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THE INDIVIDUAL AND EMPLOYER MANDATES IN THE PRESIDENT'S HEALTH CARE LAW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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THE INDIVIDUAL AND EMPLOYER MANDATES IN THE PRESIDENT'S HEALTH CARE LAW

TUESDAY, APRIL 14, 2015

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

The Subcommittee met, pursuant to call, at 10:08 a.m., in Room B–318, Rayburn House Office Building, Hon. Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Tuesday, April 7, 2015
No. HL–01

CONTACT: (202) 225–3943

Chairman Brady Announces Hearing on the Individual and Employer Mandates in the President's Health Care Law

Congressman Kevin Brady (R–TX), Chairman of the Subcommittee on Health, today announced that the Subcommittee will hold a hearing on the individual and employer mandates and associated penalties in the President's health care law. **The hearing will take place immediately following a brief Subcommittee organizational meeting on Tuesday, April 14, 2015, in Room B–318 of the Rayburn House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, April 28, 2015**. For questions, or if you encounter technical problems, please call (202) 225–3625 or (202) 225–2610.

FORMATTING REQUIREMENTS:

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

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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

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

Chairman BRADY. The hearing is called to order.

With the successful replacement of the flawed formula for paying local doctors under Medicare nearly complete, I want to welcome everyone to the first hearing of the Health Subcommittee in the 114th Congress.

I would like to offer especially a warm welcome to the new Members of our Subcommittee: Ms. Jenkins, Mr. Marchant, Ms. Black, and Mr. Davis.

Joining us today are three qualified witnesses: Doug Holtz-Eakin of the American Action Forum; Scott Womack of Womack Restaurants; and Sabrina Corlette, a Senior Research Fellow, Project Director, and Adjunct Professor at Georgetown University.

Welcome, as well.

Tomorrow marks the end of the tax season and, with it, the annual ritual of navigating a needlessly complicated maze of IRS forms and regulations.

New this year is the controversial mandate within the President's Affordable Care Act that requires all Americans to buy government-approved health care or pay the Internal Revenue Service. Also, this year, local businesses with more than 100 full-time workers will be forced to comply with an ACA mandate to offer qualified health care or pay the IRS.

Now, we have been told that these mandates are an essential part of President Obama's health care law, that they are absolutely necessary to control costs and keep everyone insured. Without these mandates, we are warned, health insurance markets would not be able to function properly.

Here is the irony: Before the ACA, too many Americans couldn't afford to buy insurance because it was too expensive. Now the President's law makes insurance even more expensive, then forces people to buy it.

What ObamaCare does is force people to pay for healthcare plans they don't want, can't afford, and, for some, this meant losing the coverage they already had. This should come as no surprise. The Affordable Care Act doesn't let people pick a plan that fits their needs. Instead, the law forces Americans to choose from a list of plans that Washington picks for them and forces them to buy.

This is not how affordable healthcare reform should work. Washington should not be in the business of telling Americans how much health care they need and then penalizing them if they decide to go their own way.

Even the President at one point was against this mandate, stating, "A mandate means that in some fashion everyone will be forced to buy health insurance. But I believe the problem is not the

folks trying to avoid getting health care; the problem is they can't afford it."

We should empower families and patients and put them at the center of the healthcare system, not government bureaucrats. So I believe we can do better. I think we can both lower the cost of health care and encourage people to buy coverage, all without taxes or mandates or penalties.

One idea is to give people a portable, advanceable tax credit that you could use to help pay for any healthcare plan you buy regardless of where you buy it. Another is to give people more choices. Let them choose plans that work for them, like high-deductible healthcare plans and health savings accounts. These are just some ideas that would lower costs and encourage more people to buy coverage, and nobody would have to buy something they don't want.

I know Members on both sides of the Committee have strong feelings about the law's individual and employer mandates, so I look forward to our discussion today.

Before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

I now recognize the Ranking Member, Dr. McDermott, for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I feel like it is springtime. And farmers plow their field; they have to plow the dirt before they go to work. And we are out with our plow today. It is the same plow we had in January of 2011. We have the same cast of characters here, and we will probably have the same hearing, I suspect.

I would like to ask unanimous consent to enter into the record an article from *Atlantic Monthly*, October 2000, called, "Health Care: A Bolt of Civic Hope."

Chairman BRADY. Without objection.

[The submission of The Honorable Jim McDermott follows:]

Health Care: A Bolt of Civic Hope

October 2000 Issue

http://www.theatlantic.com/magazine/archive/2000/10/health-care-a-bolt-of-civic-hope/378391/

NAME a nettlesome social problem -- your favorite measure of cultural woe -- and chances are that today's record-long economic expansion has the statistics on it moving in the right direction. Violent crime, welfare rolls, child poverty, teen pregnancy, suicide, abortion, and divorce are all down. Jobs, SAT scores, air quality, the Dow, charitable giving, and even wages for less-skilled workers are all up. The trend lines are almost uniformly encouraging -- all except one.

The number of Americans without health insurance has soared during the current boom, from 37 million in 1993 (when Bill Clinton said it was a national problem requiring immediate attention) to 44 million today. Why? In part because so many of the jobs being created are at the low end of the labor market, where employers can't afford to offer health benefits or, if they do, employees can't afford to pick up their share, and in part because health-care costs -- after a brief respite in the mid-1990s, thanks to managed care -- are on the rise again, leading smaller firms to drop coverage. Experts say that the number of uninsured people could soon rise to 50 million if times remain good, and to 60 million or more if the economy dips.

More than four in five uninsured Americans work year-round or live in families headed by someone who does. These waitresses, taxi drivers, and plumbers earn too much to be eligible for Medicaid but too little to buy coverage in the notoriously high-priced market for individual policies. They contract preventable diseases and are avoidably hospitalized more often than the insured, and are vulnerable to devastating financial loss from illness in ways unthinkable in other advanced nations. To be sure, some folks go without insurance only briefly, and a few who can afford it go without by choice (mainly people in their twenties who feel certain they'll live forever). But "the hard fact is this: the percentage of the population going without insurance involuntarily is growing year after year, in good times and bad," as one politician wrote his colleagues last year. "This is clearly a structural problem we ignore at our peril." The writer? House Majority Leader Richard Armey, of Texas.

Yet ignoring the problem of the uninsured is one of the few things that both Democrats and Republicans seem eager to do in the current presidential campaign. George W. Bush wants to offer tax subsidies of up to $2,000 per family to buy private insurance. But decent family policies cost more than twice that amount. And the roughly $10 billion a year Bush says he will devote to his plan means that his vaunted "compassion" will touch only a small fraction of the uninsured. This might not be surprising from a Republican candidate save for one striking fact: Bush's father in 1992 offered a version of the same plan that was considerably more generous -- $5,100 per family, adjusted for inflation, at a cost of $50 billion a year. And the father offered his generous plan when the federal budget deficit was nearly $300 billion; the son puts forth his token gesture at a time of comparably outsized surpluses.

Curiously, this shrinking of ambition when federal resources are finally available on a scale equal to the problem also characterizes the Democrats. Vice President Al Gore is offering a patchwork of coverage extensions, mainly for children -- who, because they incur fewer costly illnesses than adults, are a bargain to insure. His plans are a pale shadow of what the Administration was aiming for back when the problem was smaller.

Why are our leaders content to let the problem worsen while our means for addressing it have grown? The unflattering answer is because doing so is both safe and cheap. Today's uninsured are low-income workers with little political voice; in the broad-based recession of the early 1990s it was middle-class anxieties that had politicians scurrying to respond. A policy of rationing health coverage by income also saves money. The uninsured do get care in emergency rooms, county hospitals, and other sites of last resort. But these citizens consume just two thirds as much in health resources as their insured neighbors, because they don't get preventive care, regular checkups, and other services most people take for granted. We can fix the problem of the uninsured only by spending more money on people with little political clout -- and, if necessary, by somehow disguising that this is what we're up to.

Any such attempt, of course, will take place in the shadow of the Clinton health fiasco of 1993-1994. The political lesson both parties drew when Hillary Clinton's bulky plan was attacked unfairly as "socialized medicine" but quite fairly as too complex was that efforts to expand coverage must be incremental. "Step by step" is the approved mantra.

Yet incremental "achievements" since 1994 have been a bust. Senators Ted Kennedy and Nancy Kassebaum sponsored a bill passed in 1996 that was

hailed by both parties as a model for future health reform. The measure was supposed to guarantee continued access to insurance for those who changed or lost their jobs. But insurers were free to charge whatever they liked in these situations, and people quickly found that "access" meant very little when a policy might cost $15,000 a year. Similarly, a plan costing $5 billion a year for the nation's 10 million uninsured children passed with great fanfare in 1997; aid was targeted so narrowly and complexly, however, that only one in five children it was meant to reach have been signed up. Bolder proposals, meanwhile, have proved easy to shoot down as unaffordable. Just ask Bill Bradley.

Indeed, in a year when a Democrat won his party's presidential nomination by attacking another Democrat for trying to insure all Americans, it is tempting to declare universal coverage a lost cause -- tempting but wrong. As it turns out, circumstances have quietly evolved in recent years in ways that leave both parties ready to make an ambitious push, together, on health coverage. This has taken place in a way scarcely visible in the Capitol's day-to-day political jockeying, but the parties, as they align, are poised to produce a movement of surprising power. Republicans, reeling from the failed "revolution" of Newt Gingrich and their associated image as uncaring thugs, have looked for ways to address the frustrations wrought by managed care. Many believe that giving voters more power to choose their health coverage will derail heavy-handed Democratic efforts to regulate private health care. At the same time, many liberal Democrats have come to terms with the fact that power in Congress will be roughly balanced between the parties for the foreseeable future. They've therefore become open to ways of expanding coverage that were once ideologically out of bounds. It sounds perverse, but some optimists say we're just one good recession away from seeing the political energy unleashed to solve this problem.

Luckily, we don't need a recession, because there's a pragmatic solution at hand that can command bipartisan support: tax subsidies for people who need help to buy insurance from competing private health plans. This is basically the scheme that President Bush offered in 1992 and that his son -- in embarrassing (but expandable) miniature -- offers today. It is the same general idea that Bill Bradley pushed earlier this year, and that policy analysts from shops as diverse as the Democratic Leadership Council and the conservative Heritage Foundation have been refining for a decade. A few bipartisan groups of legislators have put forth tiny versions of such a plan, but the time will be ripe after next month's election for the real thing. And although tax subsidies are not perfect (experts say, for example, that the poorest Americans will still need

programs of direct aid and better-funded local clinics), and plenty of details remain to be thrashed out, this scheme offers the most realistic way of bringing the parties together to right an enduring wrong.

The story of the coming "grand bargain" on health care is one of Democrats accepting the existence of a private insurance industry and Republicans accepting the need to help make sure that everyone can buy a decent policy. It is a story of liberals agreeing that innovation shouldn't be regulated out of U.S. health care and conservatives agreeing that justice has to be regulated into it. It is a classic tale of mutual mistrust finally being trumped by mutual political advantage. I know this because after I had scoured Washington for months, talking with several dozen officials, health experts, and interest groups across the political spectrum in search of a workable way to get the parties together on this, an old-time single-payer liberal and a conservative Republican sat down with me and proved that the thing can be done.

The Politicians

THE moment Jim McCrery walked into Jim McDermott's office, near the Capitol, I felt relief. At least the meeting was going to happen. For two weeks we had been planning this session, yet every day I'd half expected one or both of them to call the whole thing off as unnecessary and strange. Why, after all, would a Republican and a Democrat, both of whom serve on the health subcommittee of the powerful House Ways and Means Committee, want to sit down for a journalist in an election year for a session resembling a negotiation? Politicians don't generally volunteer for press encounters they can't control. And as I had learned while making the rounds of Washington's health-policy gurus, getting a liberal and a conservative to discuss a pragmatic way to work toward universal coverage can get complicated.

It was an easy decision to seek out a duo in the House rather than in the Senate, because "the people's chamber" is ground zero for the partisanship that any consensus would have to transcend. The first pairing I thought of was Bill Thomas and Pete Stark -- the chairman and the ranking member, respectively, of the Ways and Means health subcommittee. But Thomas sees Stark as a hopeless liberal relic, and Stark sees Thomas as a heartless market fundamentalist. Thomas made it clear that he would participate in such a discussion only if paired with a centrist Democrat, such as Ben Cardin, of Maryland. But as I told Thomas, there was nothing interesting in the likelihood that he and a centrist Democrat could reach a deal. That happens every day. The question was whether a big-government liberal and a market-loving

conservative could get together. If they could, maybe there'd be a chance for progress.

And so I turned to the Democrat Jim McDermott, of Seattle, and the Republican Jim McCrery, of Shreveport, Louisiana. McDermott, age sixty-three, went to Congress in 1988 after sixteen years in the state legislature. A psychiatrist by training, he is the longtime leader of the single-payer advocates in Congress, who wish to adopt a Canadian-style approach, under which the government doles out cash to regional health authorities that cover everyone and private insurance essentially doesn't exist. Since the Republican sweep of 1994, however, McDermott has stopped pushing this system. He even co-sponsored a Republican bill backing modest health tax credits in 1997.

McCrery, age fifty-one, is the Republican to watch on health care, according to several prominent Republican policy analysts. Also a member of Congress since 1988, he has studied the issue intensively in recent years, and argues that smart politics and sound policy require Republicans to shed their traditional view that health is not "their" issue. McCrery is among those being named as possible successors to Bill Archer, the retiring chairman of Ways and Means, in the scramble expected if the Republicans hold the House this fall.

McDermott scores 85 percent "liberal," McCrery 83 percent "conservative," on rankings compiled by *National Journal,* a Washington-based politics and policy magazine. They voted opposite ways on ten of twelve important votes tracked by that magazine in the past Congress. Personally, too, as I couldn't help noticing while they kibbitzed in McDermott's office, they're a study in contrasts. McDermott is a big man with a hearty laugh, whose boisterous energy seems better suited to the stump than to the Freudian couch. McCrery is slender and soft-spoken. He had to be asked to speak up for my tape recorder.

Staffers for both men had been pressing me for days for a write-up of the plan I had said I would offer as a point of departure for our talk. In the end, however, I decided that putting anything in writing was too risky -- it would be combed by staff members for unacceptable terms and could easily become a pretext for cancellation. Now, while a photographer posed McDermott and McCrery in unnaturally close positions, the two men, who plainly like each other, cracked uneasy jokes about what they had gotten themselves into. Finally they sat down -- McDermott on my left, of course, and McCrery on my right -- on a standard-issue government couch, beneath a wall of photos that included Mahatma Gandhi and a younger, dark-haired McDermott with Ted Kennedy. McDermott, smiling, said he appreciated the gesture his colleague had made by agreeing to

meet in the office of the minority party. The tension soon eased, and they took off their jackets; in the event, they put off meetings and skipped a vote to extend an hour of planned conversation to nearly two.

"What We're Gonna Give Everybody"

WE began. I sketched out an approach that my interviews with them, with their House and Senate colleagues, and with assorted analysts and interest groups had suggested could gather broad support. The basic idea would be to offer people a tax credit usable for the purchase of a health-insurance policy (and to pay the

WEB ONLY

TRANSCRIPT
A Conversation With Jim McDermott and Jim McCrery
The full transcript of Matthew Miller's
conversation with the two congressmen.

amount of the credit directly to those too poor
to owe income taxes). It would be generous enough to buy a decent "Chevrolet" from among competing private health plans. Individuals would have access to some form of insurance pool to ensure affordable group rates. It might be phased in to establish a system parallel to today's employer-based coverage -- offered first, perhaps, to those not covered by either a government plan (such as Medicaid) or a company. The idea would be to avoid giving employers an incentive to drop existing coverage in the near future. Over time, however, it could move the nation away from a system centered on coverage offered by employers to one in which individuals received subsidies and were responsible for -- and perhaps mandated to buy -- their own coverage in the private market.

Obviously, a hundred difficult details are glossed over in this sketch, I said, but something similar was outlined repeatedly by the diverse group I consulted. Could something like this be the beginning of a deal? What follows is a compressed account of the conversation.

McDermott spoke first. "In order to get us off dead center," he said, "we've got to try something in the middle here and see if it'll work. I'm so frustrated by having spent thirty years watching it get worse that I'm willing to try practically anything to get us moving."

"Jim's not going to get what he wants [that is, a single-payer system] anytime soon," McCrery said. "I or some right-wing person is not going to get an unfettered market, which is the individuals fending for themselves. So if we want to solve the problem, we've got to come up with something that's kind of a combination. I think that's possible along the tax-subsidy lines. If we don't do anything, if we just keep going like we're going, eventually I think we'll end up with single-payer. We'll end up with the government controlling just about everything in health care."

This was an argument that McCrery had made to me earlier: that the tendency today to put a patch here and a quick fix there, typified by the push for an HMO patients' "bill of rights," leads inexorably toward heavy-handed federal solutions. "That might take forty years or fifty years," he continued, "but we're going that way now. So I'm willing to accept a lot more government intervention in the market than I normally would to create a system that will have some vestige of the market left in it."

We turned to the key components of a potential health deal, starting with benefits. If a tax subsidy were used, "there would be the element of different levels of health care for different people," McCrery said. "Somebody who is wealthier is probably going to buy a policy that would be richer in benefits than the basic benefit package that I would pay one hundred percent for from the government. That would enable the market to continue to be more innovative than under a single-payer system."

It's the classic conservative argument: beneficial innovations always begin as luxuries for the wealthy. Think of automobiles, telephones, airplanes: first came the breakthroughs funded by the rich and benefiting the rich, and later came dissemination to the masses. This pattern of capitalism, as Milton Friedman argues, has produced higher living standards for more people than any rival form of social organization.

McDermott seemed unconvinced. "But if you and I both need to have doctor visits and all this stuff, right up to the level of a bone-marrow transplant at a hundred and twenty thousand dollars a crack," he asked, "why wouldn't you guarantee that to everybody in the United States? What would you leave above the line that you would say that people who are wealthier can get for themselves?"

"The catastrophic examples are not the kinds of things I'm talking about," McCrery replied. "I'm talking about variances in bells and whistles in insurance policies -- if you want a private room, if you want extra [nursing] help in the

room, all those things that people could purchase if they wanted to. The basic plan that would be provided by the government to low-income folks would not have all those."

McDermott wasn't satisfied. "One of the big difficulties will be us agreeing on a basic package."

"But having said that," McCrery added, "I don't think it's impossible."

"No, it's not impossible," McDermott agreed.

McCrery, like Bill Bradley earlier this year, suggested the federal-employee health plan as a model. It doesn't define benefits down to every test and procedure, but it assures general areas of coverage, such as major medical expenses and surgical fees. This way there's no stifling of the extraordinary innovation that is now sweeping health-care delivery, whose future shape can't be foreseen. Go too far in defining things rigidly, the Republicans argue, and you end up with inanities like Medicare, which unaccountably still fails to cover prescription drugs, thirty-five years after the program's inception.

"Ultimately," McDermott said, "there has to be a come-to-Jesus meeting someplace where that package is defined: This is health insurance for the country. This is what we're gonna give everybody."

