

SMALL BUSINESS HEALTH CARE: COSTS AND OPTIONS

HEARING BEFORE THE SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE ONE HUNDRED FOURTEENTH CONGRESS SECOND SESSION ON EXAMINING SMALL BUSINESS HEALTH CARE, FOCUSING ON COSTS AND OPTIONS

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SMALL BUSINESS HEALTH CARE: COSTS AND OPTIONS

TUESDAY, JUNE 28, 2016

U.S. SENATE,
Subcommittee on Primary Health and Retirement Security,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:05 p.m., in room SD-430, Dirksen Senate Office Building, Hon. Michael Enzi, chairman of the subcommittee, presiding.

Present: Senators Enzi, Scott, Cassidy, Murphy, and Bennet.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. I'll go ahead and call to order this HELP Subcommittee on Primary Health and Retirement Security roundtable, at a square table, but this is as close as we come to round around here. I got word from Senator Sanders to go ahead.

I'll do my opening statement, and when he gets here, he can do his opening statement, and if he isn't here by the time I finish, then we'll go ahead and start having you give a summary of your testimony, and then following that, we'll have the discussion and questions.

I'd like to thank all of you for coming today, and I'd like to thank the staffs on both sides of the aisle for working on putting together a bipartisan conversation about what's important to small business in the area of healthcare. I'd also like to thank all my colleagues for being interested in this and ready to engage in important discussion. There will be more here throughout the afternoon.

I think we have here at the table representation from many experts who have a valuable perspective about what the reality is for small businesses helping their employees purchase health insurance. I'm anxious to get to the real discussion, but I'd like to touch on the heart of what I hope we can get to today.

Small businesses are the backbone of our economy. In Wyoming today, we're watching our communities being decimated by the collapse of the energy sector. Thousands of jobs have been lost, but, as you know, those losses never happen in isolation. Main street businesses feel the hit with their customers. They feel the crunch of a down economy, and we have to consider what additional pressures they have to face.

Small businesses as a whole are different than big businesses. Despite the fact that they're not legally required to offer health insurance, so many small employers do. Offering health insurance

helps give their business a competitive advantage and incentivizes employee retention, but many employers also offer health insurance plans out of a sense of responsibility to their employees.

We want employers to stay involved in the health of their employees. But Washington has done nearly everything possible to make it a bad business decision to continue to offer health insurance options. Policymakers often want to be supportive of small businesses but may not truly understand the challenges they actually have on the ground.

I know that when I was running my small shoe store, I found out that any business that I looked at looked easy to operate, so long as I didn't have to get behind the counter and run it. People don't realize the decisions that have to be made, how long in advance they have to be made, how you train people, how you acquire people, and how difficult all that is. You may be the owner of a small business, but you're also usually the same person who opens the store, who waits on the customers, who cleans the bathroom, who stocks the merchandise, all while trying to meet payroll every week and keep up on any new government regulations.

I also know the amazing satisfaction you get when you see your business take off, the point where you think that you're really going to make it work. The business owners I know see that as a shared success with their employees. It's a community. You know their families. You want to make sure those people are taken care of.

The Federal Government has tried a variety of approaches to fix the small group market. There's general agreement that we still aren't there yet, and some would say that we've made things worse.

Today, I'd like to focus the discussion on the biggest challenge for small businesses wishing to help their employees with health care, and that cost. It's the No. 1 reason that small businesses say they do not provide health insurance assistance for their employees. This is not a discussion about one particular bill or priority. I'd ask our panel today to think beyond what the market was before the Affordable Care Act and what it is under the Affordable Care Act. We need to look at what small businesses actually want in the next 10 to 15 years. That translates into affordable options with more flexibility and fewer restrictions.

The landscape in healthcare has rapidly changed. We must be willing to consider a variety of options. Perhaps it should not resemble today's market at all. If we try to fit health insurance into an outdated mold with priorities and sacred cows of a decade ago, we won't be able to make much progress.

