditure of any funds, other than by express terms of this Agreement nor does it create special consideration by SBA regarding any other matter. This Agreement shall not limit any Cosponsor from participating in similar activities or arrangements with other entities.

3. Cosponsored Activity

a) Name of activity/event(s): Affordable Care Act Weekly Webinar Series

b) Date(s): Weekly, beginning during mid-July 2013 – December 31, 2013

c) Place: Online at www.smallbusinessmajority.org

d) Estimated Number of Attendees: 300 per webinar

e) Estimated Direct Cost of Cosponsored Activity: $1,000 for SBM online expenses

f) Summary of event/activity: SBA and SBM will cosponsor a weekly webinar providing educational information on what the Affordable Care Act means for small business owners. Content will include information on the small business health care tax credit, the SHOP marketplaces, and employer shared responsibility provisions, along with other Federal resources on where individuals can go to learn more about what parts of the law may apply to their businesses.

4. Cosponsors' Responsibilities
The Cosponsors agree that each will do the following in support of the cosponsored activity:

(a) SBA will:

- Provide SBM with template presentation, including content, to be used for all webinars.
- Work in conjunction with SBM to modify the template presentation as necessary.
- Identify subject-matter-experts to present on webinar topics as deemed appropriate by the SBA and SBM.
- Promote the cosponsored activity to small business through regional and national mediums, including but not limited to SBA's website.
- Maintain final approval over all draft content and marketing materials, including information posted to SBM's website.
- Work with SBM to identify particular webinars to be archived and hosted for on-demand viewing throughout the cosponsorship period.

(b) SBM will:

- Work in conjunction with SBA to modify SBA's template presentation as necessary.
- Assume primary role of webinar hosting including technology support and registration portal.
- Identify subject-matter-experts to present on webinar topics as deemed appropriate by the SBA and SBM.
- SBM will ensure that all webinars are accessible to all members of the public pursuant to Section 508 of the Rehabilitation Act.
- Provide SBA a list of attendees, including contact information, for each presentation following each week's webinar. SBM will also provide aggregate data totals of webinar participants to the SBA upon the conclusion of each webinar in the series and a total upon the conclusion of the cosponsored activity.
- Record all webinars and work with SBA to identify particular webinars to be archived and hosted for on-demand viewing throughout the cosponsorship period. All archived cosponsored materials will comply with Section 508 of the Rehabilitation Act.
- Promote the cosponsored activity through its public relations efforts, including but not limited to SBM's web site, emails, and other mediums. All releases to be approved by SBA prior to release.

5. Budget and Fees
A budget showing estimated direct costs and anticipated sources of funds is attached and will be followed to the extent practicable (Attachment A). The Cosponsors agree that no fees will be charged to participants for the cosponsored activities outlined in this Agreement.

6. Appropriate Recognition
Each Cosponsor will be given appropriate recognition for cosponsorship of the activity outlined in this Agreement, however such recognition does not constitute an express or implied endorsement by SBA of any of the opinions, products or services of any Cosponsor, its subsidiaries or its contractors. As such, all appropriate disclaimers and authorization numbers will be visible on all Cosponsored Materials. SBA has the right to determine what constitutes appropriate recognition, in its reasonable discretion.

7. Cosponsored Material
Cosponsored material refers to all print and electronic materials used to promote the cosponsored activity or material used during or as the cosponsored activity. This includes, but is not limited to, flyers, brochures, mailers, email promotional pieces, web pages, cosponsored promotional items, or any other physical, print or electronic item bearing SBA's name or logo.

8. Use of SBA Logo
Each Cosponsor agrees to use its name and logo in connection with SBA's on cosponsored materials or in factual publicity only for the cosponsored activity as outlined in this Agreement. Factual publicity includes dates, times, locations, purposes, agendas, fees and speakers involved with the activity. Any materials, print or electronic, bearing SBA's logo must include the appropriate disclaimers as outlined in paragraph 10 and be approved in advance by SBA's Responsible Program Official.

9. Web Activity
SBM will create a web site located at www.smallbusinessmajority.org to maintain information about the schedule for the cosponsored webinars, host the webinars and coordinate registration for the webinars. SBM agrees there will be no commercial advertisements or commercial promotions of any kind, including its own products or services, displayed on this cosponsored site. SBA further agrees that the cosponsored website will comply with applicable Federal law, including Section 508 of the Rehabilitation Act (29 U.S.C. § 794d).

10. Disclaimers
All cosponsored materials, print or electronic, bearing the SBA name or logo must be approved in advance by SBA's Responsible Program Official and contain the following statement(s):

1. Cosponsorship Authorization # 13-2110-118. SBA's participation in this cosponsored activity is not an endorsement of the views, opinions, products or services of any cosponsor or other person or entity. All SBA programs and services are extended to the public on a nondiscriminatory basis.

2. Reasonable arrangements for persons with disabilities will be made if requested at least two weeks in advance. Contact: Rhett Buttle – (202)535-3224

3. This Web site is provided as a public service under Cosponsorship Authorization # 13-2110-118. It is not an official U.S. government Web site and may contain links to non-U.S. government information. Inclusion of such links does not constitute or imply an endorsement by SBA. SBA is not responsible for the content, accuracy, relevance, timeliness or completeness of linked information. Please use caution when considering a product, service or opinion offered by a linked Web site.

11. Licensing of Cosponsored Material
To the extent SBA and SBM agree to archive any cosponsored webinars, SBA will possess an irrevocable, non-exclusive, worldwide, royalty-free license to use any copyrighted cosponsorship material developed for the cosponsorship outlined in this Agreement. SBM will be responsible for obtaining all rights, fees and clearances, if necessary, for the purpose of SBA's license. Should SBA decide to use copyrighted cosponsored material after the term of this Agreement, SBA will remove SBM's logo but retain a copyright notice on all print or electronic versions of the material.

12. Points of Contact
The respective Points of Contact for this Cosponsorship will be Rhett Buttle for SBM and Chris Van Es for SBA. These individuals will facilitate contact between the Cosponsors to plan, organize and execute the activity(s) contemplated in this Agreement.

13. Term, Amendment and Termination
This Agreement will take effect upon signature of all Cosponsors and will remain in effect through January 31, 2014. This Agreement can only be amended in writing. Any Cosponsor may terminate its participation in the activity upon 30 calendar days advance written notice to the other Cosponsors. Such termination will not require changes to materials already produced, and will not entitle the terminating cosponsor to a return of funds or property contributed.

14. Signature

Each of the persons signing this Agreement represents that he/she has the authority to enter into this Agreement on behalf of the entity involved.

SBA: _____ Date July 14, 2013

Fred Baldassaro
Assistant Administrator,
Office of Communications and Public Liaison

Small Business Majority: _____ Date 7/9/2013

Rhett Buttle
Vice President
Small Business Majority

Attachment A – Proposed Budget

Direct Expenses	**In-kind**
Webinar Technology Setup	$1000
Total Expenses	$1000

Sources of Income	**In-kind**
SBM	$1000

Attachment B

Draft Agenda

Affordable Care Act 101

1:00 PM	Welcome and Introductions
1:05 PM	Affordable Care Act 101: What Small Business Owners Need to Know • Overview • Small Business Health Care Tax Credit • SHOP Marketplaces • Employer Shared Responsibility
1:45 PM	Questions
2:00 PM	Closing

Draft Schedule

July 18, 2013

July 25, 2013

August 1, 2013

August 8, 2013

August 15, 2013

August 22, 2013

August 29, 2013

September 5, 2013

September 12, 2013

September 19, 2013

September 26, 2013

October 3, 2013

October 10, 2013

October 17, 2013

October 24, 2013

October 31, 2013

Webinars will continue into November and December as needed

Post-Hearing Questions for the Record
"Implementation of the Affordable Care Act: Understanding Small Business Concerns"
July 24, 2013

Questions for Mr. Dennis:

From Ranking Member Risch
Mr. Dennis, in testimony provided during the hearing, the small business health tax credit was lauded as a way the ACA addresses its disproportionate impact on small businesses. According to a recent GAO report, the credit is far too small and claiming it is far too complicated for the small businesses it seeks to help. According to GAO, out of the projected four million small businesses estimated to be eligible for the credit, only 28,000 have claimed the full credit. While the IRS offers "3 Simple Steps" on its website, those three steps become 15 calculations, 11 of which are based on seven worksheets, some of which require multiple columns of information. **Does NFIB feel that this credit or other so-called "market initiatives" help small businesses face the complexity or cost of this law? Could you speak to how small businesses with limited resources and wherewithal are supposed to claim the credit when GAO estimates it takes professional tax preparers up to five hours on average to gather the necessary documentation and perform the calculation?**

Dennis Answer - There are at least two important points to recognize about the credit. The first is that the credit is very narrowly drawn, making it difficult to use and of comparatively little value to individual small businesses that are able to take advantage of it. There are four eligibility criteria: employee-size, average wages paid, an offer of employee health insurance, and at least half of the insurance paid by the employer. NFIB estimated in 2011 that about 245,000 small, employing businesses are eligible for the full-credit and 1.165 million for the partial credit, rather than the four million projected by the Administration. We are correct.

The second point is that the credit serves as a windfall, not as an incentive. Awareness of the credit is low, less than half had ever heard of the credit by mid-2011and only 23 percent of those who had, thought that they would benefit from it and many of those are ineligible. Low initial use as reported by GAO supports the NFIB awareness data. The numbers aware of credit should rise over time, but then the credit expires. Further, the credit is of insufficient size to stimulate a business to commit to a purchase of employee health insurance. GAO reports the average credit claimed to be $2,748 *per firm* while Kaiser reports the cost of health insurance in 2012 averaged $15,745 (family) or $5,615 *per employee.* The credit's size is scheduled to increase, but only those using a SHOP exchange will be eligible. Another factor affecting the credit's incentive effect is that the credit is temporary and will expire. The purchase of employee health insurance, in contrast, is a long-term commitment employers make to their employees. A small employer simply cannot and almost certainly will not purchase insurance to take advantage of the credit and then turn around and drop coverage when the credit expires. That also makes the credit irrelevant as an incentive.

Ninety percent of small employers use a tax professional to help them file their tax return. Those who file it themselves are among the smallest businesses, those targeted by the credit. Numerous

reports from tax professionals say that filing for the credit is very difficult for them. One can only imagine how difficult it would be to claim the credit for those without tax expertise.

According to the NFIB, the Health Insurance Tax will cost nearly 250,000 jobs, with 59% of those losses falling on small businesses. The CBO and Joint Committee on Taxation have confirmed that this tax will be directly passed onto purchasers in the form of higher premiums and costs- particularly in the fully insured market where most small businesses purchase insurance. **Could you explain why the tax will lead to higher premiums and how it is at odds with the law's stated goal of making coverage affordable? During the ACA debate, the tax was billed as a "tax on insurance companies." Can you explain why this tax will be borne by individuals and families, most of whom work for small businesses?**

Dennis Answer – Congress believed that the ACA would bring additional customers to insurance companies and that insurance companies should pay a tax on that new, windfall business to help fund the Act. But it forgot, or never understood, that insurance companies have the ability and the incentive to pass on added costs to their customers. Their customers are the fully-insured market, which is part individual market and part small group market. Self-insured firms are not part of the fully-insured market, meaning that virtually all large firms and their employees will not share in paying the tax. As a result, the tax falls on small businesses and individuals. Responsible estimates place the tax cost at 2 - 3 percent of premium. That cost compounds so that by 2020, it amounts to $5,000 per policy, though that figure will vary by a number of factors, including participation, that is, the number of policies sold. Remember, the tax is estimated at over $100 billion during the next decade.

The validity of some of the data presented in this hearing has been questioned by some Members of this Committee. **Would you like to provide further explanation behind the information that you presented?**

Dennis Answer – The Chair indicated earlier in the hearing that *Politico* reported that the so-called HIT Coalition funded the NFIB Research Foundation's simulation of the HIT tax. The *Politico* report is **not** correct. The NFIB Research Foundation originally simulated the HIT Tax prior to the formation of the HIT Coalition. The simulation was subsequently updated, and the HIT Coalition did use it in their publicity. However, I cannot emphasize too strongly that the NFIB Research Foundation has never accepted funds, directly or indirectly, from an insurance company, an organization of insurance companies, or a coalition that insurance company participation in, in order to conduct research on HIT or any aspect of small business and health insurance.

Post-Hearing Questions for the Record
"Implementation of the Affordable Care Act: Understanding Small Business Concerns"
July 24, 2013

Questions for Chiquita Brooks-LaSure:

From Ranking Member Risch
Ms. Brooks-LaSure, the GAO has reported that critical tasks have delayed the establishment of federal exchanges, including certification of the plans to be offered on those exchanges. Politico reported a few days ago that Mississippi just nearly averted a crisis in its exchange because no insurers had signed up to offer coverage, which would have left tens of thousands of working-class individuals without the subsidies promised under the law to make said plans "affordable."

1. **What kind of comfort does this give small businesses who will be required to provide insurance under the employer mandate in 2015? What is CMS doing to make sure that insurers will participate on the exchanges once small businesses are required to provide coverage? How do you respond to the rising rates insurers are already passing onto small businesses due to this lack of competition and assessment of the Health Insurance Tax?**

Answer: Most employers in the small group market are not subject to the employer responsibility provision of the Affordable Care Act. For small employers that choose to offer coverage, the reforms in the law will help employers and their employees have access to better coverage at a lower cost in 2014. The Affordable Care Act is working to increase transparency and competition among health insurance plans and drive premiums down. Employers are benefitting from the Affordable Care Act, which includes a range of cost-saving, quality-improving measures that are contributing to a slowdown in health care cost growth. The law includes provisions intended to foster coordinated care, reduce preventable health complications during hospitalizations, and promote the adoption of more efficient health information technology. This slowdown should help employers save money.[1]

Historically, small businesses have been vulnerable to sharp swings in their rates based on the health of a few employees. The Affordable Care Act's single risk pool provision and other market reforms will help to stabilize premiums so that small businesses don't have to worry about those sharp swings from year to year. The single risk pool provision prevents insurers from segmenting enrollees into separate rating pools in order to increase premiums at a faster rate for higher-risk individuals more than lower-risk individuals, as is often the practice today. Starting in 2014, health insurance issuers will maintain a single statewide risk pool for each of

[1] For example, in 2012, premium growth for employer-sponsored insurance was at its lowest rate (3 percent) since the Medical Expenditure Panel Survey started in 1996. Already six states (Colorado, DC, New Mexico, Oregon, Vermont, and Washington) have released information showing that proposed premiums for the small group market are estimated to be approximately 18 percent lower than the premium a small employer would pay for similar coverage without the Affordable Care Act. See: http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.cfm.

their individual and small employer markets, unless a state chooses to merge the individual and small group pools into one pool. Premiums and annual rate changes will be based on the health risk of the entire pool.

Additionally, many small employers will be able to choose from a variety of plans within new SHOP Marketplaces and offer those plans to their employees for January 1st coverage. SHOPs will allow employers and employees the ability to conduct side-by-side comparisons of Qualified Health Plans based on benefits and premiums. SHOPs also can save businesses money by lowering administrative costs faced by employers. Billing will also be consolidated in all SHOPs no later than 2015. Finally, businesses may be eligible for small business tax credits when they offer health coverage for employees through a SHOP. Beginning in 2014, a tax credit of up to 50 percent of certain employers' share of health insurance coverage will be available to employers obtaining coverage through SHOPs.

CMS has been pleased with the response from insurers to participate in the Marketplaces. CMS is reviewing applications from issuers to offer qualified health plans in the Federally-facilitated Marketplaces; CMS has received qualified health plan submissions from more than 120 issuers.

The Administration continually emphasizes "choice" for small employers and individuals under the health care law. Recent press reports about the Administration's Request for Information on Stop Loss Insurance suggest that the Administration is contemplating steps to limit self-insured and stop loss options for smaller and medium-size plans.

2. **Can you confirm that the Administration is not drafting regulations or planning any executive actions along those lines?**
3. **Consistent with the treatment of stop loss insurance coverage under these areas of the law, will the Administration continue to recognize stop loss coverage as liability insurance when implementing provisions of the ACA?**

Answer to #s 2&3: Stop loss insurance protects against health insurance claims that are catastrophic or unpredictable in nature and provides coverage to self-insured group health plans once a certain level of risk has been absorbed by the plan. Stop loss protection allows an employer to self-insure for a set amount of claims costs, with the stop loss insurance covering most or all of the remainder of the claims costs that exceed the set amount, generally referred to as the ``attachment point."

The Administration published a Request for Information (RFI) regarding Stop Loss Insurance in the Federal Register on May 1, 2012. The comment period for this RFI closed on July 2, 2012. We are considering the comments we received to the RFI and cannot comment on any potential future regulatory action.

From Senator Michael B. Enzi

I am very interested in the use of stop loss insurance. I have heard from a number of small business owners that stop loss is a key part of self-insuring and provides them with more flexibility when it comes to covering their workers. I sent a letter, along with Senators Coburn and Snowe, last June to your Department requesting information on how you will treat stop loss insurance in the future.

1. **Can you commit to me that the Department of Health and Human Services and the Administration will not implement any rules that will limit the ability of small businesses to self-insure?**

Answer: The Administration published an RFI regarding Stop Loss Insurance in the Federal Register on May 1, 2012. The comment period for this RFI closed on July 2, 2012. We are considering the comments we received to the RFI and cannot comment on any potential future regulatory action.

From Senator Deb Fischer

The cost of implementation of the ACA when it was first passed and enacted ostensibly expected that the deadlines provided under the law for the different provisions to take effect would be met. However, a number of the statutory deadlines have not been met, such as the effective date of the employer mandate and the requirement of states to verify eligibility for individual subsidies.

1. **With these delays dragging on the implementation, is the cost to implement the ACA higher than expected and, if so, by how much?**

Answer: Numerous experts agree that the delay of the employer shared responsibility provisions will have little impact on the overall implementation of the law, mainly because about 96 percent of employers with more than 50 workers already provide insurance. The one-year delay in the application of the employer shared responsibility provision does not have a large operational impact on Affordable Care Act implementation, and does not affect the law's overall goals.

Since CMS is only responsible for certain provisions of the law, we do not have an estimate for the total cost of implementation. The President's FY 2014 Budget included $1.5 billion for implementation of the Marketplaces. However, this spending is balanced by the law's ability to reduce the deficit. According to CBO estimates, the law in its entirety will reduce the deficit by approximately $100 billion over the next decade and more than $1 trillion in the decade after that.

Post Hearing Questions for the Record for Mark Iwry
Senate Committee on Small Business
"Implementation of the Affordable Care Act: Understanding Small Business Concerns"

Ranking Member Risch

Question 1:

Mr. Iwry, in addition to cutbacks by small business, even major labor unions have urged Congress to revise the definition of the 30-hour workweek to 40 hours to avoid these disastrous effects to business. The Department of Treasury exercised what it says is its authority under Section 7805A of the Internal Revenue Code to delay the employer mandate because of concerns raised by the business community. Do you believe that projections of layoffs and reduced hours warrant similar analysis by the Department to waive or revise the 30-hour-workweek definition? Do you have information on the average family income in the U.S. and how a cutback to a 30-hour workweek would affect those families? Could you make that information available to the Committee?

The 30-hour full-time workweek definition is specifically set forth in the statute. In December of 2012, the Treasury Department and IRS issued proposed regulations that address the 30-hour full-time workweek definition. They include alternatives and safe harbors to make it easier for employers to determine whether their employees work at least 30 hours per week on average. Employers generally expressed appreciation for the flexibility provided under the proposed regulations. We continue to look for ways to make compliance easier for taxpayers within the confines of the law, and continue to work with employers and other stakeholders to implement the statutory employer responsibility provisions in as workable a manner as possible.

Question 2:

Mr. Iwry, in testifying before the House Energy and Commerce Committee on July 18, you stated that the delay decisions the Treasury has made do not affect the marketplace ("PPACA: Implementation in the Wake of Administrative Delay," House Energy & Commerce Committee on July 18, 2013). The philosophy behind the exchanges is that with more plan options, insurers can better gauge competition and thus offer reduced premium rates. How are insurers supposed to gauge competition when the SHOPs will only be providing one option to small businesses until 2015? Could you explain your statement that delay will not affect the marketplace? Can you respond to the increased premiums that small businesses have reported to this Committee?

The transition relief provided for the information reporting provisions and employer responsibility provisions of the Affordable Care Act does not apply to the dates on which the Marketplaces begin providing coverage. Coverage is scheduled to become available in the Marketplaces beginning at the start of 2014. In addition, employers that are eligible for the Small Business Health Options Program (SHOP) generally are not subject to the employer responsibility provisions (Code section 4980H) or the employer information reporting provisions under Code section 6056, so that transition relief with respect to those employer responsibility and reporting provisions has no bearing on coverage offered in the SHOP. An insurer or small

employer may gauge competition by examining the coverage offered on the Marketplaces, including the SHOPs.

The Affordable Care Act also provides for a single risk pool and other market reforms that will help to stabilize premiums so that small businesses will no longer be vulnerable to sharp swings in their rates from year to year based on the health of a few employees. The single risk pool provision prevents insurers from segmenting enrollees into separate rating pools in order to increase premiums at a faster rate for higher-risk individuals than for lower-risk individuals.

Question 3:

In your testimony, you say that most small businesses are not affected by employer reporting requirements in the law. In his testimony, Mr. Dennis stated that Sections 6055 and 6056 contain substantial reporting requirements, but no rules have been promulgated as to how employers will have to comply with the requirements. How will the IRS make sure that small businesses are taken into consideration when developing these rules? Can you explain how a small business near the 50-employee threshold will not be affected by these reporting requirements? Will they not still be required, under the law, to annually measure and account for their FTEs (or equivalents) to determine whether they are subject to the Employer Mandate?

Proposed regulations regarding information reporting under Code sections 6055 and 6056 were issued in September. Section 6056 does not apply to employers with fewer than 50 full-time equivalent employees, and section 6055 applies to employers only if they are self-insured, which generally includes few employers with fewer than 50 employees. After the regulations are finalized, the requirements will take effect on January 1, 2015. Under the transition relief provided earlier this year, taxpayers will not need to report under section 6055 or 6056 for 2014, so employers will not need to begin collecting data to report under these sections until 2015. These proposed regulations take into account small employers based, in part, on comments from and dialogue with representatives of small businesses, such as the U.S. Chamber of Commerce, and small businesses have further opportunity to comment on the proposed regulations through the rulemaking process.

While it is true that employers will need to count employees beginning in 2014 to determine whether they are subject to the employer responsibility provisions of the Affordable Care Act, the rules for counting employees were issued in December 2012. These are contained in proposed regulations that provide that employers can rely on them until final regulations are published. They also provide that, to the extent the final regulations are more restrictive than the proposed regulations, the future guidance will not be applied retroactively and employers will be given sufficient time to come into compliance with the final regulations.

Question 4:

The Administration continually emphasizes "choice" for small employers and individuals under the health care law. Recent press reports about the Administration's Request for Information on Stop Loss Insurance suggest that the Administration is contemplating steps to limit self-insured and stop loss options for smaller and medium-size plans. Can you confirm that the Administration is not drafting regulations or planning any executive actions along those lines?

On May 1, 2012, the Departments of Health and Human Services (HHS), Labor, and the Treasury jointly published a Request for Information in the *Federal Register* requesting public comments to contribute to the Departments' understanding of the current and emerging market for stop loss products. . We are reviewing these comments and considering the issues raised in them. The Departments remain interested in the possible effects of self-funded arrangements with stop loss insurance and will continue to work with stakeholders to monitor the use of such arrangements.

Question 5:

Stop loss insurance covers aggregate group and individual losses that exceed certain agreed upon thresholds, and operates as a safety net for small employers maintaining self-funded group health plans. Stop loss coverage is considered liability insurance under the Section 9832(c)(1)(C) of the Internal Revenue Code. In its final regulations implementing Code sections 4375 and 4376, the Department of Treasury also recognized that stop loss should not be considered a "specified health insurance policy." Further, the Department of Health and Human Services exempted stop-loss policies from the reinsurance contribution requirements. Consistent with the treatment of stop loss insurance coverage under these areas of the law, will the Administration continue to recognize stop loss coverage as liability insurance when implementing provisions of the ACA?

On May 1, 2012, the Departments of Health and Human Services (HHS), Labor, and the Treasury jointly published a Request for Information in the *Federal Register* requesting public comments to contribute to the Departments' understanding of the current and emerging market for stop loss products. We are reviewing these comments and considering the issues raised in them. The Departments remain interested in the possible effects of self-funded arrangements with stop loss insurance and will continue to work with stakeholders to monitor the use of such arrangements.

Post Hearing Questions for the Record for Mark Iwry
Senate Committee on Small Business
"Implementation of the Affordable Care Act: Understanding Small Business Concerns"

Senator Deb Fischer

Question 1:

The cost of implementation of the ACA when it was first passed and enacted ostensibly expected that the deadlines provided under the law for the different provisions to take effect would be met. However, a number of the statutory deadlines have not been met, such as the effective date of the employer mandate and the requirement of states to verify eligibility for individual subsidies. With these delays dragging on the implementation, is the cost to implement the ACA higher than expected and, if so, by how much?

The Congressional Budget Office (CBO) has consistently projected that the Affordable Care Act as a whole will significantly reduce the budget deficit over time. In other words, the ACA is more than fully paid for. For example, in July of 2012, the CBO estimated that, repealing the Affordable Care Act would increase the federal budget deficit by $109 billion between 2013 and 2022, and would further increase the deficit in the following decade by about ½ of 1 percent of GDP. The CBO's more recent estimates (May 2013) have reaffirmed the ACA's contribution to deficit reduction in the first and second decades.

SENATE SMALL BUSINESS COMITTEE
HEARING ON
"The Affordable Care Act"

July 24, 2013

These are the answer for the records to be inserted into the transcript for this hearing:

Lead-In:
CHAIR LANDRIEU: Chair Landrieu. Now, you testified that in one of the states, and I do not know if you want to identify what it is--where you said the average of states that have cooperated and engaged in setting up these exchanges for small business, the rates have gone down by 18 percent. Is that what you testified and could you elaborate, please? Do you know the Affordable Care Act requires CMS to share data with the States, the Department of Justice, and the Inspector General, amongst others, to help fraud and abuse? Will this authority help the strike force continue their good work?

MS. BROOKS-LaSURE: Yes, sir.

CHAIR LANDRIEU: What states are those please?

INSERT: Page 32, Line 18

MS. BROOKS-LaSURE: Colorado, District of Columbia, New Mexico, Oregon, Vermont, and Washington.

Lead-In:
SENATOR ENZI: Can tell you that in all of the Committees, there is a whole lot more interest in what is going to happen, and that is because starting January 1st, all the Senators, all the Congressmen, and all of their staff are going to have to go on the exchange to get their insurance, and there are a lot of unanswered questions about that. So both sides of the aisle are rather intense on this exchange. Some of the questions that they have asked is because we were told that it was beta tested, the exchange is beta tested already, so one of the people on the other side of the aisle asked, Who tested it and if they could have a list. And that is apparently not available.

MS. BROOKS-LaSURE: In terms of our testing, thank you, Senator, for the question, we are undergoing very rigorous testing. So we at HHS are testing with our Federal partners. That has been ongoing for the last year. Senator Enzi. How do you write the program without having a basic plan defined? That is another question that has been asked in all three of these Committees.

SENATOR ENZI: How do you write the program without having a basic plan defined? That is another question that has been asked in all three of these Committees.

MS. BROOKS-LaSURE: So I am not sure if I am understanding your question.

SENATOR ENZI: You give the silver plan as being 74 percent, gold 80 percent, and bronze. But what does that consist of?