I asked McDermott why defining a detailed benefit package is crucial to liberals when there's no government-defined package in the employer-based system under which most Americans now get their coverage. What's more, as Bill Thomas argues, any honest observer has to concede that a move to what Democrats deride as "two-tier" care would be a vast improvement over the five- or six-tier care we have today, which runs from princely to truly pauperish. And as Richard Armey told me, there are precedents for leaving the actual benefit undefined: with food stamps, Uncle Sam provides the wherewithal but doesn't tell poor folks what to eat; the mortgage-interest deduction helps millions without any need for the government to tell people what kind of house to buy. Why not simply make the health subsidy generous enough and let people pick among competing offerings?

McDermott responded that it's hardly an advertisement for the system of different employers' plans we have today, under which one person may be covered for, say, certain cancer treatments, while another cancer patient is exposed to financial ruin. In any major reform such inconsistencies should be rationalized in favor of some common notion of what every citizen ought to

have. It will also be a fight, McDermott believes, to make any tax subsidy substantial enough to buy a decent package, because many Republicans essentially want a cheap tax-style voucher that they can ratchet down over time to limit costs.

Yet both men think that differences here can be bridged. The occupant of the Oval Office, McCrery said impishly, needs to "lock us in a room with his people and say, 'Okay, let's come up with a [benefit] plan that Jim McDermott, Jim McCrery, and President Bush can support.'" McDermott moaned at the very thought. But later he agreed. "If you locked the door and said we don't get any lunch until we come up with a benefit package," he said, "we would have one and be out of here."

"It Would Fundamentally Alter the Insurance Business"

I ASKED the congressmen to turn to another central issue: if individuals are subsidized to buy coverage from private plans, how do we protect people who have predictably high medical costs from sky-high insurance premiums that leave them shouldering the full burden of their own care? Everyone agrees that access to reasonably priced insurance for these unlucky souls should be a priority. How to go about achieving it is another matter. Chip Kahn, the head of the powerful Health Insurance Association of America, the industry's lobbying group, told me that insurers want a separate "high-risk" insurance pool, funded by broad-based taxation, to handle these people (as happens now in some states). Liberals say that such funds invariably mean lousy care, and prove that greedy insurers want only healthy customers who don't actually need insurance. Pete Stark is sharp in his response. "Let's cut the crap," a longtime aide told me he has said, and just redline. "You tell me, Chip Kahn, which healthy folks you want to make money off of, and which sick folks you want the government to take, and we'll cut out all the make-believe."

McDermott was warming to a similar rant when McCrery interrupted him. "I wouldn't have a high-risk pool," he said. "I'd just do community rating."

"Community rating" means that everyone pays the same premium, regardless of age, sex, or medical history. This is, of course, the liberal dream. Rates for decent policies in the individual market can easily top $10,000 a year for people with a history of health problems. Community rating, though controversial in theory, is actually widespread today. Employees of large companies enjoy it on a de facto basis, as health risks are spread among

thousands of workers. It is the chief virtue of today's otherwise anomalous employer-based system, in which the United States, alone among advanced nations, looks to employers to manage most health coverage.

Our employer-based system was a federally engineered accident. Wage freezes during World War II left fringe benefits as the chief means by which big firms were able to compete for employees. Health care as a job-related perk became common. The government then established a large tax subsidy to ratify this arrangement. Every big company is essentially a socialized health republic, in which the young subsidize the old, and the healthy subsidize the sick -- all of whom pay the same premiums for the same plans.

Reorganizing the individual insurance market to make such pooling work would be more complicated. If insurers were forced to offer the same rate to all comers, young workers would pay far more than they would under policies that recognized their relatively low actual health costs. In large companies young workers opt into such a system because their bosses pick up most of the tab. For this to work in an individual market, the incentive must somehow be replicated -- or else coercion must be involved.

What cannot be done is to let young, healthy workers opt out, or the insurance pool will face a classic actuarial disaster. It's not physics: if younger workers decline coverage, the average health costs of those remaining in the pool will be higher, and premiums will rise. But higher premiums will prompt more young, healthy workers to drop coverage. The vicious circle will continue until premiums are sky-high and only the sickest are insured, at exorbitant rates.

This is essentially what happened in New York in 1993, when the state forced insurers to apply community rating to their individual policies. Well-meaning officials hoped to extend affordable coverage to everyone; instead they got a new glut of uninsured. The lessons of Insurance 101 are clear: community rating in an individual insurance market requires either a mandate that everyone buy insurance or a subsidy generous enough to keep younger and healthier people in the pool.

McCrery said he was for both the mandate and the generous subsidy -- at least for people of lower income. That a conservative on the health subcommittee of Ways and Means backs these ideas is stunning. McCrery is one of few in his party at present who take this view. He is also one of few Republicans who have studied the issue so closely.

McDermott was amazed. "Did you know that?" I asked him.

"No, I didn't know that."

I asked McCrery, "What brought you to community rating?"

"I looked at it nine ways to Sunday," he explained, "and I don't think there's any other way to do it. I mean, that's not true, there is another way to do it, but I think the simplest way to do it is just to have community rating. Yes, you can have a high-risk pool, with people moving from under the red line to above the red line, but why fool with all that? It's complicated, it's troublesome, it distorts the market. Why not just have community rating and then let insurance companies compete on the basis of value?"

"Covering everybody," McDermott said.

McCrery nodded. "They'd have to take all comers, but they would compete on the basis of service, economies of scale, efficiencies that they could muster to provide better prices, all those kinds of things. They could still be in the business; they'd just have to compete on those bases and not on getting lucky [that is, picking healthier people to insure]."

I turned to McDermott. "You like that?" I asked. His eyes opened wide.

"Yeah," he said. "I don't want to say anything to mess it up." Both men laughed.

The top insurance lobbyist insists that community rating is a nonstarter, I pointed out. Is there anything legitimate in his opposition?

"Depends on what you mean by legitimate," McCrery said. "To them, it's legitimate. Because, I mean, much of their business now ..."

"They don't have the problems that Jim and I face, which include equity in the society," McDermott injected. "They have a different mandate. I mean, corporations take in as much money as they can, pay as little out so that they have it to give to their stockholders. It's not good or bad, it's just what they are." He looked at his colleague. "That's not what Jim and I are. He represents all 600,000 in his district, and I represent all 600,000 in my district. I can't say, well, I represent 440,000 and the other 160,000 are not my concern. I don't have that option."

"It would fundamentally alter the insurance business," McCrery said.

It would -- by bringing the business back to the way it was, in a sense. Community rating was the way health insurance worked, even in the individual market, until the 1960s. Before then insurers didn't have the data to segment people in sophisticated ways according to health risks. Furthermore, health costs were a fraction of what they are today, meaning that people didn't have much to gain by shopping for cheaper plans, and unlucky insurers burnt by a few high-cost illnesses weren't left reeling. But costs and premiums have soared famously for decades now. The data and the technology needed to identify and price policies for lower-risk customers became available. It didn't take long for entrepreneurs to realize that they could target younger, healthier people with lower rates, sweep up a ton of customers, and make a bundle. The fragmentation of the insurance market -- with its emphasis on "cherry picking" the best risks -- began in earnest.

"The Human Genome Project is going to have an impact on this whole process unlike anything we can really imagine at this point," McDermott said. "Because if I'm an insurance company and I get a drop of your blood and I can do your genetics and I find you have these and these and these proclivities, I'll insure you for everything but those. What is insurance at that point?"

"The game is over at that point," McCrery agreed.

I told them I had asked Chip Kahn, of the insurance association, about this, and he had assured me that insurers would never use genetic information that way. The two legislators exploded in thigh-slapping laughter.

"No comment," McDermott finally managed to say.

Is it reasonable to think that community rating could succeed politically? I asked McCrery. Sure, he said -- group insurers essentially already operate under such a system in big companies. I said, But what about the individual marketplace?

"Well, I may have to settle for less [than its purest form]," McCrery said. "I've talked with insurance companies about this. They tell me that as long as they can underwrite based on age and gender [but not health status], they have no problem, they can make it work."

Cecil Bykerk, an executive vice-president and the chief actuary of Mutual of Omaha, one of the largest insurers in the individual marketplace, later told me the same thing. Mutual looks at people's health status only when they sign up, he explained; once they are in the pool, it doesn't go back and adjust their rates for subsequent health developments (as auto insurers do after accidents). As it turns out, prudent pricing can be based largely on age and sex. (This is true, of course, as long as everyone buys insurance as insurance, and doesn't buy in only when he or she becomes sick; as the famous example has it, buying insurance only when the house is on fire defeats the risk-pooling concept altogether.)

At a minimum, then, McCrery's approach would remove any detailed assessment of health risk from the underwriting process, making it impossible to demand unaffordable premiums from sick Americans or to leave them uninsured. McCrery added that if insurers could go this far, they could go all the way and offer the same rates to everyone, period. He would use a reinsurance fund to compensate unlucky insurers that ended up with an undue share of high-cost cases. McCrery conceded that his scheme would make health insurance look more like a regulated utility, and would put today's entrepreneurial cherry pickers out of business. But better that government guarantee access to insurance at equitable prices, he reasons, than that government involve itself directly in the delivery of health care, or in drug prices, doctors' fees, and more -- as it is sure to do, he thinks, if the present system continues to erode until voters ask liberals to fix things their way.

"If we want to save the private health-care system," McCrery told me in a separate conversation, "Republicans are going to have to accept some things that normally would be contrary to our basic philosophy."

is a nationally syndicated columnist who is based in Los Angeles. He is a senior fellow at the Annenberg Public Policy Center of the University of Pennsylvania.

Mr. MCDERMOTT. This is an article that was written by Matthew Miller after an interview he had with Jim McCrery, who was then the Chairman of the Ways and Means Committee, and me about what the healthcare plan would look like when it happened. This is now 15 years ago.

Everything, practically speaking, that we discussed in that article is in the bill. And all of it Jim agreed to because he knew that you had to make some compromises on a whole bunch of things, one of which was, if you are not going to have a single payer system, then you had to have everybody in. And that meant that employers had to be in and all the people of the United States had to be in.

So this issue is—we have been over it before. If this were an honest discussion, my Republican colleagues would tell you how the individual mandate has balanced risk pools and reduced adverse selection in the health insurance market, or they would tell you how the employer mandate has forced big corporations to pull their weight and cover every employee who works a full workweek, or they might mention how both requirements have taken this country closer than ever to universal coverage.

But we are not going to talk about those things today, and there is a reason for that: Because the hearing isn't about the individual mandate or the employer mandate. What this hearing is about is scoring political points at the expense of the Affordable Care Act. We did it in 2011. We have done it a number of times. It is about continuing a tired, baseless line of attack that will generate no new ideas whatsoever about how to make the law better.

We have been through this before. The House has staged 56 votes to repeal or undermine the law. The Ways and Means Committee has held no less than a dozen hearings to attack the shared-responsibility requirement. In fact, in the 2011 committee hearing, Republicans invited the same two witnesses. Mr. Holtz-Eakin and Mr. Womack were here at that time.

Unfortunately, not one of those hearings has generated a productive discussion of what should be done to improve the law. Not one has led to a meaningful proposal that would ensure greater health security for the American people. I do know that Ms. Black has a bill in that would improve the employers' reporting. So I know that some people are thinking about it, but we haven't had a hearing about it.

And not one has resulted in an alternative plan if my Republican colleagues succeed in dismantling the law. If the Court takes it down, there is nothing on the table. Years of attacks through hearings, lawsuits, press conferences, television ads, op-eds, speeches, and repeal votes, but still no plan to replace it.

Now, while my Republican colleagues have focused on destroying healthcare reform, we have focused on trying to make it work. And, over the past 5 years, the law has been an indisputable success.

Middle-class families now enjoy greater health security than ever before. More than 16 million Americans have gained coverage, thanks to the law. The uninsured rate is at the lowest in history in this country. And 129 million Americans with preexisting conditions can no longer be discriminated against by insurance companies.

The economy is looking better and better, much to the distress of the Republicans. Since the law was enacted, over 12 million jobs have been added to the economy. Now, we were told it was going to cut jobs and there weren't to be any jobs in this country and everything. We have 12 million new jobs since this all happened. Healthcare spending has grown at the lowest rate in five decades, shrinking as a share of GDP for the first time since the 1990s.

But we all know there is more work to be done. I have never said this was a perfect bill. I never thought it was. It wasn't my bill. I didn't like some parts of it. But no legislation is perfect when it is first passed, and it is the duty of Congress to refine and improve the laws it has implemented. Our success in finding a permanent solution to the SGR could be a reminder that it is possible to solve problems and pass legislation through regular order.

And I encourage my Republican colleagues to move beyond the cynical attacks on this law and join me in working to make the law better. It is the law of the land. Until the Supreme Court rules in May or June or whatever they do, it is the law of the land, and we will see what happens then. But that is what the American people expect from us. They expect compromise, and they deserve the Congress to do that.

And I yield back my time.

Chairman BRADY. Mr. Holtz-Eakin, you are recognized for 5 minutes. Thanks for joining us today.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM

Mr. HOLTZ-EAKIN. Chairman Brady, Ranking Member McDermott, Members of the Committee, thank you for the chance to be here today.

I have a written statement for the record. Let me just make a few points about that, focusing on the individual mandate.

Taken at face value, the individual mandate is a policy to eliminate the uninsured. Everyone must have insurance. And if you evaluate it from that perspective, it is clear the individual mandate is not working. We have over 6 million people paying a penalty rather than having insurance, and tens of millions more remain uninsured. So I don't think it really should be even evaluated on that standard. It is simply not going to work.

Instead, it is best viewed as a complement to the rating rules in the Affordable Care Act—in particular, the guaranteed issue rule and the community rating of the insurance policies. Without it, a mandate, those rules combine to guarantee that someone can wait until they are sick, apply, and get insurance. Those who are healthy stay out, those who are sick are in. The risk pools are not balanced, we get very high premiums, and the system is unworkable.

So the individual mandate is intended to offset the impact of those particular rating rules. And for that to work, you have to have an individual mandate that is effective and tight and with people complying with it. And I don't think you can make that case with the ACA's individual mandate, certainly not so far.

In looking at alternatives to the individual mandate, there is a table in my written statement, Table 1, and I would just walk through it real quickly and show you some of the implications.

You could repeal the individual mandate, and our estimates are that this would lead to 7 million fewer people being covered with insurance. And, as a result of the 7 million fewer, there would be less in the way of exchange subsidies. Somewhere around $200 billion in subsidies would be saved.

This is quite simply the impact of higher premiums. If you repeal the mandate, the young and healthy leave the risk pools, premiums go up, fewer people are covered with insurance, and you get the impact.

Now, the trick is to get rid of both the mandate and the rating rules. And, in the table, we have two different ways of doing that. One way is to repeal the individual mandate along with the community—the rating restrictions, so relax the age bans and allow the young, in particular, to have relatively low premiums. Or the alternative way to do it is to simply allow people to buy the insurance they want outside the exchanges in nonqualified health plans, something that has been done temporarily by the Administration.

Both of those have roughly the same effect, right? You have the ability to buy a policy at a lower price. That offsets some of the insurance loss. The real big difference between those two is that, if you do it the first way and rely on the exchanges, you still have to pay the exchange subsidies. On the other hand, if you allow people to buy policies that they want outside, they are not subsidized. You get about the same coverage implications and very different budgetary implications.

And then the final row in the table basically says, suppose you just do all of this, you allow the relaxation in the community rating, you drop the individual mandate, you allow people to buy policies that they want outside the exchanges, and, essentially, the message there is: You can achieve the same coverage that the Affordable Care Act is achieving, and you can do it at roughly the same budget cost without forcing people into the exchanges and with the individual mandate.

So it is clear that there are alternatives that are workable that can get the same end result that we are seeing right now. And I would be happy to answer questions about alternatives in what follows.

Thank you.

[The prepared statement of Mr. Holtz-Eakin follows:]

Assessing Alternatives to the ACA's Individual Mandate

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

Douglas Holtz-Eakin, President*
American Action Forum

April 14, 2015

* The views expressed here are my own and not those of the American Action Forum, the Partnership for the Future of Medicare or the Center for Health & Economy. I thank Tara O'Neill, Conor Ryan, and Christopher Holt for their assistance.

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for the opportunity to testify today regarding potential alternatives to the individual and employer mandates imposed by the Patient Protection and Affordable Care Act (ACA). I hope to convey three main points today:

1. The individual mandate is not working as envisioned. Even for those who complied, the end result is coercive purchase of coverage they do not value.
2. The American Action Forum (AAF) found that repealing the individual mandate and other restrictions imposed on health insurance products under the ACA can lower premium costs, cover a comparable number of individuals, and allow the market to more accurately reflect consumers' desires.
3. The employer mandate will contribute to slower job growth and lead to a greater reliance on a part-time workforce.

Introduction

This tax season, millions of Americans are feeling the impact of the ACA on their tax return for the first time. Those who failed to obtain minimum essential health insurance coverage last year will have had to send the Internal Revenue Service (IRS) a check for $1,130, on average.[1] Setting aside the impact on these millions of people's wallets, this figure is also worth noting because it highlights the ineffectiveness of the individual mandate. Yes, the estimated 6.3 million people paying the penalty didn't buy health insurance, but neither did the more than 30 million who qualified for an exemption from the mandate.[2] If the mandate were 100 percent effective, everyone would have health insurance. However, there were still tens of millions of people uninsured in the U.S in 2014.

The Individual Mandate: Theory vs. Reality

The individual mandate, in concert with the guaranteed issue and community rating provisions, is the theoretical keystone of coverage in the ACA. In reality, however, it is not being enforced in a manner that fully realizes its potential. This undermines the law's ability to achieve its goals of affordable access to health care for all. The importance of the individual mandate is best understood as a support for the guaranteed issue and community rating provisions. These provisions are intended to ensure that everyone is able to purchase insurance at a reasonable price, regardless of any preexisting conditions. In a market with guaranteed issue and community rating, a healthy person may wait until the onset of poor health to purchase coverage, defeating the very purpose of insurance. The individual mandate must be included, requiring everyone to purchase and maintain coverage, in order to bring healthy people into the insurance pool, spread the risk, and lower the average premium cost relative to what it would be if all people in the pool were unhealthy. The combination of these three things—guaranteed issue, community rating, and

the individual mandate—underlie the ACA's theory for creating an affordable health insurance pool for everyone.

In reality, the individual mandate has been less of a mandate and more of a suggestion. We estimate that 6.3 million people will be required to pay the mandate penalty as a result of not purchasing qualified coverage in 2014. Many of these individuals will escape the mandate by applying for hardship exemptions, and there remain more than 30 million uninsured individuals who are exempted from the mandate because of Medicaid expansion decisions or low household income. The individuals that have responded to the mandate tend to be older (65 percent of Marketplace enrollees in 2015 were aged 35 and older) and presumably less healthy, thus not holding premium prices down as much as anticipated.[3] Given the inability to implement and enforce these policies as necessary to achieve the results imagined from their theoretical application, we should instead seek other avenues for achieving the availability of affordable coverage for all. Some such options include:

1. Require guaranteed renewability of coverage conditioned on maintaining continuous coverage.
2. Support the creation/continuation of high-risk pools for those with excessive health care costs.
3. Repeal the community rating restrictions under the ACA.
4. Allow non-qualified health plans to be sold outside of the Marketplace.
5. Repeal the community rating restrictions and allow non-qualified health plans outside of the Marketplace.