I think we agree here that cost is a problem. If the Federal Government has created an affordability problem or exacerbated it, we should identify it and figure out how to fix it. Our government is even more deeply embedded in healthcare now than ever, and we're seeing the impact of that in rising premiums and tighter family budgets.

Just to clarify the process, after Senator Sanders speaks or prior to him being here, I'll ask each of the participants to speak briefly. You've submitted statements. Your entire statement will be a matter of record for this roundtable. After your introductory comments, if you'd like to respond to something that's been said or one of the

questions that we ask, if you'd just stand your name tag up on end, we'll know to call on you and we'll try to keep track of the order of that.

First, I'd like to welcome a fellow Wyomingite, Tom Glause, who is the Insurance Commissioner in Wyoming. He has firsthand knowledge of the insurance markets and how policies impact costs.

I also understand that you have an accounting degree. I'm always glad to see that. There are two of us in the Senate.

Next is Warren Hudak. Mr. Hudak is the president of Hudak and Company, an accounting firm in Cumberland, PA. He has seven employees and has personal experience in purchasing health insurance as a small employer.

I appreciate you taking time away from your business to participate.

I want to welcome Mr. Thomas Harte. He's the president of Landmark Benefits in New Hampshire. Mr. Harte's company provides employee benefit services to over 300 corporations and thousands of employees.

You have participated in our roundtable before, and I appreciate you coming back again.

Ms. Sarah Lueck is Senior Policy Analyst at the Center on Budget Policy and Priorities here in Washington, DC. Ms. Lueck works on issues related to health reform implementation, specifically, health insurance exchanges and private market reforms included.

I want to thank you all for your time. Also, another thing that we do is at the conclusion, we allow a short period of time for people to submit written questions that we would hope that you'd be willing to answer as well, and those become a part of the record, too.

At this point in time, we'll go ahead and begin the discussion, and if each of you would summarize your comments, which will be in the record completely, we'd appreciate it. That leaves more time for more questions and comments.

We'll begin with you, Mr. Glause.

**STATEMENT OF TOM GLAUSE, COMMISSIONER, WYOMING
DEPARTMENT OF INSURANCE, CHEYENNE, WY**

Mr. GLAUSE. Good afternoon, Chairman Enzi and members of the Subcommittee on Primary Health and Retirement Security. Thank you for asking me to participate in this Roundtable Discussion on Small Business Health Care: Costs and Options. My name is Tom Glause. I am the Insurance Commissioner for the State of Wyoming.

As the least populated State in our Nation, Wyoming faces challenges in providing health insurance coverage for its citizens. Since the passage of the ACA, a large number of health insurance companies have left the Wyoming market. Currently, Wyoming has only one insurer participating in the Federal marketplace for both individuals and small group plans.

The exodus from the health insurance market has been for a variety of reasons, including financial insolvency, changing focus of product lines, and effects of the ACA. As the State is currently experiencing an economic downturn, employers are reporting that

they must reduce or cut employer-provided health insurance in order to maintain employment positions.

We have seen a slow but steady increase in the number of participants in the individual marketplace, but very little participation in the SHOP plans. As of May 31st, Wyoming's only SHOP carrier reports just 103 contracts covering less than 300 lives. Wyoming has traditionally had the highest rate of employer-provided healthcare coverage in the Nation. According to the Kaiser Family Foundation, in 2014, the national average for employer-sponsored health plans was 49 percent, whereas Wyoming was 61 percent.

The mandated coverage for essential health benefits has been costly and burdensome on small employers. Wyoming employers report that they want to provide coverage for their employees but feel constrained by the cost and the requirements that the small group plans must contain the ACA's 10 essential health benefits.

In 2015, the Wyoming State legislature passed statutory language to clarify that if a small employer offers coverage to its employees, the employer has the option of offering coverage to the employees' dependents. In some cases, this legislative change has allowed the employees' dependents to obtain individual coverage on the marketplace.

Network adequacy continues to be an issue. It was before the ACA, and it remains an issue today. Wyoming only has 196.7 physicians per 100,000 residents, compared to an average of 265.5 nationally. In addition, Wyoming covers almost 98,000 square miles. Needless to say, our providers are widely scattered.