MS. BROOKS-LaSURE: It is based on our standards and our regulation and then states are—

SENATOR ENZI: Can you send me the list of the exact things that are on that, not just the general ones like that?

INSERT: Page 57, Line 11

MS. BROOKS-LaSURE: On February 20, 2013, the Department of Health and Human Services (HHS) released a final rule that helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limiting their out of pocket expenses.

Specifically, this rule outlines health insurance issuer standards related to the coverage of essential health benefits (EHB) and the determination of actuarial value (AV), while providing significant flexibility to states to shape how EHB are defined.

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures that health plans offered in the individual and small group markets, both inside and outside of Health Insurance Marketplaces, offer a core package of items and services, known as "essential health benefits." Under the statute, EHB must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

The Affordable Care Act also directs that EHB be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the final rule defines EHB based on a state-specific benchmark plan. States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to EHB offer benefits substantially equal to the benefits offered by the benchmark plan. This approach best strikes the balance between comprehensiveness, affordability, and state flexibility. The final rule also gives issuers the flexibility to offer innovative benefit designs and a choice of health plans.

The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products by enrollment in the state's small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the HMO plan with the largest insured commercial non-Medicaid enrollment in the state. Twenty-six states selected their own benchmark. The final rule also clarifies that in the remaining states that do not make a selection, HHS will select the

largest plan by enrollment in the largest product by enrollment in the state's small group market as the default base-benchmark plan. The selected benchmark plans are already finalized for benefit year 2014.

Actuarial Value, or AV, is calculated as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 70 percent, on average, a consumer could expect to be responsible generally for 30 percent of the costs of all covered benefits in that plan.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain AVs, or metal levels: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Issuers may offer catastrophic-only coverage to eligible individuals. "Metal levels" will allow consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider networks, and other factors, help the consumer make an informed decision.

CAPITOL CITY
Legal Medical Solutions

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August 4, 2013

The Honorable Mary L. Landrien
United States Senator
Chairwoman - Small Business Committee
Washington, DC 20510

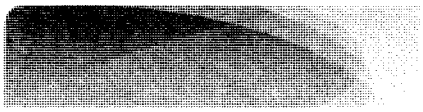
Dear Senator Landrieu:

It is with great pleasure that we write this letter in support of the Affordable Care Act (ACA). As small business owners we support ACA because we believe it will help to foster a community of healthier employees. The growth of our business is established by the dependability of our labor force. Additionally when you have healthy individuals working this creates a better work environment for our contractors as well as the clients we serve. We believe that everyone should have access to affordable healthcare. We were overjoyed when the ACA passed and look forward to its full implementation in Louisiana. If you have any questions please feel free to contact us at 225-907-4370.

Sincerely,

Alejandro "Al" Perkins, Esq.
Co-Owner

Dina G. Perkins, MHA, CPC
Co-Owner



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Phone: 225-869-5676

August 4, 2013

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United States Senator
Chairwoman - Small Business Committee
Washington, DC 20510

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Sincerely,

Alejandro "Al" Perkins, Esq.
Co-Owner

Dina G. Perkins, MHA, CPC
Co-Owner

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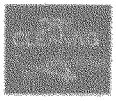


August 1, 2013

To The Honorable Mary L. Landrieu
United State Senator
Chairwoman - Small Business Committee
Washington, DC 20510

Dear Senator Landrieu,

It is with great pleasure that I write a letter in support of the Affordable Care Act. As a small business owner I support ACA because I believe it will help to foster a community of healthier employees. The growth of my business is established by the dependability of my employees. And when you have healthy individuals working this creates a better work environment for the employees as well as the consumers. It's my belief that everyone should have access to affordable healthcare. I was overjoyed when the Affordable Care Act passed and I look forward to its full implementation in Louisiana. If you have any questions please feel free to contact me at 225-357-4678.

Sincerely,

William "Bill" Dickerson, Owner
Plank Road Cleaners
Baton Rouge, LA

Hugh W. Raetzsch Jr.
President
Lyons Specialty Co., LLC/AA Vending
Port Allen, LA
&
Chairman of the Board
American Wholesale Marketers Association
Fairfax, VA

U.S. Senate Committee on Small Business & Entrepreneurship
Wednesday, July 24, 2013

Small Business Impact of the Patient Protection & Affordable Care Act

Mr. Chairman, members of the committee, I appreciate this opportunity to discuss my concerns, and the concerns of many other convenience industry distributors, regarding implementation of the Affordable Care Act and its impact on our companies.

I am president of Lyons Specialty Co., based in Port Allen, Louisiana, a family owned and operated wholesale distributor of products to some 550 convenience store retailers in both Louisiana and Mississippi. I am also chairman of the American Wholesale Marketers Association (AWMA), which represents similar convenience industry distributors nationwide.

Our company's family includes 85 full-time and four part-time employees who work in our warehouse, drive our trucks, sell our products, or work in our office. Currently, we provide health insurance coverage opportunities to every full-time employee after 30 days on the job, paying 75 percent of the premium for that individual's coverage. About half of our employees now take advantage of that opportunity.

What will we do now that the Affordable Care Act is in place? Frankly, I am not sure. And, from speaking with many of my fellow distributors who are members of AWMA, I know they are facing the same questions.

At Lyons, we believe providing a good health insurance option for our employees is the right thing to do – both from a business and personal standpoint. It puts us in a sound competitive position when we are seeking new employees and helps reduce costly turnover. Most of my AWMA colleagues feel the same way.

And I can tell you that this is important. Our industry traditionally has faced high rates of turnover, particularly among our hourly workers. Often the work is strenuous, lifting and moving cases of food and grocery products hour after hour or spending long hours driving a delivery vehicle and then physically moving the products into the store.

So offering a good benefits package is important to us from a business standpoint, because it is costly and time-consuming to seek out, hire and train new individuals.

But we are facing some serious challenges as a result of the ACA. The unknowns have been recounted time and again, and they continue to complicate the issue for us.

The ultimate cost of compliance is unknown.

How we actually comply is unknown.

What types of reporting systems and their cost is unknown.

How do we manage the complexity of the law's requirements as they pertain to our business? That is unknown.

I promise you, we do not have office personnel sitting around and waiting for more work; nor are they skilled in this area. Must we hire a consultant to manage this? What will that cost?

Our industry operates on a very, very tiny profit margin and no matter how efficient we become in our operations, it is very difficult for many companies to exceed one or two percent. For some companies in our industry, adding unknown additional costs could literally mean the difference between survival, and continuing to provide jobs, and shutting their doors, putting valued employees -- many of whom are moms and dads with kids to support – out of work.

That is not an exaggeration, and I do not think it is the objective of the Affordable Care Act.

In preparation for this testimony, I asked our company's insurance broker for some help in documenting the issues involved. He worked fast and literally overnight sent me more than two pages of single-spaced bullet points covering everything from the unknown cost that makes it virtually impossible for us to plan and even consider expansion, to the reporting burden that we will face and confusion about the exchanges.

Most of that has already been well documented. So I will just tell you about what we face at Lyons.

While it's great that the Obama Administration delayed implementation of the employer mandate for a year – even though that just drags out some of the uncertainty even longer – the individual mandate is, of course, still in place. So that means we have to make a decision.

As I said, we offer health insurance coverage – two different types of policies, one with a high deductible to keep it as affordable as possible – to our fulltime workers, which is by far the majority of our workforce. As some companies are considering, we could completely realign our workforce to get as many as people as possible under the 30-hour threshold so we could get under the 50-employee limit and thus not be subjected to the law.

That is not what I want to do.

That would play havoc with the efficiencies we have worked so hard to create through investment in the latest equipment, facilities and training, and quite frankly, it would not be fair to the men and women who work for Lyons and have been loyal to our company, helping us to succeed.

But if we continue our benefit plans as they are currently structured and our employees who do not participate in our health plan decide to do so rather than obtain coverage on the state exchange, then our annual cost to absorb those additional workers will be $150,000 per year or more. And, that is just the tip of the iceberg because of the unknown additional costs of recordkeeping, reporting, and other related factors. Can we absorb that extra cost? We cannot.

On a purely financial basis, the bottom line cost to Lyons of paying the penalty per full-time employee for not providing coverage actually would be less than what we are paying now to cover those employees who do participate in our health plan. So the answer is clear, right? We should just throw out our health insurance plan, wash our hands of it, and let them run off to the exchange for coverage.

Not so fast.

If we do that, if we cannot offer them affordable and effective health insurance coverage as part of their benefits package, we would lose whatever competitive advantage we have in attracting the best employees available. That is an important factor in today's competitive environment, and as the economy improves and the competition increases for the best workers, it will become even more important.

I can tell you that I do not like that option, although when the numbers are crunched, it may seem to make the most sense.

But the more important problem is the toll that it would take on our employees, people who give their heart and soul to our company; who love their jobs, and whose service and talents we value.

Right now the average individual policy costs about $400, of which the company pays 75 percent, or $300, leaving the employee to cover the remaining $100. For many employees, that $100 per month is simply impossible. They are living paycheck to paycheck, some even taking out loans from the company to survive. That is why so many have not signed up for our coverage and are willing, instead, to roll the dice and risk the devastating cost of a catastrophic health event. They just can't afford it.

For those who need to cover their family, with the average premium at about $900 per month, their out-of-pocket cost is about $600 because we cover 75% of the individual coverage cost, not the family. That is a big, big number for them.

So how will the ACA affect them? Under the law, they will be forced to find coverage or pay a fine themselves. How will we deal with that issue when they come to us looking for help? We are doing the best we can right now, and we are doing it without any kind of government requirement or mandate. But if they cannot afford to purchase the coverage we provide at work, paying only one-fourth of the premium cost, how will they be able to afford even subsidized coverage through the exchange?

Then, of course, we have the uncertainty of the exchanges themselves. Louisiana has rejected a state-run exchange, which means the federal government will operate the exchange in our state. What does that mean? What will it involve? What kind of participation will there be from the insurance industry? How would our employees access it, and what would be their costs and benefits if they obtain coverage there?

All of those are unanswered questions further complicating the unknown.

As business people, it is very difficult for us to operate in such a vacuum. At our company, and in many convenience distributorships across America, we are trying to do the best we can for our employees. And as I said, we have not needed a directive from the federal government to do so.

Thank you very much.

July 23, 2013

Senator Mary Landrieu
Chairwoman
Senate Committee on Small Business and Entrepreneurship
428A Russell Senate Office Building
Washington, DC 20510

Dear Senator Landrieu,

We hope this letter finds you well.

Small Business Majority welcomes the opportunity to comment on the small business tax reforms that can accelerate the start-up and growth of small businesses. Lawmakers on both sides of the aisle agree small business owners are the backbone of our economy, which is why it is so critical that positive steps are being proposed to help level the playing field for them. Entrepreneurs have long felt at a disadvantage when it comes to tax policies, and they support targeted policies that would benefit the vast majority of small firms, not those that only benefit a few. Following are our comments on some tax reforms that can help small businesses succeed.

Small business expensing

Small business expensing is an issue which entrepreneurs have shown significant concern over. Small Business Majority's scientific polling found that in 2012, more than eight in 10 entrepreneurs were anxious that the Section 179 deduction limit was set to drop to $25,000 in 2013. While they can be thankful for the one-year extension that stopped that from happening, a temporary fix is not sufficient enough.

In an effort to eliminate uncertainty over this issue for good and give small businesses some cash flow flexibility, a proposal to permanently allow expensing of capital investments up to a quarter of a million dollars would be welcome news for small firms. That's 10 times what the limit is set to fall to in 2014, sans tax reform. Our research found the vast majority of small business owners would like to see the amount of expenses small business can deduct permanently raised to $1 million. While this plan would not set the bar quite that high, it is a step in the right direction that small businesses support.

Start-up costs

In addition to making changes to the Section 179 deduction as discussed above, combining three existing provisions for start-up and organizational expenses into a single provision is applicable to all businesses. In effect, it would double the dollar amount small firms can expense for startup costs. For entrepreneurs just getting their businesses off the ground, that can make a huge difference. Small Business Majority supports this element of the tax proposal because we know from our extensive experience with small and micro-businesses that start-up costs can be a major barrier for entrepreneurs who are otherwise ready to grow and put more Americans back to work.

Cash accounting

It's also crucial to simplify the accounting process for small business owners. We can do this by creating a uniform rule under which all businesses with gross receipts of $10 million or less would be able use the cash method of accounting. In coordinating this rule with the uniform capitalization rules, small businesses would be generally exempt from complex requirements for allocating

inventory. This would save them a great deal of time and energy so they can focus more effort on growing their businesses. It's also important to note that sole proprietors would be able to exercise this cash method of accounting regardless of their level of gross receipts. With 21 million self-employed business owners across the United States, this rule could be a boon for the self-employed community.

Business tax returns

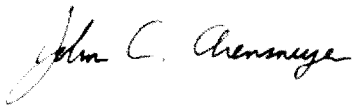
Proposals to change due dates for business tax returns, in order to ease tax compliance for small companies, is also something that can be beneficial to small firms. Small business owners often have insufficient time to prepare their tax returns, as the information needed for their tax forms is sometimes not yet available at the time they must file. Because of this, they frequently end up needing to request an extension. By adjusting the dates for when all the different types of businesses must file their taxes—such as partnerships, S corporations and C corporations—entrepreneurs will have more leeway to get organized for future tax seasons, and will still have the option for an extension if they need it.

Partnerships and S corporations

Many business owners organize their companies as partnerships or S Corporations, and although these small businesses may look very similar on the outside, they have quite different sets of rules when it comes to federal taxes. To streamline some of those rules for current business owners and improve the tax system for future businesses as they organize, the proposal lays out two options to reform tax structures for partnerships and S corporations. Each of these options would do a number of things to improve the archaic nature of both tax structures as they currently function. Improvements would range from reducing double taxation of certain business income to cutting down on complications between federal and state tax returns for small businesses organized certain ways.

Thank you for the opportunity to comment on small business tax reform. If you have any questions please contact Rhett Buttle, Vice President, External Affairs, at rbuttle@smallbusinessmajority.org or (202) 828-8357.

Sincerely,



John Arensmeyer
Founder and CEO, Small Business Majority

Written Testimony for U.S. Senate Small Business Committee

Submitted by Howard "Rocky" King, Executive Director, Cover Oregon

July 24, 2013

Offering health insurance to employees is becoming increasingly challenging for Oregon's small employers, which account for more than 50 percent of the private sector jobs in the state, according to the Small Business Administration (SBA). Starting in October 2013, Oregon small business owners with 50 or fewer employees will be able to shop for, compare and enroll in health insurance plans for their businesses through Cover Oregon, our state-run health insurance exchange.

Over the past year, we have been talking to small business owners about their needs, frustrations and input on how to make health insurance more accessible. With that in mind, we are working to create the most desirable marketplace in Oregon for small employers and their agents to access health benefits solutions that offer meaningful choice. This is achieved by providing access to an exceptional online shopping experience, reliable online support tools, quality customer service, simple unified premium billing and payment, and the ability to provide guidance that includes eligibility for employer tax credits and Section 125 plans.

Cover Oregon will provide clear information on a broad range of insurance plans so small businesses can make side-by-side comparisons and choose the right plan for them. It will give small businesses more choice in carriers and plans, allow them to set the dollar amount they'll spend, and provide one-stop shopping to compare and purchase plans. In addition, small business owners can set the amount they can pay toward premiums and let employees choose from many plans offered through Cover Oregon. No matter how many plans small businesses select, they receive one monthly bill and can conveniently manage everything through Cover Oregon.

In order to get the word out to small business owners about Cover Oregon, we have developed a comprehensive marketing and outreach strategy focused on: 1) traditional marketing channels that will reach small business owners such as advertising, media coverage in targeted publications, and community meetings; 2) strategic alliances with insurance agents and Oregon business associations to provide information and content they can share with networks; 3) grant-funded outreach to business organizations and associations to support year-round outreach; and 4) reaching businesses not affiliated with associations through direct mail and working with state agencies to identify those doing business in Oregon.

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Salem, Oregon 97303
Phone: 503-373-9417
Fax: 503-373-9422

coveroregon.com

The Small Employer Program online browsing and purchasing experience will mirror as closely as possible the flexible, intuitive and informative approach developed for the individual side of Cover Oregon. That groundwork has been adapted to both the employer and employee to present a positive experience for a first-time shopper as well as an expert, returning shopper.

Once the employer has finished browsing, sorting, filtering and comparing plans they will be offered four models of plan choice to offer their employees.

1. *Single Plan Choice.* The employer chooses one insurance carrier and plan that their employees must enroll in.
2. *Carrier Choice.* The employer chooses one insurance carrier, but lets their employees select from all plans offered by that carrier.
3. *Metal Tier Choice.* The employer selects a benefit plan level – platinum, gold, silver or bronze. The employee can then select from any carrier and plan on that metal level.
4. *Broad Choice.* Based on the metal level of the employer's selected reference plan, employees can select from all carriers and all plans available on that tier, on one metal tier higher than the reference plan and any number of tiers lower than that plan.

After making a choice from these four options, the employer will be guided through a series of decisions that will help them determine potential eligibility for the small employer tax credit and establish the parameters of the shopping experience their employees will go through.

Between the enabling legislation in Oregon and the Affordable Care Act, Cover Oregon will have standardized plans at the gold, silver and bronze levels. Eight carriers have filed plans and premiums for participation in the Small Employer Program. Together these carriers represent more than 70 filed plan offerings in the small employer market.

Cover Oregon will also launch with the option for small employers to offer Section 125 plans. The ability to pay for benefits on a pre-tax basis represents a win for both the employer and employees. Cover Oregon will provide the option to produce the required Plan Document and Employee Salary Redirection Agreement forms for the small employer free of charge, if the employer wants a Premium Only Plan (POP).

In all instances where employee choice of insurance carrier is offered, Cover Oregon will often be the only entity other than the employer with knowledge of all pieces of current group enrollment and eligibility. As such, Cover Oregon will conduct an automated renewal for the group on behalf of all participating carriers.

Cover Oregon will also have a robust set of financial tools to enable the functionality, as well as additional functionality to administer commission payments for affiliated agents. These

payments will be a pass through of commissions paid by the participating carriers in Cover Oregon, but will need to be accounted for upon receipt and payout.

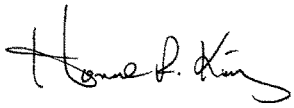
Cover Oregon will routinely report on all aspects of the employer portal shopping experience. This will facilitate our continual process improvement and prioritization of enhancements as we examine weak points and leverage strong points of the experience.

Because agents currently are associated with an extremely high proportion of small employer business in Oregon, it is vital that we facilitate their interactions with potential small employer program business as well. Cover Oregon has scheduled more than 60 agent trainings statewide to promote its value proposition and build momentum within the agent community.

The integration of Small Employer Program functionality into the core processes of Cover Oregon will allow greater flexibility for all Oregonians using it. Small employers, employees and agents are all also individuals who could use different aspects of Cover Oregon to meet varied needs. As a result, individuals will be able to use Cover Oregon as employers of one or many companies, as an employee or dependent of an employee, or as an individual seeking commercial plans or plans with financial help. This seamless integration is at the core of what Oregon is building.

We look forward to working with Members of Congress to make implementation of Cover Oregon a success and believe that we can be a model for how other states launch their Small Employer Plans. For questions, please contact Amy Fauver at 503-373-9403 or afauver@coveroregon.com

Sincerely,



Howard "Rocky" King
Executive Director, Cover Oregon

Society of Actuaries: ACA Impact Will Vary "Substantially Across State Lines"

Posted on July 17, 2013 by AHIP Coverage

The *New York Times* has a front-page story this morning examining the impact of the Affordable Care Act (ACA) on individual market premiums in New York. The article states that, "State insurance regulators say they have approved rates for 2014 that are at least 50 percent lower on average than those currently available in New York."

When examining the impact of the ACA on premiums, it is important to note the wide variation in impact that is likely to occur across states. As a previous Society of Actuaries (SOA) study found, consumers can expect the "average change in individual market costs varying substantially across state lines."

According to the SOA report, "the significant state-by-state variation can be attributed to many factors, including whether or not the state sponsored a high-risk pool, differences in current underwriting practices, and demographic characteristic and income level differences in state populations. In simplest terms, the states that will see large increases generally have low current individual costs and those showing decreases have high current individual costs, with all states moving closer together but at a higher level overall."

GOP FTR
for the
July 24 ACA
Hrg.

PREDICTED COSTS OF THE FUTURE

NEWLY INSURED UNDER THE AFFORDABLE CARE ACT (ACA)

ALABAMA	50.3%	KANSAS	21.9%	MASSACHUSETTS	-12.8%	NEW MEXICO	34.9%	SOUTH DAKOTA	29.0%
ALASKA	19.2%	IDAHO	62.2%	MICHIGAN	25.8%	NEW YORK	-10.8%	TENNESSEE	46.4%
ARIZONA	22.2%	ILLINOIS	50.8%	MINNESOTA	18.8%	NORTH CAROLINA	13.6%	TEXAS	33.8%
ARKANSAS	40.9%	INDIANA	67.6%	MISSISSIPPI	43.2%	NORTH DAKOTA	8.8%	UTAH	28.4%
CALIFORNIA	61.6%	IOWA	9.7%	MISSOURI	58.8%	OHIO	80.9%	VERMONT	-12.5%
COLORADO	39.1%	KENTUCKY	18.9%	MONTANA	20.1%	OKLAHOMA	29.3%	VIRGINIA	28.4%
CONNECTICUT	28.8%	KENTUCKY	34.1%	NEBRASKA	30.8%	OREGON	14.9%	WASHINGTON	13.7%
DELAWARE	29.3%	LOUISIANA	28.6%	NEVADA	29.2%	PENNSYLVANIA	28.6%	WEST VIRGINIA	35.3%
D.C.	51.9%	MAINE	4.1%	NEW HAMPSHIRE	36.8%	RHODE ISLAND	-6.6%	WISCONSIN	60.0%
FLORIDA	26.5%	MARYLAND	66.6%	NEW JERSEY	-1.4%	SOUTH CAROLINA	36.8%	WYOMING	31.6%
GEORGIA	27.8%								

SOCIETY OF ACTUARIES

As many of you know, New York was one of eight states that enacted insurance market reforms in the 1990s without requiring everyone to purchase coverage. As the *Times* story notes, these reforms caused significant disruption in the state's individual insurance market:

"For years, New York has **represented much that can go wrong with insurance markets**. The state required insurers to cover everyone regardless of pre-existing conditions, but did not require everyone to purchase insurance — a feature of the new health care law — and did not offer generous subsidies so people could afford coverage. With **no ability to persuade the young and the healthy to buy policies**, the state's premiums have long been among the highest in the nation. 'If there was any state that the A.C.A. could bring rates down, it was New York,' said Timothy Jost, a law professor at Washington and Lee University who closely follows the federal law."

The article adds that "Because the cost of individual coverage has soared, only 17,000 New Yorkers currently buy insurance on their own. About 2.6 million are uninsured in New York."

Given that New York previously enacted many of the insurance market reforms required by the ACA, the impact on premiums in that state will be much different than in the vast majority of states that do not currently have those reforms in place.

- See more at: http://www.ahipcoverage.com/2013/07/17/society-of-actuaries-aca-impact-will-vary-substantially-across-state-lines/#sthash.RxAzB3et.dpuf

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Cost of the Future Newly Insured under the Affordable Care Act (ACA)

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I. Executive Summary

Background

In March 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law includes numerous provisions that aim to accomplish this goal. One way in which the ACA increases access to commercial health insurance coverage is by restricting insurers from denying coverage, excluding individuals with pre-existing conditions, and varying premiums based on an individual's health status. To minimize the adverse selection that could result from certain provisions, the ACA includes other provisions, such as premium and cost-sharing subsidies administered via a Health Benefits Exchange (HBE) and an individual tax penalty for those who do not purchase sufficiently valuable health insurance coverage. These provisions aim to increase overall participation in health insurance plans. The ACA includes additional provisions to expand health coverage to U.S. residents, such as the option for states to expand Medicaid to nearly all adults below 138 percent of FPL, a requirement for all large employers to offer health insurance to full-time employees or face a penalty, and a tax credit to small employers to offset the cost of insurance and thus incentivize them to offer coverage. [1]

Our baseline estimates indicate that of the 52.4 million individuals who would have been expected to otherwise lack health insurance coverage in the absence of the ACA, 32.4 million will obtain coverage, assuming all ACA provisions were fully implemented and presented in 2014, and assuming all states expand Medicaid.[2] This includes 10.4 million individuals who gain coverage through the individual exchange, 0.4 million individuals who gain private non-group coverage, 2.2 million individuals who gain coverage in a Small Business Health Options Program (SHOP) Exchange, 5.4 million individuals who gain other employer coverage, and 14.0 million individuals who gain coverage through Medicaid expansion, if all states participate, which may not occur. Given that all states will not participate in the Medicaid expansion, state-level estimates comparing number of uninsured under expansion versus no expansion are presented in ***Figure S-1*** and ***Figure S-2***.

Project Scope

The SOA's research objective is to provide guidance to state exchange officials and administrators, federal officials and administrators, and actuaries assisting states and health plans. The goal of the project is to estimate the morbidity and/or cost for newly insured individuals in the individual market (and to some degree, the small group exchange) relative to the morbidity and/or cost for the current commercially insured population. This analysis will primarily focus on the individual, non-group market. In order to plan for the impact that these currently uninsured individuals will have on the health insurance markets, it is important to understand their costs relative to the costs for people already enrolled, for whom many health insurers have experience and data.

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[1] The ACA provides the option for states to expand Medicaid to 133% of FPL and includes a provision to disregard 5% income of a family's income for eligibility determination, which effectively increases eligibility to 138% of FPL.
[2] The 32.4 million estimate is an overestimate, as many states have indicated that they will not participate in Medicaid expansion.

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The key research questions explored in this analysis include:

- What is the anticipated enrollment for the currently uninsured under the ACA?
- For the newly insured, what is their relative morbidity and what could reasonably be expected for relative costs, compared to the currently insured?
- What will be the general impact of the newly insured on the overall post-reform health care industry and insurance market, in terms of supply and demand for health care services and insurance carriers?
- How will health care costs for the newly insured differ by state?
- What will be the relative health status and cost for individuals who remain uninsured and how will this vary by state?
- If states expand Medicaid under the ACA, what is the impact on Medicaid costs and enrollment?

Note that the ACA's affect on *premium* is not modeled in this research; rather, *long-term relative claims cost* is modeled. Many aspects of the ACA will affect premiums, including changing benefit designs, new taxes and assessments, federal risk mitigation programs, minimum loss ratio rules, rate review rules, and premium subsidies.

Research Model Used

Our research estimates are made using The Lewin Group Health Benefits Simulation Model (HBSM). The HBSM is a micro-simulation model of the U.S. health care system. HBSM is a fully integrated platform for simulating policies ranging from narrowly defined insurance market regulations to Medicaid coverage expansions and broad-based reforms involving multiple programs such as the ACA. It was developed in 1989 to simulate the wave of reform proposals that culminated in the health reform proposal introduced by President Clinton in 1993. The model was used by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) in 1990 and has been in almost constant use since then by The Lewin Group at the state and national levels. The Lewin Group has been using this model since 2010 to assist clients with ACA planning, strategies and actions. The SOA retained Optum, who chose to use the HBSM model and engage The Lewin Group to conduct this research study. Optum is the parent company of The Lewin Group. Randy Haught and John Ahrens, authors of this report, are employees of Optum. However, the authors' analyses and interpretations are based upon their own professional expertise and are offered within the scope of work they were asked to perform by the SOA. Their findings or conclusions do not necessarily represent a position of Optum or Lewin.

The HBSM is explained in greater detail within the Technical Notes and in Appendix A and B. The reader is encouraged to read and understand the model and assumptions prior to using the model results for analysis.