Alternatives to the Individual Mandate

Using a microsimulation model for the U.S. health insurance market, AAF has examined the effects of possible alternatives to the individual mandate on the number of people insured and the cost to the government.[4] In looking at the impact of these various options, we first estimated the impact of just repealing the individual mandate. We estimate that repealing the mandate by itself and doing nothing else would result in 7 million fewer people insured in 2025 and reduced spending by the federal government on premium and cost-sharing assistance of $191 billion over 10 years compared with expectations under current law. Without any replacement provisions, repealing the mandate would also lead to significant premium increases, especially among generous insurance products.

1. Require guaranteed renewability of coverage conditioned on maintaining continuous coverage

An alternative policy for protecting against expensive medically underwritten insurance premiums is to require individuals to maintain continuous coverage in exchange for guaranteed

renewability of insurance. Guaranteed renewability provides similar protections to guaranteed issue for those with poor health status and relief from the fear of coverage cancellation while the conditional continuous coverage provision diminishes the incentive to not purchase insurance until one's health status becomes poor, thus reducing the likelihood of sending the market into a death spiral, as predicated in the theory discussed previously. Guaranteed renewability, rather than guaranteed issuance, and the removal of the mandate to purchase insurance limits the heavy-handed intrusion of the federal government into the marketplace and instead allows individuals to make a decision as to what is best for them while still encouraging the purchase of coverage at a young age, before one is unhealthy and forced to accept higher premiums and risk denial of coverage when it is desperately needed.

2. Create of high-risk pools for those with pre-existing conditions

While continuous coverage and guaranteed renewability will work well to keep the uninsured rate low for a majority of the population and eliminate the issue of "pre-existing conditions" for those who are currently healthy, it is not a well-suited solution for those who currently have a pre-existing condition and does not provide a safety net for individuals who forgo insurance and develop sudden illness.[5] For this population, high-risk pools can be established and/or continued where individuals can gain insurance made affordable through the provision of subsidies.

3. Repeal community rating restrictions under the ACA

In addition to repealing the individual mandate and instituting alternative protections against medical underwriting, we next estimated the effects of simultaneously repealing the community rating restrictions imposed by the ACA, which prevents an insurer from accounting for health status and limits the amount an insurer may vary premium rates based on age to a 3:1 ratio, meaning an elderly person cannot be charged more than three times what a younger person is charged. Prior to the ACA, the average ratio of age variations was 5:1.[6] The restrictive community rating imposed by the ACA leads young and healthy individuals to subsidize the care of old and sick individuals through artificially high premiums. Repealing this limit, in theory, should allow premium prices to decline for the younger population, thus removing some of the current financial disincentive to buy insurance. We find that repealing both the individual mandate and the age rating restrictions would result in only 4 million fewer people insured in 2025, compared with expectations under current law, as opposed to the 7 million fewer insured estimated from repealing the mandate alone. Despite the decline in enrollees, spending would increase by $15 billion as the result of increased enrollment among low-income households who would qualify for premium and cost-sharing assistance. This increase in enrollment among low-income households is largely due to higher enrollment among younger households attracted by lower premiums. The combination of these two provisions will lead to much higher variability in premiums, with average premiums increasing for some products and decreasing for others.

4. Allow non-qualified health plans to be sold outside of the Marketplace

Another alternative is to allow non-qualified health plans to be sold outside the Marketplace. Under the ACA, in order to be considered a "qualified health plan" and thus eligible for sale in the health insurance Marketplace, a plan must cover the "essential health benefits" and meet minimum actuarial value requirements. Plans that do not qualify under these rules are prohibited by the ACA. The administration has granted some leeway to the enforcement of these provisions on existing health insurance plans, allowing some individuals currently in non-qualified plans to remain in those plans through the end of 2016. Repealing the mandate and allowing the sale of non-qualified health plans outside the Marketplace, according to our model, would result in 3 million fewer people insured in 2025—5 million fewer people insured through the Marketplace and 2 million more people insured outside the Marketplace. This would result in reduced spending of $193 billion on premium and cost-sharing assistance. While much of the savings are due to fewer people purchasing insurance through the Marketplace and thus not obtaining subsidies, it is important to note that the 2 million we estimate would purchase plans outside of the Marketplace are doing so without access to the subsidies available inside the Marketplace. This indicates that removing the mandates to cover "essential health benefits" and meet specific actuarial values reduces the cost of coverage and allows individuals the ability to purchase the care they desire without the need for financial assistance from the government.

5. Repeal the age rating restrictions and allow non-qualified plans outside the Marketplace

Finally, we looked at the effect of implementing all of these actions, and, not surprisingly, found positive results. Repealing both the individual mandate and the age rating restrictions while also allowing non-qualified health plans to be purchased outside the Marketplace would result in between 0 and 500 thousand more insured individuals and an increase in spending on premium and cost sharing assistance of $14 billion. The increase in the number insured results from a net of 2.5 million fewer people purchasing coverage through the Marketplace and 3 million more purchasing coverage outside the Marketplace. Again, as in the earlier model repealing the age restrictions, spending increases even though total number of people insured through the Marketplace decreases, because of increased enrollment among low-income, young adults.

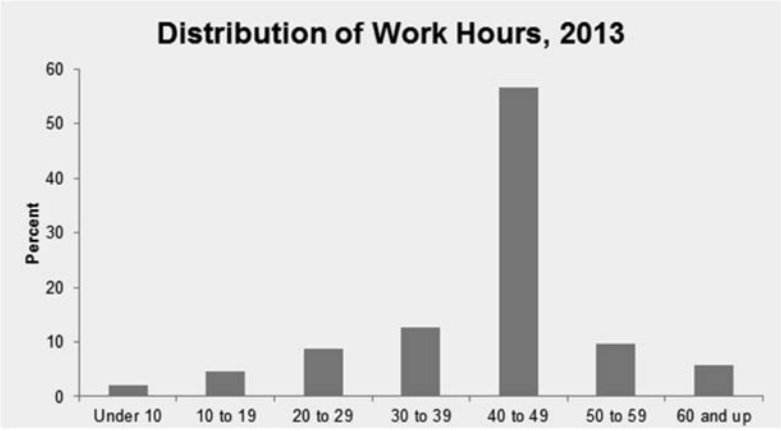
Table 1: AAF Modeling of Alternative Policies to the Individual Mandate

Policy	Effect on Insurance Coverage	Effect on Federal Budget
Repeal the Individual Mandate	7 million fewer insured individuals in 2025	A reduction of $191 billion in federal spending on financial assistance
Repeal the Individual Mandate and Community Rating Restrictions	4 million fewer insured individuals in 2025	An increase of $15 billion in federal spending on financial assistance
Repeal the Individual Mandate and allow non-QHP plans outside of the Marketplace	3 million fewer insured individuals in 2025	A reduction of $193 billion in federal spending on financial assistance
Repeal the Individual Mandate, Community Rating Restrictions, and allow non-QHP plans outside of the Marketplace	Less than 500 thousand more insured individuals in 2025	An increase of $14 billion in federal spending on financial assistance

The Employer Mandate and its Negative Consequences on the Labor Market

In 2014, AAF research revealed significant evidence that the employer mandate and other ACA regulations have been negatively impacting employment and pay. The employer mandate and other ACA regulations have made employers more sensitive to health care costs, which they offset by reducing pay and employment. As a result, since the ACA's passage, the rise in premiums has cost employees an average $935 per year and has reduced employment by 350,544 jobs nationwide.[7]

The employer mandate impacts hiring and employees' hours because, once fully implemented, it will require employers with 50 or more full-time employees to provide health insurance and carries a specific, per-employee fine for noncompliance.[8] The financial impacts to those that do not provide coverage or for firms that are looking to hire the 50th worker are clear. For example, a 49-employee firm that does not provide coverage and elects to hire their 50th employee now faces a fine of $40,000 per year, which is the $2,000 per employee penalty above the first 30 employees. A small firm can skirt this requirement by switching to part-time workers.[9] The chart below (using 2013 data) reveals that the ACA's definition of "full-time" work as 30 hours per week is at odds with the empirical realities. AAF found that 72 percent of employees in 2013 worked at least 40 hours per week. Further, 50.2 percent worked exactly 40 hours per week. As a result, with the full-time threshold at 30 hours per week, the employer mandate could subject millions of workers to a dramatic reduction in hours.[10]



The employer mandate could be particularly costly for a full-time employee who works 40 hours per week and does not receive health insurance through the employer. If the employer wants to avoid the cost of the mandate and decides to reduce the worker's hours to reclassify him or her as part-time under the ACA, it would cost the employee 11 hours to go from 40 hours to 29 hours per week. If the worker's hourly earnings rate is $24.57 (the December 2014 national average), this means the employee would lose $270.27 per week or $14,054.04 per year.[11]

Despite a mandate to offer coverage, financial incentives are embedded in the ACA that encourage employers to drop health benefits and shift workers onto the health insurance exchanges, as virtually all employers and some low and moderate income employees would be financially better off for doing so. AAF found that there are about 43 million workers for whom it makes sense to drop insurance.[12] While the Congressional Budget Office (CBO) estimated that only 19 million people would receive subsidies, AAF's research suggests that number could easily triple. As a result, the CBO's cost estimate could grow from $450 billion over the first 10 years to $1.4 trillion.[13]

The employer mandate is a key failing of the law, as it will not actually compel employers to add coverage, and it depends on a complicated reporting system that the administration was unable to implement by the deadline set in the legislation. While firms are still trying to understand how this law will fully impact their business, they are making decisions to limit their future financial liabilities, and thus hiring less than they would in the absence of the law.

Conclusion

The individual and employer mandates have and will continue to disrupt both the health insurance market and the labor market. They are only necessary to enforce the ACA's limited and over-regulated choices for consumers, ineffectively pushing people into insurance coverage that does not necessarily meet their needs. By repealing some of the burdensome requirements imposed by the ACA, consumers would find more health insurance options better aligned with their needs and at a price that would allow for the purchase of coverage without depending on federal financial assistance, eliminating the need for such intrusive mandates.

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[1] Our estimates on the number of individuals that will pay the penalty and the average value of the penalty are calculated using the county-level demographic information from the American Community Survey and state-wide enrollment statistics from the Department of Health and Human Services.

[2] https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/#hardshipexemptions

[3] http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

[4] Estimates footnote: All American Action Forum budgetary cost, insurance coverage, and premium estimates in this testimony were performed using a health insurance microsimulation model originally published by Stephen Parente: Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.

[5] http://americanactionforum.org/daily-dish/march-17th-edition1

[6] http://www.ahip.org/Issues/Age-Rating.aspx

[7] http://americanactionforum.org/research/obamacares-impact-on-small-business-wages-and-employment

[8] The employer mandate only applies to businesses with 100 or more employees in 2015; this will drop to businesses with 50 or more employees in 2016.

[9] http://americanactionforum.org/testimony/how-the-affordable-care-act-and-the-employer-mandate-impacts-employers-an-o

[10] http://americanactionforum.org/research/changing-the-acas-definition-of-full-time-work

[11] http://www.bls.gov/data/

[12] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

[13] http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf

Chairman BRADY. Thank you, Doctor, very much.

Mr. Womack, you are welcome, and you are recognized for 5 minutes, as well.

STATEMENT OF SCOTT WOMACK, PRESIDENT, WOMACK RESTAURANTS, INCORPORATED

Mr. WOMACK. Chairman Brady and Mr. McDermott, thank you for the invitation to testify at this hearing.

My name is Scott Womack, owner and president of Womack Restaurants, an 11-unit IHOP—or, excuse me, Popeyes franchisee in Kansas City. I am pleased to be here today to testify on behalf of the U.S. Chamber of Commerce. I also come before you today as a restaurant industry veteran with over 25 years of experience to represent my company, my industry, and small-business entrepreneurs.

My first jobs were as a busboy and cook, and, after college, I joined the grocery industry. After 5 years, I got fired, and I found myself starting over. I was very lucky to land a job with IHOP as a manager, and, with a $15,000 loan from my parents, I bought my first IHOP franchise.

Over the following 20 years, I built an additional 15 IHOP restaurants. In 2013, we purchased a group of Popeyes restaurants in Kansas City. And, last fall, we sold our IHOP restaurants.

Now, I frequently say that the restaurant industry is a story of first opportunities and second chances. First jobs, first careers, and a first shot at small-business ownership. And second chances for people starting over—a forced career change, reentering society after incarceration, or a second job for those digging out of a financial hole.

That story is my story. I am very thankful for the opportunities I have been given and the opportunities that our company has been able to provide. No other industry can tell this story of turning lives around.

It has been 5 years since the Affordable Care Act was passed, and I want to provide you a real-world update from the front lines of the restaurant industry.

First, I have to note an important point of context. Small-business restaurant owners and franchisees, we sign leases, mortgages, and franchise agreements with terms of 15 to 20 years. We personally guarantee those agreements. A lease for a single restaurant is usually an obligation for at least a million dollars over its lifetime. There is no escape clause in these agreements for Federal legislation. So when costs go up, if you can't adjust, you default and likely go bankrupt. There is no agency to bail us out. Please keep these numbers in mind as you consider future legislation, because we have put it all on the line.

Now, like most of you, I didn't get a chance to read the ACA before it was passed, but I heard the promise of lower insurance premiums and lower actual costs, improved insurance coverage, and affordable access for everyone.

At the time, my company offered generous health coverage to our salaried management and office staff. Our fears were that the cost of offering coverage to our entire workforce would bankrupt us. After careful consideration, we chose to offer coverage to everyone.

Now, our reality today under the ACA is very different than what was promised. Over the last 4 years, our insurance premiums have risen 60 percent. Our single coverage now costs $6,400 annually. Family coverage costs $19,200 annually. However, we have also had to double our deductibles to $2,500 and raise the out-of-pocket limits by two-thirds.

While our insurance offering complies with the ACA as affordable, only 4 percent of our hourly staff have enrolled. And as I sampled fellow franchisees, I found that 3 to 4 percent enrollment is the rule across the industry.

Now, we are required to offer the same benefit to all our staff. We had been paying a portion of our managers' dependent coverage, but now we are unable to do so due to the potential cost across the entire company. This is a big loss for our management and office staff. As you may be aware, my offering of coverage to employees in many cases makes them ineligible for subsidies for their dependents.

The reporting required is costly, complex, and confusing. All employers have had to either write new software or buy new software or contract with a service to do so. And, as I write this, it is still unclear as to whether the Federal Government can actually use the data in these systems.

It is clear that the assumptions inherent to the ACA were wrong. Five years later, our costs have gone up significantly. The controls and mandates did not help. Hourly employees do not want to buy policies that they were not buying before, even at a generous price. When a single surgery can still leave them with several thousands of dollars in bills, they do not want to get in the game. And the result of expanding coverage to all of our staff is a reduced benefit to our managers and office staff.

While our industry was initially alarmed at the potential cost of covering everyone, we at least hoped the costs would indeed come down. It was clear to me then that the promises of the ACA were in conflict with each other—expanding coverage, improving health care, while lowering cost—but, sadly, it is clear to me now that the law has not delivered.

Thank you.

[The prepared statement of Mr. Womack follows:]

Statement of the U.S. Chamber of Commerce

ON: Individual and Employer Mandates in the President's Health Care Law

TO: U.S. House of Representatives Committee on Ways and Means Subcommittee on Health

DATE: April 14, 2015

1615 H Street NW | Washington, DC | 20062

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides opportunities, not threats. In addition to the American Chambers of Commerce abroad, an increasing number of our members engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on issues are developed by Chamber members serving on committees, subcommittees, councils, and task forces. Nearly 1,900 businesspeople participate in this process.

Testimony before
United States House of Representatives Committee on Ways and Means
Subcommittee on Health
Tuesday, April 14, 2015

Hearing on
Individual and Employer Mandates in the President's Health Care Law

Testimony of
Scott Womack
President
Womack Restaurants, Inc.

Chairman Brady, Ranking Member McDermott, Members of the Ways and Means Committee, thank you for the invitation to testify at this hearing. My name is Scott Womack, Owner and President of Womack Restaurants, an 11 unit Popeyes franchisee in Kansas City. I am pleased to be here today to testify on behalf of the U.S. Chamber of Commerce, the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region.

I also come before you today as a restaurant industry veteran with over 25 years of experience to represent my company, my industry and small business entrepreneurs. My first jobs were as a busboy and cook. After college, I joined the grocery industry, but after 5 years, was fired, and found myself starting over. I was lucky to land a job with IHOP as a manager, and with a $15,000 loan from my parents, bought my first IHOP Franchise. Over the following 20 years, I built an additional 15 IHOP restaurants. In 2013, we purchased a group of Popeyes restaurants in Kansas City, and last fall, we sold our IHOP restaurants.

I frequently say that the restaurant industry is a story of first opportunities and second chances: first jobs, first careers, and a first shot at small business ownership. And second chances for people starting over: a forced career change, re-entering society after incarceration, or a second job for those digging out of a financial hole. That story is my story. I am very thankful for the opportunities I have been given, and the opportunities that our company has been able to provide. No other industry can tell this story of turning lives around.

It has been five years since the Affordable Care Act was passed, and I will provide you a real world update from the front lines of the restaurant industry. I first have to note an important point of context: small business restaurant owners and franchisees sign leases, mortgages and franchise agreements with terms of 15 to 20 years. We personally guarantee these agreements. A lease for a single restaurant is usually an obligation for at least $1,000,000 over its lifetime. There is no escape clause in these agreements for federal legislation. When costs go up, if you can't adjust, you default and likely go bankrupt. There is no agency to bail us out. Please keep those numbers in mind as you consider future legislation, because we have put it all on the line.

Like most of you, I didn't get to read the ACA before it was passed. But I heard a promise of lower insurance premiums and lower actual costs, improved insurance coverage and affordable access for everyone. At the time, my company offered generous health coverage to our salaried management and office staff. Our fears were that the cost of offering coverage to our entire workforce would bankrupt us. After careful consideration, we chose to offer coverage to everyone.

Our reality today under the ACA is very different than what was promised. Over the last four years, our insurance premiums have risen 60%. Our single coverage now costs $6,400 annually and family coverage costs $19,200 annually. However, we have also had to double our deductibles to $2500 and raise the out-of-pocket limit by two thirds.

While our insurance offering complies with the ACA as affordable, only 4% of our hourly staff have enrolled. As I sampled my fellow franchisees, I discovered that 3% to 4% enrollment is the norm across the industry. Andy Puzder, CEO of CKE Restaurants (Carl's Jr. and Hardees), wrote in a January 13, 2015 Wall Street Journal op-ed that only 2% of his company's 6900 employees had enrolled.

We are required to offer the same benefit to all our staff. We have been paying a portion of our managers' dependent coverage, but now we are unable to do so, due to the potential cost across the company. This is a big loss for our management and office staff.