Uncompensated care remains a concern in nearly all care facilities in our State. A May 2016 report from the Wyoming Hospital Association indicates a 3 percent annual increase in uncompensated care. The Association anticipates larger increases because of increasing unemployment, an increasing number of high deductible health insurance plans, and an increasing number of uninsureds.

Wyoming has the second highest premium rates in the Nation, second only to Alaska. On the individual market, in 2016, the average monthly premium before the advanced premium tax credit was \$571, compared to the national average of \$396. Wyoming employers have reported that the tax benefits of providing coverage are often difficult and convoluted. Others report that it's less expensive to pay the tax than to provide health insurance coverage.

The Wyoming Small Employer Reinsurance Plan has begun a run-out of the program and the claims. The number of ceded lives into the plan has continued to decline, indicating a decreasing number of small employer-sponsored plans.

In conclusion, there are two primary considerations for small businesses when considering whether to provide health insurance to its employees. The first is cost: the cost of the premiums to the employer and the employee and the cost of time in administering the program. The second is choice. Can the small employers provide coverage that their employees need with networks that are sufficient and out-of-pocket costs that are reasonable?

Thank you for inviting me to this roundtable discussion, and I look forward to your questions.

[The prepared statement of Mr. Glause follows:]

PREPARED STATEMENT OF TOM GLAUSE

Good afternoon, Chairman Enzi and members of the subcommittee on Primary Health and Retirement Security. Thank you for asking me to participate in this Roundtable Discussion on Small Business Health Care: Costs and Options. My name is Tom Glause. I am the Insurance Commissioner for the State of Wyoming, appointed to this position by Governor Matt Mead in January 2015.

As the least populated State in our Nation, Wyoming faces challenges in providing health insurance coverage for its citizens. Perhaps some observations and information about my State may be helpful in discussions regarding small employer plans in general but specifically regarding the small employer market in rural settings.

Since the passage of the ACA, a large number of health insurance companies left the Wyoming market. Currently, Wyoming has only one insurer participating in the Federal Marketplace for both individuals and the small group or SHOP plans. The exodus from the health insurance market has been for a variety of reasons, including insurer financial insolvency, changing focus of product lines, and effects of the ACA.

As the State is currently experiencing an economic downturn, employers are self-reporting they must reduce or cut employer-provided health insurance in order to maintain employment positions. We have seen a slow but steady increase in the number of participants on the Individual Marketplace but very little participation in the SHOP plans. As of May 31, Wyoming's only SHOP carrier reports just 103 contracts, covering less than 300 lives. The individual Marketplace reports 23,770 enrollees for 2016.

Wyoming has traditionally had the highest rate of employer provided health coverage in the Nation. According to the Kaiser Family Foundation, in 2014, the national average for employer sponsored health plans was 49 percent, whereas Wyoming was 61 percent, followed closely by Maryland at 60 percent.

The mandated coverage of the Essential Health Benefits (EHB) has been costly and burdensome on small employers. Wyoming employers report they **want** to provide coverage for their employees but feel constrained by cost and the requirement that these small group plans must contain the ACA's 10 Essential Health Benefits. Employers have expressed concern over their desire to provide benefits to their employees and the coverage mandate that is not required of large group employers. In 2015, the Wyoming State Legislature passed statutory language to clarify that if a small employer offers coverage to its employees, the employer has the option of offering coverage to the employee's dependents. Wyo. Stat. § 26-19-306(c)(vi). In some cases, this legislative change allowed the employee's dependents to opt for individual coverage on the Marketplace.

Network Adequacy was an issue before the ACA and remains an issue today. Wyoming reports 196.7 physicians per 100,000 people whereas the national average is 265.5 per 100,000. In addition, Wyoming covers 97,818 square miles—needless to say, our providers are widely scattered.

Uncompensated Care remains a concern in nearly all care facilities in our State. A May 2016 report from the Wyoming Hospital Association indicates at least a 3 percent annual increase in uncompensated care but the association anticipates larger increases because of increasing unemployment, increasing numbers of individuals with high deductible plans, and increasing numbers of uninsured.