The HBSM model outputs are based on expected cost results in 2014, but assuming full implementation of the 2016 penalties (when full penalties apply) and also assuming that ultimate enrollment in the various programs and the Exchanges is completed right away. Reality will likely result in a lag in enrollment shifts, such that not all people who are modeled

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to ultimately take coverage will do so in immediately in 2014, as presented in this research. Observations from prior Medicaid expansions show that it may take three to four years to reach an ultimate enrollment state. In addition, this research does not reflect that newly insured individuals may have a pent-up demand for services due to previously unmet health care needs, and further does not reflect that the earliest new enrollees may differ from the average risk group that will ultimately enroll. Therefore, each user of this report will need to make their own assumptions for each state with respect to how the initial years' (2014 and 2015) enrollment and distribution of risks may occur, as well as the appropriateness of the model for 2016 and subsequent years. In order to assist the practitioner in modifying the results, Excel worksheets are provided for each state to facilitate the process.

Key Findings

Key findings are summarized in ***Figure S-1*** and ***Figure S-2*** by state. Due to the changing status of participation in the Medicaid expansion for individual states, ***Figure S-1*** shows the percent uninsured, non-group enrollment, and non-group costs pre- and post- ACA for each state assuming that all states expand Medicaid, resulting in many of the uninsured enrolling in Medicaid. ***Figure S-2*** shows these same results for each state, but assumes that none of the states expand Medicaid. The reader can select the appropriate table based on the state's current Medicaid participation status. The three findings summarized below assume Medicaid expansion in all states. Although the costs shown in the tables are at projected 2014 levels, the actual enrollment and percentage increases in costs reflect an "ultimate" or "steady-state" environment, which we assume corresponds to about 2016 or 2017 (after three years of exchanges). Therefore, mitigating strategies being considered in 2013 for 2014 and 2015 (for example, some states are considering transitioning state high risk pools gradually) are not reflected in this model. The research models the long-term likely scenario when high risk pools have been fully transitioned into the market.

Finding 1: After three years of exchanges and insurer restrictions, the percentage of uninsured nationally will decrease from 16.6 percent to between 6.8 and 6.6 percent, compared to pre-ACA projections.

In the first section of ***Figure S-1***, estimates are shown for the percentage of all individuals uninsured in absence of the ACA and compared to two estimates of the percentage of all individuals uninsured in under the ACA, assuming full implementation and presented in 2014 dollars and population counts. Note that the counts are annual equivalents so that an individual who is uninsured for three months would count as 0.25 uninsured. This approach can result in differences with other counts of the uninsured which might be based on a snap shot on a given date, or count someone who is uninsured at any time in a year.

One of the key findings of our analysis is that the impact of the ACA on reducing the number of uninsured will vary substantially across states. Some of the factors that may explain these differences include: proportion of population that is uninsured prior to the ACA; portion of the uninsured below 400 percent of FPL, which is based in part on current Medicaid eligibility levels in the state; and average non-group costs.

To provide a range of results, the percentage of uninsured are simulated under two models: a price "elasticity" model and a "utility" function model. The elasticity model simulates the

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decision to take coverage based upon the change in the net cost of coverage to the individual under reform, a decision which varies by demographic characteristics of the individual. The utility function models an amount that someone is willing to pay to be protected against the risk of going without insurance; they choose coverage if the cost is less than that figure.

Finding 2: Under the ACA, the individual non-group market will grow 115 percent, from 11.9 million to 25.6 million lives; 80 percent of that enrollment will be in the Exchanges.

The middle section of ***Figure S-1*** provides estimates for the number of non-group individuals covered pre-ACA compared to the number of those expected to be covered post-ACA; this is shown under the elasticity model. The percentage of non-group individuals in the Exchanges is shown as well. We model that 80 percent of non-group coverage will be through the Exchanges, since subsidies will only be available for coverage purchased through the Exchanges. Our model assumes that people purchasing non-group coverage who are eligible for subsidies will purchase through the Exchanges. Much of the increase in coverage is a result of the premium and benefit subsidies for lower income individuals, many of who will select the "silver" benefit tier since that is the tier for which benefit subsidies are tied.

Finding 3: The non-group cost per member per month will increase 32 percent under ACA, compared to pre-ACA projections.

In the last section of ***Figure S-1***, the average non-group allowed per member per month cost, excluding those in high risk pools (state-run pools that existed pre-ACA and federally funded state pools under ACA), is shown in absence of the ACA; these costs reflect the "underwritten" risk in most states.[3] The percentage increase between pre- and post-ACA estimates is shown as well. The post-ACA figures include the impact of a) high risk pool members, b) employers dropping group coverage, and c) increased morbidity from selection by those currently uninsured who now purchase coverage. The results of this analysis indicate that there will be significant variation across states in the impact of the ACA on average cost in the non-group market. These estimates come from ***Figure 5*** of the state-specific tables. Since the populations before and after ACA may be significantly different, ***Figure 6A*** shows the increase by age bracket. States that show a decrease in average costs under the ACA are primarily those that currently use community rating in the non-group market. The reduction in average costs for these states reflects the younger and healthier individuals that will enroll due to the reduced cost from the premium subsidies.

Our analysis also indicates that while high risk pools generally have few enrollees, the cost per individual is very high. Movement of the high risk pool individuals into the non-group Exchange will generally create a significant increase in cost. However, it can be reasonably argued that proportionately more uninsured individuals will have similar risks in states that had relatively small high risk pools. The reader is encouraged to further examine this issue.

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[3] Our analysis assumes that both the State and Federal High Risk Pools will be rolled into the exchanges at some point in time. However, individual states may decide not to transition its state high risk pool enrollees in 2014 and phase this transition in over time. Reader should refer to their individual state's plan. For example, Maryland is planning to transition high risk pool enrollees into the exchange over time.

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Figure S-1. Summary of "Ultimate" Findings- Assuming All States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA Elasticity	% Uninsured Post-ACA Utility	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	4.9%	4.2%	117,257	295,633	86.8%	$263	$422	60.3%
Alaska	20.6%	8.5%	8.3%	22,702	62,501	83.8%	$436	$520	19.2%
Arizona	21.1%	12.0%	12.1%	250,488	570,681	81.5%	$290	$355	22.2%
Arkansas	18.1%	6.0%	4.9%	112,882	233,527	82.7%	$238	$335	40.9%
California	18.2%	8.4%	8.1%	1,789,865	3,163,015	72.4%	$260	$420	61.6%
Colorado	18.0%	7.9%	7.5%	293,851	502,554	75.7%	$262	$365	39.1%
Connecticut	12.7%	6.0%	6.0%	126,997	255,216	76.7%	$399	$514	28.8%
Delaware	9.5%	4.9%	4.9%	25,902	56,946	80.8%	$380	$491	29.3%
District of Columbia	12.3%	5.7%	5.5%	25,343	41,271	76.4%	$348	$528	51.9%
Florida	19.6%	8.3%	8.0%	843,935	1,684,727	79.4%	$313	$396	26.5%
Georgia	18.2%	6.9%	6.6%	349,454	762,955	81.6%	$310	$396	27.6%
Hawaii	8.0%	3.8%	3.9%	26,584	73,534	83.8%	$374	$456	21.9%
Idaho	16.6%	5.8%	6.1%	98,954	186,187	77.3%	$211	$343	62.2%
Illinois	13.1%	5.9%	5.6%	471,343	978,648	80.1%	$304	$459	50.8%
Indiana	14.3%	5.2%	4.8%	178,442	463,393	88.0%	$272	$455	67.6%
Iowa	13.2%	4.8%	5.0%	147,357	267,001	77.1%	$350	$384	9.7%
Kansas	16.6%	6.6%	6.3%	151,303	254,839	81.3%	$306	$364	18.9%
Kentucky	16.7%	5.6%	5.3%	143,620	346,334	84.3%	$297	$398	34.1%
Louisiana	15.7%	4.9%	4.6%	166,093	335,015	78.5%	$346	$444	28.6%
Maine	13.9%	5.4%	6.0%	43,870	121,784	84.3%	$468	$487	4.1%
Maryland	13.1%	6.0%	5.8%	184,809	386,491	78.4%	$284	$473	66.6%
Massachusetts	8.5%	4.9%	5.6%	178,053	362,583	75.7%	$519	$453	-12.8%
Michigan	12.2%	4.5%	4.4%	307,935	699,656	86.1%	$321	$404	25.8%
Minnesota	13.2%	4.9%	5.5%	247,752	524,708	82.1%	$356	$424	18.9%
Mississippi	18.2%	5.3%	4.7%	103,368	214,209	86.8%	$291	$417	43.2%
Missouri	17.4%	5.7%	5.2%	226,603	491,027	83.1%	$238	$378	58.8%
Montana	20.6%	7.7%	7.2%	64,363	116,419	84.3%	$331	$397	20.1%
Nebraska	14.3%	5.5%	5.5%	97,872	170,822	81.7%	$342	$448	30.8%
Nevada	20.4%	8.2%	8.6%	99,860	260,813	79.2%	$278	$359	29.2%
New Hampshire	12.2%	4.6%	5.4%	50,189	112,728	78.4%	$339	$464	36.8%
New Jersey	16.9%	7.4%	8.4%	272,731	724,548	76.5%	$481	$474	-1.4%
New Mexico	22.9%	8.8%	8.9%	42,890	173,704	89.6%	$291	$392	34.9%
New York	12.8%	6.0%	6.9%	450,240	1,615,925	84.3%	$619	$533	-13.9%
North Carolina	18.2%	6.6%	6.4%	402,677	855,147	81.7%	$361	$409	13.5%
North Dakota	14.1%	5.9%	6.2%	51,468	74,774	80.6%	$326	$353	8.4%
Ohio	13.3%	5.0%	3.6%	414,914	805,282	80.9%	$223	$403	80.9%
Oklahoma	16.9%	6.3%	5.6%	134,305	290,180	84.1%	$275	$355	29.3%
Oregon	21.0%	7.2%	8.1%	169,412	435,206	82.7%	$335	$383	14.3%
Pennsylvania	11.2%	4.5%	4.0%	488,341	863,565	80.5%	$356	$455	28.0%
Rhode Island	14.9%	6.6%	7.1%	42,842	91,031	79.4%	$587	$548	-6.6%
South Carolina	17.3%	5.9%	5.5%	161,496	367,909	87.9%	$309	$423	36.8%
South Dakota	14.3%	5.3%	5.3%	52,775	85,094	79.9%	$318	$410	29.0%
Tennessee	15.0%	5.7%	4.9%	281,421	532,091	81.7%	$260	$380	46.4%
Texas	27.1%	10.5%	10.2%	888,205	2,448,638	83.4%	$249	$333	33.8%
Utah	15.5%	6.4%	6.3%	163,811	300,123	75.9%	$245	$314	28.4%
Vermont	13.6%	6.7%	7.3%	15,376	56,986	87.8%	$587	$514	-12.5%
Virginia	15.1%	6.4%	6.1%	328,880	628,457	79.6%	$306	$393	28.4%
Washington	15.6%	6.2%	6.6%	344,620	665,284	74.2%	$314	$357	13.7%
West Virginia	15.6%	4.6%	4.0%	33,191	113,534	89.5%	$347	$469	35.3%
Wisconsin	10.4%	4.8%	4.5%	215,407	442,020	85.1%	$258	$464	80.0%
Wyoming	16.4%	6.0%	6.2%	29,076	54,265	82.6%	$434	$571	31.6%
National	**16.6%**	**6.8%**	**6.7%**	**11,931,125**	**25,618,984**	**80.4%**	**$314**	**$413**	**31.5%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

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Figure S-2. Summary of "Ultimate" Findings- Assuming No States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	8.4%	117,257	378,573	89.5%	$263	$416	58.2%
Alaska	20.6%	11.4%	22,702	74,109	86.3%	$436	$497	13.9%
Arizona	21.1%	12.4%	250,488	577,725	81.8%	$290	$367	26.3%
Arkansas	18.1%	10.0%	112,882	295,130	86.2%	$238	$334	40.4%
California	18.2%	11.3%	1,789,865	3,653,808	76.3%	$260	$403	55.2%
Colorado	18.0%	10.6%	293,851	595,460	79.4%	$262	$354	34.8%
Connecticut	12.7%	8.0%	126,997	285,552	79.0%	$399	$491	23.0%
Delaware	9.5%	4.9%	25,902	63,450	82.7%	$380	$484	27.4%
District of Columbia	12.3%	8.6%	25,343	46,803	78.7%	$348	$497	43.1%
Florida	19.6%	11.4%	843,935	2,002,920	83.0%	$313	$382	22.1%
Georgia	18.2%	10.7%	349,454	934,891	85.1%	$310	$383	23.2%
Hawaii	8.0%	4.9%	26,584	83,153	85.5%	$374	$421	12.6%
Idaho	16.6%	8.3%	98,954	224,042	81.1%	$211	$342	61.8%
Illinois	13.1%	8.2%	471,343	1,102,590	82.1%	$304	$447	46.9%
Indiana	14.3%	8.0%	178,442	560,081	89.9%	$272	$452	66.4%
Iowa	13.2%	7.0%	147,357	319,447	80.6%	$350	$369	5.5%
Kansas	16.6%	9.4%	151,303	309,683	84.6%	$306	$353	15.5%
Kentucky	16.7%	9.1%	143,620	431,290	87.5%	$297	$393	32.2%
Louisiana	15.7%	8.7%	166,093	418,914	82.4%	$346	$459	32.7%
Maine	13.9%	7.3%	43,870	137,524	86.0%	$468	$490	4.7%
Maryland	13.1%	8.1%	184,809	440,563	80.9%	$284	$459	61.4%
Massachusetts	8.5%	5.0%	178,053	373,953	76.4%	$519	$478	-8.0%
Michigan	12.2%	6.5%	307,935	854,242	88.4%	$321	$399	24.3%
Minnesota	13.2%	6.9%	247,752	613,391	84.4%	$356	$413	16.1%
Mississippi	18.2%	10.4%	103,368	278,048	89.7%	$291	$419	43.9%
Missouri	17.4%	9.5%	226,603	613,937	86.2%	$238	$370	55.8%
Montana	20.6%	11.0%	64,363	143,119	87.1%	$331	$389	17.8%
Nebraska	14.3%	7.5%	97,872	205,753	84.8%	$342	$430	25.5%
Nevada	20.4%	11.3%	99,860	303,175	82.9%	$278	$346	24.5%
New Hampshire	12.2%	6.2%	50,189	131,811	81.5%	$339	$471	38.8%
New Jersey	16.9%	10.0%	272,731	776,556	78.8%	$481	$492	2.2%
New Mexico	22.9%	12.1%	42,890	214,044	91.9%	$291	$373	28.2%
New York	12.8%	6.2%	450,240	1,708,252	85.2%	$619	$556	-10.1%
North Carolina	18.2%	10.2%	402,677	1,043,777	85.1%	$361	$392	8.7%
North Dakota	14.1%	7.5%	51,468	88,358	83.4%	$326	$353	8.3%
Ohio	13.3%	7.8%	414,914	1,000,301	84.1%	$223	$406	82.1%
Oklahoma	16.9%	9.1%	134,305	358,001	87.0%	$275	$358	30.3%
Oregon	21.0%	11.0%	169,412	522,363	86.1%	$335	$378	12.8%
Pennsylvania	11.2%	6.5%	488,341	1,054,988	83.8%	$356	$443	24.5%
Rhode Island	14.9%	9.0%	42,842	102,090	81.4%	$587	$549	-6.4%
South Carolina	17.3%	9.4%	161,496	455,872	90.0%	$309	$433	39.9%
South Dakota	14.3%	7.5%	52,775	101,767	83.1%	$318	$434	36.6%
Tennessee	15.0%	8.6%	281,421	654,610	85.0%	$260	$372	43.4%
Texas	27.1%	14.9%	888,205	2,975,371	86.9%	$249	$316	26.9%
Utah	15.5%	8.3%	163,811	348,665	79.2%	$245	$302	23.4%
Vermont	13.6%	6.9%	15,376	58,693	88.2%	$587	$546	-7.1%
Virginia	15.1%	8.8%	328,880	738,858	82.7%	$306	$380	24.1%
Washington	15.6%	8.4%	344,620	775,837	78.0%	$314	$351	11.9%
West Virginia	15.6%	8.4%	33,191	145,591	91.6%	$347	$468	35.1%
Wisconsin	10.4%	6.4%	215,407	506,471	86.8%	$258	$463	79.6%
Wyoming	16.4%	8.6%	29,076	66,105	85.6%	$434	$577	32.9%
National	**16.6%**	**9.5%**	**11,931,125**	**30,149,705**	**83.4%**	**$314**	**$405**	**28.9%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

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II. Methodology: Model and Database Overview

In the sections that follow, we provide an overview of our methodology, including discussion of our model and database used in this analysis. We then present our analysis and results for an example state (Wisconsin) for each of the eight questions outlined above.[4]

We have provided technical notes for the report throughout and in the appendices, including model results in excel files for all 50 states plus the District of Columbia that can be found on the SOA website with this report.

HBSM uses the 2002-2005 Medical Expenditure Panel Survey (MEPS) data to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage, and employment status.[5] The MEPS contains a sample of households that is representative of the economic, demographic and health sector characteristics of the population. The database is re-weighted to reflect population control totals reported in the pooled 2008-2010 March Current Population Survey (CPS) data for each of the 50 states and the District of Columbia. It is also adjusted to presume 2014 health care utilization and expenditures across the categories as described below.

These weight adjustments are done with an iterative proportional-fitting model, which adjusts the data to match approximately 250 separate classifications of individuals by socioeconomic status, sources of coverage, and job characteristics in the CPS.[6] Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in the state.[7] This approach is repeated for each state so that in the end, we effectively have 51 state databases that reflect the unique population characteristics of each state on the 250 separate dimensions.

This approach permits us to simultaneously replicate the distribution of individuals across a large number of variables while preserving the underlying distribution of individuals by level of health care utilization and expenditures as reported in MEPS. These data can be "fine- tuned" in the re-weighting process to reflect changes in health service utilization levels (e.g., hospitalizations). This approach implicitly assumes that the distribution of utilization and expenditures within each of the population groups controlled for in this re-weighting processes are the same as reported in the MEPS data. Finally, population counts were projected to 2014 base year using Census Bureau population projections by state, age and sex.

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[4] Wisconsin was chosen as an example for this report because several of the members of the oversight committee were familiar with Wisconsin, making this state a more interesting case study for understanding why the model was producing its results than other states considered for the example. While there are a few states that more closely align with the overall national scenario, one of the key findings of this report is that the ACA's effect on enrollment and cost is expected to vary widely, making even states that align with the national scenario an atypical scenario. Further, we do not represent the national scenario because it is a roll up of many circumstances.

[5] For some applications, we pool the MEPS data for 2002 through 2005 to increase sample size. This is particularly useful in analyzing expenditures for people with high levels of health spending, which typically represents only a small proportion of the database.

[6] To bolster sample size for state level analyses, we have pooled the CPS data for 2008 through 2010. This is important when using the model to develop state-level analyses.

[7] The process used is similar to that used by the Census Bureau to establish final family weights in the March CPS.

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We also adjust the health expenditure data reported in the MEPS database for each state to reflect changes in the characteristics of the population in 2014. These data are adjusted to reflect projections of the health spending by type of service and source of payment in the 2014 base year. These spending estimates are based upon state-level health spending data provided by CMS and detailed projections of expenditures for people in Medicare and Medicaid across various eligibility groups. Spending data for the employer market are based on average premiums published in the MEPS Insurance Component data by firm size and state. We also adjust spending for the non-group market using state-by-state premium data obtained from the National Association of Insurance Commissioners' 2010 Supplemental Health Care Exhibit Report trended to 2014.

The result is a database that is representative of the base year population in each state by economic and demographic group, which also provides extensive information on the joint distribution of health expenditures across population groups. See **Appendix A** and **Appendix B** for a description of the model, databases and key assumptions. A more detailed documentation can be found at http://www.lewin.com/publications/publication/413/.

III. Analysis & Results

To best understand the cost of the newly insured and impact on the non-group market under the ACA, we answer a set of six questions. Our analyses for each of these questions are described below and results are presented for an example state (Wisconsin). The same tables are shown on the SOA website for all states, there are no special considerations with respect to Wisconsin, except it was one of several states reviewed closely by the Project Oversight Group. To provide a range of estimates for this analysis, we also provide a set of six scenarios using various assumptions about implementing the Medicaid expansion and the availability of premium subsidies as well as results using two different participation models, a price elasticity based model and a utility function model.

Research Questions

Question 1: What is the anticipated enrollment for the currently uninsured under the ACA?

To estimate the anticipated enrollment for the currently uninsured under the ACA, we model uninsured individual's decision to enroll through the exchanges, Medicaid or newly offered employer plans. The purpose of the participation model is to estimate the shifts in insurance coverage occurring under the ACA, including the number of individuals enrolling in the state health insurance exchanges. This is a complex task requiring detailed analysis of employer and individual responses to programs and incentives created under the ACA. Our approach is to estimate the effect of the features of the ACA that affect the employer decision to either offer or discontinue Employer- Sponsored Insurance (ESI) and whether to offer coverage through the Small Business Health Options (SHOP) exchange if eligible. Once the employer coverage decisions are estimated, our population model estimates individual enrollment into the various coverage options available under ACA, including the expanded Medicaid program, the employer's plan and individual non-group coverage in the exchange, where premium subsidies are available for individuals up to 400 percent of federal poverty level (FPL).

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The population model will be used to estimate the number and characteristics of employers and individuals electing to participate in each of the various forms of public and private coverage, in particular the number and characteristics of individuals participating in the Small Business Health Options (SHOP) exchange and the individual exchange. The key characteristics of individuals contained in the model include demographic characteristics, income, employment status, health risk profile, health utilization and health spending experience.

Appendix A and Appendix B describe the key assumptions used to model each of these key decision points for transitions from current coverage to new options under the ACA.

Figure 1 shows transitions in coverage under the ACA for Wisconsin. In each of the analyses, we make the simplifying assumption that all the ACA provisions are fully implemented (2016 provisions) in 2014. The first column of the table shows the number of individuals in the state by source of coverage prior to the ACA. The remaining columns show the transitions in coverage for those individuals due to the options available under the ACA. Here, many individuals previously covered by small employers (2-50) will transition into the employer or individual exchange (31 percent). Many individuals previously enrolled in other non-group coverage will enroll through the individual exchange (42 percent) or Medicaid (10 percent), as a result of Medicaid expansion. Of those previously uninsured, 26 percent will enroll in Medicaid, 19 percent will enroll in the individual exchange, 14 percent will select employer coverage through the exchange or privately, and 40 percent will remain uninsured. In total, about 276,000 individuals, or 4.8 percent of the Wisconsin population, will remain uninsured in 2014, under a fully implemented ACA.

Figure 1: Changes in Sources of Coverage under the ACA for Wisconsin[1/]
(Assumes Medicaid Expansion)

		Transitions in Coverage under the ACA						
Baseline Coverage	**Total**	**Employer Exchange [4/]**	**Individual Exchange**	**Private Employer**	**Private Non-Group**	**Medicare/ TRICARE**	**Medicaid/ CHIP**	**Uninsured**
Employer 2-50	678,829	174,937	37,701	440,492	513	2	19,836	5,348
Employer 51-100	140,608	24,533	6,421	107,757	13	0	1,341	542
Employer 101+	2,350,507	0	55,441	2,249,878	1,039	241	34,018	9,890
High Risk Pool	24,910	473	20,834	1,659	0	0	1,945	0
Other Non-Group	215,407	5,130	92,736	16,008	62,744	0	22,298	16,490
Retiree [2/]	71,767	0	0	60,075	0	0	11,692	0
TRICARE	73,399	0	0	0	0	73,399	0	0
Medicare	710,938	0	0	0	0	710,938	0	0
Dual Eligible	183,423	0	0	0	0	183,423	0	0
Medicaid/CHIP [3/]	738,645	6,098	46,610	14,180	314	41	671,402	0
Uninsured	602,647	23,400	116,403	63,472	1,250	0	154,357	243,764
% of Currently Uninsured		3.9%	19.3%	10.5%	0.2%	0.0%	25.6%	40.4%
Total	**5,791,080**	**234,572**	**376,148**	**2,953,521**	**65,873**	**968,045**	**916,889**	**276,034**

1/Assumes that all ACA provisions are fully implemented. Population by coverage source is presented as average monthly counts in 2014.
2/ Retiree coverage is defined as people with early employer retiree coverage who are not working.

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3/ To compare Medicaid enrollment to other sources (e.g., Statehealthfacts) Medicaid, CHIP and Dual eligibles should be added together.
4/ Employer exchange enrollment is modeled assuming all qualifying firms participate in the premium tax credit program in the initial year. However, the credit is available to each employer for only 2 years and participation has been lower than expected.

We assume that some current Medicaid recipients will enroll in their employers plan if newly offered (part-timers newly eligible, for example). Also, in states that currently provide coverage to adults above 138 percent of FPL we assume these states will discontinue that coverage in 2014 when subsidies become available and move these people into the Exchanges. [8] The following table compares the results of our analysis (for the nonelderly only) to the estimates produced by the Congressional Budget Office (CBO).

U.S. Counts	CBO 2018 (in millions) 1/		Lewin 2014 (full phase in) in millions	
Coverage Source	Prior Law Coverage	Change under ACA	Prior Law Coverage	Change under ACA
Medicaid/CHIP	31	16	46	17
Employer	160	-5	157	-2
Non-Group and Other	31	-3	22	-5
Exchange	-	23	-	21
Uninsured	58	-31	52	-31
Total	280	--	276	--

1/ March 2012 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. Estimates for 2018 are presented which represents full implementation.

Monthly spending for each group is shown in ***Figure 1A***, below. Here, under the ACA, the largest cost increases are seen in those transitioning from large employer coverage to the individual exchange or the private non-group market, in retirees transitioning to Medicaid/CHIP, and in the uninsured transitioning to private employer or private non-group coverage. Largest decreases in costs are seen in those transitioning from small employer (2-50) coverage to the private non-group market, in those transitioning from mid-sized (51-100) employer coverage to Medicaid/CHIP, and those transitioning from Medicaid to private non-group coverage. The technical notes, provided below, explain differences in costs for people leaving employer coverage for non-group.

[8] States that currently offer coverage to adults above 138% FPL include CT, DC, IL, ME, MN, NJ, NY, RI, TN, VT and WI.

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Figure 1A: Average Morbidity (Monthly Costs) under the ACA for Wisconsin (Assumes Medicaid Expansion)

		Transitions in Coverage under the ACA						
Baseline Coverage	**Total**	**Employer Exchange**	**Individual Exchange**	**Private Employer**	**Private Non-Group**	**Medicare/ TRICARE**	**Medicaid/ CHIP**	**Uninsured**
Employer 2-50	$476	$537	$559	$433	$151	$25	$527	$160
Employer 51-100	$573	$486	$671	$583	$617	$0	$121	$906
Employer 101+	$567	$0	$1,061	$552	$1,128	$289	$362	$301
High Risk Pool	$1,176	$1,220	$939	$1,808	$0	$0	$2,155	$0
Other Non-Group	$258	$249	$240	$165	$320	$0	$194	$159
Retiree	$187	$0	$0	$182	$0	$0	$1,730	$0
TRICARE	$650	$0	$0	$0	$0	$649	$0	$0
Medicare	$902	$0	$0	$0	$0	$902	$0	$0
Dual Eligible	$1,274	$0	$0	$0	$0	$1,279	$0	$0
Medicaid/CHIP	$393	$468	$391	$331	$41	$533	$407	$0
Uninsured	$154	$320	$317	$556	$2,054	$0	$378	$108
Total	**$542**	**$503**	**$482**	**$526**	**$363**	**$954**	**$418**	**$120**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and premium subsidies are not included.