As you may be aware, my offering of coverage to employees in many cases makes them ineligible for ACA subsidies for their dependents.

The reporting required is costly, complex and confusing. All employers have had to either create or buy new software as we have, or contract with a service to do so. As I write this, it is unclear whether the federal government can actually use the data in its systems.

It is clear that the assumptions inherent to the ACA were wrong. Five years later, our costs have gone up significantly. The controls and mandates did not help. Hourly employees do not want to buy policies that they were not buying before, even at a generous price. When a single surgery can still leave them with several thousands of dollars in bills, they do not want to get in the game. And the result of expanding coverage to all of our staff is a reduced benefit to our managers and office staff.

While our industry was initially alarmed at the potential cost of offering coverage to all, we at least hoped that costs would indeed come down. It was clear to me then that the promises of the ACA were in conflict with each other; expanding coverage, improving healthcare while lowering costs. Sadly, it is clear to me that the law hasn't delivered.

Chairman BRADY. Thank you, sir.

Ms. Corlette, you are recognized for 5 minutes.

STATEMENT OF SABRINA CORLETTE, SENIOR RESEARCH FELLOW, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE, CENTER ON HEALTH INSURANCE REFORMS

Ms. CORLETTE. Good morning. Thank you, Mr. Chairman, Ranking Member McDermott, Members of the Committee. My name is Sabrina Corlette, and I am a Senior Research Fellow at Georgetown University's Center on Health Insurance Reforms. Thank you for the opportunity to testify here today and for the leadership of this Subcommittee in conducting oversight of the Affordable Care Act.

This hearing today is a timely one, just a few weeks after the 5-year anniversary of the law. It is important, thus, I think, to spend some time taking stock of how the law's reforms have affected people's access to affordable, adequate health coverage. And to understand how the ACA has affected health coverage, I think it is important to understand what the world looked like before the law was passed.

On the eve of the law's passage, approximately 50 million Americans were uninsured and approximately 10 million got their health insurance through the individual market. And that market was an extremely inhospitable place, particularly for people in less than perfect health, and that is about 129 million of us. Before the reforms in the ACA, in most States, applicants for health insurance could be denied a policy because of their health status or charged more in premiums because of their health or gender.

Health insurance was and remains a very expensive product, and it is particularly expensive for people buying on their own. Before the Affordable Care Act, roughly 70 percent of people with health problems reported it very difficult or impossible to find an affordable plan.

In addition to being unaffordable, coverage prior to the ACA could be inadequate because of preexisting-condition exclusions in which insurers were allowed to permanently exclude from coverage any health problem that you might have. And insurers also were able to sell stripped-down policies that didn't cover critical services such as maternity, prescription drugs, and mental health.

And, before the ACA, policies often came with extremely high deductibles; $10,000 or more was not uncommon.

The failures of the individual market also resulted in job lock, in which people were tied to jobs they would otherwise leave in order to maintain access to health coverage.

The ACA included numerous reforms to address the rising number of uninsured and the shortcomings of the individual market, including a requirement to provide coverage to people who apply for it regardless of their health condition. Because the law prohibits insurers from discriminating against people with preexisting conditions, a mechanism is needed to prevent people from waiting until they get sick to sign up for insurance. This is known as the individual mandate.

The Congressional Budget Office has estimated that just a 5-year delay in the mandate would result in 13 million more people being uninsured and premium increases of up to 20 percent.

The ACA's employer mandate is in place because all stakeholders should contribute to a sustainable and equitable health system. Those employers that don't offer coverage are acting as free-riders, and they should be required to pay a little something when their workers receive taxpayer subsidies to get coverage. And this is something the American people understand. According to polls, 60 percent support the employer mandate.

And the evidence now is in that the ACA's reforms are working. Just yesterday, Gallup reported that the uninsured rate continues to fall. It is now at 11.9 percent, down from 18 percent in 2013. Approximately 16.4 million Americans have gained coverage, which means that 16.4 million people are more likely to receive necessary medical services and gain financial security.

There is also strong evidence that coverage under the ACA is providing better financial protection. A recent national survey found significant declines in the number of people reporting cost-related access problems.

At the same time, in spite of dire predictions that the law would cause premium growth to explode, since the ACA was passed, we have seen the slowest growth in healthcare prices in 50 years.

There have also been dire predictions about the ACA's impacts on job growth, yet here, too, the data undermines the rhetoric. Unemployment rates will largely be unaffected by the ACA, and, if you look at job data starting with the months that the ACA became law, the economy has generated 12 million new jobs. And there is no evidence of a rise in involuntary part-time work. The bottom line: The idea that the ACA is a job-killer has been thoroughly debunked.

Thank you for inviting me to testify today about the market reforms in the ACA. And while there remains uncertainty about the law's long-term impact, early data suggests that it is meeting its objectives and that concerns about people losing coverage, rising premiums, and job losses are and have been unfounded.

I look forward to your questions. Thank you.

[The prepared statement of Ms. Corlette follows:]

STATEMENT OF
SABRINA CORLETTE, SENIOR RESEARCH FELLOW
GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER ON HEALTH INSURANCE REFORMS

HEARING ON THE INDIVIDUAL AND EMPLOYER MANDATES IN THE AFFORDABLE CARE ACT
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

APRIL 14, 2015

Good morning Mr. Chairman, Ranking Member McDermott, Members of the Committee. My name is Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA). The views I share today are my own, and do not represent those of the faculty, staff, or management of Georgetown University.

I thank you for the opportunity to testify before you today, and for the leadership of this Subcommittee in conducting ongoing oversight of the implementation of the ACA. The hearing today is a timely one, just a few weeks after the 5 year anniversary of the law, and shortly before the close of the first tax filing period.

Given that we have just marked the 5-year anniversary, it is important to spend some time taking stock of how the law's reforms have affected people's access to affordable, adequate health coverage. On just about every dimension, the progress has been remarkable. In my testimony, I will thus focus on:

1) The functioning of the health insurance market, pre-ACA and the rationale for the ACA's reforms, including the individual and employer mandates
2) The impact of the ACA's reforms on access to affordable, adequate health coverage and the economy as a whole

The Health Insurance Marketplace, Pre-ACA

To understand how the ACA has affected health coverage and health insurance markets, it is important to understand what the world looked like before the law was passed. Having decent health coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.[1]

On the eve of the law's passage in 2010, approximately 50 million non-elderly Americans were uninsured,[2] and approximately 10 million Americans under age 65 obtained their health insurance through the individual market, meaning they did not have coverage through their employer or public programs such as

Medicare and Medicaid.[3] The people who buy health insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. Yet, as *Business Insider* magazine put it, before enactment of the ACA, the individual insurance market was a "basket case."[4]

Before the ACA, the individual insurance market was an inhospitable place, particularly for people with less than perfect health.[5] That's a lot of us. According to one estimate, between 50 and 129 million non-elderly Americans have at least one pre-existing condition that would threaten their access to health care and health insurance.[6] These include a wide range of conditions, from back pain and prior sports injuries to chronic illnesses such as diabetes and asthma, as well as diseases like cancer. But, before the reforms in the ACA, in most states applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers were also allowed to issue policies that didn't cover critical services like pharmacy, maternity, or mental health benefits. And before enactment of the ACA, insurers could – and did – drop (rescind) an individual's coverage if they got sick, and often imposed annual and lifetime dollar limits on covered benefits.[7]

Health insurance was, and is, a very expensive product, and it is particularly expensive for people trying to buy coverage through the individual market. Unlike those with employer-sponsored coverage, people buying on their own must pay the full cost of their premium, and their payments are not pre-tax. And, unlike those with employer coverage, there was no one to help subsidize the premium costs. According to one national survey, before the ACA, 31 percent of people buying insurance on their own spent 10 percent or more of their income on premiums, compared to only 13 percent of people with employer-based coverage.[8] The same national survey found that 70 percent of people with health problems reported it "very difficult" or "impossible" to find an affordable health plan, compared to people in better health.[9]

More often than not, a common life event causes people to lose coverage or enter the individual market – losing or changing jobs, an illness, a divorce, a birthday, or a move. Prior to the ACA, consumers had some protections to help them transition to new coverage, although these protections were often inadequate. "Safe harbors" under federal law included COBRA, which allows those who lose access to job based coverage to continue their coverage in their former employer's plan for 18-36 months, and HIPAA, which was designed to help people obtain a health insurance policy after their COBRA coverage ends. However, these safe harbors have often not been helpful because premiums are priced out of reach, or the coverage offered was inadequate. The failure of these safe harbors, and the inhospitable nature of the individual market led to the phenomenon of "job lock," in which people were tied to jobs they would otherwise leave, in order to maintain their access to affordable health insurance coverage.

At the same time, the number of "underinsured" individuals was rising dramatically before enactment of the ACA, such that, in 2013 there were twice as many as there were in 2003. Those purchasing insurance on their own were more than twice as likely to be underinsured as those who had coverage through an employer-based plan.[10] In general, someone is considered underinsured when they have insurance but because of high deductibles, high co-payments, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.[11]

Coverage prior to the ACA's reforms could be inadequate for many reasons, including:

- *Pre-existing condition exclusions*, in which insurers were permitted to permanently exclude from coverage any health problems that a consumer disclosed on their application for a policy. For example, if an applicant had a history of asthma, it was not uncommon for the insurer to carve out his or her entire upper respiratory system from the plan's covered benefits.
- *Limited benefits.* Insurers selling health insurance in the individual market often sold "stripped down" policies that did not cover benefits such as

maternity care, prescription drugs, mental health, and substance use treatment services.[12]

- *Limited coverage.* Prior to the ACA, it is estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people were in plans with annual dollar limits on their benefits.
- *High out-of-pocket costs*. Before the ACA, individual market policies often came with extremely high deductibles - $10,000 or more was not uncommon – and high cost-sharing. One study in California found that individual policies paid for just 55 percent of the expenses for covered services, compared to 83 percent for plans sold to small businesses.[13]

The ACA includes numerous reforms intended to address the rising number of uninsured in this country and the shortcomings in the individual market. These set minimum federal standards for an individual's access to affordable and adequate health insurance, with state flexibility to enact stronger consumer protections if they wish. These reforms include:

- *Improved Access to Coverage.* The ACA required insurers to provide coverage to people who apply for it, regardless of their health status. In addition, the ACA prohibits insurers from rescinding the coverage of consumers who submit medical claims, except in the case of clear fraud by the policyholder. And of course, in those states that have adopted it, low-income people can now benefit from the ACA's Medicaid expansion.
- *Improved Affordability of Coverage.* The law provides for premium tax credits and cost-sharing reductions to help make coverage more affordable. Currently 87 percent of people enrolled through the health insurance marketplaces are receiving financial assistance.[14] In addition, the law prohibits insurers from charging people more in premiums based on their health status or gender, and limits the amount they can charge based on a person's age.
- *Improved Adequacy of Coverage.* The ACA prohibits the use of pre-existing condition exclusions and sets a minimum benefit standard, called "essential

health benefits." The law also sets a new minimum level of coverage such that enrollees, on average, would not pay more than 40% of costs, and limits the total amount of out-of-pocket spending consumers must incur, currently at $6,600 per year for an individual. These new standards help ensure that insurance does what it is supposed to do: provide real financial protection.

The ACA's Individual Mandate: Critical to the Sustainability of Insurance Reforms

The ACA's individual responsibility requirement, often referred to as the individual mandate, has been by far the most controversial element of the law. However, its origins date back to Republican health reform proposals in the 1990s. It is essential to any comprehensive health reform plan to keep premiums affordable and sustain meaningful coverage. Because the law prohibits insurers from discriminating against people with pre-existing conditions, a mechanism is needed to prevent people from waiting until they get sick before signing up for insurance. If that were allowed, only those needing health care services would sign up, and the cost of insurance would be very high. As one expert has put it, "You basically can't have a functioning insurance market if people can buy insurance on their way to the hospital."[15] We need only to look at two real-life examples to illustrate why the mandate is needed:

- *Washington state insurance reforms*. In 1996, Washington adopted insurance reforms similar to those in the ACA, but without an individual mandate. As a result, the state experienced a 25 percent reduction in individual market enrollment and a decline in the number of comprehensive plans offered. The largest carrier in the market raised premiums by 78 percent.[16]
- *New York insurance reforms*. New York passed reforms in the early 1990s requiring insurers to accept all applicants, even those with pre-existing conditions. The result? Just a few years after passage, enrollment in the individual market was as much as 50 percent lower than when reforms began, and New York had the highest individual market premium rates in the country.[17]

And in fact, once the ACA's individual responsibility requirement was put into effect in New York rates dropped by an average of 50 percent.[18]

But you don't have to look only to states' experiences to understand the implications of repealing the individual mandate. The Congressional Budget Office has estimated that just a 5 year delay in the individual mandate would result in 13 million more people being uninsured and premium increases of 10-20 percent.[19]

The ACA's Employer Mandate: Discouraging Free Riders and Encouraging Shared Responsibility

The ACA's employer mandate is designed to maintain our system of employer-sponsored coverage and to discourage employers from shifting employees into the publicly funded health insurance marketplaces. The underpinning rationale for the provision is that all stakeholders should contribute something to a sustainable, equitable health care system. Those employers that don't offer coverage to their workers are acting as free riders, and they should be required to pay something when their workers receive taxpayer subsidies for health coverage. This is something the American people understand; surveys show that 60 percent of them support an employer mandate.[20] In actual fact, however, very few employers will ever pay a fine under the mandate. Nearly all large firms offer health benefits to at least some employees (98 percent of those with 200 or more employees).[21]

Repealing the employer mandate is estimated to a result in between 200,000 and 1 million individuals joining the ranks of the uninsured, and a loss in federal revenue of $150 billion over 10 years.[22]

<u>The Impact of the ACA's Private Market Reforms</u>

While we are only about 15 months out from the full implementation of the ACA's reforms, the evidence is clear that these reforms are working. First and foremost, the law is meeting its primary objective of expanding health insurance coverage. The uninsured rate at the start of 2015 was 12.9 percent, dropping from 17.1% at the end of 2013.[23] Since the law's passage, approximately 16.4 million Americans have gained health insurance coverage.[24] This means that 16.4 million people are

more likely to receive necessary medical services and gain critical financial security and protection from catastrophic medical costs.

There is also strong evidence that coverage under the ACA is providing better protection than what the market provided before the reforms were effective. A recent national survey from the Commonwealth Fund found declines in the number of people reporting cost-related access problems. For example, the number of people who did not get needed care declined from 80 million people in 2012 to 66 million people in 2014. And the number of people reporting problems paying medical bills declined from 75 million people in 2012 to 64 million in 2014.[25]

At the same time, in spite of dire predictions that the law would cause premium growth to explode, in fact we've seen the opposite. Since the ACA was passed, we have seen the slowest growth in health care prices in 50 years. And the three slowest years of growth in real per capita national health expenditures on record were 2011, 2012, and 2013. In employer-based coverage, the average annual family premium was approximately $1800 lower in 2014 than it would have been if premium growth since 2010 had matched the 2000-2010 average rate of growth.[26] For coverage on the ACA's health insurance marketplaces, premium growth has also been held in check, largely because of robust competition between insurers for market share. For example, one study found an average premium growth of only 2.9 percent for the lowest cost silver-level plans offered on the health insurance marketplaces.[27]

There have also been dire predictions about the ACA's impacts on job growth. Yet here too, the data undermines the rhetoric. The CBO estimates that ACA will reduce the total number of hours worked, by (on net) about 1.5 to 2.0 percent.[28] However, they attribute this small decline to workers *choosing* not to work because of new health insurance options, NOT to employers hiring less people or shifting more people to part time. In other words, unemployment – wanting to work but not being able to find a job – will largely be unaffected by the ACA.[29]

In fact, if you look at job data starting with the month the Affordable Care Act became law, the economy has generated 12 million new jobs over 60 months, the longest streak of private-sector job growth on record. According to the Council of Economic Advisors, over the last 12 months as the Affordable Care Act's main coverage provisions have begun to have their full effect, there are now 3.2 million

new private-sector jobs.[30] There is also no evidence of a rise in involuntary part-time work. In fact, the rate of part-time work has declined since its peak during the Great Recession.[31]

In addition, the ACA is likely to spark an increase in entrepreneurship, as workers are freed from job lock to pursue ideas and start-ups that allow them to optimize their skills and talents. In fact, in partnership with economists at the Urban Institute, my colleagues and I have projected that there will be as many as 1.5 million new entrepreneurs nationally, as a result of the ACA's insurance reforms and new coverage options.

The bottom line? The idea that the ACA is a job killer is thoroughly debunked.

Similarly, in spite of concerns that the ACA will undermine our system of employer-sponsored coverage, there is in fact no evidence to date that employers are reducing offers of coverage. In fact, a tracking poll published at the end of 2014 found that employer offer rates have stayed constant, including among firms that employ low-wage workers.[32]

Conclusion

Thank you for inviting me to testify today about the market reforms in the ACA and the impact for consumers, businesses and the economy as a whole. While there remains considerable uncertainty about the law's long-term impact, early data suggests that the law is meeting its objectives and that concerns about people losing coverage, rising premiums, and job losses are and have been totally unfounded.

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Chairman BRADY. Thank you.

Mr. Womack, thank you for bringing your real-life perspective to this issue. We have a lot of experts in Washington who have never had to actually live under this law, other than those who were forced into it, who are now paying higher premiums and much higher deductibles.

Like you, I have a local restauranteur who, you know, has instructed his four store managers they will never again hire a full-time worker. He has been advised by his accountants that he, because of the ACA, would actually be more profitable by closing three of the stores and going with one, which is exactly what he doesn't want to do. He wants to grow. And I have a small pizza business in Willis, Texas, who would like to expand to two neighboring communities but, primarily because of this, simply can't afford to do so.

So thank you for bringing this and this may be one of the reasons this is the most disappointing economic recovery in 50 years. We actually have fewer adults in the workforce today than we did when the recovery began 5 years ago. We have actually gone a little backward in that area. So it has an impact. Thank you for bringing that to us.

Dr. Holtz-Eakin, thanks for bringing some of these thoughtful alternatives to the table. You know, your numbers are so different from other models we have seen. Can you expand a little on why these alternatives would work and why others place such a high priority on the coercive model?

But it seems to me there is a dramatic difference between forcing someone into a plan they can't afford and don't want or pay the IRS, or providing incentives—for example, a lower deductible—if you maintain continuous coverage, which actually is an incentive financially to be actually doing what we hope to do, which is to keep people insured.

Mr. HOLTZ-EAKIN. Well, our estimates are built off, you know, a computer micro-simulation model. But the real reason we get results that are different from others is that the data underneath that are based on the actual choices made by employees when offered a wide variety of health insurance plans at different premiums, deductibles, and copays. And the evidence is people respond to those incentives.

And so what you find in looking at these results is that we are tracking the impact of changes in premiums and people's response to them much more carefully than many of the alternatives do.

Chairman BRADY. And so one of your points, too, if I get it correct, is that, in addition to the mandates on workers to buy government-approved health insurance and businesses to offer government-approved, there are mandates within the ACA itself that drive up the cost of health care.