Wyoming is a non-rate setting State; therefore, we rely upon the qualified health plan (QHP) determinations and rate approvals conducted by the Center for Medicare and Medicaid Services (CMS). Wyoming has the second highest premium rates in the Nation, second only to Alaska. On the individual market in 2016, the average monthly premium before the Advanced Premium Tax Credit (APTC) was \$571 compared to the national average of \$396. Some Wyoming employers have reported that the tax benefits for providing coverage are difficult and convoluted. Others report it is less expensive to pay the tax penalties than to provide health insurance coverage.

The Wyoming Small Employer Health Reinsurance Plan (WySEHRP) plan has begun a run-out of the program and claims, after it was determined that the number of ceded lives has continued to decline as transitional plans will be exiting the market. The declining number indicate a decreasing number of small employer sponsored plans.

In conclusion, in my opinion, there are two primary considerations for small businesses when considering whether to provide health insurance benefits. The first is **Cost**. The cost of the premiums to the employer and the employee, and the cost of time in administering the program.

The second is **Choice**. Can the small employer provide coverage that the employees need, with networks that are sufficient, and out-of-pocket costs that are reasonable?

Again, thank you for holding this roundtable and for inviting me to testify. I look forward to your questions.

Senator ENZI. Thank you.
Mr. Hudak.

**STATEMENT OF WARREN S. HUDAK, Jr., PRESIDENT, HUDAK
AND COMPANY, NEW CUMBERLAND, PA**

Mr. HUDAK. Chairman Enzi and members of the Senate HELP Subcommittee on Primary Health and Aging, thank you for the opportunity to be before you today. My name is Warren Hudak. I own a central Pennsylvania based accounting firm. We specialize in bookkeeping, sales tax services, payroll, and tax representation.

Our business is a typical small business. Hudak and Company is a growing firm. But rising healthcare costs continue to consume an increasingly significant share of our revenue. It's difficult to keep up with the constant implementation changes which can disrupt our business operations and consume increasingly more and more of our time. These changes are sometimes meant to help, but occur too late to provide substantial relief. I feel like most small businesses have been placed in an impossible situation. Healthcare costs are once again our No. 1 issue.

Our business has always provided assistance to our employees for health insurance. Group health insurance was expensive and volatile for our business, but we had to offer it in order to compete. We live in the Harrisburg area, which is the State's capital, and we're competing for the same labor market that the State of Pennsylvania is competing for.

We were early adopters of high-deductible group health plans paired with a health savings accounts. Our plan was canceled. We began offering health reimbursement agreements for employees to purchase health insurance on their own. The arrangement worked well for our employees, as they could choose the appropriate plans that fit their needs, even pre-existing conditions existed.

I have long been a supporter of those consumer-based options and believe they are key to curbing unsustainable healthcare costs. I, too, believe that the answer here is flexibility and choice.

[The prepared statement of Mr. Hudak follows:]

PREPARED STATEMENT OF WARREN S. HUDAK, JR.

Chairman Enzi, Ranking Member Sanders, and members of the Senate HELP Subcommittee on Primary Health and Retirement Security, thank you for the opportunity to testify before you today concerning rising small business health care costs and potential options for employers and employees to mitigate these cost increases. My name is Warren Hudak, president of Hudak and Company, a central Pennsylvania-based small business accounting firm specializing in payroll services, bookkeeping, sales tax services, and advanced tax transaction analysis.

Our business is a typical small business in many ways. Hudak and Company is a growing firm, but rising health care expenses consume an increasingly significant share of our revenue. It is difficult to keep up with the constant implementation changes, which can be disruptive to our business. These changes are sometimes meant to help, but occur too late to provide substantial relief. I feel like small businesses have been placed in an impossible situation as costs increase and competition and flexibility decrease.

COSTS AND LIMITATIONS

Our business has always provided financial assistance to our employees for health insurance. Group health insurance was expensive and volatile for our business, but we had to offer it in order to compete with larger companies and the Pennsylvania State Government.