Population Movement

The population movement under the ACA is estimated using various simulation decisions for employers and individuals in the micro-simulation database. HBSM includes a model of the individual insurance market. The model defines the non-group insurance markets to include all people who are not otherwise eligible for coverage under an employer plan, Medicare, Medicaid or TRICARE (i.e., military dependents and retirees). The model simulates premiums for individuals using the rules that prevail in each state. Premiums can be varied by age, gender and health status. This is done by compiling a "rate book" based upon the HBSM health spending data for the state reflecting how costs vary with individual characteristics.

Once the employer coverage option is simulated for employers, we simulate individual take- up of insurance given the options available. We begin by simulating eligibility and enrollment for the Medicaid program. The probability model of enrollment that we use shows a lower rate of enrollment for people with access to employer coverage. We then simulate enrollment in employer health plans for people who have access to employer insurance. Finally, we simulate the decision to take non-group coverage based upon the cost of insurance less the premium subsidy, if eligible.

We do this by using an individual insurance rating model to estimate the premium an individual would pay for a standard benefits package under current rating practices and again under the ACA reform rating rules. [9] We then estimate the premium subsidies an individual

[9] The standard benefit plan is an illustrative "silver" tiered plan covering all acute care services except adult dental

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would be eligible to receive under the ACA to determine the net cost of insurance to the individual. In addition, for people subject to the mandate, we treat the amount of the penalty for not having insurance as an increase in the cost of being uninsured which reduces the net cost of insurance to the individual.

We simulate the decision to take coverage based upon the change in the net cost of coverage to the individual under reform using a multivariate analysis of the likelihood of taking coverage given the premium and other demographic characteristics. The multivariate model shows an implicit price elasticity of -3.4, which is similar to other published estimates. The implicit price elasticity varies with the characteristics of the individual. In general, the sensitivity to price declines as age and income increases.

Similarly, we simulate discontinuations of coverage for people who have non-group coverage under current law reflecting increases in premiums due to changes in insurer rating practices. In general, younger and healthier people will see premium increases while older and less healthy people will see reductions in premiums.

Figure 2 shows the distribution of people currently (pre-ACA) uninsured in the state by age, poverty level and self-reported health status. Similar to ***Figure 1***, the remaining columns show the transitions in coverage for the uninsured due to the options available under the ACA. The last column of the table shows percentage of people remaining uninsured under the ACA.

The highest percentage of people remaining uninsured under the ACA will be for those under age 19 (60 percent) since the Medicaid expansion does not affect children, those with incomes at or above 400 percent of FPL (71 percent), and those with excellent self-reported health status (43 percent). [10] This, in part, reflects a level of adverse selection, as these uninsured individuals likely have less perceived risk of illness and thus less perceived need for insurance coverage. Affordable coverage may also be less accessible for those over 400 percent of FPL, as they do not qualify for subsidies in the exchanges.

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and our assumption for cost sharing for this tiered plan. Assumes covered services to be the same across all states.

[10] The MEPS survey asks respondents to rate their own health status and the health status of each family member as excellent, very good, good, fair or poor. This is based on the respondent's perception of their health and not based on the prevalence actual medical conditions.

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Figure 2: Changes in Sources of Coverage under the ACA for Currently Uninsured by Age, Income and Self-reported Health for Wisconsin (assumes Medicaid expansion)

		Transitions in Coverage under the ACA						
	Total at Baseline	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicaid/ CHIP	Remain Uninsured	% Remain Uninsured
Age								
Under 19	76,268	2,392	16,882	4,056	343	7,174	45,420	59.6%
19-24	128,940	5,502	17,423	22,722	15	48,567	34,711	26.9%
25-34	139,767	5,056	24,789	13,032	276	34,173	62,442	44.7%
35-44	104,605	4,712	20,479	8,520	176	23,925	46,792	44.7%
45-54	84,871	2,715	20,190	9,294	266	18,591	33,814	39.8%
55 & over	68,197	3,022	16,640	5,848	174	21,927	20,585	30.2%
Poverty Level								
Below 138% FPL	261,397	8,623	10,871	22,374	415	147,411	71,703	27.4%
138%-199% FPL	81,204	2,490	36,635	8,958	99	5,256	27,765	34.2%
200%-299% FPL	105,067	5,758	41,227	11,932	402	1,131	44,617	42.5%
300%-399% FPL	67,041	3,776	18,771	6,896	249	369	36,980	55.2%
400% FPL and above	87,937	2,753	8,899	13,311	85	190	62,698	71.3%
Self-Reported Health Status								
Excellent	463,762	16,750	88,738	51,777	816	106,536	199,144	42.9%
Good	108,637	5,416	22,813	9,772	206	33,303	37,128	34.2%
Fair	24,637	1,219	3,764	1,678	205	11,535	6,237	25.3%
Poor	5,611	15	1,089	246	23	2,984	1,255	22.4%
Total	**602,647**	**23,400**	**116,403**	**63,472**	**1,250**	**154,357**	**243,764**	**40.4%**

Assumes that all ACA provisions are fully implemented, population counts in 2014

Question 2: What is the newly insured's relative morbidity compared to the currently insured and what could reasonably be expected for relative costs? What will be the newly insured's pent up demand and for which types of services?

To estimate the newly insured's relative morbidity and costs compared to the currently insured, we use the MEPS data in the HBSM model, which report that health services utilization for uninsured individuals are substantially less than that for insured individuals. Physicians' visits per 1,000 individuals are about 1,366 for the uninsured compared with 3,282 for insured individuals under age 65. Also, hospital stays for the insured are more than double that of the uninsured. Part of the difference in utilization rates is due to the fact that the uninsured are on average younger than insured individuals. Consequently, we adjust for this when estimating how utilization would change for this population as they become insured.

We assume that uninsured individuals who become covered under the ACA would use health care services at the same rate reported by currently insured individuals with similar age, sex, income and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a

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reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forego or delay.

Using this methodology, we estimate that health spending among the currently uninsured population would increase as they become insured. That is, savings from improved primary care would be more than offset by increased use of other care, including elective services. Overall, this method results in an estimated increase in utilization of about 100 percent in spending if the uninsured were to become insured.

Figure 3 shows the number of people newly covered under the ACA by age, poverty level and self-reported health status. The table also shows the average monthly costs before and after becoming insured as well as the percent increase in health care spending. Costs in this report include total personal acute care health spending for covered and non-covered services. In total, this newly insured group will cost 112 percent more than they cost prior to gaining coverage.

Figure 3: Number and Cost of Newly Insured by Age, Income and Self-reported Health Status in Wisconsin (assumes Medicaid expansion)

	Number Newly Insured Under ACA	Average Monthly Cost Pre-ACA	Average Monthly Cost Post-ACA	Percent Change in Average Costs
Age				
Under 19	30,848	$101	$183	80.6%
19-24	94,229	$100	$199	97.8%
25-34	77,325	$146	$236	61.8%
35-44	57,813	$226	$400	76.5%
45-54	51,056	$221	$786	254.9%
55 & over	47,612	$380	$730	92.1%
Poverty Level				
Below 138% FPL	189,694	$209	$488	133.2%
138%-199% FPL	53,439	$144	$243	68.7%
200%-299% FPL	60,450	$156	$294	87.9%
300%-399% FPL	30,061	$172	$317	84.7%
400% FPL and above	25,239	$174	$310	78.4%
Self-Reported Health Status				
Excellent	264,617	$112	$278	148.9%
Good	71,509	$299	$575	92.0%
Fair	18,400	$463	$828	78.9%
Poor	4,357	$1,588	$2,475	55.8%
Total	**358,883**	**$185**	**$392**	**111.9%**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and premium subsidies are not included.

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Pent Up Demand for Services

This analysis does not include an increase in utilization due to pent up demand. Our modeling assumes an ultimate enrollment for all provisions of the ACA in the initial year of the program and does not address enrollment ramp-up issues or utilization for unmet needs of the newly insured.

The research on "pent-up" demand for health care services as individuals become newly insured has shown mixed results. A study of near elderly uninsured who are approaching Medicare eligibility found that pent-up demand exists for physician care, but not for hospital inpatient care. The study estimated that the individuals who were uninsured prior to Medicare enrollment have 30 percent more physician visits during the two years after Medicare enrollment than their previously insured counterparts.[11] Another study of the near-elderly indicate that the increased utilization experienced after age 65 by those who were uninsured prior to Medicare lead to an elevated hazard of diagnosis (relative to the insured) for virtually every chronic condition considered, for both men and women and the magnitudes of these effects are clinically meaningful.[12] A study of children newly enrolled in Medicaid found no evidence of pent-up demand for medical care among newly insured children, when they were compared to children who had been continuously insured.[13] Another study examined the effects of the Oregon Medicaid lottery after approximately one year of insurance coverage. The study presented estimates of the impact of insurance coverage, using the lottery as an instrument for insurance coverage, found no evidence of a larger initial utilization effect, suggesting that such "pent up" demand effects may not in fact be present. However, the longer run impact of health insurance on health care utilization could differ from the one-year effects. [14]

Since the possibility of pent-up demand is an important risk, especially in 2014 and 2015, the information presented in any of the Tables, which do not factor in pent-up demand, can be adjusted by the reader to reflect an assumption for pent-up demand.

Question 3: What will be the general impact of the newly insured on the overall post-reform health care industry and insurance market, in terms of supply and demand for health care services?

To measure the general impact of the newly insured on the overall post-reform health care industry and insurance market, we use the HBSM micro-simulation model to measure the impact that increased utilization of health services for newly insured has on overall health spending. As described above, we assume that uninsured individuals who become newly covered would use health care services at the same rate reported by currently insured

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[11] Li-Wu Chen, Wanqing Zhang, Jane Meza, Roslyn Fraser, MA, "Pent-up Demand: Health Care Use of the Uninsured Near Elderly," Economic Research Initiative on the Uninsured Working Paper Series, July 2004

[12] Schimmel, Jody. "Pent-Up Demand and the Discovery of New Health Conditions after Medicare Enrollment" Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA, June 04, 2006

[13] K. Goldsteen, R.L. Goldsteen, "Demand For Medical Services Among Previously Uninsured Children: The Roles of Race and Rurality," South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, October 2002

[14] Amy Finkelstein et. al., "The Oregon Health Insurance Experiment: Evidence from the First Year ," No. w17190, National Bureau of Economic Research, 2011

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individuals with similar characteristics. [15] The information provided below can be used to estimate increased health services demand as a result of the newly insured in a state. Although the table gives increases for the entire state and the relative impacts across the state can vary depending on uninsured rates and provider supply.

Figure 4 shows the total statewide spending by type of service for all insured (Column 2) and uninsured (Column 3) state residents, before accounting for the effects of the ACA. The fourth column shows the estimated increase in spending by the newly insured under the ACA by type of service. The last column presents the percent increase in system-wide spending due to the newly insured as a percent of total state-wide health spending. In this example, the increase in utilization of services by newly insured people will result in a 2.0 percent total increase in state-wide health care spending in Wisconsin under the ACA.

Figure 4: Change in Spending as a Percent of Total Spending by Type of Service in Wisconsin (millions) (assumes Medicaid expansion)

Type of Service	Spending Under Current Law by Insured Population	Spending Under Current Law by Uninsured Population	Increase in Spending Under ACA by Newly Insured	Percent Change in System-Wide Spending
Hospital Inpatient	$12,230.6	$372.3	$352.3	2.8%
Physician	$12,603.9	$386.2	$276.4	2.1%
Dental	$2,464.9	$88.0	$5.1	0.2%
Other Professional	$1,499.7	$50.9	$28.3	1.8%
Prescription Drugs	$5,492.8	$199.6	$78.8	1.4%
Medical Equipment	$489.8	$25.3	$15.5	3.0%
Hospital Outpatient	$6,852.4	$252.7	$107.6	1.5%
Total	**$41,634.1**	**$1,375.0**	**$864.0**	**2.0%**
Population	5,188,433	602,647	358,883	
Spending Per Person	$8,003.7	$2,281.6	$2,432.6	

1/Assumes that all ACA provisions are fully implemented. Spending by type of service in the MEPS data is adjusted to match CMS state health expenditures by type of service trended to 2014.

Question 4: How will premium rates in the non-group market be impacted by the new population mix? How will health care costs be impacted by the presence of the high risk pools under the ACA and how are current costs impacted by current state high risk pools?

For this report, we focused only on the changes in allowable costs. Actual premiums will vary for each insurer based on many factors which are beyond the scope of this report, since each insurer will have different circumstances and strategies with regard to competition. Besides traditional pricing inputs, 2014 will also bring to individual exchanges risk mitigation programs: reinsurance, risk corridors and risk adjustment. Reinsurance and risk corridors are

[15] Our assumption varies from the Congressional Budget Office (CBO) assumption that newly insured individuals will use between 75 and 95 percent as much as people who are currently insured. "Key Issues in Analyzing Major Health Insurance Proposals", December 18, 2008.

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temporary programs for the first three years and risk adjustment is designed to be market neutral. Therefore, these considerations are not addressed here, even though they will be a major source of analysis and conjecture as premiums are developed for 2014 through 2016.

In order to model the impact of the high risk pools, we first project enrollment to the end of 2013 and allowed costs for the state high risk pool, if present, and then the new Federal Pre-Condition Insurance Plan (PCIP). Those figures are used to assign high risk pool coverage to a subset of the non-group market.

An important finding is that new individual coverage for those currently with group coverage will have a significant impact on costs in the individual Exchange. Although the number of employers dropping coverage is not high, their impact in the non-group market can be significant (see technical notes below).

Figure 5 shows the impact of the ACA on the non-group market. This analysis shows the current enrollment and costs for the fully insured individual market and the high-risk pools. The high risk pools include both the state high-risk pool and the temporary federal high-risk pools under the ACA. This table presents the dynamics that we estimate will occur under the ACA. The first two lines show the number of individuals in the high-risk pools and the individual market and their average monthly total health care spending.

Line 3 shows the number of individuals and average costs for individuals currently covered in the high-risk pool or the individual market that leave due to the availability of other coverage options under the ACA. Lines 4 through 6 show the number of people who remain in the individual market and their average monthly spending. Lines 7 through 11 show the impact due to people entering the non-group market under the ACA from employers that discontinue coverage, Medicaid adults above 138 percent of FPL that we assume will get moved to the Exchanges and previously uninsured.

The last line shows the number of individuals and the average monthly spending per person in the Wisconsin non-group market under the ACA—about 442,020 and $464 per month, respectively.

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Figure 5: Change in Average Costs in the Non-Group Market under ACA in Wisconsin (assumes Medicaid expansion)

	Membership	Average Cost Per Month
1. Current High Risk	**24,910**	**$1,176**
2. Current Other Non-Group	**215,407**	**$258**
3. Leave Non-Group	64,003	$291
Retain Non-Group		
4. In Exchange High Risk	20,834	$939
5. In Exchange Other	92,736	$240
6. Outside Exchange	62,744	$320
Leave Other Coverage to take Non-Group		
7. Employer 2-50	38,214	$554
8. Employer 51-100	6,434	$671
9. Employer 101+	56,480	$1,062
10. Medicaid/CHIP	46,925	$389
11. Uninsured	117,654	$336
Individuals with Non-Group under ACA	**442,020**	**$464**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Figure 6 shows the distribution of, and average costs for, individuals currently in the non-group market by age, poverty level and self-reported health status, along with their average monthly spending. For this table, we assume that the non-group market consists of the fully insured individual market and the high-risk pools. The table compares those figures with the distribution and average monthly spending for individuals who we estimate will take non-group coverage under the ACA. Here, in the non-group market, we see the greatest increase in average monthly costs for individuals ages 55 and over (a 68 percent increase), those with incomes at or above 400 percent of FPL (an 83 percent increase), and those with a self-reported health status of "fair" or "poor." In total, the change in average monthly costs for non-group coverage increases by 32 percent under the ACA. The average increase per person is 29 percent but varies by age.

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Figure 6: Distribution of Non-Group Coverage Pre- and Post-ACA by age, income and health status in Wisconsin (assumes Medicaid expansion)[1/]

	Non-Group under Current Law			Non-Group under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	32,480	13.5%	$171	71,054	16.1%	$189	10.6%
19-24	34,787	14.5%	$190	53,464	12.1%	$186	-2.4%
25-34	39,606	16.5%	$255	81,396	18.4%	$322	26.2%
35-44	31,570	13.1%	$310	76,544	17.3%	$380	22.5%
45-54	42,976	17.9%	$497	79,242	17.9%	$688	38.2%
55 & Over	58,898	24.5%	$533	80,319	18.2%	$896	68.2%
				Average Increase per Person			29.4%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	64,587	26.9%	$405	59,563	13.5%	$393	-2.9%
138%-200% FPL	18,798	7.8%	$419	92,955	21.0%	$340	-18.9%
200%-300% FPL	37,122	15.4%	$334	105,406	23.8%	$498	49.1%
300%-400% FPL	37,950	15.8%	$246	70,506	16.0%	$337	37.0%
400% FPL and Over	81,860	34.1%	$355	113,590	25.7%	$649	83.1%
Self-reported Health Status							
Excellent	206,978	86.1%	$281	355,079	80.3%	$310	10.2%
Good	27,069	11.3%	$686	71,065	16.1%	$668	-2.7%
Fair	5,500	2.3%	$906	12,777	2.9%	$2,556	182.0%
Poor	770	0.3%	$3,992	3,099	0.7%	$4,818	20.7%
Total	**240,317**	**100%**	**$353**	**442,020**	**100%**	**$464**	**31.5%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Figure 6A shows the same metrics as *Figure 6;* however this figure excludes the high-risk pool members from the current non-group population. Excluding the high-risk pool results in a significantly greater change in average monthly costs for non-group coverage as compared to *Figure 6* (80 percent versus 30 percent). The average increase per person is 68 percent versus 29 percent, and the increase varies significantly by age.

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Figure 6A: Distribution of Non-Group Coverage (Excluding High-Risk Pool) Pre- and Post-ACA by age, income and health status in Wisconsin (assumes Medicaid expansion)

	Non-Group under Current Law			Non-Group under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	31,952	14.8%	$167	71,054	16.1%	$189	13.0%
19-24	34,197	15.9%	$172	53,464	12.1%	$186	8.3%
25-34	36,993	17.2%	$219	81,396	18.4%	$322	47.1%
35-44	28,983	13.5%	$227	76,544	17.3%	$380	67.5%
45-54	37,487	17.4%	$322	79,242	17.9%	$688	113.8%
55 & Over	45,795	21.3%	$384	80,319	18.2%	$896	133.2%
				Average Increase per Person			68.1%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	58,113	27.0%	$239	59,563	13.5%	$393	64.5%
138%-200% FPL	17,201	8.0%	$322	92,955	21.0%	$340	5.8%
200%-300% FPL	33,093	15.4%	$220	105,406	23.8%	$498	126.4%
300%-400% FPL	33,467	15.5%	$207	70,506	16.0%	$337	62.7%
400% FPL and Over	73,532	34.1%	$298	113,590	25.7%	$649	118.1%
Self-reported Health Status							
Excellent	192,143	89.2%	$227	355,079	80.3%	$310	36.2%
Good	19,863	9.2%	$500	71,065	16.1%	$668	33.7%
Fair	3,222	1.5%	$582	12,777	2.9%	$2,556	339.3%
Poor	179	0.1%	$149	3,099	0.7%	$4,818	3128.0%
Total	**215,407**	**100%**	**$258**	**442,020**	**100%**	**$464**	**80.0%**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Question 5: What will be the relative health status and cost for people who remain uninsured under the ACA and how will this differ by state?

Figure 7 shows the distribution of uninsured individuals under current law in the state by age, poverty level and self-reported health status along with their average monthly spending. The table compares those estimates with the distribution and average monthly spending for individuals who we estimate will remain uninsured under the ACA.

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Figure 7: Distribution of Uninsured Pre- and Post-ACA by Age, Income and Health Status in Wisconsin (assumes Medicaid expansion)[1/]

	Uninsured under Current Law			Remain Uninsured under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	76,268	12.7%	$80	45,420	18.6%	$66	-17.8%
19-24	128,940	21.4%	$101	34,711	14.2%	$104	2.7%
25-34	139,767	23.2%	$118	62,442	25.6%	$82	-30.3%
35-44	104,605	17.4%	$174	46,792	19.2%	$108	-37.8%
45-54	84,871	14.1%	$183	33,814	13.9%	$125	-31.8%
55 & Over	68,197	11.3%	$342	20,585	8.4%	$255	-25.4%
				Average Increase per Person			-24.5%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	261,397	43.4%	$183	71,703	29.4%	$114	-37.5%
138%-200% FPL	81,204	13.5%	$118	27,765	11.4%	$69	-41.8%
200%-300% FPL	105,067	17.4%	$132	44,617	18.3%	$99	-24.9%
300%-400% FPL	67,041	11.1%	$129	36,980	15.2%	$94	-27.3%
400% FPL and Over	87,937	14.6%	$144	62,698	25.7%	$132	-8.6%
Self-reported Health Status							
Excellent	463,762	77.0%	$103	199,144	81.7%	$91	-11.4%
Good	108,637	18.0%	$253	37,128	15.2%	$164	-35.2%
Fair	24,637	4.1%	$413	6,237	2.6%	$268	-35.1%
Poor	5,611	0.9%	$1,295	1,255	0.5%	$279	-78.5%
Total	**602,647**	**100%**	**$154**	**243,764**	**100%**	**$108**	**-29.9%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 and should not be confused with premium.

Here, across most all age groups, income levels, and health statuses, we see a decrease in average monthly costs for the uninsured under the ACA, with an average decrease of 30 percent across all groups. This analysis indicates that individuals remaining uninsured under the ACA will be younger, healthier and have higher incomes than the current uninsured population. Those remaining uninsured include undocumented individuals who are not eligible for subsidies, low income families who would not be impacted by the penalty and people with an unaffordable offer of coverage (more than 8 percent of income) who also would not be affected by the penalty.

Question 6: Assuming the state expands Medicaid under the ACA, what is the impact on Medicaid enrollment and costs?

Figure 8 shows the impact of the ACA on the Wisconsin Medicaid program, assuming the state had expanded Medicaid. The first line shows the enrollment and average Medicaid per member per month costs for individuals currently in the Medicaid program (excluding dual

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Medicare/Medicaid enrollees). The table compares those figures with the distribution and average monthly Medicaid spending for people who we estimate will be covered by Medicaid under the ACA. The total net change in Medicaid enrollment will be 178,244 more than pre-ACA projected enrollment; newly eligible will cost more, on average, than currently eligible.

Figure 8: Change in Medicaid Enrollment and Costs under the ACA with Medicaid Expansion in Wisconsin[1/]

	Enrollment	Medicaid Costs PMPM
Current Program	738,645	$321
Leave Medicaid for other Coverage		
Children	(10,514)	$147
Parents/Other	(56,729)	$286
Currently Eligible		
Children	6,948	$279
Parents/Other	11,398	$405
Newly Eligible		
Parents/Other	5,928	$336
Non-Custodial Adults	221,213	$410
All Newly Eligible	227,142	$408
Total Net Change	**178,244**	

1/ Assumes that all ACA provisions are fully implemented. Costs include Medicaid paid amounts PMPM presented in 2014 dollars.

Figure 9 shows the distribution of individuals currently in the Medicaid program (excluding dual Medicare/Medicaid enrollees) by age, poverty level and self-reported health status along with their average monthly total spending. The table compares those figures with the distribution and average monthly spending for individuals who we estimate will be covered by Medicaid under the ACA, assuming state participation in the Medicaid expansion. Here, those ages 19 to 24 and 55 and over will experience the most significant percent increases in the number of individuals covered by Medicaid under the ACA with expansion, compared to current law. Those below 138 percent of FPL will experience a notable percent increase in the absolute number of individuals covered by Medicaid, while families with incomes of 138 percent of FPL and above will experience percent decreases in the number of individuals covered by Medicaid as we assume that adults above 138 percent FPL will be moved to the Exchange. Across all age, income, and health status groups, with Medicaid expansion, there will be a 24 percent increase in the number of individuals covered by Medicaid under the ACA, compared to current law projections.

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Figure 9: Distribution of Medicaid Enrollees Pre- and Post-ACA by Age, Income and Health Status in Wisconsin (assumes Medicaid expansion)[1/]

	Covered by Medicaid under Current Law			Covered by Medicaid under ACA			Change in Covered
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Number
Age							
Under 19	438,090	59.3%	$184	435,615	47.5%	$189	-0.6%
19-24	61,895	8.4%	$690	142,575	15.5%	$405	130.4%
25-34	82,473	11.2%	$726	106,634	11.6%	$613	29.3%
35-44	77,118	10.4%	$472	88,701	9.7%	$503	15.0%
45-54	46,034	6.2%	$832	64,810	7.1%	$783	40.8%
55 & Over	33,034	4.5%	$976	78,553	8.6%	$1,047	137.8%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	490,595	66.4%	$386	717,526	78.3%	$416	46.3%
138%-200% FPL	119,267	16.1%	$285	91,573	10.0%	$262	-23.2%
200%-300% FPL	81,893	11.1%	$590	67,869	7.4%	$637	-17.1%
300%-400% FPL	22,903	3.1%	$345	19,016	2.1%	$389	-17.0%
400% FPL and Over	23,987	3.2%	$445	20,905	2.3%	$481	-12.8%
Self-reported Health Status							
Excellent	569,235	77.1%	$228	700,263	76.4%	$238	23.0%
Good	123,176	16.7%	$591	153,354	16.7%	$649	24.5%
Fair	37,340	5.1%	$1,284	51,173	5.6%	$1,258	37.0%
Poor	8,894	1.2%	$4,443	12,099	1.3%	$4,349	36.0%
Total	**738,645**	**100%**	**$393**	**916,889**	**100%**	**$418**	**24.1%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014.

Alternate Scenarios & Sensitivity Testing

The included spreadsheets present our state-level analysis of the cost of the newly-insured under the ACA. For each state we generated the following three scenarios using our price elasticity based model:

1. The Lewin Group Baseline ACA Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL;
2. Simulation of ACA without Medicaid Expansion but Exchange Subsidies between 100-400% FPL; and
3. Simulation of the ACA without the availability of premium subsidies in the Exchanges, but includes the Medicaid Expansion;

Using a utility model, which is described in Appendix A (page A-16), we generated three additional scenarios:

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1. Baseline Utility Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model ;
2. Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model with one-third less risk aversion; and
3. Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model with two-thirds less risk aversion.

As described in ***Appendix A***, our approach is to adapt an existing model of consumer aversion to risk called the "utility" function, which has been widely used to estimate coverage under health reform. The model assigns a utility "score" to being insured equal to an individual's expected health spending less the premium, the consumer's valuation of protection from unexpected health care costs, and the value of health services consumed. For each individual, a utility score is computed separately for each of the benefits packages offered in the exchanges. From the lowest actuarial value of coverage to the highest, these will be "catastrophic," followed by bronze, silver, gold, and platinum.

We also compute a utility score for being uninsured that included an individual's average expected out-of-pocket health spending if uninsured less other costs of being uninsured, including the penalty and an implied valuation of the cost of the risk the individual faced when uninsured. We adjust health care costs for individuals to match spending levels reported by uninsured people with similar characteristics, so the costs reflect the lost utility of reduced access to health care.

People are assumed to take coverage if the utility score for any of the five benefits packages exceeds the utility score for being uninsured. Others are assumed to go without insurance. As discussed in the Appendix, the model allows for the possibility that individuals respond to a premium increase by moving to a less comprehensive health plan rather than dropping coverage.

The utility function uses the statistical variance in expected spending to represent the risk an individual faces by going without insurance. The model estimates the cost of this risk to the individual based on estimates of consumer risk aversion drawn from the literature (based on the Arrow-Pratt risk aversion theory). This could be thought of as the amount that someone is willing to pay to be protected against this risk.