And if you thoughtfully rethink some of those mandates and offer plans that are more tailored to patients, to people, rather than Washington, that you can actually lower the cost of those, attract more into buying those plans, and provide incentives so that they have a reason to stay on the plan rather than, frankly, go without, pay the IRS, and then when they get sick they go to a plan, which drives up, what, costs for everyone else?

Is that sort of the overall thought?

Mr. HOLTZ-EAKIN. Yeah. That is the message.

So there are three important mandates and rating rules. One is the essential health benefits. And the, sort of, generosity of that is going to peg the base premium that people are going to pay.

Then the second is the guaranteed issue, that people must be able to buy a policy.

And the third is the community rating rules, which say that you can't, you know, have big differences in premiums across ages. And that raises premiums for the young and healthy as a transfer to the older and sicker.

Chairman BRADY. Can you talk a little about community rating restrictions and repealing that helps provide incentive for people to buy plans without the coercive mandate?

Mr. HOLTZ-EAKIN. The big impact is on the younger and healthier, who saw dramatic increases, double digits, in their premium costs because of the community rating, right? Because we are really forcing them into the pool—that is the mandate—forcing them to pay higher premiums—that is the community rating—so as to cover the cost of the older and sicker and the poor.

Chairman BRADY. And, prior to the ACA, younger workers who were healthier had a greater band of prices versus those who were older and sicker. The ACA restricted those, in effect, shifting costs from those who are older and usually had more healthcare costs to those who are younger and who don't. Is that correct?

Mr. HOLTZ-EAKIN. Absolutely. Yes.

Chairman BRADY. All right. Thank you.

The Urban Institute just issued a paper claiming that continuous-coverage provisions supported by Republicans is tantamount to the individual mandate in the law.

And, in your opinion, is that the case? Is forcing all Americans to buy coverage the equivalent of providing incentives to maintain coverage?

Mr. HOLTZ-EAKIN. So the continuous-coverage notion is one where you would say, okay, if you buy health insurance—say, at 26, you leave your parent's policy—if you buy health insurance and you maintain continuous coverage of any form—individual, small group, employer—at no point may you be medically underwritten, right, we can't go back and underwrite that person for any health problem they develop, that is a powerful incentive to get in when you are young and cheap.

Chairman BRADY. Yeah.

Mr. HOLTZ-EAKIN. The pool is, as a result, balanced. And the actuaries can figure out the likelihood of developing any sort of health problem over the course of that person's life, and you can price policies pretty clearly.

So that is a pretty simple idea, but it is not a mandate to buy health insurance. It is a set of rating rules. And we have rating rules all the time. Every State insurance commissioner has to worry about rating rules, and there are things you can and cannot rate on. And it is no more than that.

Chairman BRADY. So the world-will-end-without-an-individual-mandate claim, if you structure incentives right, we know that they can work.

Mr. HOLTZ-EAKIN. You can get balanced pools, you can get a lot more options for people in the variety of insurance products, and, as a result, they can get both the kinds of coverage they need and the prices they want to pay, much more tailored to their tastes.

Chairman BRADY. Right. Thank you, Dr. Holtz-Eakin.

I now recognize Dr. McDermott for his 5 minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to explore a concept with you. We have probably 20 million people presently without health insurance coverage. Is that about what you think it is?

Mr. HOLTZ-EAKIN. It is somewhere in that vicinity, yeah.

Mr. MCDERMOTT. Now, none of them are going to get sick this year. We all know that. They are all healthy. And none of them are going to get sick. There is not going to be automobile accidents or skiing accidents or leukemia or anything. Nothing is going to happen to them.

Is that a premise on which you are basing this?

Mr. HOLTZ-EAKIN. No. Why do you——

Mr. MCDERMOTT. Who, then, pays for their health insurance?

Mr. HOLTZ-EAKIN. They don't have health insurance.

Mr. MCDERMOTT. Well, excuse me, for their health care. Or are we going to let them die in the street?

You don't assume they are going to die in the street. They are going to come into the healthcare system. Who pays for it?

Mr. HOLTZ-EAKIN. Those costs are spread broadly through the system——

Mr. MCDERMOTT. So they are free-riders.

Mr. HOLTZ-EAKIN. They are spread broadly through the system in terms of, you know, uncompensated care.

Mr. MCDERMOTT. Now, you are setting forth the concept that free-riding is okay in America, that people ought to sit and say, "I am not going to pay." You would have that concept in your neighborhood? "I am not going to pay my property taxes because my house never caught on fire. So why do I have to pay for the fire department?" You wouldn't accept that, would you?

Mr. HOLTZ-EAKIN. So the question is, what is the nature of these costs? Is this essential medical? They will essential medical here at a hospital; that is the law of the land. But they won't be able to undertake any sort of discretionary health care unless they pay for it out of their pockets.

So they aren't going to shift all their costs. They can't do that uniformly. It is only for the key, core, medically necessary, you show up at the emergency room and great treated.

Mr. MCDERMOTT. But you are telling——

Mr. HOLTZ-EAKIN. How big is that? So the next question is, how big is that? And if you look seriously at the numbers, this is a small number. So there may be some free-riding going on, but this is $10 billion, $15 billion in a several-trillion-dollar healthcare system.

It is not the driving force behind premiums. And it is certainly, in my view, not such a big problem that it is worth a wholesale rewrite of the healthcare system and an individual mandate to force people in. It strikes me as a disproportionate——

Mr. MCDERMOTT. Let me interrupt you. Because you are saying that in America it is okay for me to expect everybody else to pay for stuff and I get it for free. That is what you are basically saying. Because the healthcare industry is going to have to take care of me. If I get sick and they haul me down to George Washington Hospital, if I don't have health insurance, they by law must take care of me, right?

Mr. HOLTZ-EAKIN. That is true. That is fine.

Mr. MCDERMOTT. And that cost will be paid to you, and that is okay with you?

Mr. HOLTZ-EAKIN. I view that as a problem. No world is perfect. But that problem is not a big problem in our healthcare system.

Mr. MCDERMOTT. It is estimated that it is about $1,000 a year on your healthcare premiums——

Mr. HOLTZ-EAKIN. That is too high.

Mr. MCDERMOTT [continuing]. Going for uncompensated care.

Mr. HOLTZ-EAKIN. I would be happy to get back to you for the record, but we did a lot of work prior to filing an amicus brief with the Supreme Court cases, and I believe those numbers are just too large.

Mr. MCDERMOTT. They are what?

Mr. HOLTZ-EAKIN. Too large. A thousand dollars, no.

Mr. MCDERMOTT. You don't think it is nearly that much.

Mr. HOLTZ-EAKIN. No, I do not.

Mr. MCDERMOTT. So the penalties that we are charging people for not insuring themselves you don't think are too—I mean, what was it this year? Ninety-eight dollars or——

Mr. HOLTZ-EAKIN. Look, the vast majority of people are exempted. So, I mean, this individual mandate——

Mr. MCDERMOTT. Okay.

Mr. HOLTZ-EAKIN [continuing]. I mean, there are 20 million people, as an estimate, who have been exempted. So it is not much of a mandate, sir.

Mr. MCDERMOTT. So you are saying that we should just let that continue out there. They don't have any kind of healthcare coverage in advance——

Mr. HOLTZ-EAKIN. No.

Mr. MCDERMOTT [continuing]. So they don't have any preventive care. So we want to wait until they have had——

Mr. HOLTZ-EAKIN. No.

Mr. MCDERMOTT [continuing]. The stroke. You don't do anything about their——

Mr. HOLTZ-EAKIN. That is not what I am saying, sir.

Mr. MCDERMOTT [continuing]. Blood pressure before.

Mr. HOLTZ-EAKIN. No one disagreed at the beginning of this debate, going back to 2007, 2008, 2009, that we needed better insurance options and higher quality care at lower cost. There was no dispute about that. The question is, how do you get there?

I believe we could harness market incentives to produce a much better insurance system than we saw circa that time and probably better than the one we have right now, and people would want to buy insurance then.

Insurance is a valuable product. It is something that gives them a financial security against the costs of both inpatient and outpatient care. And people buy insurance for that reason.

Mr. MCDERMOTT. How about the people who are not in now? How do they get into the system you are talking about? They have to pay, the first year, some high price to get——

Mr. HOLTZ-EAKIN. People have to buy products in America, yes. I mean——

Mr. MCDERMOTT. But if it covers the cost, you don't care what the coverage is as long as they have a piece of paper that says, "I have insurance"; is that right?

Mr. HOLTZ-EAKIN. No. I am not sure what you are saying.

Mr. MCDERMOTT. Well, we have mandatory insurance on automobiles. You have to have a certificate for your insurance before you can get your license plate in most progressive States.

Mr. HOLTZ-EAKIN. Sure.

Mr. MCDERMOTT. And that means that you have to pay for it up front.

Mr. HOLTZ-EAKIN. Certainly, there will always be some sort of standard that qualifies as insurance, because most plans that I have seen include a subsidy for people who cannot afford to get insurance. And, prior to the ACA, that standard was the standard option FEHB in most States. And so there will always be something that satisfies the requirement of being insurance.

Chairman BRADY. Thank you.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate you holding this important hearing.

You know, just about half of Americans receive health insurance through employer-sponsored health plans. Unfortunately, due to ObamaCare, it is actually becoming harder for employers to provide their employees with affordable coverage. Out-of-pocket costs and premiums are skyrocketing, and employers face piles of paperwork to try to, you know, comply with the burdensome employer mandate.

If we want to promote affordable employer-sponsored health insurance, it certainly isn't through an employer mandate. Rather, what employers should have is the ability to provide coverage that best meets the needs of their business and their employees.

Mr. Holtz-Eakin, it is good to see you again. Thank you for being here.

I want to ask you about two proposals I think can play an important role toward achieving that goal.

First off, last week, I met with a constituent by the name of Jeff Scheumack from Plano, Texas, who is president of Bioautomation Corporation. We talked about an issue that I have worked over a decade to try to fix. That issue is association health plans.

You see, Jeff's company only has 14 employees and, therefore, doesn't face the employer mandate, but Jeff wants to do the right thing and offer insurance. However, because the company is a small business, the group insurance plan for his business would be more expensive than for a large business. Jeff would like to have an association health plan so he and other small businesses can join together to purchase more affordable health insurance.

What are your thoughts about association health plans as one of the ways to help employers, particularly small business, get affordable health insurance?

Mr. HOLTZ-EAKIN. The goal is always to broaden the pools. And small pools, 14 employees, are going to run into this problem. So an association health plan is one way to get a bigger pool and, as a result, have better purchasing power and a better spreading of risks and would certainly be of some assistance to him.

Mr. JOHNSON. Well, I would like to talk to you about another constituent of mine by the name of Scott Burday, who is owner of Trinity Integrated Solutions in Frisco, Texas.

Also a small business, Trinity Integrated Solutions is not required to provide health insurance, but, for over 16 years, employees have been able to purchase their own insurance plans that best meet their needs in the individual market. Trinity Integrated Solutions then reimbursed workers for 100 percent of their premiums on a tax-free basis, just like the tax benefit for employees covered under a group health plan.

But now Mr. Burday faces a fine of $100 a day if he continues to do this. Why? Because ObamaCare deemed these health reimbursement accounts inadequate coverage. So now Scott is forced to stop doing what has worked for his business and workers for the last 16 years. Instead, he will have to choose between offering no coverage to offering a group health plan that is 15 percent more expensive.

I am going to ask you, shouldn't we give small businesses, such as Trinity Integrated, the flexibility to reimburse its employees' health insurance premiums even if the employee purchases that coverage under the individual market?

Mr. HOLTZ-EAKIN. The health reimbursement accounts were a great tool for small businesses. Their employees could get the coverage they wanted. There was a lot of flexibility involved. And, with the ACA, the IRS has deemed them to be illegal, essentially, that you cannot verify they are buying quality coverage that meets the essential health benefits standard. And it is $36,000 fine for everyone.

It strikes me as a real step backwards from the point of view of offering small businesses the tools to manage their costs.

Mr. JOHNSON. It is supposed to be a free country, isn't it?

Thank you, sir. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Johnson, you can call Scott Burday and tell him help is on the way. Mr. Boustany and I have a bill—we would love to have you as a coauthor—that fixes the problem that you just outlined. So if you want to have your staff talk to either my staff or Charles' staff, we will get you on board.

Mr. JOHNSON. Thank you.

Mr. THOMPSON. I was interested, Dr. Holtz-Eakin, in your comment about the small number of people, to Mr. McDermott's question.

You know, in my district, at the time—districts have changed, but, at the time, the uncompensated-care costs in my congressional district were running about $50 million a year. And I suspect they are about the same in every congressional district across the country. And, you know, you start adding that up, and pretty soon you are talking about real money. It is, I think, about $22 billion a year based just on those numbers.

But your comment reminded me of the guy that called my office to tell my staff that we didn't need to do healthcare reform and he was living testimony. He was in a car accident, he spent 3 months in a hospital, 7 months in recovery after that, and he didn't have any insurance, and he was perfectly fine today. And my staff asked him, they said, "Well, how did you pay for it?" He said, "I didn't pay for it. I told you, I didn't have the insurance. I don't have any money. But I am fine today." And I don't understand how you could think that that type of model wears well with the American public. Folks believe that everybody should, in fact, pay their fair share.

But my——

Mr. HOLTZ-EAKIN. So——

Mr. THOMPSON [continuing]. Question is to Ms. Corlette. And, based on current data, it appears that more than 95 percent of employers have fewer than 50 full-time employees and, therefore, are not subject to the employer mandate.

So would it be accurate to say that, in reality, the employer mandate only affects a small number of employers?

Ms. CORLETTE. Yes, I think that is accurate. Not only that, sir, but roughly 98 percent of employers with 200 or more workers already provide health insurance. And I think that number is about 94 percent for employers between 50 and 199 workers. So we are talking about a fairly small number of free-riders who are not currently providing health insurance who we——

Mr. THOMPSON. What?

Ms. CORLETTE. Ninety-eight percent of employers with more than 200 workers do provide health insurance. And I think it is about 94 percent in that 50-to-199-worker category. So we are really talking about a small number of employers that would actually have to pay a mandate.

Mr. THOMPSON. So, in your opinion, notwithstanding the mandate, what drives employers to offer their employees health insurance?

Ms. CORLETTE. Well, you know, employers, for a long time, have been offering health insurance to maintain and recruit a healthy, productive workforce. And they have been doing that voluntarily because it makes good business sense.

And I think one of the ironies here, of course, is that the Affordable Care Act was designed to build on our employer-based system, and there was a deliberate intention not to disrupt or overturn that employer-based system but, rather, to build on it. But if you are going to build on it, then everybody needs to contribute.

Mr. THOMPSON. Based on your work, do you think that the mandate would deter employers from offering coverage?

Ms. CORLETTE. I do not.

Mr. THOMPSON. Do you think that employers will continue to offer coverage with or without a mandate?

Ms. CORLETTE. I do. Yes. And, in fact——

Mr. THOMPSON. Why?

Ms. CORLETTE [continuing]. Ninety-nine percent of employers report in national surveys that the Affordable Care Act is really not changing any of their decisions regarding employee benefits.

Mr. THOMPSON. So, on January 1, the employer mandate kicked in for employers with at least 100 workers. Have we seen any evidence to date that suggests that most employers stopped or will stop offering coverage based on that mandate?

Ms. CORLETTE. We have not, sir.

Mr. THOMPSON. Thank you.

I have no further questions. Yield back.

Chairman BRADY. Thank you.

Mr. Roskam, you are recognized for 5 minutes.

Mr. ROSKAM. Thanks, Mr. Chairman.

Serving in the House of Representatives I think is some of the most interesting work I have ever done in my life, because there is this very unusual juxtaposition that a Member of Congress experiences almost on a weekly basis. And I am having one of those moments right now, and I want to explain it to you.

Saturday morning, I am in front of 200 people at the Wheaton bowling alley in Wheaton, Illinois, talking to them about what is going on here. And they were not a happy group, shall we say. A lot of concerns about the direction of the government and all that sort of stuff I hear all the time from people like Mr. Womack—do you pronounce it "Womack" or "Womack"?

Mr. WOMACK. "Womack."

Mr. ROSKAM. "Womack." We have a "Womack" here, so you will be hearing this all day long. Mr. "Womack."

I hear from a lot of people like Mr. Womack who describe this situation as it relates to this new health care law, and it is very jarring and it is unsettling.

And yet your testimony, Ms. Corlette, was very disconnected from what he said. And so I am wanting to hear from you how you reconcile the testimony of somebody—and let me reread two of the paragraphs in his testimony and then juxtapose that with what you said. And help me square it up, because it just doesn't make sense to me.

So this is the guy on the front line that says this: "Our reality today under the ACA is very different than what was promised. Over the last 4 years, our insurance premiums have risen 60 percent." This is his company. "Our single coverage now costs $6,400 annually, and family coverage costs $19,200 annually. However, we have also had to double our deductibles to $2,500 and raise the out-of-pocket limits by two-thirds."

Okay. Pause on that. Enter your testimony.

And, at the conclusion of your testimony, you say, "Concerns about"—you said a lot of things that were pretty declarative. In fact, of all the speakers so far, you have been the most enthusiastic about the Affordable Care Act. You are more enthusiastic than Mr. McDermott, who basically said, "Hey, I didn't write that thing. I voted for it, but I want to improve it." But you are a cheerleader for this.

And your cheerleading I find a little unsettling, because you said this: "Concerns about rising premiums"—and I am using ellipses here—"have been totally unfounded." "Totally unfounded." That means it is a false claim. That means there is no foundation. That means it is almost insincere or naive or just plain foolish for him to assert that the Affordable Care Act is having an impact on these costs.

So is that true? Is everything that he said that I characterized, is that just not true? How do you square up what you said with what he said?

Ms. CORLETTE. Thank you, Congressman Roskam, for the question.

So, first of all, I give Mr. Womack credit for trying to offer comprehensive decent health insurance to his workers. It is the right thing to do.

Second of all, Mr. Womack is, I think, an example of employers struggling with rising costs, which employers have been doing for a long, long time. And, in fact, their costs have been rising for a couple of decades now.

And the overall—and, again, I am looking at overall data, right? And what I can tell you is, in the 5 years since the Affordable Care Act was passed, the overall growth in healthcare prices has been at the slowest rate in history.

Mr. ROSKAM. So you are arguing—just in the interest of time——

Ms. CORLETTE. Uh-huh.

Mr. ROSKAM [continuing]. You are arguing that his costs would have gone up, and you are saying, don't focus in on what the Affordable Care Act promised. You are saying, focus in on what was happening before the Affordable Care Act.

I mean, the first half of your testimony was a reflection in looking back. It was not talking about the claims of the Affordable Care Act.

So you are making the argument, hey, Mr. Womack, this problem is going to be your problem no matter what, and it has been mitigated and made better?