We were early adopters to a high-deductible group health plan paired with a health savings account (HSA). Our plan was canceled three different times, so we began offering a health reimbursement arrangement (HRA) for employees to purchase health insurance on their own. The arrangement worked well for our employees as they could choose the appropriate plans that fit their needs, even those with pre-existing conditions. I have long been a supporter of consumer-driven health insurance arrangements, and believe they are key to curbing unsustainable health care cost increases.

In 2013, the Internal Revenue Service (IRS) issued guidance¹ that prohibited the use of employer payment plans, including stand-alone HRAs. Enforcement of the prohibition began July 1, 2015. Facing a threat of \$100 per employee per day penalties, we had to again change how we help employees. Any financial assistance must be treated as taxable income, decreasing the value of the contribution, and the contribution cannot be contingent on the purchase of health insurance. It felt like another punch in the nose.

Our family's most recent individual policy premiums increased substantially this year. We shopped around but there was only one other carrier available in our county, and it excluded some of our current doctors, so we stuck with our current plan. Insurance company competition has not improved, it feels worse. It amazes me that there are not more choices in the area. Prescriptions costs have skyrocketed, as well. Costs went up, but coverage worsened.

OPTIONS FOR RELIEF

I do feel there are policy solutions that can provide relief from high costs for small businesses, provide increased options for small business employees, and provide increased competition amongst insurance companies.

Last week, the House of Representatives passed the *Small Business Health Care Relief Act of 2016* by voice vote.² The Senate should quickly consider the bipartisan companion bill.³ This bill would help employees afford health insurance, and allow employers to continue to play a role in supporting their employees through the utilization of HRAs. Certainly, lawmakers who drafted the ACA did not intend to punish small businesses for helping their employees with health care costs. Our business is proof that this arrangement worked.

In order to increase competition in my area and other places with limited options, interstate purchasing of insurance plans should be permitted. Interstate purchasing would allow new entrants into markets and force insurance companies to compete for small business and individual customers.

Initial 2017 premium filings in Pennsylvania are discouraging, as insurance companies are requesting significant increases for individual market plans and moderate increases for small business plans. According to NFIB Research Foundation, small business owner optimism remains near historic lows.⁴ The political climate continued to be the second most frequently cited reason for why owners think the current period is a bad time to expand. The Senate can begin to restore much needed confidence by quickly sending the *Small Business Health Care Relief Act* to President Obama's desk, and working toward other solutions to lower the cost of health insurance.

Thank you again for allowing me to share small business concerns before the committee today. I look forward to answering any questions.

Senator ENZI. Thank you.

¹Notice 2013-54, Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements, <https://www.irs.gov/pub/irs-drop/n-13-54.pdf>, (subsequent guidance included in Notice 2015-17).

²H.R. 5447, the *Small Business Health Care Relief Act of 2016*, introduced by Congressmen Boustany (R-LA) and Thompson (D-CA), <https://www.Congress.gov/114/bills/hr5447/BILLS-114hr5447pcs.pdf>, passed on 06/21/2016 (previous version was H.R. 2911).

³S. 3060, the *Small Business Health Care Relief Act of 2016*, introduced by Senators Grassley (R-IA) and Heitkamp (D-ND), <https://www.Congress.gov/114/bills/s3060/BILLS-114s3060is.pdf>, (previous version was S. 1697).

⁴*Small Business Economic Trends*, NFIB Research Foundation, May 2016, <http://www.nfib.com/surveys/small-business-economic-trends/>.

Mr. Harte.

STATEMENT OF THOMAS M. HARTE, PRESIDENT, LANDMARK BENEFITS, INC., HAMPSTEAD, NH

Mr. HARTE. Chairman Enzi, good morning.

Ranking Member Sanders, thank you.

Members of the subcommittee, thank you for having me back again to discuss some of the challenges that are being faced by all of my clients as it relates to health insurance premiums, access to care, access to plans, bifurcated networks, and the many challenges that small businesses are facing in the wake of healthcare reform.