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IV. Limitations and Caveats

The results of our analysis are projections, not predictions, and they are dependent upon the set of assumptions used. The results are likely to vary under a different set of assumptions. Future experience will not exactly conform to these projected results. We have conducted sensitivity testing of our results to changes in assumptions. However, given that we are modeling a complex system, changes in some assumptions can produce significant changes in results, due to the interrelationships of factors influencing the results.

We have relied on various sources for data and information upon which the underlying assumptions have been developed. In some cases, there has not been adequate experience data upon which to develop assumptions, and we have had to rely on judgment.

The analyses are based upon our understanding and interpretation of the ACA and its related regulations. Regulations provided after October, 2012 have not been modeled, so a review of Appendices A and B is recommended so the reader can confirm any subsequent changes against the model used for the results in this report. States will be allowed some flexibility in varying certain aspects of the ACA, which may impact results differently than what has been presented. Users of this report will need to make some assumptions as to how developments in each state might affect how actual results will play out.

We suggest readers carefully consider possible variations in outcomes and the actions of competitors and regulators when using this report. We suggest that actual per member per month figures generally should not be used, but instead focus on the change in figures between different risk classes. Readers will need to make important assumptions regarding possible pent-up demand in 2014 and 2015 and initial enrollment forecasts for the first two to three years will also have to be assumed and may be subject to wide variation based on assumptions for each state. How states with current high risk pools address transition to the post-ACA market will also have an important impact on results in the initial years, and adjustments should be made to report figures since the report figures assume an "ultimate" impact (generally after approximately three years).

It is advised that readers not to take any action solely with reliance on this report. Any of the results presented could prove to be different for any one state or health plan.

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V. Technical Notes

The technical notes below provide additional insights into some of the analyses results discussed above.

Leaving Employer Coverage for Non-Group Coverage

We model individuals moving from employer coverage to non-group coverage under the ACA. *Figure 10* shows the impact of the ACA on the non-group market in Wisconsin. Lines 7 through 9 of the table show the number of individuals and average cost for those entering the non-group market under the ACA that previously had employer coverage. The average cost for this group is substantially higher than average cost for other groups and is one of the primary reasons our simulations show a large increase in average costs in the non-group market from current law to the ACA.

Figure 10: Change in Average Costs in the Non-Group Market under ACA in Wisconsin

	Membership	Average Cost Per Month
1. Current High Risk	**24,910**	**$1,176**
2. Current Other Non-Group	**215,407**	**$258**
3. Leave Non-Group	64,003	$291
Retain Non-Group		
4. In Exchange High Risk	20,834	$939
5. In Exchange Other	92,736	$240
6. Outside Exchange	62,744	$320
Leave Other Coverage to take Non-Group		
7. Employer 2-9	38,214	$554
8. Employer 51-100	6,434	$671
9. Employer 101+	56,480	$1,062
10. Medicaid/CHIP	46,925	$389
11. Uninsured	117,654	$336
Individuals with Non-Group under ACA	**442,020**	**$464**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Our analysis of average costs for all workers and dependents in Wisconsin shows that costs are substantially higher than for people purchasing non-group coverage under current law. The average monthly cost for people in the non-group market was $258 (excluding the high risk pool enrollees) compared to $548 for people with employer coverage.

Figure 11 shows the number of members and average monthly cost by size of group pre-ACA. Even if people with average risk in the employer group market moved to non-group they would tend to increase the average cost in the non-group market.

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Figure 11: Average Costs in the Employer Market pre-ACA in Wisconsin

Group Size	Members	Avg Cost
2-9	281,346	$491
10-50	397,483	$466
51-100	127,836	$593
101-499	473,333	$551
500-999	219,230	$532
1000-4999	299,043	$501
5000+	756,235	$569
Government	615,440	$615
Total	**3,169,944**	**$548**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Some employers who now offer insurance will decide to discontinue that coverage under the ACA. This will occur among employers seeing an increase in premiums under the Act. We also expect some insuring employers to discontinue coverage in cases where their workers can obtain subsidized coverage through the exchange at a lower cost. These employer decisions are modeled in two steps:

- Employers dropping coverage due to increase in the net cost of coverage; and
- Employers dropping coverage in response to subsidies for individual coverage.

Employers Dropping Coverage due to Increase in the Net Cost of Coverage
In this step we assess the impact of changes in the cost of insurance to the employer on the number of employers offering coverage. Employer health insurance premiums will be affected by changes in rating practices under the Act. In general, small fully-insured employers with younger and healthier workforces will see premiums increase while employers with older and less healthy individuals will see premiums reduced. In addition, the small employer tax credit will reduce premium costs for some firms.

We use HBSM to estimate the change in net premium costs for employers under the Act. We also estimate the penalty for not offering coverage, which we treat as an increase in the cost of not offering coverage, which has the effect of reducing the net cost of obtaining insurance.

We model the decision to offer coverage using a multivariate model of how changes in premiums affect the likelihood of offering coverage. The implicit price elasticity varies from -0.87 for small firms to less than -0.20 for larger firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Employers Dropping Coverage in Response to Subsidies for Individual Coverage
Some employers may discontinue coverage under health reform because their workers become eligible for free or subsidized coverage in the exchange. Because these subsidies are available

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only to people without access to employer coverage, the employer must discontinue its plan for the workers to get these subsidies.

We model this by:

- Estimating the number of insuring employers where workers can obtain coverage at a lower cost in the exchange (reflecting any change in premium resulting from community rating); and
- Estimating the percentage of these firms that discontinue coverage.

We model the employer decision to discontinue coverage based upon a multivariate model of how changes in the price of alternative health coverage affect the likelihood of switching to the alternative source of coverage. The plan switching elasticity is -2.54, which means that a one percent lower cost results in 2.54 percent of employers discontinuing coverage so workers can obtain subsidize coverage in the exchange.

We model the employer cost as the total premium cost (employee and employer share) less small employer tax credit if eligible less tax benefit of employer coverage. We model the cost for employees in the non-group market as the non-group premium in the Exchange less subsidies plus the cost of the employer penalty, which is assumed to be passed on to workers as lower wages. The results of our simulations show that employers with higher cost members are more likely to discontinue coverage, which would allow their workers to obtain coverage in the Exchanges at adjusted community rates and with the aid of subsidies if they are eligible.

Figure 12 shows that employees and dependents that leave employer coverage due to employers discontinuing coverage and employees leaving employer coverage on their own due to the Medicaid expansion are about 30 percent more costly than the group average member ($712 compared to $548).

Figure 12: Average Costs for Members that Leave Employer Coverage Relative to the Average for all with Employer Coverage in Wisconsin

Employer Pre-ACA			All Who Leave Employer under ACA		
Group Size	**Members**	**Avg Cost**	**Group Size**	**Members**	**Avg Cost**
2-9	281,346	$491	2-9	27,363	$747
10-50	397,483	$466	10-50	36,035	$489
51-100	127,836	$593	51-100	8,318	$621
101-499	473,333	$551	101-499	29,996	$631
500-999	219,230	$532	500-999	16,694	$781
1000-4999	299,043	$501	1000-4999	18,374	$536
5000+	756,235	$569	5000+	11,312	$587
Government	615,440	$615	Government	24,012	$1,282
Total	**3,169,944**	**$548**	**Total**	**172,103**	**$712**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

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Figure 13 shows the number of workers and dependents that we simulate to leave employer coverage and the programs that they would enroll into. Primarily, those below 138% of FPL will enroll in the Medicaid expansion. The average costs for this group is low relative to the average cost of all members that leave employer coverage since most are low-income, young adults. For the remainder of those that leave employer coverage, we perform a second simulation to determine who decides to purchase non-group coverage. For each individual/family, we estimate the cost of insurance under prior law and again under the ACA. These costs reflect:

- Prior law premium includes the amount that the employee paid for employer coverage; and
- Premiums under the ACA include the cost of insurance under community rating less premium subsidies in the exchange.

We estimate the likelihood of taking the coverage based upon the difference in premium before and after the ACA using a premium elasticity averaging about -3.4. This means that on average a one percent reduction in premium corresponds to a 3.4 percent increase in the number of people taking coverage.

The effect of the mandate is simulated on the basis of the penalty the individual/family would pay under the act if they remain uninsured. We treat the penalty as an increase in the cost of remaining uninsured, which has the effect of reducing the net new cost of taking coverage under the act.

The second two blocks of *Figure 13* shows that higher cost workers and dependents that lost employer coverage are more likely to select into non-group and those that are lower cost will opt to go uninsured due to the adjusted community rated premiums in the non-group market. Thus, our simulations show that this "double selection" effect results in relative high cost employees and dependents entering in the non-group market under the ACA.

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Figure 13: Average Costs for Members that Leave Employer Coverage and How They Sort Into Programs under the ACA in Wisconsin

Move from Employer to Medicaid			Move from Employer to Non-Group			Move from Employer to Uninsured		
Group Size	Members	Avg Cost	Group Size	Members	Avg Cost	Group Size	Members	Avg Cost
2-9	12,220	$1,028	2-9	14,345	$542	2-9	798	$120
10-50	7,616	$360	10-50	23,870	$591	10-50	4,549	$167
51-100	1,341	$144	51-100	6,434	$696	51-100	542	$906
101-499	8,209	$346	101-499	17,724	$864	101-499	4,064	$192
500-999	3,448	$187	500-999	10,535	$1,030	500-999	2,711	$571
1000-4999	4,537	$608	1000-4999	12,809	$536	1000-4999	1,027	$224
5000+	8,981	$626	5000+	2,219	$446	5000+	112	$230
Government	8,844	$425	Government	13,193	$2,018	Government	1,975	$199
Total	**55,195**	**$564**	**Total**	**101,129**	**$860**	**Total**	**15,779**	**$274**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

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Provider Payment Levels

The HBSM model adjusts payment levels for individuals simulated to move from Medicaid to commercial insurance and from commercial insurance to Medicaid. This is done using state-level Medicaid physician fees relative to Medicare (KFF StateHealthFacts), national Medicare physician fees relative to commercial insurance (MedPAC) and hospital payment to cost ratios for Medicaid relative to commercial insurance (The Lewin Group estimates).

However, health care for the uninsured is currently paid for by a variety of sources including out-of-pocket, free from hospitals and clinics, other indigent care programs and funding sources, Worker's Compensation, and other private sources such as automobile insurance. Provider payment levels may vary for all these different sources and there is no standard approach for determining how each of these payment levels compares to payment levels by Medicaid or commercial insurance. Therefore, we do not attempt to modify payment levels for the newly insured in the HBSM model but show the potential increase in their health care utilization as they become insured and the associated spending for that increased utilization.

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The authors would also like to thank the actuaries and researchers who provided over twenty seven pages of comments on our draft report. The comments and observations could be broken down into three main categories. The first category was requests for clarification of terms used and what was being described. Wherever possible, we have added additional clarification throughout the report to address those comments. The second category included professional edits, often around semantics, and to be more precise. For example, our reference to "current law" as meaning approaches in effect prior to 2014, even though ACA is actually "current law." However, the main provisions addressed in this report just haven't been implemented yet. Rather than re-doing labels in hundreds of tables, we just define what we meant by the terms we used. The third category included concerns and even disagreement with some of the assumptions used in our model and concerns that the results in tables were not always a smooth curve as one would expect if building tables. For example, there are costs at some age groupings that are higher than the next highest age grouping, a result seldom seen in actuarial tables. Our approach in displaying model results was to avoid any "editing" of results to make results appear smoother. We have left that to the readers of the report so that they can decide on the level of smoothness and assumptions to be made in so doing. We would expect actuaries to have different assumptions regarding such an important issue that is being modeled. In client situations, we are able to change assumptions based on client input, but for this study, we used our baseline assumptions and have documented them so that the reader is aware. However,

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sensitivity testing of key assumptions is outside the scope of the project.

Based on the comments, we offer some general considerations when using this report. First, actual per member per month figures generally should not be used, but instead focus on the change in figures. Readers will need to make important assumptions regarding possible pent-up demand in 2014 and 2015 and initial enrollment forecasts for the first two years will also have to be assumed and may be subject to wide variation based on assumptions for each state. Generally, smoother results are desirable and looking at other "similar" states may provide another input in to so doing. State specific results may be too broad for most analysis, generally, for client work, we provide results at smaller county or groupings of counties level. There will be differences between results from this report and other reports, and the reader should consider some of the likely reasons for that by reading documentation to the extent it is available. Regulations have continued to be produced, whereas the output of the model in this report was frozen as of late September. Therefore, regulations that have come out since, especially those in late November, 2012, are not reflected (though most of those impact premium calculations which are not a major focus of this report). A model must make general assumptions on premium determinations and cannot duplicate all of the nuances of pricing in such a dynamic state. That said, it is our belief that the subsidies will be the most important consideration to take into account.

We hope that this report will help the reader in addressing issues that will be very important in preparing for 2014 and beyond.

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Appendix A - Assumptions for Modeling Coverage Changes Under the ACA

This Appendix describes the data and assumptions used to model each of these key decision points. These analyses were developed using The Lewin Group Health Benefits Simulation Model (HBSM), which is a micro-simulation model of the U.S. healthcare system, designed to provide estimates at the national, state and county levels. The model has been developed over a period of 22 years to estimate the impacts of major changes in the health care system such as the recently enacted Patient Protection and Affordable Care Act (ACA). The model provides estimates of changes in coverage and health spending for the federal government, states, private employers, consumers and providers.

The key to the model is a representative sample of households reporting sources of health insurance coverage, income, employment status, family relationship, demographic characteristics and health spending by source of payment and type of service. The basic data sources are the Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality and the Current Population Survey (CPS) conducted by the Bureau of the Census. The model also incorporates the American Community Survey (ACS) which is a large household survey that makes it possible to provide estimates at the county and sub-county levels (for large counties only).

Figure A-1 presents a flow chart showing each key decision point in the model. A central element of the analysis is modeling the premiums for the coverage available to individuals and the amount of the subsidies and penalties they face in deciding whether to take coverage. A key element of the process is a detailed simulation of premiums in the individual and small group markets under the premium setting and underwriting practices that apply in each state. Thus the outcome of the employer decisions affects the choices available to individuals.

The following sections describe the baseline data and assumptions used to model changes in coverage and costs under the ACA. A more detailed documentation of the HBSM model can be found at http://www.lewin.com/publications/publication/413/.

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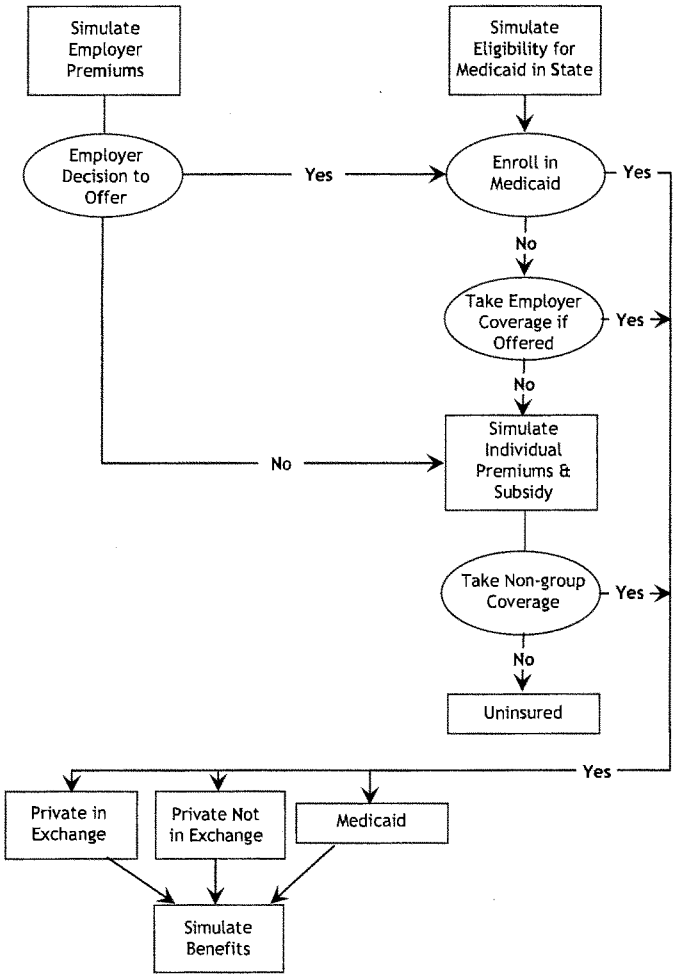
Figure A-1: HBSM Simulation Flowchart for modeling ACA



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A. Development of Baseline Data

HBSM operates on a database of households that are matched to a database of synthetic employers. The model is based upon the pooled Medical Expenditures Panel Survey (MEPS) data for 2002 through 2005. These data provide information on sources of coverage and health expenditures for a representative sample of the population. These data were adjusted to reflect the population and coverage levels reported in the 2008-2010 Current Population Survey (CPS) data. We pooled three years of CPS data in order to increase the sample size at the state level.

We chose the MEPS data because it is the only data source that provides both the detailed income and coverage detail we need together with detailed information on health conditions, health service utilization and spending. These data have enabled us to develop a model that simulates premiums endogenously, including risk selection effects. It also enables us to model policies affecting "uninsurable" populations and simulate the effects of benefits design.

We develop a sample of employers based upon two employer surveys. We statistically match the 2006 KFF survey of employers with the 1997 RWJF Survey of employers. The KFF data provide information on health plan characteristics, while we rely upon the RWJF data to provide information on the demographic characteristics of people working within each employer. Workers in the household data are statistically matched to an employer in the employer database so that we have detailed information on each worker's employer and health plan if present.

Household Data

The HBSM baseline data are derived from a sample of households that is representative of the economic, demographic and health sector characteristics of the population. HBSM uses the 2002-2005 MEPS data to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage, and employment status. We then re-weighted this database to reflect population control totals reported in the 2008-2010 March CPS data.

We make adjustments to the CPS to account for the under-reporting of Medicaid coverage and use these data to estimate the number of uninsured for the entire year, as designed by the CPS. The count of uninsured all year in the MEPS data is adjusted to match the CPS estimate. The result of the methodology produces an average monthly count of uninsured in our model of 52.4 million nationally in 2014, which is similar to the CBO estimate of the average monthly number of uninsured. However, estimates of uninsured at the state-level will appear higher than other sources, which are based on the CPS definition of full year uninsured.

These weight adjustments are done with an iterative proportional-fitting model, which adjusts the data to match approximately 250 separate classifications of individuals by socioeconomic status, sources of coverage, and job characteristics in the CPS. Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in each state. The population weights are then projected to 2014 using U.S. Census Bureau population projections to account for population changes by age and sex for each state between 2010 and 2014.

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Once the MEPS data are re-weighted for population and coverage, we adjust the health expenditure data reported in the MEPS database for each state. These data are adjusted to reflect projections of the health spending by type of service and source of payment in the base year (i.e., 2014). These spending estimates are based upon state-level health spending data provided by CMS and detailed projections of expenditures for people in Medicare and Medicaid across various eligibility groups. Spending data for the employer market are based on average premiums published in the MEPS Insurance Component data by firm size and state. We also adjust spending for the non-group market using state-by-state premium data obtained from the National Association of Insurance Commissioners' 2010 Supplemental Health Care Exhibit Report and projected cost for people in current state and temporary federal high-risk pools.

The result is a database that is representative of the base year population in each state by economic and demographic group, which also provides extensive information on the joint distribution of health expenditures across population groups.

Employer Database

The model includes a database of employers for use in simulating policies that affect employer decisions to offer health insurance. We use the 2006 survey of employers conducted by the KFF. These data include about 3,000 randomly selected public and private employers with 3 or more workers, which provide information on whether they sponsor coverage, and the premiums and coverage characteristics of the plans that insuring employers offer. However, because the KFF data do not include information on the characteristics of their workforce, we match the KFF data to the 1997 RWJF survey of employers, based upon firm characteristics and the decile ranking of the actuarial value of health plans in each database given coverage and cost-sharing features of each plan.

While dated, the RWJF data provide a unique array of information on the demographic and economic profile of their workforce. Thus, we rely upon the KFF data for information on health benefits, but rely upon the RWJF data for the distribution of each employer's workforce by full-time/part-time status, age, gender, coverage status (eligible enrolled, eligible not enrolled and ineligible), policy type (i.e., single/family); and wage level. However, these data do not provide detailed information on worker health status and health spending required to simulate the effect of policies affecting group insurance rating practices and other behavioral responses.

To be able to simulate these aspects of reform, we develop a "synthetic" database of firms that, includes detailed health status and spending information for each worker and dependent in the firm. The first step is to statistically match each MEPS worker, which we call the "primary worker", with one of the employer health plans in the 2006 KFF/RWJF data. We then populate that firm by randomly assigning other workers drawn from the MEPS file with characteristics similar to those reported for the KFF/RWJF database.

For example, a firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's worker profile. If this individual is in a firm with 1,000 workers, he/she is assigned to a Kaiser/HRET employer of that size and the firm is populated with that individual plus another 999 MEPS workers. This process is repeated for each worker in the HBSM data to produce one unique synthetic firm for each MEPS worker (about 63,000 synthetic firms). Synthetic firms are

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created for all workers including those who do not sponsor health insurance, and workers who do not take the coverage offered through work.

Thus, if a firm reports that it employs mostly low-wage female workers, the firm tended to be matched to low-wage female workers in the MEPS data. This approach helps assure that RWJF/Kaiser/HRET firms are matched to workers with health expenditure patterns that are generally consistent with the premiums reported by the firm. This feature is crucial to simulating the effects of employer coverage decisions that impact the health spending profiles of workers going into various insurance pools.

Month-by-Month Simulation

HBSM simulates coverage on a month-by-month basis. This is necessary because economic conditions and coverage vary over the course of the year. These changes can lead to changes in eligibility for public programs and can greatly affect the cost of proposals to expand coverage. Moreover, eligibility for Medicaid and SCHIP is determined on a monthly income basis. Failure to account for these transitions over the course of the year can lead to errors in estimating program impacts by omitting periods of part-year eligibility.

The household database used in HBSM is organized into 12 separate months. The MEPS data identify sources of insurance coverage by month for each individual in the survey. Thus, for example, an individual could be uninsured for five months and covered under Medicaid for the next seven months. These data also include information on employment status at certain times of the year which can be used to approximate the months in which each person is employed, particularly for people reporting employer coverage (which is reported by month). Earnings income, which is reported on an annual basis, is allocated across these months of employment. The individual health events data provided in MEPS also enables us to identify health services utilization in each month, which is important in allocating health spending to months of coverage by source.

B. State-level Simulation of Insurance Markets

One of the most important features of the ACA is its sweeping reforms of insurance and premium rating practices. HBSM includes models of insurance markets in each state. The model simulates the widely varying rating methodologies used within each state for the non-group market and employer groups.

Group Rating Practices

We model premiums for each synthetic firm in the insurance markets based upon the small group rating rules in each state and reported health expenditures for the workers assigned to each plan. This includes community rating, age rating, and rating bands. Experience rating based upon reported health expenditures for the workers assigned to each firm is also used for fully insured plans where permitted (usually for mid-sized firms). We also estimate premiums for self-funded plans based upon the health services utilization for people assigned to each firm.

We simulate these rating practices by developing a "rating book" for each state based upon the rating factors allowed in each state. In many states, premiums may vary widely by age, industry, gender and health status. This information is available for each worker and dependent

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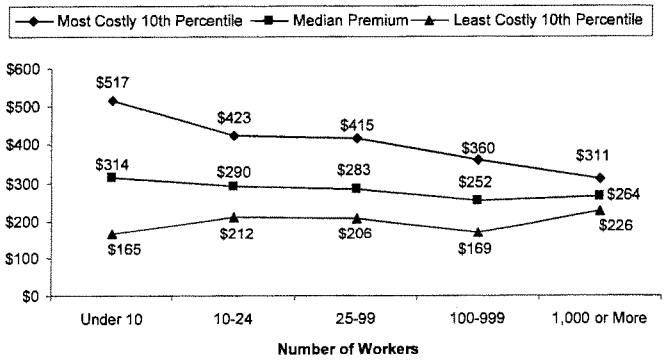
assigned to each of the firms in the database. Health status rating is simulated by identifying individuals in the file with chronic conditions and high expected costs, given their reported level of utilization in the prior year. We developed separate rating books for each state that limits rate variation by age or health status.

States typically define the small group market as firms with 50 or fewer workers. We simulate premiums for larger fully insured firms based upon estimates of expected costs based on reported spending in the prior year. For self-funded plans, premiums are assumed to equal per-worker costs by family type. In addition, we simulate premiums for all employers, including those that do not offer coverage, so we can simulate uptake of coverage as premiums are changed due to reform.

Figure A-2 illustrates that the variability in PMPM premium costs varies widely across employers by size of group. For example, among firms with fewer than 10 workers, PMPM premiums range from about $460 for firms in the 10 percent most costly firms compared with average costs of $157 for firms in the 10 percent least costly firms. By comparison, PMPM premiums in firms with 1,000 or more workers vary from $372 for the 10 percent most costly groups to $215 for the least costly 10 percent of firms. Assuring this range of variability is preserved in the data is essential to modeling reforms that can have large effects for small numbers of firms.

Figure A-2: Estimated Average Health Insurance Costs (PMPM) for Most Costly and Least Costly 10 Percent of Employer Groups in 2006: Includes Benefits and Administration [a/]



a/ Estimates for a standard benefits package.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Because these premiums are estimated for a uniform benefits package, it is necessary to perform a final adjustment to reflect the actual provisions of the plan offered by individual employers. We do this by estimating the actuarial value of each plan using the coverage and cost sharing data reported in the KFF employer data. We then adjust the premium estimated for the plan by the ratio of the actuarial value of the employer's plan and the actuarial value of the standard benefits package used in the analysis.

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Individual Insurance Market Simulation Model

HBSM also includes a model of the individual insurance market. The model defines the non-group insurance markets to include all people who are not otherwise eligible for coverage under an employer plan, Medicare, Medicaid or TRICARE (i.e., military dependents and retirees). The model simulates premiums for individuals using the rules that prevail in each state. Premiums can be varied by age, gender and health status. This is done by compiling a "rate book" based upon the HBSM health spending data for the state reflecting how costs vary with individual characteristics.

We simulate health status rating in the individual market in states where this is permitted. In these states, the premiums that individuals pay reflect the claims experience of the group or some other indication of worker health status. We simulated these premiums using a "tiered rating" process that classifies people into several risk levels based upon expected health spending based upon prior year health expenditures.

In most states, insurers are permitted to deny coverage to people with health conditions. Thirty-three states have a high risk pool available to those who cannot obtain coverage due to their health condition. We simulate this by selecting a portion of the population reporting in MEPS that they had a chronic health condition and are also covered under a non-group plan. The conditions we used to identify "uninsurable" individuals are based upon the condition lists used in several states to identify people as eligible for the high risk pool. We also identify uninsurable people among the uninsured.

C. State-level Model of Medicaid and CHIP

The Model simulates a wide variety of changes in Medicaid and the Children's Health Insurance Programs (CHIP) eligibility levels for children, parents, two-parent families, and childless adults. The model simulates certification period rules, deprivation standards (i.e., hours worked limit for two-parent families), "deeming" of income from people outside the immediate family unit and other refinements in eligibility. As under the program, the model simulates eligibility on a month-by-month basis to estimate part-year eligibility.

HBSM estimates the number of people eligible for the current Medicaid program and various eligibility expansions using the actual income eligibility rules used in each state for Medicaid and SCHIP. The model simulates enrollment among newly eligible people based upon estimates of the percentage of people who are eligible for the current program who actually enroll. In addition, it simulates the lags in enrollment during the early years of the program as newly eligible groups learn of their eligibility and enroll.