Ms. CORLETTE. I think the evidence is pretty indisputable that the growth in healthcare costs and premiums has slowed since the——

Mr. ROSKAM. I know, but——

Ms. CORLETTE [continuing]. Passage of the Affordable Care Act. Now, that may be——

Mr. ROSKAM [continuing]. Go back to him now.

Ms. CORLETTE [continuing]. Cold comfort to somebody like Mr. Womack, who every year gets a little bit of a percentage increase in his premiums. But what the Affordable Care Act promised——

Mr. ROSKAM. Right.

Ms. CORLETTE [continuing]. To do——

Mr. ROSKAM. So my friend——

Ms. CORLETTE [continuing]. Was to——

Mr. ROSKAM [continuing]. Going back to my friend, who just said 60 percent. Sixty percent. Come on.

Ms. CORLETTE. But that is not in 1 year, correct? That is over 4 years. The Affordable Care Act reforms did not go into effect until last year. So——

Mr. ROSKAM. Okay.

Ms. CORLETTE [continuing]. A lot of that growth——

Mr. ROSKAM. God bless you. You are what a true believer looks like.

So let me reclaim—oh, my time is gone. It went so fast. It was so interesting.

Thank you for taking the time.

Chairman BRADY. Thank you.

Mr. Pascrell, you are recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Chairman, thank you for your introductory remarks on the bipartisanship we saw in passing SGR repeal. However, I am very disappointed to learn, Mr. Brady, that the Senate, in considering SGR, will vote on an amendment repealing the individual mandate—the only nongermane amendment. We worked to keep politics out of the SGR. This is very, very disappointing. I think it is going to go down the tubes, but that is what they are introducing.

You would think that my colleagues—cobble together all of the time they have spent together trying to undermine the Affordable Care Act—and not make it better. How different, 9, 10 years ago, with part D, what we did compared to what they did. After we voted against it, we cooperated. But that is immaterial to you—they would have been able to come up with an alternative. They haven't come up with an alternative.

In this Committee alone, we have had over a dozen hearings just on issues related to the individual and the employer mandates, not to mention nearly 64 votes to repeal or undermine. And how many have we had on this elusive alternative I keep hearing about? Zero.

The reality is that this Act is working. It is not perfect, as Mr. McDermott said. We have never passed perfect legislation, now that I think of it.

More than 11 million Americans have health insurance coverage through the marketplaces. It is startling that only a little more than 11 percent still don't have insurance when you compare it to 1 year ago, 2 years ago, 10 years ago.

We have to end the day of the freeloader, because healthcare costs affect the economy. That is what we set out to do, and we are on our path here. Not perfect. Better than zero, though.

Additionally, 6 million young adults, half of whom might have otherwise been uninsured, have been able to stay on their parents' health care.

Mandating that everyone must be covered is counter to a free lunch. The individual and the employer responsibility provisions have been key to the success of the law in keeping premiums steady.

How many times have I been through hearings on social issues since I have come to the Congress and heard many people on the other side question whether the real people or the right people are getting the benefit? "Do they really need it?" All of a sudden, we have changed our attitude and our altitude.

The individual responsibility provision keeps free-riders who could afford to purchase health insurance from forcing everyone else to ultimately pay for the health. You saw the problems we had when major corporations started to part-time their workforce. And then we discovered where those folks got their health care and who was paying for it, and you are looking at him.

Let us all remember that the individual mandate was a bipartisan idea. Challenge me on that. I will tell you chapter and verse. It is interesting that only when Democrats enacted comprehensive health reform that the other side became opposed to the idea of individual responsibility.

I have a letter here, Mr. Chairman, from one of my local newspapers. Since we have had anecdotal stories today, let me introduce it. JoAnn Lucchetti of Wallington, New Jersey, in my district, discusses her decision to retire after 30 years in advertising sales. She put off retirement because, before the ACA, she could not afford to buy insurance on the individual market and she was not yet old enough to enroll in Medicare. Got the picture.

She writes, "That all changed on January 1, 2014. ObamaCare allowed me the freedom to walk away and explore other options on a part-time basis. And, by the way, my resignation resulted in the hiring of two recent college graduates."

I ask unanimous consent that her letter be entered into the record, Mr. Chairman.

Chairman BRADY. Without objection.

[The submission of The Honorable Bill Pascrell follows:]

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The Record: Letters, Sunday, Feb. 9

THE RECORD

Pro and con of

Obamacare

Regarding "Report sees ACA leading to fewer hours on job" (Page A-7, Feb. 5):

Once again the Republican Party seizes a headline and irresponsibly runs with it. The old adage of think before you talk does not seem to apply.

I refer to the Congressional Budget Office's recent report stating Obamacare may cut the equivalent of 2.5 million full-time jobs from the work force. If you read more than the headline, the report goes on to say Obamacare will also reduce unemployment. While it may appear as a contradiction, it truly is not as I am the perfect example of the CBO's findings.

My career spans 30-plus years as an account executive in advertising sales. I have paid my dues, worked my way up and made a fairly lucrative living wage. However, my inner clock let me know it was time to pass the torch and move on. I was excited to start a new chapter, yet found myself in quite the conundrum.

I was still too young for Medicare, yet could not afford individual health insurance. It personally prevented me from moving forward and denied new, younger talent the opportunity to join the work force.

That all changed on Jan. 1. Obamacare allowed me the freedom to walk away and explore other options on a part-time basis. And by the way, my resignation resulted in the hiring of two recent college graduates.

So don't tell me I am lazy or lack ambition or initiative. I have played by the rules and now can take some time to stop and smell the roses.

JoAnn Lucchetti

Wallington, Feb. 6

Mr. PASCRELL. Ms. Corlette, can you talk a little bit about the challenges that people like Ms. Lucchetti, who are wanting to retire before they are eligible for Medicare, or those who leave jobs to start their own businesses or attend to family matters—many of us are in that situation—were facing in the individual insurance market before the Affordable Care Act?

Chairman BRADY. Ms. Corlette, I am afraid time has expired.

Mr. PASCRELL. If you have a couple of seconds.

Chairman BRADY. I think if you could answer that by letter or perhaps when another Member questions you.

Ms. CORLETTE. Certainly.

Chairman BRADY. Time has expired.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman. I want to thank you, as well, for holding this hearing on this important topic.

And we have heard our friends on the other side talk about this isn't a perfect law. And we would agree, it is not. What we are trying to get to here is how to address the law and make the policy at the Federal level consistent with patient-centered health care. As a physician, formerly practicing physician, I can tell you that right now we are moving down the path of government-centered health care. And your constituents, our constituents, the American people aren't fond of government-centered health care, because the decisions are removed from them, the choices are removed from them.

We have heard that the growth of healthcare prices has been the slowest for a significant period of time. And I would ask the American people to ask themselves, for whom? For whom is the cost less? And the answer to that question is the government. Prices are down for the government. But if you are an individual out there making $30,000 or $40,000 a year and you have health coverage and the deductible is $6,000 or $12,000, which some of them are, let me suggest to you that you don't have health coverage, because you aren't able to afford the deductible.

And we see that in my former practice. I have my former colleagues call me and talk to me about the challenges that they have because of the coverage that they currently have, and they are not able to make any arrangements to make payment. They turn around and walk out of the office because they can't afford the services that they need. So the quality of health care is actually diminishing because of this law.

I want to talk a little bit about the consequences of the employer mandate on workers and full-time work.

Mr. Womack, you mentioned that your costs have gone up 60 percent for health coverage. Now, that money that is now going to provide health coverage that is oftentimes more lavish than people even desire, and you are being dictated, mandated to do so, how many folks could you have hired if you had been able to push that money back into your business to be able to provide more jobs?

Mr. WOMACK. Oh, it would be hard for me to give you a number, but, you know, without a doubt, that is the one area of our business that, you know, we would spend more money on, is hiring more people.

Mr. PRICE. So we hear from Ms. Corlette that there is, "no evidence of involuntary part-time work." And I know that she would likely say that there is no evidence of any decrease in jobs created by the ACA.

Would you agree with that?

Ms. CORLETTE. Job growth has actually been at its fastest pace in the last year since 1998.

Mr. PRICE. So you would agree that there has been no effect on jobs.

Now, Dr. Holtz-Eakin, I have in my hand here—in fact, I ask unanimous consent to insert into the record an article from *Investor's Business Daily*——

Chairman BRADY. Without objection.

Mr. PRICE [continuing]. On the employer mandate effects of ObamaCare.

Here is an article with a list of cuts to work hours and jobs due to the employer mandate, 18 pages long. And I will just site a couple of them on the first two pages from the State of Georgia.

Southern Polytech State University limited students to 20 hours per week. Georgia Tech capped hours for students and temp workers at 25 hours a week. Chatham County reduced hours of part-time and seasonal workers to lower than 30 hours a week. The city of Gainesville began limiting part-time work hours, Kennesaw State limiting teacher loads, et cetera, on and on and on.

That is 18 pages, 18 pages, small type, of job after job after job, person after person, American after American, who are having their hours cut, their job limited, because of the employer mandate. So I would respectfully suggest that you edit your talking points because they are simply not accurate.

From an anecdotal standpoint, I have a car dealership in my community; 168 full-time workers before the law, now 2. Now 2. One hundred sixty-six individuals were moved to part-time work. That is real stuff. That is real consequences for people out there.

Let's talk about a little money consequence. Dr. Holtz-Eakin, the President's spokesperson, recently said that he didn't think it was accurate that millions of individuals—"millions of individuals were going to get a tax bill as a result of the ACA."

I know that you have done some work on this. What is your estimate on the number of folks who will have to pay more taxes because of the ACA, the Affordable Care Act?

Mr. HOLTZ-EAKIN. Our estimate is there are 6.3 million who will pay the penalty this tax year.

Mr. PRICE. And how much money is that, do you recall?

Mr. HOLTZ-EAKIN. I don't, but I can certainly get that number to you.

Mr. PRICE. My understanding is——

Mr. HOLTZ-EAKIN. There is also the additional piece, which is mistaken subsidy payments which they have to repay.

Mr. PRICE. And so what we are doing is taking more money out of the pockets of American people to do not what they want but what the government is forcing them to do. And so, in the area of health care, choices are being significantly limited not just for individuals but for physicians as well.

And I yield back.

Chairman BRADY. Thank you.

Mr. Davis, you are recognized.

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

Can I ask each one of our witnesses, if you would just take about 30 seconds and describe what you would consider to be the purpose of the Affordable Care Act.

Mr. HOLTZ-EAKIN. I believe its intent was to cover more Americans with quality health insurance and to provide higher quality care at lower cost. The intent I don't think there is any dispute about.

Mr. DAVIS. Thank you.

Mr. Womack.

Mr. WOMACK. I would agree with that.

Ms. CORLETTE. I would also agree with that.

Mr. DAVIS. Mr. Womack, let me ask you—and let me commend you on your efforts to provide coverage for your employees. How many employees do you have?

Mr. WOMACK. We have about 200 employees right now.

Mr. DAVIS. And do you go on the open market to get the coverage? Or have you tried any of the alternatives, such as exchanges or——

Mr. WOMACK. I don't think we are eligible for exchange coverage. That is a good question. I don't think we are. But we have been on the open market.

And just for the record, we did not cut hours for our employees either. So I just wanted to get that out there.

Mr. DAVIS. I really commend you, again, for that effort, because it seems that you are doing what some people say can't be done, but you are doing it.

Listening to this discussion just sort of reminds me of something my father used to always say, and that is, "Where one sits will often determine where they stand," when it comes to issues and decisions and rationale that is used.

Ms. Corlette, I mean, there are many of us who feel that the Affordable Care Act has done exceptionally well, especially when you consider where we started or where we have come from. How do we improve it? Can we? What do we do?

Ms. CORLETTE. Thank you, Congressman, for that question.

And while I do believe the Affordable Care Act was an important step forward and has led to an unprecedented expansion in coverage and is meeting its goals, I am not a completely unadulterated cheerleader, in the sense that I believe there are areas for improvement.

And, actually, I think it was Congressman Price, perhaps, or maybe it was Congressman Roskam who mentioned one of them, and that is around the area of consumer deductibles or cost-sharing. While the ACA did take an important step forward in terms of limiting people's out-of-pocket costs so that there is a maximum in any year that somebody would have to pay if they had a car accident or cancer or something like that, many people are finding the deductibles in the new health plans to be a significant barrier to accessing services.

So I think that is something that we need to look at and provide some more financial protection, particularly for folks at the lower end of the income scale.

Mr. DAVIS. Dr. Holtz-Eakin, I am intrigued by this notion that somehow payment occurs for health care that individuals will receive, even if they are not insured, if they are not covered, that somehow or another the cost just filters back into the delivery system. But somehow it has to get paid for, because there is no such thing as a free lunch or free health care or free anything.

How does that reconcile with the idea of individuals paying as opposed to the general public paying?

Mr. HOLTZ-EAKIN. So let me try to be clear about this. Let's take an upper-bound estimate of the uncompensated care, $100 billion. That is probably too high. It is probably somewhere in the $70 billion to $80 billion range at most. We spend $3 trillion on health care in the United States. And insurance is a product designed to cover that healthcare bill by moving it from people who can't afford it to people who can.

But there is a $3 trillion bill. The uncompensated care is only 3 percent of that bill. That means that insurance policies are 3 percentage points higher than they would be otherwise, at most. And so that is what the individual mandate is trying to solve, this one-time 3-percentage-point cost in the health insurance.

Okay. Does it solve it? No. It is not a very strong mandate. There are tens of millions of people who are either not going to obey it or have been exempted from it. So we are not getting people in the pool. We are still probably making the free-riding worse because they can always come back later. We guaranteed that they can get in.

So there is no consequence to free-riding for a lot of these folks. And so we have a very elaborate system that infringes on people's liberty and doesn't really solve a small problem. That is it.

Mr. DAVIS. But if we are going to reduce the cost of health care overall——

Mr. HOLTZ-EAKIN. That has nothing to do with free-riding. That is the cost of health care. That is the delivery system.

Mr. DAVIS. I yield back.

Chairman BRADY. Thank you. Time has expired.

Mr. Buchanan, you are recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman.

And I want to thank our witnesses for the opportunity today.

I want to pick up on Mr. Roskam, his point. Everybody brings a different background when they come here to Congress, but I have been in business 30 years. Before that, I was a franchise owner. I was a franchisee, then a franchise owner. And then I was a dealer, franchise again. So I appreciate the fact that so many franchise owners throughout the country and franchisors put it all on the line.

I would love to have you come to my district to talk to a lot of people. I was chairman of our local chamber in Sarasota, Florida, maybe 15 years ago. The number-one issue was available and affordable health care and the rising cost. And those costs are still today continuing to rise.

It is not unusual, I go to townhall meetings, I meet with different people; it is $2,000 a month. I had one woman in Bradenton, another community I represent. She said that she has six employees. She is paying $2,000 a month. She said, I can get it for $1,000, but I have a $10,000 deductible. That is the reality that is going on out there every day.

And I would tell you that cost—he mentioned 15. It is 15 percent, 20 percent every year, including now. And, yeah, the employers are somewhat paying a little bit less, but guess what? It is getting pushed to the employees. It used to be where the employer, myself, over the years, you paid 100 percent for the family and everybody. Then it got down where you paid 75 percent of the family. Then you are just paying for the employee and the family is on their own. That is what is happening in America.

I have some people that are in town today, who have 300 employees. They are in the restaurant business in our area. A lot of their employees were working 40, 45 hours a week. You have 300. Now they are working 29. He said, not only do they not have health insurance, but their wages got cut 30, 40 percent. That is the reality.

I had another employer come to me. He had 80 employees. Now he is trying to find a way he can get under 50.

So you don't have the subsidy—some people get the subsidy, but if there are no subsidies, people are being buried with healthcare costs. To think the fact that someone is paying—he mentioned, was it $17,000 a year for health care for a family? How much did you mention?

Mr. WOMACK. Nineteen thousand dollars.

Mr. BUCHANAN. Nineteen thousand dollars a year. That is insane. Who can afford to pay that? That is why this system is still broken today. It didn't work back 10 years ago, and it still doesn't work today.

But I guess I would be interested in getting your comments in terms of—you mentioned how many employees? You have 300 employees. I want to deal with reality, because your story is the reality I hear back home. So, maybe, why don't you frame that again? How many employees? And what has happened to your employees in terms of their healthcare coverage?

Mr. WOMACK. Well, it was 200 employees. And we made the offer—and before we made the offer of coverage, you know, we spoke with our staff just to get a feel for what the appetite was. And it was very clear to us that, without throwing my employees under the bus, they basically said, "I wasn't paying before, and I am not paying now." And that has been our experience.

Mr. BUCHANAN. So how many people have full coverage for a family that you are paying or they are paying partly $19,000 out of the 200?

Mr. WOMACK. Oh, very few. I don't know the number of family enrollees that——

Mr. BUCHANAN. So, really, there is no coverage, or there is not much coverage. Or if it is minimal coverage, maybe it is for the employee. But if they want it for the family, they have to pay the difference.

Mr. WOMACK. Correct.

Mr. BUCHANAN. So, as a result of that, nobody has much insurance.

Mr. WOMACK. Correct.

Mr. BUCHANAN. And that is the reality with a lot of businesses across the country.

That is why I would ask you, Ms. Corlette, to come to Sarasota, Florida, come to Bradenton, come to some of our townhalls, meet with some of our business chambers. It was the number-one issue. I chaired the Florida chamber. It was the number-one issue, was rising cost.

It is not unusual today to pay—I hear it every day—$1,700, $2,000 a month. And that is the reality. And it keeps going up 15, 20 percent a month.

With that, I yield back.

Chairman BRADY. Thank you.

Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

Thank you to our witnesses here today.

Obviously, this is a complex issue, and the American people are very frustrated. I hear a lot of folks back home, and it is anecdotal, but there is a pattern. And I think it is very important, just like it was very important prior to this whole thing, that we listen to the American people.

Ms. Corlette, you referenced that 70 percent, I think it was 70 percent, of Americans thought their health care was expensive or extremely costly. I can't remember the exact words. Is that accurate?

Ms. CORLETTE. I believe that was from a survey that found that 70 percent of people with health conditions could not find an affordable health plan.

Mr. SMITH. Okay. And yet we understood prior to the passage of ObamaCare that roughly 70 percent of the American people were happy with the coverage they had. Of course, they were told they could keep that, and that certainly has not been the case.

But I want to speak more specifically, in terms of our meeting here today, about the employer mandate and the various coverage. CoOportunity Health was a program in Nebraska and Iowa that left 120,000 Nebraskans and Iowans without coverage, some of whom were, you know, on that plan, having lost the previous plan that they were told they could keep but they lost anyway.

Should there be, in your opinion, an opportunity for those folks to be waived from the individual mandate while they continue to shop because they were removed from the plan that, while I guess it no longer existed—should they be able to take more time or have the waiver to find coverage?

Ms. CORLETTE. Well, as I understand it, the insurance departments in Nebraska and Iowa are working very closely with other health carriers in the State to make sure there is a seamless transition for folks who were enrolled with CoOportunity Health. So, ideally, there would be very, very few people who would experience a gap in coverage of any significant length.