1. Simulating Medicaid Eligibility and Enrollment

Because the MEPS data do not report the state of residence, Medicaid simulations in HBSM begin with the CPS data. We simulate the number of people eligible for expansions in coverage using the 2008-2010 CPS data. The CPS includes the detailed data required to simulate eligibility for the program including income by source, employment, family characteristics and state of residence. These results are integrated into the MEPS data in HBSM in a later step described below.

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It is necessary to allocate reported income across months to perform month-by-month simulations. We do this by allocating reported weeks of employment across the 52 weeks of the year according to the number of jobs reported for the year. Reported weeks of unemployment and non-participation in the labor force are also allocated over the year. We then: distribute wages across the weeks employed; unemployment compensation over weeks unemployed; workers compensation income over weeks not in labor force. Other sources of income are allocated across all 12 months of the year.

Using these data, we can estimate the number of program filing units (single individuals and related families living together) who meet the income eligibility requirements under the current program in their state of residence. The model also simulates the number of people who would be eligible under proposed increases in income eligibility. In particular, the model can estimate the number of non-custodial adults who are eligible under expansions affecting these groups.

Eligibility for the Medicaid expansion is restricted to legal U.S. residents that have been resident in the US for at least five years. However, undocumented immigrants are not eligible for the Medicaid expansion. Legal immigrants that have been in the country for five or less years are ineligible for the Medicaid expansion. To model this requirement, we impute undocumented status and length of time living in the U.S. for people in our HBSM model using citizenship and length of time living in the U.S. as reported in the CPS, which is then controlled to national estimates by the Pew Hispanic Center. [16] Since the CPS data is state specific, it provides the information necessary to estimate the number of undocumented and legal immigrants living in the U.S. for five or fewer years at the state level.

Once estimated, we incorporate our Medicaid expansion estimates into the MEPS based household data for each state. We do this by simulating eligibility in the adjusted state-specific MEPS data based on monthly income, age and family type. New eligibility and enrollment is calibrated to replicate the CPS based estimate.

2. *Individual Decision to Enroll in Medicaid and CHIP*

We simulated the decision for newly eligible people to enroll in the Medicaid expansion based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance. HBSM simulates eligibility on a month-by-month basis to capture part-year eligibility for the program.

We assume that currently eligible but not enrolled children will be enrolled as a newly eligible parent becomes covered under Medicaid. Also, we assume that eligible families will enroll in instances where the parent loses employer coverage because their employer decides to discontinue their health plan (discussed above). We also simulated a small increase in enrollment due to the penalty for Medicaid eligible people with income high enough to be required to pay taxes (people with incomes below the income tax filing threshold ineligible under the Act).

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[16] Gretchen Livingston, "Hispanics, Health Insurance and Health Care Access", September 2009.

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We assume that in states that currently provide coverage to adults above 138 percent of FPL will discontinue that coverage in 2014 when subsidies become available and move these people into the exchanges. [17] We assume that CHIP is continued and states do not move children above 138 percent of FPL into the exchanges but continue the CHIP program.

Based upon these analyses, our estimated take-up rates average 25 to 74 percent, as shown in *Figure A-3*:

Figure A-3: Individual Decision to Take Medicaid

	HBSM Estimate
Newly eligible without access to employer coverage:	74%
Newly Eligible with access to employer coverage:	39%
Currently eligible and uninsured who enroll:	25%

D. Individual Decision to Take Private Non-Group Coverage

For people not eligible for Medicaid, we model the decision for uninsured individuals to take non-groups coverage based upon a multivariate model of how changes in the price of insurance affect the likelihood of taking coverage. In addition, we model the decision for insured individuals to discontinue their coverage in cases where their premium increases using the same multivariate model.

Eligibility for premium subsidies is restricted to legal U.S. residents regardless of the length of time they have resided in the country. However, undocumented immigrants are not eligible for premium subsidies within the Exchanges. Legal immigrants that have been in the country for five or less years are ineligible for the Medicaid expansion but would be eligible for premium subsidies if their income is below 400 percent of FPL. To model this requirement, we impute undocumented status and length of time living in the U.S. for people in our HBSM model using citizenship and length of time living in the U.S. as reported in the CPS, which is then controlled to national estimates by the Pew Hispanic Center. Since the CPS data is state specific, it provides the information necessary to estimate the number of undocumented and legal immigrants living in the U.S. for five or fewer years at the state level.

1. Decision for Uninsured to Take Non-Group Coverage

For each individual/family, we estimate the cost of insurance under prior law and again under the act. These premiums reflect:

1. Prior law premium includes the cost of insurance for the individual in the individual market under the rating rules that apply in their state of residence;

[17] States that currently offer coverage to adults above 138% FPL include CT, DC, IL, ME, MN, NJ, NY, RI, TN, VT and WI.

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2. Premiums under the act include the cost of insurance under community rating less premium subsidies in the exchange; and
3. The effect of the tax exclusion for health benefits on the after tax cost of coverage.

We estimate the likelihood of taking the coverage based upon the difference in premium before and after the act using a premium elasticity averaging about -3.4. This means that on average a one percent reduction in premium corresponds to a 3.4 percent increase in the number of people taking coverage.

The effect of the mandate is simulated on the basis of the penalty the individual/family would pay under the act if they remain uninsured. We treat the penalty as an increase in the cost of remaining uninsured, which has the effect of reducing the net new cost of taking coverage under the act.

Figure A-4 presents HBSM estimates of the percentage of uninsured people taking individual coverage by expected claims costs and family income:

Figure A-4: Uninsured Individual Decision to Take Private Coverage (with subsidy and penalty effect)

Expected Claims Costs	Family Income Level			
	Under $25,000	$25,000-$50,000	$50,000-$75,000	$75,000 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate	HBSM Estimate
$0 to $1,000	76%	39%	27%	19%
$1,000 to $10,000	93%	68%	49%	16%
$10,000 or more	94%	86%	58%	51%
Uninsurable Diagnosis	91%	79%	58%	37%

1/ Many survey respondents in the MEPS data that we identify as having an uninsurable condition have expected spending less than $10,000 per year.

2. *People with Non-Group Insurance who Discontinue Coverage*

We also simulate discontinuations of coverage for people experiencing an increase in their Non-group premium. The model calculates the premium for covered people as described above, which reflects changes in premiums due to rating changes, premium subsidies and the penalty they would pay (penalties are treated as a reduction in the cost of being uninsured which reduces the net cost of obtaining coverage).

For those facing a net increase in premium costs we simulate the likelihood of discontinuing coverage using the multivariate model described above (Average price elasticity of -.3.4). HBSM estimates of people discontinuing non-group coverage are shown in *Figure A-5* by percent change in premium and expected health spending.

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Figure A-5: Percentage of People with Non-Group Insurance who Discontinue Coverage

Percent Change Premium	Expected Claims Costs			
	$0 to $1,000	$1,000 to $10,000	$10,000 or more	Uninsurable
	HBSM Estimate	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	65%	49%	0	0
25% to 50%	38%	16%	0	0
10% to 25%	10%	6%	0	0
-10% to 10%	1%	0	0	0
-10% to -25%	0	0	0	0
-25% to -50%	0	0	0	0
-50% or more	0	0	0	0

n/a - Assumes people with reductions in price do not discontinue coverage.

3. Individual Decision to Purchase Coverage through the Exchange

We use a series of assumptions to estimate the number of people taking non-group coverage who will be enrolled in the exchange. These assumptions include:

1. Anyone taking individual coverage that is eligible for premium subsidies will purchase coverage in the exchange. This is because subsidies are available only for people participating in the exchange.
2. People currently purchasing non-group coverage who are not eligible for subsidies will remain with their current plan outside the exchange.
3. All uninsured people not eligible for subsidies that take individual coverage will take coverage through the exchange.

Using these assumptions, the percentage of people taking coverage in the exchange is zero to 100 percent, as shown in *Figure A-6*:

Figure A-6: Individual Decision to Purchase Coverage through the Exchange

	Lewin Assumption
People qualifying for premium subsidies:	100%
People who now have non-group coverage but do not qualify for subsidies:	0%
People who are uninsured and deciding to take non-group coverage but do not qualify for subsidies:	100%

E. Individual Decision to Take-up Existing Employer Coverage

Using the MEPS and Bureau of the Census data, we estimate that there are up to six million uninsured people who have been offered health insurance from an employer but have declined

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the coverage. These include uninsured workers and any uninsured spouses and children who could have been covered as dependents. This also include uninsured dependent children whose parent has taken coverage for his/her self but has not elected the family coverage option. These people are likely to have declined coverage because they have difficult affording the required premium contribution.

In response to the mandate, many of these workers are expected to take the coverage offered by their employer to avoid paying the penalty. We simulate the decision to take coverage using the multivariate model of the decision to take coverage given the change in the price of coverage under the Act. As discussed above, this model yields an overall average price elasticity of -3.4, although this varies with the characteristics of the individual.

The price of coverage to the worker is defined to be the share of the employer premium paid by the worker under reform compared with the employer premium the worker would pay under current policy. This allows us to model the effect of changes in premiums resulting from health insurance rating reforms in smaller firms. In addition, we count the amount of the penalty they would pay for remaining uninsured under the Act (unless exempt from the mandate) as an increase in the cost of being uninsured which has the effect of reducing the net cost to the individual of taking the employer's plan.

Figure A-7 presents HBSM estimates of the percentage of uninsured workers taking employer coverage by change in premium and size of employer:

Figure A-7: Uninsured Workers Who Have Declined Employer Coverage under Current Law Who Take That Coverage as a Result of the Mandate

Rate Change (Includes Premium Changes and Subsidies)	Group Size	
	Under 200	200 or more [a/]
	HBSM Estimate	HBSM Estimate
50% or more	5%	0%
25% to 50%	13%	0%
10% to 25%	1%	0%
-10% to 10%	36%	26%
-10% to -25%	16% [b/]	0%
-25% to -50%	27% [b/]	0%
-50% or more	NA	0%

a/ Under the Act, firms with 200 or more workers are required to use automatic enrollment.
b/ sample size may be too small to provide reliable results.

F. Employer Decision to Start Offering Coverage

We model the employer decision to provide coverage based upon multivariate models of how changes in the price of insurance affect the likelihood of offering coverage. We model the employer decision to offer coverage in the following two steps:

- Based on change in net cost of coverage; and

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- Based on changes in worker demand for coverage.

1. *Changes in Net Cost of Coverage to Employer*

The likelihood of offering coverage is dependent upon several factors including the price for insurance. The ACA will change the price of insurance to employers in three ways:

1. New small employer tax credits;
2. Changes in premium due to community rating in firms with higher cost workers; and
3. A New Penalty for employers who do not offer insurance.

HBSM estimates the change in premiums for each employer for coverage under the law. We do this by simulating the premiums each employer will face under current practices and under the insurance rating rules under the Act. In general, younger and healthier people will pay more for coverage while older and less health people will pay less. We also reflect the amount of the small employer tax credit they would qualify for to estimate net premium costs. We Model the effect of the penalty for not offering coverage as an increase in the cost of being uninsured, which reduces the net cost of providing coverage.

We model the decision to offer coverage using is a multivariate model of how changes in premiums affect the likelihood of offering coverage. The price elasticity varies from -0.87 for small firms to less than -0.20 for large firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Figure A-8 presents HBSM estimates of the percentage of employers who decide to offer coverage due to price changes (including subsidy and penalty effects) by the percentage change in premiums (including subsidy effects) and group size.

Figure A-8: Employers Who Decide to Offer Coverage Due to Price Changes by Change in Premiums and Group Size

Rate Change (Includes Premium Changes and Subsidies)	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	0%	0%	n/a
25% to 50%	0%	0%	n/a
10% to 25%	0%	4%	n/a
-10% to 10%	3%	17%	59%
-10% to -25%	14%	26%	n/a
-25% to -50%	25%	58%	n/a
-50% or more	38%	0%	n/a

N/A - No firms in Cell under ACA.

2. *Changes in Worker Demand for Coverage*

The requirement for people to have insurance coverage will increase the demand for employer sponsored insurance. Uninsured workers who now face a penalty for not having coverage will want to obtain that coverage at the lowest possible price, which will often be employer insurance. Employer coverage is generally less costly to administer because of the economies of

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scale in selling and administering coverage for a group. Premium payments for employer health benefits are also tax exempt, which increases the value of employer insurance to the individual as compared with individual coverage.

The model simulates the decision for employers to start offering coverage as a result of the individual penalty for being without coverage. As discussed above, we treat the individual penalty as an increase in the cost of going without insurance that effectively reduces the net cost of taking coverage for the group. We use this as an estimate of the economic benefit to individuals in the group if the employer were to offer coverage.

We model the employer decision based upon the multivariate model of the likelihood of taking coverage as the price of insurance changes as described above. This model shows an average price elasticity of -0.34, which means that a one percent reduction in the net cost of insurance results in 0.34 percent of affected employers offering coverage. Firms are assumed to offer coverage only if employer insurance is less costly than non-group coverage with premium subsidies.

In this analysis, the number of people taking coverage is determined on the basis of the change in price attributed to the individual penalty only (the impact of other factors affecting premiums is modeled in other steps described in this document.) Thus, a health reform program with no penalty for being without coverage has no impact on the number of employers offering coverage.

Figure A-9 presents HBSM estimates of the percentage of non-insuring firms that decide to offer coverage due to increased worker demand for coverage, based on these assumptions.

Figure A-9: Employer Decision to Start Offering Coverage Due to Increased Worker Demand for Coverage (worker weighted)

Average Earnings of Workforce	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
Less than $30,000	2.8%	1.2%	5.1%
$30,000- $50,000	7.1%	1.1%	5.3%
$50,000- $75,000	10.4%	5.9%	9.3%
$75,000 or more	16.4%	n/a	23.2%

n/a - due to small sample size we expect immaterial results.

G. Employer Decision to Discontinue Coverage

Some employers who now offer insurance will decide to discontinue that coverage under the ACA. This will occur among employers seeing an increase in premiums under the Act. We also expect some insuring employers to discontinue coverage in cases where their workers can obtain subsidized coverage through the exchange at a lower cost. These employer decisions are modeled in two steps:

- Employers dropping coverage due to increase in the net cost of coverage; and

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- Employers dropping coverage in response to subsidies for individual coverage.

1. *Employers Dropping Coverage due to Increase in the Net Cost of Coverage*

In this step, we assess the impact of changes in the cost of insurance to the employer on the number of employers offering coverage. Employer health insurance premiums will be affected by changes in rating practices under the Act. In general, employers with younger and healthier workforces will see premiums increase while employers with older and less healthy individuals will see premiums reduced. In addition, the small employer tax credit will reduce premium costs for some firms.

We use HBSM to estimate the change in net premium costs for employers under the Act. We also estimate the penalty for not offering coverage, which we treat as an increase in the cost of not offering coverage, which has the effect of reducing the net cost of obtaining insurance.

We model the decision to offer coverage using is a multivariate model of how changes in premiums affect the likelihood of offering coverage. The implicit price elasticity varies from -0.87 for small firms to less than -0.20 for larger firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Figure A-10 shows HBSM estimates of the percentage of employers who decide to discontinue coverage due to price changes (including subsidy and penalty effects) by group size and percentage change in premium (including subsidy effects).

Figure A-10: Employer Decision to Discontinue Coverage Due to Changes in Net Premium (worker weighted)

Rate Change (Includes Premium Changes and Subsidies)	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	18%	0%	n/a
25% to 50%	21%	11%	n/a
10% to 25%	15%	8%	n/a
-10% to 10%	1%	1%	0%
-10% to -25%	0%	0%	n/a
-25% to -50%	0%	0%	n/a
-50% or more	0%	0%	n/a

N/A - No firms in Cell under ACA.

2. *Employers Dropping Coverage in Response to Subsidies for Individual coverage*

Some employers may discontinue coverage under health reform because their workers become eligible for free or subsidized coverage in the exchange. Because these subsidies are available only to people without access to employer coverage, the employer must discontinue its plan for the workers to get these subsidies.

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We model this by:

1. Estimating the number of insuring employers where workers can obtain coverage at a lower cost in the exchange (reflecting any change in premium resulting from community rating); and
2. Estimating the percentage of these firms that discontinue coverage.

We model the employer decision to discontinue coverage based upon a multivariate model of how changes in the price of alternative health coverage affect the likelihood of switching to the alternative source of coverage. The plan switching elasticity is -2.54, which means that a one percent lower premium results in 2.54 percent of employers discontinuing coverage so workers can obtain subsidize coverage in the exchange.

Figure A-11 presents HBSM estimates of the percentage of employers discontinuing coverage due to the availability of subsidized non-group coverage by average worker earnings and group size.

Figure A-11: Employer Decision to Discontinue Coverage due to Availability of Subsidized Non-group Coverage in the Exchange (worker weighted)

Average Earnings of Workforce	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
Less than $30,000	24%	24%	8%
$30,000- $50,000	6%	1%	4%
$50,000- $75,000	3%	1%	2%
$75,000 or more	1%	0%	1%

H. Employer Decision to Offer Coverage in the Exchange

Some employers are permitted to provide coverage for their workers through the exchange. This means that the employer will pay a premium to the exchange and allow the workers to select one of the plans offered in the exchange. This differs from a scenario where employers simply decide not to offer coverage.

Initially, only firms with 100 or fewer workers are eligible to offer coverage for their workers through the exchange in this way. Under the act, these workers are not eligible for subsidies because the employer is contributing to the cost of their insurance.

We assume that premiums in the exchange are about four percent less costly than premiums for coverage sold outside the exchange because of reduced reliance on insurance agents and brokers, who typically receive a commission on sales. Aside from this, the act requires that insurer premiums outside the exchange must be the same as inside the exchange.

We simulate the shift of employers from their current health plan to coverage offered in the exchange based upon the plan switching elasticity of -2.54 discussed above. This means that a

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one percent reduction in premium results in 2.54 percent of employers shifting their coverage to the exchange. We also assume that employers that qualify for the premium tax credits would take coverage in the exchange since these credits will only be available through the exchange.

HBSM estimates of the percentage of employers shifting to the exchange are presented in ***Figure A-12***.

Figure A-12: Employer Decision to Offer Coverage in the Exchange

	HBSM Estimate
Firms with fewer than 50 workers:	45%
Firms with 50 to 100 workers:	4%
Firms with over 100 workers (ineligible	0%

I. Utility Function Model

For this study, we also used a "utility" function to provide sensitivity analyses around our results. The utility function has been used by several researchers to simulate how consumer choice of insurance coverage is affected by both financial factors, uncertainty and consumer aversion to risk.[18,19,20] The utility function provides a "score" measuring the benefit to an individual of taking a given insurance product. The score includes the amount of the premium less expected health care costs, plus a valuation of the value to the consumer of protection from unexpected health care costs based upon the Arrow-Pratt model of absolute risk aversion. This approach has also been used to model take-up of insurance under health reform by Pauly and Herring, and Eibner and Girosi.[21]

For each individual in the model, we calculated the utility score for taking insurance under each of the five benefits packages ($U_{i,j}$). We estimate for each person the expected level of spending based upon their health status and health spending reported in MEPS. For each individual, we estimate expected total spending, expected out-of-pocket spending if insured and the variance in expected health care costs. The methods used to estimate these expected cost values are presented in the following section and are illustrated in ***Figure A-13*** below.

We calculate the utility score separately for each of the five benefits packages that would be available in the exchange (i.e., Bronze, Silver, Gold, Platinum and Catastrophic if eligible) based upon expected spending levels and the cost-sharing provisions of each plan. We also calculate a utility score for being uninsured. People are assumed to select among the six possible coverage

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18 Pauly, M., Herring, B., "Expanding Coverage Via Tax Credits: Trade-offs and Outcomes," *Health Affairs*, 20, no. 1 (2001): 9-26.

19 Pauly MV., and Herring, BJ., "An Efficient Employer Strategy for Dealing with Adverse Selection in Multiple-Plan Offerings: an MSA Example," *Journal of Health Economics*, 19 (2000)

20 See: Pauly, MV., Herring, B., Song D., "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured, " *Forum for Health Economics & Policy*, Vol. 5, no. 5, 2002; and Eibner, C., et al., "Establishing State Health Insurance Exchanges: Implications for Healthy Insurance Enrollment, Spending, and Small Businesses," (report to the Department of Labor), RAND Corporation, 2010.

21 Christine Eibner, et al, "Establishing State Health Insurance Exchanges: Implications for Health insurance, Enrollment, Spending and Small Businesses," RAND, 2010.

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states (i.e., five benefits packages or uninsured) based upon whichever coverage state yields the highest utility score given the individual's unique expectation of health spending.

We estimate utility scores for coverage under each of the benefits packages that will be available in the exchange using the following equation.

$$(1_j) \qquad U_{i,j} = -E(OOP_{i,j}) - NPrem_{i,j} - 0.5rVar(OOP_{i,j}) + Uhealth_i$$

Three of these values are imputed to individuals from the data shown above in ***Figure A-13***. These include:

$E(OOP_{i,j})$ is expected out-of-pocket health spending if insured under benefits package $_j$ (column 4, ***Figure A-13***);

$Var(OOP_{i,j})$ is the variance in expected out-of-pocket spending if insured under benefits package $_j$ (column 5, ***Figure A-13***, squared); [22]

$Uhealth_i$ is a measure of the utility of health services consumed, which we assume is equal to the value of total expected health care costs for the individual if insured under all five benefits packages (column 2, ***Figure A-13***);[23] and

$NPrem_{i,j}$ is the net premium defined to be premiums less subsidies that we compute separately for each unique policyholder in the model for each of the five benefits packages.

Where:

i= Individual in the simulation; and

j= Alternative benefits packages.

We assume the coefficient for "r" is the midpoint of various Arrow-Pratt absolute risk aversion coefficients (.00084) published in studies of consumer risk aversion for unexpected health spending used by other authors.[24]

In setting these utility values we include the patient cost-sharing subsidies that would be provided under the Act for income eligible individuals. Under the ACA, the exchange will buy-up an individual's benefits package (with a supplemental premium payment) to increase the actuarial value of the plan to levels shown in ***Figure A-14***. Thus, for example, the utility of the Silver benefits package is greatly enhanced for those who are eligible for subsidies.

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[22] As discussed above, the ACA alters the risk of going without coverage by prohibiting insurers from implementing pre-existing condition exclusions. We model this effect by assuming that the variance in out-of-pocket spending is reduced for people who do not have chronic conditions. The variance is equal to standard deviation squared.

[23] Estimates assume a level of spending consistent with an individual who has health insurance. This measure does not include an estimate of consumer surplus.

[24] See: Friedman, B., "Risk Aversion and Consumer Choice of Health Insurance Option," *Review of Economics and Statistics*, Vol. 56, May 1974; Marquis, MS., and Holmer, MR., "Choice under Uncertainty and the Demand for Health Insurance," The Rand Corporation, N-2516-HHS, 1986; and, Manning, WG., and Marquis, MS., "Health Insurance: The Trade-Off Between Risk Pooling and Moral Hazard," (Report to the National Center for Health Services Research and Health Care Technology Assessment), December 1989.

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We then calculate the utility score for going without insurance (U_n) using a similar formula:

$$(2) \qquad U_n = -E(OOP_n) - \text{penalty} - 0.5rVar(OOP_n) + Uhealth_n$$

Here, we estimate spending for people if uninsured using the expected spending data imputed to each policy-holder from ***Figure A-13*** below, reduced by one-third to reflect the lower levels of spending without insurance. This is based upon more conservative CBO estimates of increased spending for the uninsured. The values in the second equation include:[25]

> $E(OOP_n)$ is the expected value of out-of-pocket spending without insurance which we assume is equal to total expected health spending if insured (column 2, ***Figure A-13***) reduced by one-third;
>
> $Var(OOP_n)$ is the variance in expected out-of-pocket spending, which for the uninsured is equal to expected total health spending without insurance. We assume this is equal to the variance in expected total spending if insured (column 3, ***Figure A-13*** squared) reduced by one-third;
>
> Penalty is the dollar amount of the penalty an individual or family would pay if they go without insurance; and
>
> $Uhealth_n$ is the expected total amount of spending if uninsured, which we assume to be equal to total spending for the insured (column 2, ***Figure A-13***) reduced by one-third.

For these calculations, we use expected spending amounts for each person, including one for expected spending while insured and a second while uninsured. Thus, the utility function while uninsured reflects the lost utility of reduced health spending due to a lack of coverage. The methods we use to do this are described in the following section.

1. Expected Health Care Costs

The key elements of this analysis are our estimates of expected health spending and the variance in expected health spending for each policy holder in the data. We develop these estimates based upon subsamples of the MEPS data for 2005 through 2007 that provide information on spending for each individual for two consecutive years. These data permit us to estimate average expected health spending at the beginning of the year based upon each individual's reported health spending in the prior year. This results in expectations of spending that vary with health status, as approximated by prior year health spending. These data also enable us to estimate expected out-of-pocket costs and the variance in total expected spending used in our utility function (***Figure A-13***).[26]

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[25] We used a list of about 50 health conditions to identify people in the MEPS with a chronic condition based upon the ICD-9 condition codes in these data. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in Colorado, Tennessee and Texas. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

[26] The model imputes spending in the prior year based upon spending in the survey period for those who do not report spending data for two consecutive years.

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Figure A-13: Average Cost Per Person in Two Consecutive Years by Percentile Ranking of First Year Spending at 2011 Spending Levels: Privately Insured Only

Percentile of Year 1 Cost per Person	(2010) Year 1 Total Spending	(2011) Year 2			
		Expected Total Spending	Standard Deviation of Expected Total Spending	Expected Out-of-Pocket	Standard Deviation of Out-of-pocket Spending
10 Percent	$0	$949	$4,685	$206	$858
20 Percent	$95	$1,225	$8,038	$215	$696
30 Percent	$286	$1,498	$6,907	$261	$659
40 Percent	$514	$1,661	$5,223	$389	$1,089
50 Percent	$835	$2,247	$6,001	$446	$889
60 Percent	$1,329	$2,879	$6,425	$591	$1,105
70 Percent	$2,130	$3,618	$7,731	$757	$1,147
80 Percent	$3,594	$4,798	$8,353	$1,027	$1,688
90 Percent	$6,605	$7,076	$13,720	$1,252	$1,707
95 Percent	$11,894	$9,267	$16,070	$1,520	$2,054
97.5 Percent	$19,865	$13,080	$22,933	$1,792	$2,529
98.75 Percent	$30,991	$18,084	$30,983	$2,666	$4,476
100 Percent	$81,910	$39,450	$57,158	$3,158	$6,974
Average	$4,043	$4,105	$12,405	$708	$1,611

a/ Data is based upon the MEPS for 2004-2005, 2005-2006, and 2006-2007. We adjusted these data to correct for an undercount of people with the very highest expenditures, based upon actuarial data for people in commercial health plans.
Source: The Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

These data reveal the expected "regression to the mean." That is, people with the highest expenses in the first year tend to have lower expenses in the next year, while people with little expense in the first year have higher costs in the following year. For example, an individual receiving heart bypass surgery can be expected to have high health expenditures in that year, but costs in the following year will tend to be lower as they recover. Similarly, people with little or no spending in a given year may become ill and start to make greater use of the system in the second year.

As discussed above, we use expected spending amounts for each person, including one for expected spending while insured and a second while uninsured. We estimate these amounts in the following steps:

- Currently uninsured: For people who were uninsured in the MEPS survey, we used reported spending to estimate spending levels while uninsured. To estimate spending for these people while insured, we adjusted these spending amounts to match health spending reported by insured people with similar demographic and health status characteristics. These estimate costs are then used to estimate what expected spending levels would have been at the beginning of the year as illustrated in ***Figure A-13***.
- Currently Insured: We assumed that health expenses while insured are assumed to be the same as they reported in the MEPS. We estimated spending while uninsured by adjusted these amounts to reflect the lower levels of spending reported by uninsured people with similar characteristics. These estimates of costs were then used to estimate

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what expected spending levels would have been at the beginning of the year as illustrated in Figure 13.

2. *Alternative Benefits Packages*

As discussed above, for each individual, we calculate a utility score for each of the coverage options available through the exchange. These include the Bronze, Silver, Gold, Platinum and Catastrophic package (available for people under age 30 only). The services covered under the Bronze, Silver, Gold and Platinum packages are the same; they differ only in terms of point-of-service cost sharing. These packages are denoted in terms of "actuarial value," where a plan that covers all of these services without patient cost sharing would have an actuarial value of 1.0.

The Bronze benefits package is to have an actuarial value of 0.6, which means that the cost sharing parameter (deductibles and copayments) are set at the level required to on average cover 60 percent of the cost of covered services. The actuarial value increases with each succeeding level of coverage to 0.7 for Silver, 0.8 for Gold, and 0.9 for the Platinum package. In *Figure A-14*, we present actuarial values of each plan. We assume that the Catastrophic plan, which is available to only people under age 30 or people facing premiums under the Bronze package that exceed 9.5 percent of income, would cover the same services with cost sharing calibrated to an actuarial value of 0.5.

Figure A-14: Example Co-payments Meeting Actuarial Standards under ACA: Illustrative Estimates for 2011 [a/]

	Actuarial Value
Benefit Packages in the Exchange	
Platinum Package	.90
Gold Package	.80
Silver Package	.70
Bronze Package	.60
Bronze Small Employer	.60
Catastrophic	.50
Cost Sharing Subsidy Health Plans	
Less than 150% FPL	.94
150% to 200% FPL	.87
200% to 250% FPL	.73
250% to 400% FPL	.70

a/ The Act also reduces the maximum out-of-of pocket spending limits by income level.

Source: The Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

3. *Accounting for Risk Factors under the ACA*

We model the effect of open enrollment and pre-existing condition exclusions based upon their effect on risk to the individual for going uninsured. The challenge in using this function is estimating the perceived risk of going without insurance under the ACA. For elimination of the mandate to cause the premium spiral that many expect, the perceived risk of going without insurance must be low enough that many relatively healthy people feel comfortable going without coverage. But if the perceived risk of going uninsured is high, we should see little coverage loss from lifting the mandate.

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The ACA alters the financial risk of going without coverage by prohibiting insurers from imposing pre-existing condition exclusions. If not for the annual open enrollment period, this would permit people to delay taking coverage until they need services without fear of pre-existing condition exclusions. This could ignite the premium spiral that many fear if the mandate is eliminated. However, under the ACA, the individual would not be able to take that coverage for up to 11 months until the annual open enrollment period, which retains for the individual substantial risk for going without insurance.

We assume that people reporting a chronic health condition in the MEPS have high perceived risk of going without coverage which we account for by using 100 percent of the variance in expected health costs as a measure of perceived risk.[27,28] For people who did not report a chronic health condition, we assume that they consider themselves to be at risk for accidents and emergency care if uninsured. Based upon data from the Agency for Healthcare and Quality (AHRQ), about 34 percent of all hospital admissions for the commercially insured population originate in the emergency room.[29] Based on this estimate, we use 34 percent of the variance in total expected health spending as a proxy for perceived risk for these individuals.

4. Simulation of the ACA

We estimate the number of people taking coverage under the ACA as written using the methodology described above. People are assumed to choose the coverage option that yields the highest utility score given their expected health spending and eligibility for subsidies. Thus, an individual is assumed to go uninsured if the utility score for being uninsured is greater than the utility scores for the five health plans. Alternatively, individuals are simulated to take one of the five health plans (four if over age 30) with the highest utility score. Older and sicker people tend to elect plans with higher actuarial values, while younger and healthier people tend to enroll in less comprehensive coverage.

We calibrate the model to reflect estimates of the impact of the ACA on coverage using the probability/elasticity-based methodology described in prior sections. Specifically, we calibrate baseline results under the ACA to replicate the estimates of the number of people remaining uninsured that the model generates using the probability models described above at the national level. However, the demographic and health status distributions of the newly insured vary under the two models. Upon reviewing the simulations, we found that the results were sufficiently similar such that we ultimately calibrated the utility model only for non-subsidy-eligible people who would have had non-group coverage under prior law.

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[27] See: Pauly, MV., Herring, B., Song D., "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured, " Forum for Health Economics & Policy, Vol. 5, no. 5, 2002; and Eibner, C., et al., "Establishing State Health Insurance Exchanges: Implications for Healthy Insurance Enrollment, Spending, and Small Businesses," (report to the Department of Labor), RAND Corporation, 2010.

[28] We used a list of about 50 health conditions to identify people in the MEPS with a chronic condition based upon the ICD-9 condition codes in these data. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in Colorado, Tennessee and Texas. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

[29] See: Owens, P., and Elixhauser, A., "Hospital Admissions That Began in the Emergency Department, 2003," Agency for Healthcare Research and Quality, February 2006.

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5. *Allowing for Downgrades in Coverage*

An important aspect of this simulation is that it models both discontinuations of coverage and downgrades in coverage resulting from increases in premiums. We anticipate that eliminating the mandate will increase premiums enough that many people will discontinue coverage. However, for some of these individuals, the utility score for less comprehensive coverage will continue to be greater than the utility of going without insurance, even at the higher premium levels. In our simulations, these individuals are assumed to downgrade their coverage to a less comprehensive plan rather than simply becoming uninsured.

For example, someone simulated to purchase the Silver plan under the ACA may respond to the premium increase by purchasing the Bronze plan. In our simulations, this will happen in cases where the utility score of the Bronze plan for that individual is still greater than the utility score for going uninsured.

Allowing for coverage downgrades has the effect of reducing our estimates of coverage loss due to the elimination of the mandate because some of these individuals will move to a lower-cost health plan rather than actually going uninsured.

6. *Sensitivity Analysis*

Because utility functions are driven by the assumptions, it is important to test the sensitivity of the estimates to alternative assumptions. There is evidence that a substantial portion of the uninsured see themselves as "risk-averse." Data from the 2007 Health Tracking Household Survey conducted by the Center for Studying Health System Change (HSC) indicate that 49.6 percent of uninsured people with "No Health, Medical Bill or Access Problems" report themselves to be risk-averse.[30] Thus the risk of being uninsured for medical emergencies may motivate many of the uninsured to obtain coverage, particularly if premium subsidies are available. Consequently, we performed sensitivity analysis that incorporates alternative measures of consumer risk and risk aversion.

Some risk-averse individuals may decide to continue purchasing coverage to protect against catastrophic health care costs, even though they expect to spend less than the premium amount. The use of open enrollment periods would heighten this sense of risk. Conversely, many people have little idea of what their expected spending will be in the coming year, since people cannot predict medical emergencies.

In this study, we performed two sensitivity analyses of the utility function to model potential adverse selection into the non-group market. The first assumes that people are one-third less risk-averse (meaning that healthier people are more likely to assume the risk of going uninsured) and a second scenario that assumes people are two-thirds less risk averse. This was done by changing the Arrow-Pratt risk aversion coefficient for "r" in the utility function from 0.00084 to 0.00054 to model one-third less risk aversion and 0.00028 to model two-thirds les risk aversion.

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[30] Cunningham, P., "Who Are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges", The Center for Studying Health System Change, No. 18, December 2010.

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J. Estimating Health Spending for Newly Insured

The MEPS data report that health services utilization for uninsured people is substantially less than among insured people. The data show physicians' visits per 1,000 people are about 1,349 for the uninsured compared with 3,283 for insured people. Also, hospital stays for the insured are more than double that of the uninsured. Part of the difference in utilization rates is due to the fact that the uninsured are on average younger than insured people. Consequently, we adjust for this when estimating how utilization would change for this population as they become insured.

We assume that uninsured people who become covered under a coverage expansions proposal would use health care services at the same rate reported by currently insured people with similar age, sex, income and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forego or delay.

1. Modeling Pent-up Demand for Newly Insured

The research on "pent-up" demand for health care services as people become newly insured has shown mixed results. A study of near elderly uninsured who are approaching Medicare eligibility found that pent-up demand exists for physician care, but not for hospital inpatient care. The study estimated that the people who were uninsured prior to Medicare enrollment have 30 percent more physician visits during the two years after Medicare enrollment than their previously insured counterparts. [31] Another study of the near-elderly indicate that the increased utilization experienced after age 65 by those who were uninsured prior to Medicare lead to an elevated hazard of diagnosis (relative to the insured) for virtually every chronic condition considered, for both men and women and the magnitudes of these effects are clinically meaningful. [32]

However, other study findings have been inconclusive as to the extent of pent-up demand. One study of children newly enrolled in Medicaid found no evidence of pent-up demand for medical care among newly insured children, when they were compared to children who had been continuously insured. [33] Another study examined the effects of the Oregon Medicaid lottery after approximately one year of insurance coverage. The study presented estimates of the impact of insurance coverage, using the lottery as an instrument for insurance coverage,

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[31] Li-Wu Chen, Wanqing Zhang, Jane Meza, Roslyn Fraser, MA, "Pent-up Demand: Health Care Use of the Uninsured Near Elderly", Economic Research Initiative on the Uninsured Working Paper Series, July 2004

[32] Schimmel, Jody. "Pent-Up Demand and the Discovery of New Health Conditions after Medicare Enrollment" Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA, Jun 04, 2006

[33] K. Goldsteen, R.L. Goldsteen, "Demand For Medical Services Among Previously Uninsured Children: The Roles of Race and Rurality", South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, October 2002

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found no evidence of a larger initial utilization effect, suggesting that such "pent up" demand effects may not in fact be present. [34]

Our baseline estimates for the effects of the ACA do not include an adjustment for pent-up demand in our HBSM modeling due to the mixed study findings.

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[34] Amy Finkelstein et. al., "The Oregon Health Insurance Experiment: Evidence from the First Year ",

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Appendix B - The HBSM Rate Book Description

The purpose of this document is to present the "rating book" used to simulate premiums for individuals and firms in the individual and small employer markets. For modeling purposes, we compute an individual market premium for all individuals and family units in HBSM (regardless of whether they are currently covered) using the current rating rules in each state. We also compute a premium for each unit using the rating restrictions under the ACA. Both premiums are based on a standard benefits package and are used to model coverage changes due to changes in the price of insurance. Similarly, we estimate premiums for each of our "synthetic groups" in HBSM, which are described below, using the current rating rules in each state and the rating restrictions under the ACA. Our "Methods and Key Assumptions for Modeling Cost of Newly Insured Under the ACA" document describes how these premiums are used to model changes in coverage.

Our "rate book" is actually a series of adjustment factors that are applied to a base rate to determine a premium for an individual or group. Our practice is to estimate a "base rate" for policy holders in each risk pool defined by markets and legislation using HBSM, such as the individual market. Using the spending data provided in HBSM, we estimate separate base rates for single policy holders and family policy holders, which include dependent costs.

These rates are then used to estimate a premium for each policy holder simulated to be in a given risk insurance pool using HBSM. For each policy holder in the pool, we multiply the base rate by a series of adjustments for risk factors included in the rating process, subject to state laws and regulations. The use of rating factors varies by state, primarily due to differences in state laws governing the rating process.

However, the rating factors used may differ by insurer. For example, insurers often have the option to rate by industry and other factors, subject to the laws that apply in the state. In these cases, we use information on the prevalence of the use of individual rating factors in the industry to determine its use in the simulation model.

The rating factors themselves are estimated from the Medical Expenditures Panel Survey (MEPS) data using health spending amounts for all privately insured individuals in the data. These data form the basis of rate setting in the individual and small group markets. Premiums are ultimately adjusted to reflect actual health spending for privately insured people nationally as estimated by the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS).

In the first section, we present the approach used to simulate rating in the individual market within HBSM. In the second section, we present the methods used to model premiums for firms in the small group market. The third section describes our method for simulating enrollment and costs for individuals in high-risk pools. The final two sections present our approach to simulating premiums in the individual and small group markets under the ACA.

A. Individual Market under Current Law

The model simulates premiums for people in the individual market using the rating factors that apply in their state of residence. The rating factors included age, gender, and an "expected loss

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ratio," which we use as a proxy for health status rating information in states where health status may be used in the rating process.

The key steps in the process include:

- Identification of "uninsurable" people;
- Age and gender adjustment;
- Estimation of expected costs;
- Health status adjustment; and
- Special rates for uninsurable people.

1. Identification of Uninsurable Individuals

We use the MEPS data to estimate the number of people with chronic health conditions that would be classified as uninsurable by an insurer. The MEPS data include detailed information for each health condition reported by individuals in the survey. This permits us to identify health conditions using ICD-9 condition codes reported in these data at the three-digit level.

We used a list of about 69 health conditions to identify someone as uninsurable. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in 19 states. [35] We included conditions that were on eligibility lists in at least 5 states. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

2. Estimation of Expected Costs for Population

In most states, rating in the individual market reflects a certain degree of medical knowledge of the applicant that is generally used to adjust premiums for health status. Insurers can obtain this information based upon health spending in the prior year or through medical underwriting questionnaires for new applicants. In this analysis, we estimate "expected health spending at the beginning of the year for which rates are being determined. This estimate of expected costs is based upon health spending for each individual in the MEPS data.

The MEPS provides spending information for each individual in the survey for over 24 months. This enables us to estimate average spending in a year based upon their spending in the prior year. ***Figure B-1*** presents average spending in the second year based upon their percentile ranking of their spending in the prior year.

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[35] States include AK, CO, IA, KY, MD, MN, MT, NE, NC, ND, NH, NM, OK, OR, TN, TX, WA, WV and WY.

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Figure B-1: Average Cost Per Person in Two Consecutive Years by Percentile Ranking of First Year Spending at 2010 Spending Levels: Privately Insured Only

Percentile of Year 1 Cost per Person	(2010) Year 1	(2011) Year 2
10 Percent	$0	$749
20 Percent	$134	$865
30 Percent	$337	$1,057
40 Percent	$614	$1,522
50 Percent	$1,023	$1,998
60 Percent	$1,706	$2,920
70 Percent	$2,774	$3,669
80 Percent	$4,777	$4,541
90 Percent	$9,375	$7,121
95 Percent	$15,663	$11,379
97.5 Percent	$25,096	$12,511
98.75 Percent	$38,282	$18,590
100 Percent	$210,600	$31,065
Average	$3,851	$3,940
Median	$995	$910

Source: The Lewin Group Estimates using the Health benefits Simulation Model (HBSM).

These data reveal the expected "regression to the mean." That is, people with the highest expenses in the first year tend to have lower expenses in the next year. For example, an individual receiving heart by-pass surgery can be expected to have high health expenditures in that year. However, costs in the following year will tend to be lower than the prior year as these individuals recover. Similarly, people with little or no spending in a given year may become ill and start to make greater use of the system in the second year.

These data are used to provide a projection of the average expected level of spending for each individual in the coming year based upon their percentile ranking of spending in the prior year. We then convert these data to an "expected loss ratio," which is defined as total expected health spending over the base rate for a given benefits package.

3. *State Rating Regulations*

We use data compiled by the National Association of Health Underwriters (NAHU) on state regulations for the individual market as the basis for determining rating methods in the model. Based upon these rules, we identify seven types of state rating scenarios that apply, depending upon the rate variation permitted in a state. These include:

- Uninsurable individual in states permitting medical underwriting;
- +/- 50% rating bands;
- +/- 30-35% rating bands;
- +/- 20-30% rating bands;
- Adjusted community rating; and

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- Pure community rating.

In states that do not have significant rating restrictions, we assume that individuals are rated on single year of age, gender and expected loss ratio for each individual (*Figure B-2*). In states with rate band limits of 50 percent or more, we assume that rates vary by age and loss ratio subject to a 4:1 limit. Rate bands on age and expected loss ratio of 3:1 are used in state with rating bands of 30 to 50 percent. In states that specify rating bands of less than 30 percent, we assume rate bands on age of 3:1.

Figure B-2: Rate Tables by Type of State Regulation [a/]

	Age Rating	Loss Ratio
1: no rating structure	Single Year	4:1
2: +/- 50% rating bands	4:1	4:1
3: +/- 30-35% rating bands	4:1	3:1
4: +/- 20-25% rating bands	3:1	2:1

a/ Separate approach is used for "uninsurable" people as described below.

For community rates states, the premium is equal to the base rate. In states with adjusted community rating (rate variation by age only), we assume premiums are set according to a 4:1 rating band by age. Health status and expected loss ratios are not used in community rated states.

A separate set of rating rules is used for people deemed to be "uninsurable" because they have pre-existing chronic health conditions. For uninsurable people with high health care costs in the prior year, we use expected health costs as the basis for setting the premium. These rating methods are described below in greater detail. *Figure B-3* presents a summary of the rating rules in the individual market by state.

Figure B-3: State Rating Regulations for the Individual Market

State No	State Name	Rating Limit	High Risk Pool
1	Alabama	1: NRS: no rating structure	1
2	Alaska	1: NRS: no rating structure	1
3	Arizona	1: NRS: no rating structure	0
4	Arkansas	1: NRS: no rating structure	1
5	California	1: NRS: no rating structure	1
6	Colorado	1: NRS: no rating structure	1
7	Connecticut	1: NRS: no rating structure	1
8	Delaware	1: NRS: no rating structure	0
9	Dist of Columbia	1: NRS: no rating structure	0
10	Florida	1: NRS: no rating structure	1
11	Georgia	1: NRS: no rating structure	0
12	Hawaii	1: NRS: no rating structure	0

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State No	State Name	Rating Limit	High Risk Pool
13	Idaho	2: +/- 50% rating bands	1
14	Illinois	1: NRS: no rating structure	1
15	Indiana	1: NRS: no rating structure	1
16	Iowa	2: +/- 50% rating bands	1
17	Kansas	1: NRS: no rating structure	1
18	Kentucky	3: +/- 30-35% rating bands	1
19	Louisiana	1: NRS: no rating structure	1
20	Maine	5: ACR: adjusted community rating	0
21	Maryland	1: NRS: no rating structure	1
22	Massachusetts	5: ACR: adjusted community rating	0
23	Michigan	1: NRS: no rating structure	0
24	Minnesota	4: +/- 20-25% rating bands	1
25	Mississippi	1: NRS: no rating structure	1
26	Missouri	1: NRS: no rating structure	1
27	Montana	1: NRS: no rating structure	1
28	Nebraska	1: NRS: no rating structure	1
29	Nevada	2: +/- 50% rating bands	0
30	New Hampshire	4: +/- 20-25% rating bands	1
31	New Jersey	6: C: pure community rating	0
32	New Mexico	1: NRS: no rating structure	1
33	New York	6: C: pure community rating	0
34	North Carolina	1: NRS: no rating structure	1
35	North Dakota	1: NRS: no rating structure	1
36	Ohio	1: NRS: no rating structure	0
37	Oklahoma	1: NRS: no rating structure	1
38	Oregon	5: ACR: adjusted community rating	1
39	Pennsylvania	1: NRS: no rating structure	0
40	Rhode Island	1: NRS: no rating structure	0
41	South Carolina	1: NRS: no rating structure	1
42	South Dakota	3: +/- 30-35% rating bands	1
43	Tennessee	1: NRS: no rating structure	1
44	Texas	1: NRS: no rating structure	1
45	Utah	3: +/- 30-35% rating bands	1
46	Vermont	6: C: pure community rating	0
47	Virginia	1: NRS: no rating structure	0
48	Washington	5: ACR: adjusted community rating	1
49	West Virginia	3: +/- 30-35% rating bands	1
50	Wisconsin	1: NRS: no rating structure	1
51	Wyoming	1: NRS: no rating structure	1

Source: National Association of Health Underwriters (NAHU)

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4. Age and Gender Rating Factors

Most states permit rating by age and in many cases gender. However, the degree of premium variation within these rating factors is often limited by state law. Consequently, we develop age rating adjustment by single-year of age and under increasingly more narrow age rating bands from 4:1 to 3:1 and do not include gender rating.

The age adjustments are estimated from the MEPS data for privately insured people. For states with no rating restrictions, we assume that premiums vary with individual year of age and gender (***Figure B-4***). We use a "smoothing" technique to eliminate spurious variation in rates from one year's age to the next. ***Figure B-5*** presents the age rating factors assuming alternative rating bands apply by age. We simplify this process by creating wider age bands, which has the effect of reducing the variation in adjustment factors.

These adjustments are performed separately for individual policy holders and family policy holders. The model uses a base rate for individuals and a base rate for family coverage, both of which vary with the age of the policyholder only.

Figure B-4: Age Rating by Single-year of Age

Age	Individuals		Family	
	Male	Female	Male	Female
17	0.4869	0.6008	0.4016	1.6568
18	0.4469	0.5868	0.5579	1.5048
19	0.4503	0.6320	0.8402	1.2249
20	0.4303	0.8518	1.0727	0.8905
21	0.4403	0.9057	1.0727	0.7201
22	0.4503	0.9640	1.1487	0.6747
23	0.4476	0.9989	1.0530	0.7020
24	0.4576	1.0664	0.9027	0.7068
25	0.4662	1.3368	0.8242	0.7227
26	0.4762	1.2984	0.8106	0.7676
27	0.5000	1.2995	0.8773	0.7805
28	0.5120	1.2711	0.9247	0.7490
29	0.5243	1.2457	0.9284	0.7200
30	0.5368	1.2937	0.8832	0.8285
31	0.5497	1.3247	0.8832	0.8285
32	0.5629	1.3564	0.8881	0.8530
33	0.5815	1.4013	0.9053	0.8271
34	0.6007	1.4475	0.9153	0.7442
35	0.6225	1.1780	0.9838	0.6967
36	0.6423	1.2155	1.0953	0.6761
37	0.6622	1.2531	1.2067	0.6761
38	0.6887	1.3033	1.2071	0.6868
39	0.7152	1.3534	1.1226	0.7012
40	0.7450	1.2852	1.0025	0.7448
41	0.7748	1.2556	0.9341	0.7900
42	0.8046	1.2260	0.9069	0.8208
43	0.8377	1.2015	0.9033	0.8508
44	0.8741	1.1820	0.9119	0.8656
45	0.9105	1.1092	0.9021	0.8906
46	0.9503	1.1423	0.9208	0.8464
47	0.9900	1.1754	0.9533	0.7726
48	1.0430	1.2085	1.0383	0.6960
49	1.0960	1.2416	1.0771	0.6681
50	1.1522	1.2747	1.0888	0.6642
51	1.2152	1.3112	1.1270	0.6298
52	1.2781	1.3476	1.2501	0.6008
53	1.3476	1.3973	1.4569	0.6252
54	1.4204	1.4469	1.5695	0.7218
55	1.4966	1.4966	1.6303	0.8404
56	1.5794	1.5496	1.5560	0.9069
57	1.6621	1.6059	1.5217	0.9273
58	1.7548	1.6688	1.4037	0.9276
59	1.8542	1.7350	1.3323	0.9605
60	1.9568	1.8045	1.2751	1.1107
61	2.0661	1.8740	1.3481	1.4748
62	2.1820	1.9502	1.5066	2.1395
63	2.2945	2.0197	1.7577	2.9443
64	2.4137	2.0926	2.1359	3.6889
65	2.8144	2.3277	2.6246	4.2686

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Figure B-5: Age Rating Factors in States with Rate Bands by Age

	Individual	Family
States with Age Adjustment Limited to 4:1 Rate Band		
< 20	0.5737	1.0426
20-24	0.6646	0.8932
25-29	0.6712	0.8165
30-34	0.8899	0.8566
35-39	0.8856	0.9603
40-44	1.2239	0.8895
45-49	1.5479	0.9085
50-54	1.4842	1.0865
55-59	1.4457	1.3230
60+	2.2627	2.0021
States with Age Adjustment Limited to 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

5. Health Status Adjustment

The final step is to adjust the age and gender rated premium estimated above to reflect the health status of the individual. We use the model to create a "loss ratio" for each individual, that is computed as the ratio of expected costs for an individual over the age and gender rated premium discussed above.

Each premium is then multiplied by an expected loss ratio that adjusts for differences in the expected level of spending for the individual that is not explained by the age adjustment. We did this by applying the age and gender premium for each individual in MEPS and computing the ratio of expected costs to the age and gender adjusted premium, which we have called the loss ratio.

We then tabulate all privately insured people in the MEPS by various groupings of the expected loss ratio to create factors for use in simulating the rating process. To simulate the limits on rate variation in the individual markets, we create separate groupings that have the effect of limiting rate variation to 4:1, 3:1 and 2:1 (*Figure B-6*).

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Figure B-6: Rate Variation with Expected Loss Ratio

Loss Ratio: 4:1 Rate Band	
0-50	0.4944
50-75	0.8730
75-100	0.9874
100-125	1.0967
125-150	1.1829
150+	1.8891
Loss Ratio: 3:1 Rate Band	
0-75	0.6447
75-100	0.9874
100-125	1.0967
125+	1.5543
Loss Ratio: 2:1 Rate Band	
0-100	0.7964
100-115	1.0876
115+	1.4344

This enables us to simulate the effect of limitations on rate variation. For example, for a state with a 4:1 rating band, the model uses loss ratio adjustments ranging between 0.4944 and 1.8891. The loss ratio factor varies from 0.6447 to 1.5543 in a state limiting rate variation to 3:1.

6. Special Rates for Uninsured people with Chronic Conditions (Uninsurable)

In this step, we assign a premium to uninsured individuals representing what they would have to pay for coverage given their health status. This amount is computed even for people in states where insurers are permitted to decline coverage to individuals due to health status. These individual are assigned a risk adjustment based upon the amount of their expected spending. Uninsurable people who are in the 90th percentile or more of the general population in terms of prior year spending are assigned a loss ratio adjustment factor that is equal to their computed loss ratio. Because people in the uninsurable group generally have higher costs than others, many of the uninsurable people have spending at or above the 90th percentile (*Figure B-7*).

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Figure B-7: Rating for Uninsurable Individual [a/]

Uninsurable People – At or Above the 90th Percentile on prior year Health Spending	
Below 90th percentile	1.8891
95th percentile	2.8881
97.5th percentile	3.1754
98.75th percentile	4.7183
100th percentile	7.8881
Insurable People – Below 90th Percentile on Prior Year Spending by Expected Loss Ratio Group	
0-50	0.4944
50-75	0.8730
75-100	0.9874
100-125	1.0967
125-150	1.1829
150+	1.8891

a/ Uninsurable individuals are defined to be people with one or more chronic conditions that are typically used in states to identify people eligible for a state high-risk pool.

For uninsurable people below the 90th percentile in prior year spending, we adjust the premium based upon a 4:1 rating band based on their expected loss ratio.

B. Small Group Rating under Current Law

We simulate rating practices in the small group market using a "synthetic" firm database. These data are based upon a survey of employers from the Kaiser Family Foundation survey of employers which we have statistically matched to a sample of workers from the MEPS household data that obtain the detailed health spending and demographic data required to simulate the impact of small group rating practices, including the detailed data required on each member of the employer's workforce.

The process used to simulate premiums in the small group market is similar to that used to simulate individual premiums, except that it is at the firm level. We develop a "rate book" methodology that simulates premiums under the methods permitted in each state, including health status rating. This enables us to simulate the changes in premiums that will result from changes in rating practices mandated in health reform.

The methods we use to simulate small group premiums are presented in the following sections:

- Synthetic firm data;
- Expected health spending by firm;
- Insurer rating practices;
- Age and Gender Adjustment;
- Industry and group size adjustments; and
- Loss ratio adjustments.