I will also say that the mandate——

Mr. SMITH. Should they be required to pay a penalty?

Ms. CORLETTE. Well, the mandate penalty only kicks in if you have been uninsured for 3 months. So for folks who are able to move into another plan—and I think the goal for both States is to really ensure a seamless transition for folks—they really should not be without coverage for as much as 3 months. That would be——

Mr. SMITH. I can't suggest anyone would be without coverage as a good idea. I mean——

Ms. CORLETTE. Right.

Mr. SMITH [continuing]. Notwithstanding any mandate, I think it is a good idea to have health insurance. But the pattern that I have observed among Nebraskans is that the plans are more expensive, the premiums are higher, the copays are higher. In fact, the copays are so much higher that some providers are seeing people walk away from those high copays, still leaving uncompensated care. These patterns are there.

And I suppose some numbers—you know, we can extrapolate from some numbers and say, well, it could be a lot worse. I have a hard time standing in front of Nebraskans and telling them that, especially when they have experienced what I would say are pretty extreme situations relating to their finances and the increasing cost of health care.

Mr. Holtz-Eakin, can you reflect a little bit on overall choices in health care? Do consumers have more plans from which to choose today than prior to this ObamaCare debate?

Mr. HOLTZ-EAKIN. I don't have any numbers on that, but, certainly, the individual market in the exchanges, you are limited to four actuarial choices. And that is considerably different than many people had experienced, because we know they had plans that were essentially declared illegal, and that made them unhappy; they would have preferred to have them. So that limited their choices.

Mr. SMITH. Uh-huh.

Ms. Corlette, back to choices, if patients and providers could come up with something that they found amongst themselves as a good situation but did not comply with what planners in Washington, D.C., had in mind, do you see a path for accommodating those concerns?

Ms. CORLETTE. Well, first of all, I find it kind of funny that people talk about this Washington-designed benefit—oh, pardon me.

Chairman BRADY. I apologize.

Ms. CORLETTE. That is all right.

Chairman BRADY. Time has expired. Again, I would encourage you to be able to answer that, perhaps, in a future question or——

Ms. CORLETTE. I can submit it in writing.

Chairman BRADY. Yeah, that would be perfect. Thank you.

Mr. Kind, you are recognized.

Mr. KIND. Thank you, Mr. Chairman.

I want to thank our witnesses for the testimony here today.

And, Mr. Holtz-Eakin, let me start with you, because I think you were understating the significance as far as the individual-responsibility component of what this is at. Of course, there is the free-rider problem that we were trying to address. We were also trying to get at the guaranteed-issue problem, and that currently is a

major problem in the healthcare system, but also the preexisting condition issue, as well, which would make it very difficult to make sure that people with preexisting conditions could get the coverage they need unless everyone is in. I mean, that is what makes Medicare so popular. Virtually every senior in Medicare has some form of preexisting condition, yet none of them are denied coverage.

And I don't see how we can make that work unless you prohibited insurance companies from denying people who had a preexisting condition. Otherwise, if you do away with that requirement, the individual mandate, I think people are just going to sit around and wait until they do get sick or injured and then decide to go out and get healthcare coverage in their life. And there is no way any healthcare system could sustain that. There is no insurance pool that could sustain that.

So, yeah, the free-rider and 3 percent issue is important to address, but I have a lot of rural hospitals, a lot of hospitals in Wisconsin who were complaining for years about the uncompensated care that they had to swallow or the cost-shifting that had to occur because of the number of uninsured. And that uninsured rate has come down tremendously.

But I also think Mr. Buchanan raised a very important issue. And, Mr. Chairman, I would suggest as an appropriate topic at a future hearing is for us to have another hearing on why there is cost-shifting going on within the healthcare system. Because, clearly, there is. And I think there are a lot of market forces and dynamics that are at play there.

I think, Ms. Corlette, you are right. I think per-person spending on health care is at a 60-year low.

The Congressional Budget Office, Mr. Holtz-Eakin, that you came from is consistently revising down their forecast on Medicare and Medicaid spending over the next 10 years. In fact, in the last year alone, over a trillion dollars' worth of savings since passage of the Affordable Care Act. And from January to March of this year, an additional $146 billion of less spending in Medicare and Medicaid over the next 10 years. That is moving the dial.

When you look at the long-term unfunded financial obligations we face, most of it was being driven in the healthcare system. For those numbers to be coming back right now is a great untold story as far as our longer-term budget implications.

But there is tremendous cost-shifting, and the average worker probably is seeing higher premiums, higher out-of-pocket, higher copays. And I think some of that is unrelated to the actual expense within the healthcare system.

And as long as we remain the only developed Nation in the world that relies on employer-based healthcare coverage for their workers, we will always get businesses complaining about healthcare costs, and we will always have employees complaining about the additional premiums and copays and out-of-pockets, that they are expensive. And so we have to make a decision as a Nation, whether we want to continue with this type of system or whether the rest of the developed world has figured something out that we haven't yet.

But I am also getting tired, Mr. Chairman, of just having these hearings where you have one side that uses the Affordable Care

Act as a convenient whipping post to score political points, the other side doing their best to defend it and highlight and accentuate the positive things that are happening. And I have to believe there is a lot of bipartisan overlap on issues that both parties can agree to, that we can work on together, some common ground.

So let me end with that question, with you, Mr. Holtz-Eakin, and then Ms. Corlette too. Do you see some areas of overlap that Republicans and Democrats share on changes that still have to be made within the healthcare system that we can start coming together on and working in a more positive fashion, rather than having these weekly hearings beating up ACA or defending ACA, which gets us very little traction as far as what we ultimately need to see happen in the healthcare system?

So, Mr. Holtz-Eakin, let me start with you, and maybe you can take a crack at that. What are some areas of common ground here?

Mr. HOLTZ-EAKIN. I think you just saw one of them, and that is the SGR repeal, which is just the leading edge of transforming Medicare into a social safety net program that is financially sustainable into the future and delivers better care.

That involves, in my view, changing payment models not just to doctors but to providers broadly, getting much more coordinated care to our seniors, delivering care in what is a care-appropriate and cost-efficient setting, often in the home, using a variety of modern technologies. I mean, it is a 21st-century Medicare system.

That, to me, is the most potent force for genuine delivery system reform. The Medicare system is a big payer, and if we——

Mr. KIND. I would agree with you on that. I think there has been a lot of bipartisan agreement, getting to a value- or quality-based reimbursement system. If you align the financial incentives right, I think you are going to see a lot of innovation, a lot of creativity in how to deliver those results at a much better price.

Ms. Corlette, do you have——

Ms. CORLETTE. Yeah, no, I actually completely agree. I think the Affordable Care Act, the idea was to get everybody in the tent. But the next big effort for policymakers is going to be healthcare costs.

And we have been able to take a little bit of a breather because cost growth has been slower than anybody expected the last few years, but we can't, you know, be sure that that will be the case forever. So I think the next big challenge on both sides of the aisle will be tackling those healthcare costs.

Chairman BRADY. Thank you.

And, Dr. Holtz-Eakin, just for the record, were you proposing eliminating the preexisting-condition provision?

Mr. HOLTZ-EAKIN. No. The——

Chairman BRADY. You were talking about how to get to continuous coverage——

Mr. HOLTZ-EAKIN. We are talking about alternatives, yes.

Chairman BRADY. Alternatives. Possibly bipartisan alternatives.

Mr. HOLTZ-EAKIN. Yes. I think, for example, if you did the continuous coverage, there is an incentive for people to get into the pool before they develop a condition, and they can be medically underwritten. And if there are still people who need to get covered, high-risk pools are a good alternative.

Chairman BRADY. Got it. Thank you very much.

Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman.

Back in the 24th District in Texas, the Affordable Healthcare Act is not working. People in my district view it as a government intervention into their private and their business lives. And the number-one failure that they talk to me about is it has actually driven up the cost of their health care, which they were perfectly happy with before the Affordable Healthcare Act was passed into law.

The biggest problem I hear from people is that it is costing them hours. Now, I have a very upper-middle-class district, but we have thousands and thousands of people that have had their hours cut back so that their employer no longer had to provide coverage for them.

And now what we are finding out, once they have their hours cut, they have a loss of income. Then they are going to the exchange to try to struggle to find some kind of coverage, and they are finding that the coverage that is available to them, which is usually the bronze coverage, is actually a piece of paper that, de facto, doesn't provide them very much health care.

In fact, they show up at the doctor's office or some of them are thoughtful enough to call ahead and say, I am coming in, here is the insurance I have, and, you know, what is the expectation, how much money should I bring. And what is actually happening is that people are finding out how much money they are having to pay and they are not coming, they are not going to the doctor. And if they go, they go in a catastrophic—they find themselves, they are in catastrophic situations where the $6,000 deductible actually is meaningful. And then the doctors and the hospitals are absorbing a fairly inordinate amount of uninsured cost, because they are actually having to pick up that first $6,000, because the people, they are basically indigent at that point.

Yes, they have signed up for the Affordable Healthcare Act. They have signed up at the level that the subsidy is given to them. I think that the record will show, after the first couple of years, that people are not upgrading to the next plan up or the next plan up and they are just taking whatever is given to them.

The other concern that I am beginning to hear from my constituents is that the penalties are about to ramp up. Now, $95, admittedly, was not much of a penalty at all to move people from point A to point B. And many of them weren't paying—they are not paying any income tax anyway, so $95 out of their tax return is not going to matter that much. But the next level we go to, I believe, is $325, and that is 2016. At that point, it is going to really begin to challenge people. And then, in 2017, it goes to $695 per adult.

Mr. Holtz-Eakin, when we go to those kind of levels, what will be the effect on the participation in the affordable healthcare plan?

Mr. HOLTZ-EAKIN. It remains to be seen. But, you know, those are all numbers that would suggest people have a greater incentive to get some sort of coverage, whatever it may be, and, you know, we should see the exchange numbers go up or the Medicaid participation increase, other things being the same.

Mr. MARCHANT. And that increased participation, will it drive the costs up, or will it bring costs down?

Mr. HOLTZ-EAKIN. When people are covered, they consume more health services, and it will drive up the national healthcare bill somewhat.

Mr. MARCHANT. Okay. Thank you very much.

Chairman BRADY. Thank you.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

And thank all of you for your testimony.

I think this hearing is especially well-timed given that tomorrow is tax day. This is the first year that the taxpayers are facing the ObamaCare reckoning, if you will.

Mr. Holtz-Eakin, after the President's unilateral delay of the employer mandate last year, I introduced legislation to offer the same tax and regulatory relief to individuals by delaying the individual mandate penalty, as well. Unfortunately, the President threatened to veto the legislation.

When I introduced the bill, I was concerned that this confusing law was still misunderstood by many Americans and that, in addition to failing to enroll millions, it would also be a liability for millions more on tax day. And I think our experience shows this to be correct. I think you said 6-million-plus Americans will pay the individual mandate tax because they did not enroll, while another 15 million to 30 million will receive a hardship exemption.

Mr. HOLTZ-EAKIN. Right.

Ms. JENKINS. And, of those who did enroll, many are facing the reality of repaying Uncle Sam out of their tax refund to cover excessive subsidies given out by the exchange.

HHS found that, of those selecting a health plan over the exchange last year, 87 percent were eligible for subsidies because of the high cost of the plans. H&R Block reported in February that 52 percent of folks who received a subsidy would be paying back at least a portion of that money to the government when they paid their taxes. People may have to pay back their subsidy for any number of reasons—they switched jobs, they got married, or incorrectly reported information in the first place. The Kaiser Family Foundation estimates that the average repayment will be $794.

So, Mr. Holtz-Eakin, I was wondering, this tax scheme does seem expensive and burdensome, so I would just like you to give us some advice and counsel and reiterate, if you will, what are the key guideposts that this Committee should keep in mind as we work toward an alternative system.

And I know one fellow Member asked about bipartisan solutions, and I am not particularly concerned about that. I want to know what the right thing to do is that focuses us on patient-centered coverage, to make it affordable, to get everyone covered, that still maintains our freedoms and our liberties without the harmful effects to the pocketbooks for individuals, families, businesses, or the American economy.

Mr. HOLTZ-EAKIN. Well, I certainly believe that greater flexibility in the insurance offerings is step number one. And I think the large number of insurance regulations that were imposed overdid it and harmed the choices people would have at premiums they could afford. And so reexamining the essential health benefits, the community rating provisions, I think, is the place to go.

In the end, you will have to have a system that is also much simpler. I did testimony in front of a Ways and Means Subcommittee last year on how complex the subsidy verification system is in the Affordable Care Act. It requires an enormous amount of information from individuals, their families, from employers and, you know, in my view, is probably four times as complicated as the EITC, which already has an error payment rate of something like 20 to 25 percent. And I am skeptical that even with the best functioning software we will ever really get this right.

So a simpler way to deliver to the American people subsidies that many of them will in fact need and which, you know, people agree should be made available so they can afford insurance, that is an important thing for this Committee to look at, better ways to implement the subsidy systems.

And then the most important thing is to be much more, I think, interested in healthcare reform, delivery system reform, allowing innovative delivery models to sprout across the land. Because that is where the cost is, in the end. Insurance just covers the cost of the care. The care costs too much; that is the problem. My concern with the Affordable Care Act is it is very much a top-down, let's pick a delivery system model and enforce it. That is a risky strategy.

I would prefer to see, for example, a big reliance on Medicare Advantage, where there are lots of plans that cover lots of different geography and have real incentives to really coordinate care—that is where the accountable care organizations learned about care coordination—and to make those plans better and to, in the process, develop delivery systems that are cheaper and deliver higher quality care.

Chairman BRADY. Thank you.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman. I want to really thank you for allowing me to be part of today's hearing.

Many of the mandates contained within ObamaCare continue to concern many Members of Congress, business owners, and individuals, with good reason. These mandates are not only onerous, the rules surrounding them are opaque and sometimes contradictory.

I am especially concerned about provisions of the law dealing with the calculation small businesses must perform in order to determine whether or not they are required to offer insurance to their employees and to which employees they must offer insurance.

For instance, due to a misaligned statute in regulation, an employee for a business may be considered a seasonal worker while not at the same time considered a seasonal employee. This creates confusion for employers that are trying to obey the law but can't afford an expensive team of HR and tax professionals in order to ensure they are in compliance.

This mismatch of policy also creates strange practical effects, in which an employer may be unable to rehire a seasonal worker to fill a temporary, short-term position without triggering a penalty.

This issue, in particular, led me to introduce a bipartisan bill, Simplifying Technical Aspects Regarding Seasonality Act, or the STARS Act, H.R. 863. This legislation would provide one clear definition of "seasonal employment" rather than multiple definitions

applied to different aspects of the ACA's employer provisions. This is just one example of a flawed mandate approach taken by ObamaCare.

Mr. Holtz-Eakin, the contradictory definitions of "seasonal employment" I mentioned could lead to individuals gaining and losing employer-sponsored coverage several times over the course of a year, a process known as "churn."

Are you concerned that this could lead these individuals, through no fault of their own, to face either subsidy claw-backs or penalties under the individual mandate? And are there negative effects caused by the churn?

Mr. HOLTZ-EAKIN. Congressman, I think this is a very important issue. I am not going to pretend to have mastered all the rules on seasonality. We had a little quiz before the hearing to see if we knew the answer. Suppose I have 51 employees, they only work for 119 days, so they are under the 120, but they worked 13 hours every day. Are we obligated to offer them insurance? We think the answer is yes, but we would love to talk to you about it, as well.

So I endorse, really, the effort to clarify this. It has bad business implications if you are churning your employees. You can't run a business if you have to turn everyone over. It is also bad for the employee's health care, because every time they churn through their insurance policy, they are likely getting a different set of providers and a different network. That is not good for their care. So this isn't a good situation for anyone.

Mr. RENACCI. Yeah. Well, this is exactly one of the issues I think Mr. Kind talked about earlier. This is a bipartisan issue, a fix that we need to really make.

Mr. Womack, you mentioned an example of uncertainty caused by these complex mandates. Do you have any idea of what that costs you as an employer?

I mean, I was an employer also for 30 years before I came here. I actually had seasonal businesses, car dealerships. You name them, I seemed to be a part of them, including a CPA firm. And I still have a lot of contacts back home that are telling me the ability to try and justify and come up with these costs of time and whether you are full-time, part-time—can you tell us a little bit about some of the issues that you are running into?

Mr. WOMACK. Well, you know, we struggled with the decision whether to offer coverage or not. I mean, we spent a lot of time looking at that. A lot of people in our industry have decided to not offer coverage or, as some have indicated, to cut back hours in their workplace, and we decided not to do that. But it was really a calculated risk on our part as to whether employees were going to sign up or not.

As far as putting a dollar amount on it, I can't begin to tell you. I can tell you it did have an impact on my decision to sell my IHOP restaurants last year. Because, you know, when we had the opportunity to sell, quite frankly, it was something I jumped at. Because, you know, that part of the industry was a lot more labor-intensive, a lot more employees per dollar, and, you know, our concern was where this was all going to go.

Mr. RENACCI. Thank you.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Mr. Young, you are recognized.

Mr. YOUNG. Well, thank you, Mr. Chairman, for allowing me to be part of this Subcommittee hearing. I don't typically sit on this Subcommittee.

I want to thank all our witnesses, including Mr. Womack, a fellow Hoosier.

I want to ask questions along the lines of the new 30-hour-workweek definition of full-time employment under the Affordable Care Act. You are all familiar with the fact that the ACA redefines a full-time workweek from the traditionally understood standard of 40 hours down to 30 hours.

And I have heard, as have all my colleagues, from employers, restaurants, you know, school, corporations, and others about the adverse impact of this, and not just on operations of an enterprise but on the workers themselves. Thirty-nine school districts in the State of Indiana have actually sued the Federal Government on account of this provision. Industries that employ low-skilled workers are particularly adversely impacted. Eighty-nine percent of workers impacted don't have a college degree.

And just to give some sense of the hourly impact on wages, an employee going from 35 hours down to 29 hours is effectively receiving a 17 percent pay cut courtesy of this health care law. An employee going from 39 hours down to 29 hours is losing an entire workweek's worth of wages.

So, Mr. Womack, as a restaurant owner, as someone who has owned businesses for a number of years, could you share with us the real-world impact of this new 30-hour standard on your business and perhaps speak to those who indicate that the 30-hour threshold is having no impact on business?

Mr. WOMACK. Well, as I just indicated, I have seen numerous other people in the industry, you know, seek to meet that threshold.

It is interesting, my industry, in particular, you know, we have a lot of flexibility, and we can adjust to a lot of things, and we have done that. But, as you indicated, there are numerous organizations out there—school systems are a great example, universities and so on—where, you know, they have fixed budgets coming from their States and they don't have any flexibility. And so, you know, looking at this cost, they have had to make that cut. And we haven't done that.

I have a bigger concern, you know, that by offering coverage to our pool of employees, we have gotten numerous comments from our staff saying, hey, the fact that you have offered me coverage now makes me ineligible for exchange plans, ineligible for subsidies for my dependents, and so on. That is a big gap there. And, you know, there are just a lot of people at the lower end of the income scale who cannot play in this healthcare economy——

Mr. YOUNG. Yeah.

Mr. WOMACK [continuing]. Even if they had the healthcare coverage.

Mr. YOUNG. So there is a related burden on employers that we have heard much about, as well, and that is the reporting requirements associated with the ACA.

And, perhaps, Mr. Womack, you could indicate any resources you have had to invest in on account of the reporting requirements and maybe even tell us how much time and money have been involved in these investments.

Mr. WOMACK. Well, a tremendous amount of time.

We have spent the last several years looking at how we were going to report. And when the requirement first came out, we kind of thought, okay, we think we can do that. And then what we found was the data was not readily available. We do our own payroll. We do our own accounting. You know, we have our own bookkeepers in house. And what we realized was the data wasn't sitting there in our system; we had to create it.

And because of the requirement, the way it was written, it is literally something that has to be done on a monthly basis even though we are not doing it.

Mr. YOUNG. So I come from a small-business family, and I know there is a limited pot of resources. And if they are diverted to do one thing as opposed to another, that has real-world consequences.

Where might you have otherwise spent these resources invested in compliance?

Mr. WOMACK. Well, absolutely into additional payroll, into more people.

Mr. YOUNG. More people.

Mr. WOMACK. We are in a business where the more people we can put into our restaurants, the better we can perform. So we are constantly having to choose between, you know, the service that we give and other things in our budget.

Mr. YOUNG. Thank you.

I yield back.

Chairman BRADY. Thank you, Mr. Young.

I know some lawmakers in Congress, probably on both sides of the aisle, are tired of these hearings. But my guess is, Mr. Womack, you are probably tired of struggling with higher healthcare costs and trying to juggle the impact of this law on your business. And you are like so many others who are trying to do this.

There may be only a few, frankly, businesses percentage-wise that the mandate may hit directly, but I think it is probably 100 percent that are impacted by this law in some way and that they are making business decisions to that effect. Would you agree?

Mr. WOMACK. Absolutely. Yeah.

Chairman BRADY. Mr. Holtz-Eakin, I think we are looking for bipartisan solutions. You brought together today ideas on how we can continue important provisions like preexisting conditions but encourage continuous coverage in a way that is smarter, more tailored to what the worker or those who wish to be covered—would work better for them and lower the cost.

Any words of advice as we wrap up the hearing?

Mr. HOLTZ-EAKIN. Well, I would certainly encourage the Committee to look at those alternatives. I think we are increasingly finding that this system, whatever its intentions, is not working in a way that is best for the consumers of the health insurance products but also for the other participants in the healthcare system.

And so I really think it is important to not stop here and to actually push forward to a much more efficient healthcare system that

is really built from the ground up and allows a lot of choice on the ground.

Chairman BRADY. Absolutely. Thank you.

Ms. Corlette, I think, like Dr. McDermott, there are a wide range of opinions about why healthcare costs have slowed. There is no consensus that this is due primarily to the ACA. Most cite a combination of a pretty poor economic recovery so people are reluctant to spend, higher out-of-pocket costs for people, again, that drives down those healthcare costs, better or worse. And so I still think there is a great deal more to be seen before drawing the conclusion that 5 years of declining healthcare costs are due to the ACA. I just don't see that.

And I had breakfast with some of our local hospitals over the break, and they told me that the fastest growing part of uncompensated care for them is not the uninsured, it is the underinsured. It is people who, frankly, have an ACA exchange plan but they simply can't afford the copays and deductibles. And I think that is a reality we have to deal with.

Mrs. Black somehow raced back to the Capitol and made it in time for the hearing. As a new Member of our Committee and a valued leader in health care, Dr. McDermott and I are proud to give you the last question here today.

Mrs. BLACK. Well, thank you.

Mr. MCDERMOTT. He did a magnificent filibuster while he waited.

Mrs. BLACK. And I am so grateful to both of you and to the panelists for giving me the opportunity to ask my question, because it is a little bit different than some the others have asked.

And, Mr. Womack—and please excuse me if I am winded, but I ran that entire hall. It was pretty good for me.

I wanted to ask you about the employer reporting piece. Because I am now hearing more and more about this and how it is affecting the employers in my district—in particular, the fact that the IRS was not very timely in getting the instructions out on even how to do this employer reporting. But my understanding is that these instructions are going to require pretty significant amounts of information about your employees on a monthly basis.

Have you had any experience at this point in time with being able to make sure you are meeting that mandate? What is it taking? Have you had to hire additional people on, maybe in HR, to help you do that? Can you speak to that?

Mr. WOMACK. Sure.

We spent the last several years looking at this, and the disturbing thing to us was that the data didn't exist in our systems for that. And so we had to get with our accounting software firm that provides us the software, and they were doing this for several clients, but they had to build a new report for us that actually does calculations every month.

You know, one of the wrinkles in this whole thing is, when someone comes on board in the middle of the year, it is an entirely different process than someone who worked the prior year. And that calculation just occurs over and over and over, to the extent that you are doing this monthly and then setting that data aside and accumulating it throughout the year.

And it doesn't sound like a big deal until you realize that it is not, and I would have to illustrate this some other time, but it is not data that you already have. And, you know, we have our own accounting system, our own payroll system. So you would think that it would have been simpler if we had simply been able to say, this person is eligible and this person is not. But, instead, we had to do a whole host of other calculations.

And, you know, basically, no one had this. All of the big payroll companies had to create it.

And, you know, as I shared in my testimony, you know, the other concern I have is whether the Federal Government is ever actually going to be able to do anything with the data I am creating. It has to go to the IRS and then go to the exchange, and then someone has to connect the dots later on to see if it actually applies.

Mrs. BLACK. So can you estimate or have you done any numbers to see what the cost of this was to you, in setting this up?

Mr. WOMACK. I know we spent about $8,000 on the software, but it is literally hundreds of hours that we spent. And part of the problem, as someone else shared, was that we really didn't know what we were doing until recently. We spent a bunch of time trying to figure it out, and then we got conflicting information later. And it has been hundreds of hours.

Mrs. BLACK. So the fact that the IRS didn't give guidance until February, and then you were responsible for starting to collect this information in January——

Mr. WOMACK. In all fairness to the IRS, and I know it is hard to believe I would say that, but it is really the legislation, the big soup that was created in the legislation, that put the IRS in a very difficult position.

Mrs. BLACK. And so it might be helpful if Congress were looking at that and listening to employers to figure out how it is that we might be able to help you out to be able to abide by the law, I would say.

And I thank my colleague from Washington in mentioning that I am working on something that would really help to give some relief to our employers on that.

And I think it is also interesting, as you related, that we are not even sure how this information is really going to be used, if the IRS or even if HHS has the ability to be able to use this information in a way that would say it was worth the money and the time that we are asking from our employers.

Since you are an industry where, I would imagine, you have a number of part-time employees and a lot of turnover, is this going to affect you and those employees that you are giving insurance to? In trying to keep the records on people leaving and people coming, I would think that would cause an additional complication.

Mr. WOMACK. Yeah. We have rolled with it, and we have figured out how to work it. It has taken a few years to do that. But it is definitely more of a burden.

Mrs. BLACK. Well, I appreciate what you do for the employees that you have employed in your company. You are providing jobs for them. You are certainly someone who cares about them, obviously. You are providing insurance.

And I think I am going to take away one thing that you said that I am going to keep in my mind and repeat when I am back in the district as I meet with the employers, that no agencies are going to bail you out when these additional costs are put on you, these mandates that you don't have a funding mechanism for.

So thank you so much.

Thank you again, Mr. Chairman.

Chairman BRADY. Thank you.

And, Dr. McDermott, would like to ask a followup question?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

You suggest that there is too much detail, and it is not the usual HR kind of detail that you had to provide for the IRS.

My assumption is that their rules and regulations were put in for you to give data so that they could pick up fraud, if people were trying to cheat. Is that correct?

Mr. WOMACK. Absolutely.

Mr. MCDERMOTT. Do you think that you could give data that would help them be able to do that?

Because we all care about wasting money. We don't want money to be wasted on these subsidies. So if the subsidies are going to be there, we have to construct a system. Do you think that it is possible to make a system that would give them the data they need and make it possible for a business to fill it out?

Mr. WOMACK. Yeah, I do. I think the issue is, if you do it on a monthly basis and then turn that data in literally 15, 16 months later, you have really defeated the purpose. If we could have an annual-type eligibility and then rework the rules around that annual eligibility so that everybody knows, you know, January 1 what the status of a person is, that would just be wonderful.

Mr. MCDERMOTT. And the correction would be done at the end of the year, whenever whatever happens.

Mr. WOMACK. Correct. I mean, we are already in a situation where people are going to get to the end of the year and may have received subsidies that they shouldn't have gotten. That situation already exists. The difference is we are collecting all this information that is not useful, at least in my opinion, and then turning it in late.

Mr. MCDERMOTT. Okay. Thank you.

I hope, Mr. Chairman, we could have a hearing on Ms. Black's bill.

Chairman BRADY. Thank you.

I would like to thank the witnesses for their testimony today. There is a reason you have been asked back through the years; it is you are knowledgeable on a complicated issue. And we appreciate the insight very much.

And we appreciate your continued assistance in getting answers to the questions that were asked where time may have run out.

As a reminder, any Member wishing to submit a question for the record has 14 days to do so.

If any Member submits a question to you, we ask for your timely response to that.

With that, thank you for a good hearing.

The meeting is adjourned.

[Whereupon, at 12:01 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

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Testimony of Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

Submitted for the Record

U.S. House of Representatives Ways and Means Subcommittee on Health Hearing
Individual and Employer Mandates in the President's Health Care Law
April 14, 2015

Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee:

On behalf of the American Academy of Actuaries'[1] Health Practice Council, I appreciate the opportunity to provide written testimony on your subcommittee's recent hearing on the individual and employer mandates under the Affordable Care Act. My comments will focus on the individual mandate.

Insurance markets must attract a broad cross section of risks

For health insurance markets to be viable, they must attract a broad cross-section of risks. In other words, they must not enroll only higher-risk individuals; they must enroll people who are lower risks as well. If an insurance plan draws predominantly those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk.

Adverse selection is a byproduct of a voluntary health insurance market. When people can choose whether or not to purchase insurance coverage, their decisions reflect in part how their expectations for healthcare needs compare to the insurance premium charged. Adverse selection results in higher premiums that, in turn, may lead to more lower-risk individuals opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding such spirals requires minimizing adverse selection and instead attracting a broad base of lower-risk individuals, over which the costs of higher-risk individuals can be spread. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

How the various rules and regulations that apply to health insurance markets are defined can affect the degree to which adverse selection occurs. In particular, guaranteed-issue

[1] The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

provisions, which prohibit insurers from denying coverage based on pre-existing conditions, can exacerbate adverse selection concerns by giving individuals the ability and incentive to delay purchasing insurance until they require health care services. Likewise, limiting or prohibiting premium variations by health status or other characteristics correlated with health spending can raise the premiums for younger and healthier individuals, relative to what they would pay if these characteristics could be used as rating factors. Such pure or modified community rating rules could cause younger and healthier individuals to opt out of coverage, leaving a higher-risk insured population.

The individual mandate is important to reducing potential adverse selection arising from guaranteed issue and modified community rating rules

Increasing overall participation in health insurance plans, especially among lower-risk individuals, is an effective way to minimize adverse selection. The Affordable Care Act (ACA) includes an individual mandate, which is an integral component of the law. The mandate, along with the premium subsidies and other provisions, provides incentives even for individuals in good health to obtain coverage, mitigating premium increases due to guaranteed issue and modified community rating. Without the individual mandate, fewer people would be insured and the risk pool would be more heavily weighted to those with higher costs. The result would be higher premiums.

Alternatives to the individual mandate

In the absence of an individual mandate, other mechanisms could be used to either encourage lower-cost individuals to purchase coverage and/or to offset the higher costs associated with adverse selection. However, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives. Below is an annotated list of potential alternatives, many reflecting options explored by the Government Accountability Office (GAO) in consultation with health policy experts, including representatives from the American Academy of Actuaries.[2] These options could be pursued alone or combined with one or more other options. When assessing any of these options, policymakers must balance providing individuals, especially healthy individuals, with incentives to enroll when first eligible against not being overly punitive so that individuals who delay enrollment face barriers so high that they find it difficult to ever enroll subsequently. In addition, the impacts on particularly vulnerable populations, such as those with low incomes or pre-existing health conditions, need to be considered.

Less frequent open enrollment periods. When guaranteed issue requirements prohibit insurers from denying coverage to individuals with pre-existing conditions, open enrollment periods limit the extent to which individuals can delay obtaining coverage until they need it. The ACA includes an annual open enrollment period during which individuals can sign up for coverage. Enrollment is not allowed outside of this period except under certain qualifying circumstances, such as a change in marital status.

[2] Government Accountability Office, "Private Health Insurance Coverage: Expert Views on Approaches to Encourage Voluntary Enrollment," 2011. Available at: http://www.gao.gov/new.items/d11392r.pdf.

Less frequent open enrollment periods, for instance, having a one-time open enrollment period or an open enrollment period every two to five years instead of annually, would provide a greater incentive for people to purchase coverage sooner rather than later. It would reduce adverse selection arising from individuals delaying enrollment until they have high healthcare needs.

Late enrollment financial penalty. A late enrollment penalty is often suggested in combination with less frequent open enrollment periods. If an individual does not enroll in coverage when it is first available, subsequent enrollment would require a higher cost. This could be done, for instance, through a premium surcharge or a reduction in premium subsidy. Imposing a higher premium on those who delay enrollment could provide an incentive for people to purchase coverage when it is first available. Premium penalties may need to be significant if a goal is to offset the costs of those who delay enrollment until they have high-cost healthcare needs. Otherwise, the increased costs stemming from adverse selection would be spread to other enrollees in the form of higher premiums.

The late enrollment penalty in the Medicare program imposes a higher premium on individuals who don't sign up for Part B or Part D when initially eligible and don't have creditable coverage. Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums likely play a larger role.

Late enrollment access penalty. Rather than charging a higher premium for those who delay enrollment, another form of a late enrollment penalty would be to remove the guaranteed issue and modified community rating requirements for late enrollees. In other words, insurers would be allowed to underwrite for those who do not enroll when first eligible. Individuals with pre-existing conditions could then be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions. By limiting or excluding coverage for pre-existing conditions, such a penalty would reduce premium increases resulting from adverse selection.

Expanded reinsurance program. The ACA includes a temporary reinsurance program to offset the higher costs to plans of higher-risk individuals enrolling during the early years of the program. It was expected that higher-risk enrollees would be more likely to enroll sooner, and lower-risk individuals would eventually enroll, due to the individual mandate and its penalties which increase over time. The reinsurance program is funded through assessments on all plans and provides payments to plans in the individual market. In 2014, the reinsurance program reduced net claim costs in the individual market by 10-14 percent, leading to lower premiums.[3] The reinsurance program is temporary and phases out between 2014 and 2016, resulting in lower offsets to premiums over time.

In the absence of an individual mandate, extending and expanding the use of reinsurance through larger assessments or other funding could help offset costs of higher-risk

[3] American Academy of Actuaries, "Drivers of 2015 Health Insurance Premium Changes," 2014. Available at: http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf.

insureds, thereby moderating premiums. Lower premiums could encourage enrollment by even healthy individuals.

Allow greater premium variation. Under the ACA, premiums in the individual market are not allowed to vary by health status, and are allowed to vary by age by only a 3-to-1 ratio. Allowing greater variation in premium rates based on age would reduce costs for younger adults, increasing the likelihood they would purchase coverage. But, costs for older adults would increase, potentially making coverage unaffordable.

High-risk pools. If the requirements regarding guaranteed issue and modified community rating were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average premiums would be lower but high-risk individuals would have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but these have generally been small, coverage has been limited and expensive, and they have typically operated at a loss.[4] In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-risk individuals in the individual market can incur high health costs, which would put upward pressure on premiums.

Coverage opt-out with payment for uncompensated care. Without an individual mandate or other mechanisms to encourage enrollment, health care providers will see a rise in uncompensated care. As an alternative to the mandate, an option would be to allow individuals to opt out of coverage, but require that they pay a share of uncompensated care costs through an annual assessment.

Weakening or eliminating the individual mandate could threaten the viability of the health insurance market

When health insurance markets include guaranteed issue and modified community rating requirements to ensure that coverage is available to people with pre-existing conditions, market viability depends on attracting a broad cross section of risks. If individuals with lower-cost health care needs opt to forgo coverage, average costs of those purchasing coverage will be higher, potentially creating a premium spiral. By encouraging enrollment among low-risk individuals, the ACA's individual mandate helps mitigate these adverse selection concerns.

Weakening or eliminating the individual mandate could result in adverse selection that would raise premiums and threaten the viability of the market, unless alternative provisions are implemented that would create equally strong incentives for low-risk individuals to obtain coverage. Alternatives include less frequent open enrollment periods with penalties for late enrollment, an expanded reinsurance program, high-risk pools, allowing greater premium variations across individuals, or allowing coverage opt-outs with assessments for uncompensated care. Although such voluntary incentives would provide incentives for healthy individuals to obtain coverage when first eligible, they would likely not be as effective as a strong individual mandate. In addition, special

[4] Congressional Research Service, "Health Insurance: State High Risk Pools," 2011.

consideration would be needed to ensure access to coverage for vulnerable populations, for instance those with low incomes or pre-existing health conditions.

August 17, 2016

The Honorable Kevin Brady
Chairman, Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member, Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of Associated Builders and Contractors (ABC), a national construction industry trade association with 70 chapters representing nearly 21,000 chapter members, I am writing in regard to today's hearing on the individual and employer mandates in the President's health care law and the associated penalties.

Providing quality health care benefits is a top priority for ABC and its member companies. ABC continues to call on Congress to advance common-sense health care solutions that will provide greater choice and affordability and allow private insurers to compete for business.

On March 23, 2010, President Obama signed into law the massive health care law, known as the Affordable Care Act (ACA). Five years later, the ACA continues to create uncertainty and confusion in the construction industry, making it difficult for the nation's contractors to plan for the future and create jobs.

Generally, under the employer mandate provisions of the ACA, employers with 50 or more full-time employees and full-time equivalent employees must offer full-time employees a certain level of coverage or be subject to a penalty. The increased costs related to this onerous mandate continue to be of significant concern to ABC members. ABC has advocated for repeal of the employer mandate and is in full support of Rep. Boustany's *American Job Protection Act* (H.R. 248), which would repeal the job-killing employer mandate provisions.

By forcing employers to offer government-prescribed health insurance, ABC members will no longer have the choice or flexibility to structure health care coverage options that meet the needs of their fluctuating workforce. The resulting increased costs will jeopardize the ability of ABC member companies to maintain affordable coverage options for their employees and force some to drop coverage all together.

In addition, the implementation of the ACA's employer mandate provisions requires significant employer education. The regulations implementing the employer mandate are complex and confusing and many questions remain.

We appreciate your attention to this important matter and look forward to working with you to repeal the burdensome and costly employer mandate.

Sincerely,

Geoffrey Burr
Vice President, Government Affairs

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