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1. Synthetic Firms

To simulate the impact of reform on employers, we develop a "synthetic" database of firms that, includes detailed health status and spending information for each worker and dependent in the firm, in addition to other firm characteristics information. We begin with a database of employers based upon data from the Kaiser Family Foundation survey of employer in 2006, which includes health plan characteristics data. We then statistically match these data to the Robert Wood Johnson Foundation (RWJF) survey of employers, which provides detailed information on the distribution of workers within each firm by earnings level, age, gender and other worker characteristic.

We enhance these data to include detailed information on health spending, income and family characteristics. The first step was to statistically match each MEPS worker, which we call the "primary worker", with one of the employer health plans in the 2006 KFF/RWJF data. We then populate that firm by randomly assigning other workers drawn from the MEPS file with characteristics similar to those reported for the KFF/RWJF database. For example, a firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's worker profile.

This process is repeated for each worker in the HBSM data to produce one unique synthetic firm for each MEPS worker (about 63,000 synthetic firms). Synthetic firms are created for all workers including those who do not sponsor health insurance, and workers who do not take the coverage offered through work.

2 Expected Health Spending by Firm

As discussed above, insurers often take health status into account in setting small group premiums. In states where permitted, rating is affected by historical claims experience and other health status information. To simulate the rate setting process, we develop a process for estimating expected health care costs for each firm at the beginning of each rating year, which we assume is used as the basis of all health status related decisions. We do this by calculating health spending for workers in each firm for each of two consecutive years using data provided for working families in the MEPS.

As discussed above, the MEPS include detailed health spending data for two consecutive years for each individual, which is included for each worker assigned to each firm. Thus, we are able to tabulate average spending for workers in each firm in the second year by percentile ranking of average employee spending in the prior year as shown in ***Figure B-8***.

In this simulation, we assume that the insurer is estimating this expected spending level for each firm at the end of the first year to use in setting premiums for the coming year. We do this by assigning to each firm an expected spending level for the second year using the data shown in ***Figure B-8***. This expected value is used to set premiums at the beginning of the second year.

Naturally for each firm, actual spending in the second year (which we term the simulation year) will differ from the predicted average expected spending amounts depending upon the expenses actually experienced by workers in the second year. This reflects that while insurers cannot know actual spending for each group in advance, they can use medical information to predict spending levels that will on average track with actual spending during the rating year.

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Figure B-8
Average Costs Per Person in Two Consecutive Years for Synthetic Firms Groups by Percentile Ranking of First Year Group Costs by Firm Size in 2010

Percentile of Year 1 Costs	Average Costs Per Covered Individual									
	Under 10		10-24		25-99		100-199		1,000-5,000	
	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs
10 Percent	$142	$1,132	$684	$1,578	$1,250	$1,912	$2,003	$2,406	$2,547	$2,598
20 Percent	$397	$1,633	$1,114	$1,885	$1,688	$2,250	$2,390	$2,675	$2,752	$2,815
30 Percent	$658	$1,759	$1,443	$2,123	$1,981	$2,453	$2,616	$2,818	$2,870	$2,911
40 Percent	$961	$1,885	$1,755	$2,325	$2,245	$2,608	$2,799	$2,950	$2,968	$2,987
50 Percent	$1,372	$2,311	$2,093	$2,551	$2,510	$2,752	$2,970	$3,068	$3,068	$3,078
60 Percent	$1,960	$2,730	$2,476	$2,756	$2,795	$2,936	$3,141	$3,180	$3,172	$3,194
70 Percent	$2,646	$2,744	$2,932	$3,021	$3,129	$3,058	$3,331	$3,298	$3,290	$3,294
80 Percent	$3,402	$3,398	$3,571	$3,381	$3,571	$3,296	$3,569	$3,404	$3,434	$3,412
90 Percent	$5,631	$5,446	$4,703	$3,793	$4,236	$3,599	$3,919	$3,585	$3,638	$3,538
95 Percent	$7,897	$5,619	$6,392	$4,631	$5,189	$4,004	$4,403	$3,835	$3,917	$3,784
97.5 Percent	$13,123	$8,300	$8,396	$5,376	$6,201	$4,428	$4,925	$4,200	$4,220	$4,029
98.75 Pct	$20,262	$11,294	$10,849	$5,810	$7,357	$4,672	$5,452	$4,485	$4,599	$4,548
100 Percent	$40,825	$19,210	$16,406	$7,280	$9,823	$5,332	$6,421	$4,713	$5,262	$4,931
Total	$3,467	$3,467	$2,852	$2,852	$2,913	$2,913	$3,153	$3,153	$3,151	$3,151

Source: The Lewin Group estimates using HBSM Synthetic firm data.

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3. *Insurer Rating Practices*

The methods used by insurers to rate small group insurance vary with state regulations and insurer policy. ***Figure B-9*** presents a summary of the small group rating rules that apply in each state supplied by the National Association of Health Underwriters (NAHU). In some states, insurers are not allowed to vary premiums with health status, but are allowed to vary premiums by age subject to rating bands. New York, for example, has a community rated system, which means that insurers are required to charge a single premium for each product for all small groups purchasing coverage in the state by geographic area.

Figure B-9: State Rating Limits for Small Group Markets

St No.	State Name	Group Size		Rating Limits
		Min	Max	
1	Alabama	2	50	4: +/- 20-25% rating bands
2	Alaska	2	50	3: +/- 30-35% rating bands
3	Arizona	2	50	2: +/- 50% rating bands
4	Arkansas	2	50	4: +/- 20-25% rating bands
5	California	2	50	4: +/- 20-25% rating bands
6	Colorado	1	50	5: ACR: adjusted community rating
7	Connecticut	1	50	5: ACR: adjusted community rating
8	Delaware	1	50	3: +/- 30-35% rating bands
9	Dist of Columbia	2	50	1: NRS: no rating structure
10	Florida	1	50	4: +/- 20-25% rating bands
11	Georgia	2	50	4: +/- 20-25% rating bands
12	Hawaii	1	50	3: +/- 30-35% rating bands
13	Idaho	2	50	2: +/- 50% rating bands
14	Illinois	2	50	4: +/- 20-25% rating bands
15	Indiana	2	50	3: +/- 30-35% rating bands
16	Iowa	2	50	4: +/- 20-25% rating bands
17	Kansas	2	50	4: +/- 20-25% rating bands
18	Kentucky	2	50	3: +/- 30-35% rating bands
19	Louisiana	2	35	3: +/- 30-35% rating bands
20	Maine	1	50	4: +/- 20-25% rating bands
21	Maryland	2	50	3: +/- 30-35% rating bands
22	Massachusetts	1	50	5: ACR: adjusted community rating
23	Michigan	2	50	2: +/- 50% rating bands
24	Minnesota	2	50	4: +/- 20-25% rating bands
25	Mississippi	1	50	4: +/- 20-25% rating bands
26	Missouri	2	25	4: +/- 20-25% rating bands
27	Montana	2	50	4: +/- 20-25% rating bands
28	Nebraska	2	50	4: +/- 20-25% rating bands
29	Nevada	2	50	4: +/- 20-25% rating bands

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St No.	State Name	Group Size		Rating Limits
		Min	Max	
30	New Hampshire	1	50	4: +/- 20-25% rating bands
31	New Jersey	2	50	5: ACR: adjusted community rating
32	New Mexico	2	50	4: +/- 20-25% rating bands
33	New York	2	50	6: C: pure community rating
34	North Carolina	1	50	4: +/- 20-25% rating bands
35	North Dakota	2	25	3: +/- 30-35% rating bands
36	Ohio	2	50	3: +/- 30-35% rating bands
37	Oklahoma	2	50	4: +/- 20-25% rating bands
38	Oregon	2	50	5: ACR: adjusted community rating
39	Pennsylvania	2	50	1: NR5: no rating structure
40	Rhode Island	1	50	3: +/- 30-35% rating bands
41	South Carolina	2	50	4: +/- 20-25% rating bands
42	South Dakota	2	50	4: +/- 20-25% rating bands
43	Tennessee	2	25	3: +/- 30-35% rating bands
44	Texas	2	50	4: +/- 20-25% rating bands
45	Utah	2	50	3: +/- 30-35% rating bands
46	Vermont	1	50	5: ACR: adjusted community rating
47	Virginia	2	50	4: +/- 20-25% rating bands
48	Washington	2	50	5: ACR: adjusted community rating
49	West Virginia	2	50	3: +/- 30-35% rating bands
50	Wisconsin	2	50	3: +/- 30-35% rating bands
51	Wyoming	2	50	3: +/- 30-35% rating bands

Figure B-10 summarizes the rating factors we assume are used for states with various types of rating restrictions. While many states limit premium variation with rating bands, insurers are often permitted to use a variety of other rating factors such as age, industry, group size and health status. Less is known about the use of these rating factors because they are optional to the insurer.

Figure B-10: Rate Tables used for Rating Method Type for Small Groups

		Age Rating	Loss Ratio
1:	no rating structure	based on Figure 11	4:1
2:	+/- 50% rating bands	based on Figure 11	4:1
3:	+/- 30-35% rating bands	based on Figure 11	3:1
4:	+/- 20-25% rating bands	based on Figure 11	3:1
5:	Modified community rating	4:1	None
6:	pure community rating	none	None

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Consequently, we randomly assign the rating structures that will be applied to each firm in the data, subject to state limits on premium variation. Based upon prior studies by the Congressional Research Service and information supplied by actuaries, we assume the prevalence of use for these rating factors is as shown in *Figure B-11*.

Figure B-11: Rating Factor Distribution Table

	Firm Size		
	Under 10	**10-24**	**25-99**
Age rating	100%	100%	100%
Industry	79%	97%	98%
Group size	80%	64%	80%
Health status	75%	72%	80%

4. Age and Gender Rates

Insurers typically estimate small group premiums based upon a combination of factors applied sequentially to a base premium amount. The first step is to estimate a premium based upon the age and gender of their workers. Here we start with a base rate for each individual worker that is then adjusted to reflect differences in costs by age and sex. We use single year of age by gender and health status - as reflected in the expected loss ratio - in states with minimal rate regulation (*Figure B-12*). For others, we use rating bands that vary from 4:1 to 3:1 adjustments depending upon the degree of rate compressions required in the firm's state of residence (*Figure B-13*). At this point, the firm premium is the sum of the age and sex adjusted premiums for each person in the group.

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Figure B-12: Age Rating Factors Single Year of Age by Gender Premium Adjustment

Age	Individuals		Family	
	Male	Female	Male	Female
17	0.4869	0.6008	0.4016	1.6568
18	0.4469	0.5868	0.5579	1.5048
19	0.4503	0.6320	0.8402	1.2249
20	0.4303	0.8518	1.0727	0.8905
21	0.4403	0.9057	1.0727	0.7201
22	0.4503	0.9640	1.1487	0.6747
23	0.4476	0.9989	1.0530	0.7020
24	0.4576	1.0664	0.9027	0.7068
25	0.4662	1.3368	0.8242	0.7227
26	0.4762	1.2984	0.8106	0.7676
27	0.5000	1.2995	0.8773	0.7805
28	0.5120	1.2711	0.9247	0.7490
29	0.5243	1.2457	0.9284	0.7200
30	0.5368	1.2937	0.8832	0.8285
31	0.5497	1.3247	0.8832	0.8285
32	0.5629	1.3564	0.8881	0.8530
33	0.5815	1.4013	0.9053	0.8271
34	0.6007	1.4475	0.9153	0.7442
35	0.6225	1.1780	0.9838	0.6967
36	0.6423	1.2155	1.0953	0.6761
37	0.6622	1.2531	1.2067	0.6761
38	0.6887	1.3033	1.2071	0.6868
39	0.7152	1.3534	1.1226	0.7012
40	0.7450	1.2852	1.0025	0.7448
41	0.7748	1.2556	0.9341	0.7900
42	0.8046	1.2260	0.9069	0.8208
43	0.8377	1.2015	0.9033	0.8508
44	0.8741	1.1820	0.9119	0.8656
45	0.9105	1.1092	0.9021	0.8906
46	0.9503	1.1423	0.9208	0.8464
47	0.9900	1.1754	0.9533	0.7726
48	1.0430	1.2085	1.0383	0.6960
49	1.0960	1.2416	1.0771	0.6681
50	1.1522	1.2747	1.0888	0.6642
51	1.2152	1.3112	1.1270	0.6298
52	1.2781	1.3476	1.2501	0.6008
53	1.3476	1.3973	1.4569	0.6252
54	1.4204	1.4469	1.5695	0.7218
55	1.4966	1.4966	1.6303	0.8404
56	1.5794	1.5496	1.5560	0.9069
57	1.6621	1.6059	1.5217	0.9273
58	1.7548	1.6688	1.4037	0.9276
59	1.8542	1.7350	1.3323	0.9605
60	1.9568	1.8045	1.2751	1.1107
61	2.0661	1.8740	1.3481	1.4748
62	2.1820	1.9502	1.5066	2.1395
63	2.2945	2.0197	1.7577	2.9443
64	2.4137	2.0926	2.1359	3.6889
65	2.8144	2.3277	2.6246	4.2686

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Figure B-13
Rating factors by age in states with Rating Bands

Age Adjustment: 4:1 Rate Band		
< 20	0.5737	1.0426
20-24	0.6646	0.8932
25-29	0.6712	0.8165
30-34	0.8899	0.8566
35-39	0.8856	0.9603
40-44	1.2239	0.8895
45-49	1.5479	0.9085
50-54	1.4842	1.0865
55-59	1.4457	1.3230
60+	2.2627	2.0021
Age Adjustment 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

In states with little or no regulation of rates, we assume that insurers use single year of age. In states with rating bands of +/- 50 percent, we assume rates vary with age on a 4:1 basis. The age rate band is assumed to be 3:1 in states with 30 percent to 50 percent rating bands and 3:1 in states with rating bands of less than 30 percent. We assume 4:1 rate variation by age in states with adjusted community rating, which does not permit rates to vary with health status and other factors.

5. Industry and Group Size Adjustment

We also adjust for major industry groups in setting premiums. As discussed above, we use a probability table to determine whether the insurer adjusts for industry in rating groups. ***Figure B-14*** presents two sets of rate adjustment factors by industry. The first is an adjustment for premiums that assumes the group has not been rated by age or any other factor.

The second is a factor that applies to cases where the first stage premium calculation is based on age and gender. This is a conditional adjustment that is designed to capture premium variation by industry that is not already explained by adjusting for age and gender. We estimate both of these adjustments using the MEPS data for people with employer health insurance.

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Figure B-14: Rate Variation by Industry

	Individual		Family	
	Industry not Adjusted	Age/Sex Adjusted	Industry not Adjusted	Age/Sex Adjusted
Agriculture	1.0925	1.1795	0.9339	0.9587
Mining	1.1069	1.1845	1.0010	0.9962
Construction	1.2331	1.3397	0.9626	0.9681
Manufacturing	1.1223	1.1838	1.0152	0.9649
Transportation	1.1072	1.1865	1.0469	0.9863
Wholesale Trade	0.4861	0.5710	0.9907	1.0025
Retail Trade	0.5261	0.6023	0.9890	0.9673
Finance	1.1335	1.2115	0.9910	0.9871
Services	0.8731	0.8256	1.0708	1.1256
S&L Gov	1.1679	1.0621	1.0095	1.0585
Individuals	1.0698	1.0452	0.8025	0.7697

In addition, we adjust for group size in cases where the model selects a firm to be rated on the basis of group size, in addition to other factors. The rate adjustments are conditional depending upon the factors used thus far to set the premium. Thus, for example, the group size adjustment is only the factor that explains premium variation beyond what has already been captured with a prior stage adjustment such as age or industry. *Figure B-15* presents the adjustment factors used depending upon the factors use to adjust the premium to this point in the calculation.

6. Loss Ratio Adjustments

In the final step, we perform a health status adjustment based upon a loss ratio calculated in the model for each firms in states where health status rating is permitted. We estimate these factors by using the rating factors described above to calculate a premium for each group. We then divide estimated average expected costs for the group over the adjusted premium. The result is an adjuster that accounts for the variation in expected health care costs that is not explained by the other rating factors described above.

We estimate these adjusters conditioned on the use of other rating factors in setting the premium up to this point. We assume that the loss ratio adjustment varies from 4:1 to 3:1 depending upon the allowable rate band in their state of residence. These adjusters are shown in ***Figure B-16***.

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Figure B-15: Rate Variation by Group Size

	Individual				Family			
	Group Size Adjusted Only	Age/Sex Adjusted Only	Age/Sex Industry Adjusted	Industry Adjusted Only	Group Size Adjusted Only	Age/Sex Adjusted Only	Age/Sex Industry Adjusted	Industry Adjusted Only
2-9	0.9751	0.9413	1.0076	1.0651	0.9558	0.9621	0.9312	0.9339
10-24	0.9172	0.9344	0.9813	1.0079	0.9840	1.0201	0.9977	0.9658
25-99	0.8996	0.9436	0.9800	0.9674	0.9823	1.0296	1.0084	0.9626
100-499	0.9318	0.9095	0.9856	0.9999	1.0555	1.0282	1.0025	1.0314
500-999	0.9906	1.0015	1.0031	0.9989	1.0464	1.0408	1.0189	1.0247
1000-4999	1.0503	1.0484	1.0174	0.9980	1.0397	1.0255	0.9976	1.0215

Figure B-16: Health Status Adjustment Based on Expected Loss Ratio

	No Age & Sex Adjustment				Age/Sex Adjustment			
	Unadjusted	Group	Industry	Group Size and Industry	Unadjusted	Group	Industry	Group Size and Industry
Loss Ratio 4:1 Rate Band								
0-50	0.4513	0.4635	0.4705	0.4734	0.4944	0.5137	0.5126	0.5151
50-75	0.8500	0.8523	0.8623	0.8655	0.8730	0.8645	0.8858	0.8753
75-100	0.9851	0.9785	0.9804	0.9835	0.9874	0.9879	1.0010	1.0054
100-125	1.1063	1.0818	1.0974	1.0816	1.0967	1.0719	1.0657	1.0591
125-150	1.2121	1.1993	1.1882	1.1868	1.1829	1.1768	1.1634	1.1659
150+	1.9832	2.0597	1.9976	2.0280	1.8891	1.9320	1.9125	1.9144
Loss Ratio 3:1 Rate Band								
0-75	0.6135	0.6333	0.6353	0.6400	0.6447	0.6631	0.6654	0.6666
75-100	0.9851	0.9785	0.9804	0.9835	0.9874	0.9879	1.0010	1.0054
100-125	1.1063	1.0818	1.0974	1.0816	1.0967	1.0719	1.0657	1.0591
125+	1.6204	1.6736	1.6343	1.6582	1.5543	1.5925	1.5737	1.5838

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C. Simulating Enrollment in High-Risk Pools

To determine the number of people that will be enrolled in high-risk pools prior to the implementation of the ACA, we compile the number of members and monthly allowed costs per member in existing state high-risk pools for 2013 (*Figure B-17*). We also estimate the number of members and average monthly allowed costs for people that we anticipate will be enrolled in the temporary federal high risk-pools for each state in 2013. We trend the allowed cost number to 2014 (our simulation year) by six percent to account for health care inflation.

Neither the Current Population Survey (CPS) nor the Medical Expenditure Panel Survey (MEPS), which are the primary data sources for HBSM, provides information on people enrolled in high-risk pools. Therefore, we need to impute high-risk pool coverage in HBSM. To do this, we select a subset of people with non-group coverage that also had a health condition that is typically used to determine eligibility for existing state high-risk pools.

We randomly select people that met the above criteria in each state in the HBSM data so to match the total number of people we project to be enrolled in either the current state high-risk pools or the temporary federal high-risk pools. We then adjust the average monthly spending for these people in HBSM to match our estimates for each state. We then adjusted the average covered costs for people remaining in the non-group market so to match the NAIC data, which we have assumed does not include high-risk pool enrollees.

This imputation method may potentially overstate our baseline cost estimates for uninsured people. Our coverage estimates are based on data prior to the implementation of the federal high-risk pools, where enrollees in this program would be categorized as uninsured. Thus, some of the higher cost uninsured in the data would now be covered through the high risk pool, which would reduce the overall average cost for those remaining uninsured. However, we do not believe that this makes a material difference in the estimate do to the fact that only about 164,000 of the 52.4 million uninsured are assumed to be enrolled in the Federal high risk pool. However, the reader can make a determination for a particular state based on the information presented.

Figure B-17: Estimated High-Risk Pool Enrollment and Allowed Cost in 2013

	Current State High-Risk Pools		Temporary Federal High-Risk Pools		Combined State and Federal High-Risk Pools	
State	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM
ALABAMA	2,050	$1,158	1,300	$3,824	3,350	$2,193
ALASKA	526	$2,576	46	$13,885	572	$3,485
ARIZONA	0	$0	8,453	$2,713	8,453	$2,713
ARKANSAS	2,696	$992	1,381	$1,548	4,077	$1,181
CALIFORNIA	6,051	$1,052	26,790	$3,921	32,841	$3,393
COLORADO	13,775	$1,165	1,907	$3,345	15,682	$1,430
CONNECTICUT	1,492	$1,801	1,133	$1,821	2,625	$1,810
DELAWARE	0	$0	472	$1,432	472	$1,432
DC	0	$0	100	$1,680	100	$1,680

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	Current State High-Risk Pools		Temporary Federal High-Risk Pools		Combined State and Federal High-Risk Pools	
State	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM
FLORIDA	202	$1,262	18,322	$2,690	18,524	$2,674
GEORGIA	0	$0	5,056	$2,778	5,056	$2,778
HAWAII	0	$0	246	$3,171	246	$3,171
IDAHO	1,794	$851	1,821	$7,052	3,615	$3,975
ILLINOIS	20,445	$1,271	4,412	$2,013	24,857	$1,403
INDIANA	7,364	$1,981	3,389	$2,673	10,753	$2,199
IOWA	3,234	$1,375	478	$2,604	3,712	$1,534
KANSAS	1,476	$1,860	735	$3,829	2,211	$2,514
KENTUCKY	4,430	$1,494	2,233	$1,867	6,663	$1,619
LOUISIANA	1,738	$1,330	2,521	$2,091	4,259	$1,781
MAINE	0	$0	69	$5,399	69	$5,399
MARYLAND	20,238	$1,040	1,634	$2,186	21,872	$1,126
MASSACHUSETTS	0	$0	49	$4,054	49	$4,054
MICHIGAN	0	$0	4,036	$3,927	4,036	$3,927
MINNESOTA	26,476	$1,207	1,344	$2,103	27,820	$1,250
MISSISSIPPI	3,299	$1,137	680	$3,763	3,979	$1,586
MISSOURI	3,986	$1,412	3,285	$3,291	7,271	$2,261
MONTANA	2,775	$1,154	428	$2,624	3,203	$1,351
NEBRASKA	3,824	$1,531	809	$3,905	4,633	$1,945
NEVADA	0	$0	2,363	$3,451	2,363	$3,451
NEW HAMPSHIRE	2,751	$1,121	1,149	$6,150	3,900	$2,603
NEW JERSEY	0	$0	1,638	$3,491	1,638	$3,491
NEW MEXICO	8,442	$1,509	2,076	$2,860	10,518	$1,776
NEW YORK	0	$0	6,645	$3,012	6,645	$3,012
NORTH CAROLINA	9,280	$896	8,459	$759	17,739	$831
NORTH DAKOTA	1,443	$950	185	$4,581	1,628	$1,364
OHIO	0	$0	4,453	$1,968	4,453	$1,968
OKLAHOMA	2,515	$1,735	1,316	$3,366	3,831	$2,295
OREGON	11,761	$1,313	2,324	$3,647	14,085	$1,698
PENNSYVANIA	0	$0	8,545	$1,287	8,545	$1,287
RHODE ISLAND	0	$0	204	$2,981	204	$2,981
SOUTH CAROLINA	1,739	$1,426	2,903	$2,650	4,642	$2,192
SOUTH DAKOTA	610	$1,283	271	$7,623	881	$3,233
TENNESSEE	3,132	$1,376	2,919	$2,823	6,051	$2,074
TEXAS	24,174	$1,454	14,848	$4,856	39,022	$2,749
UTAH	3,666	$1,013	1,808	$3,530	5,474	$1,844
VERMONT	0	$0	0	$0	-	$0
VIRGINIA	0	$0	4,626	$2,440	4,626	$2,440
WASHINGTON	3,706	$2,420	1,156	$4,613	4,862	$2,941
WEST VIRGINIA	1,173	$842	340	$2,498	1,513	$1,214
WISCONSIN	21,645	$1,114	3,043	$1,043	24,688	$1,105
WYOMING	1,001	$1,310	506	$1,844	1,507	$1,490

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D. Simulating Non-Group Premiums under the ACA

The model simulates premiums for people in the individual market under the ACA using rating restrictions specified in the Act. The ACA allows rating variation based only on age (limited to 3:1), geography, family composition and tobacco use (limited to 1.5:1). Similar to the steps described above for calculating individual market premiums, the HBSM model uses a premium equal to the base rate for single and family coverage which is adjusted for age, single/family coverage and state. The model does not include data on tobacco use, so we do not adjust for tobacco use. Gender, health status and expected loss ratios are not used in that ACA premium calculation.

The age adjustments are estimated from the MEPS data for privately insured people. These adjustments are performed separately for individual policy holders and family policy holders. The model uses a base rate for individuals and a base rate for family coverage, both of which vary with the age of the policyholder only. ***Figure B-18*** shows the age adjustments used for the 3:1 rating limits.

Figure B-18: Age Rating Factors in the Individual Market under the ACA

	Individual	Family
Age Adjustment Limited to 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

CMS recently released its proposed standard age curve by single year of age, which is different from the method used for this analysis. However, we do not believe this difference will make a material difference because premium subsidies have a much larger impact on the cost of insurance to individuals in our simulation as compared to premium rating practices. Using age bands will, as we have done in this analysis, has the effect of compressing premium variation for all ages within the age band. Premiums based on single year of age will result in more variation across all ages. For states that currently do not have rating restrictions, which we assume use single year of age rating plus health status rating, that will move to a 3:1 rating limit using age bands could produce a greater difference in premiums (current compared to ACA) for certain ages as compared to premiums using a single year of age curve as proposed by CMS. Since this analysis uses an elasticity model to simulate participation that is based on a change in price, then these premium differences could have an effect on who participates.

However, we estimate that most people purchasing coverage in the individual market under the ACA will receive premium subsidies, which effectively reduces premium costs. We found that premium subsidies have the largest impact on change in price of insurance and thus the largest impact on participation. Because premium subsidies have such an impact on the cost of insurance to individuals in our simulation, premium calculations using a single year of age

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curve versus an age band curve does not make a material difference for simulating non-group participation under the ACA.

E. Simulating Small Group Premiums under the ACA

The model simulates premiums for fully insured small groups (100 or fewer members) under the ACA using rating restrictions specified in the Act. Similar to the individual market, the ACA allows rating variation based only on age (limited to 3:1), geography, family composition and tobacco use (limited to 1.5:1) in the small group market. Similar to the steps described above for calculating small group premiums under current law, HBSM estimates a premium based only upon the age workers in the group. Here, we start with a base rate for each individual worker that is then adjusted to reflect differences in costs by age. As specified under the ACA, we restrict rating variation to 3:1 ratio based on the adjustments shown in ***Figure B-18***. At this point, the firm premium is the sum of the age and sex adjusted premiums for each person in the group. The model does not include data on tobacco use, so we do not adjust for tobacco use. Health status and expected loss ratios are not used in that ACA premium calculation nor are new taxes and fees.

For modeling purposes, we assume that premiums for self-insured firms and large groups are unaffected under the ACA.

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Appendix C - State Specific Excel Spreadsheets

The Excel spreadsheets can be found on the web page that is housing this report on the SOA web site.

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