As you mentioned in your opening remarks, Senator Enzi, I own an agency back in New Hampshire called Landmark Benefits. I have a bit of a unique position in conversation with you today, because not only am I an employee benefit broker representing thousands of brokers across the country who work tirelessly every single day in advocating for lower premiums for our clients, but also I'm a small business owner.

I have 17 employees, a lot of employees, just like you had back in Wyoming, and I struggle with trying to make sure that they can afford their health insurance premiums for their families, that I can afford to be generous to them. But I sit in that seat of that employer every single day that's faced with these significant rate increases.

I'm also here representing the National Association of Health Underwriters. We represent approximately 100,000 employee benefit professionals across the country. I had the honor of being their national president 2 years ago and served on their board of trustees for a time period of approximately 10 years.

Before I go into some of my comments about some of the challenges that we're faced with, last year, when I was here, I shared with you some of the issues that we needed to face as it relates to affordability, and I wanted to share some positive comments first.

First, we have talked about the PACE Act, and, Senator Scott, thank you so much for your sponsorship of that bill and your leadership with Senator Shaheen. It has certainly made a difference in my home State, but has also made a difference in many States across the country.

What my concern was when we were discussing the PACE Act was this concept of what's called rate grid overload, where small employers have these rate grids that are three columns wide, and you can have one family paying \$3,000 to \$4,000 a month in premium and another family paying \$1,500 a month in premium. The invoices are four to five pages long, and it's impossible for small business to manage that process. So I'm grateful, Senator Scott and Senator Shaheen, and thank you for that.

I also am very pleased to share with you that the moratorium on the medical device tax, the delay of the excise tax to 2020, and the health insurance tax suspension for 2017 has been received with open arms in the marketplace, because it's all about affordability. As I may say later, my guiding light is always "Are decisions that we make leading to the accessibility and affordability of health insurance?" I say that to you as Members of Congress, but

I also ask that question back home when I'm talking to the health insurance plans.

Now back to the real world of what my clients are facing. Even though we've made some improvements over the past year, I am still delivering rate increases to my clients that are difficult for me to communicate to them, but even more for them to absorb those cost increases. In the past couple of weeks, I have delivered to two clients, who are small businesses, rate increases of 29.96 percent. In my prepared testimony, you will see other clients who are faced with significant double-digit rate increases.

That contradicts recent trend reports that you've seen in national publications where we're seeing healthcare trends has come down, which is a positive step and a step in the right direction. However, when you have wage growth far below the cost of healthcare, when you have the cost of goods and services across the country rising at a slower rate than healthcare inflation, then we have to ask ourselves the question of how can we really start addressing the underlying issue in our health insurance premiums, which is the cost of healthcare.

I also want to share with you—and I'm sure my friend to my right has faced—when he looks at his own health insurance plan, he has seen that the health insurance companies are making mandatory changes to their plans without the discretion of the employer. Primary care office co-pays are doubling. Specialist office co-pays are doubling. Many people across this country are paying upwards of \$500 a month for a 30-day supply for a prescription. That's unaffordable, and what's happening is that individuals are foregoing necessary medical treatment and prescriptions to make sure that they can live a healthy life, and that's not what we want.

The bottom line for me is in order for us to address the affordability of health insurance, health plans are eliminating plan benefits for individuals. That was never the intent of the Affordable Care Act.

Two more quick issues for you is the recent success that we've seen about the adult uninsured rate dropping—again, good news for the United States of America. However, we have more and more people falling into the category that we commonly refer to as the underinsured. Deductibles have gone through the roof. They've actually increased by 47 percent in recent years, and many employers are purchasing plans that have \$5,000 or \$6,000 deductibles. Individuals couldn't afford \$1,000 deductible, let alone a \$5,000 deductible.

The State of Wyoming is not alone. Your home State is not alone. Losing carriers, lack of access to healthcare plans is a growing concern. As a matter of fact, this week, in the State of Minnesota, the largest individual health insurance company, Blue Cross and Blue Shield of Minnesota, announced that they will be exiting the individual marketplace in 2017. So you're not alone.

With that being said, I thank you again for having me back, and I look forward to sharing some other insights with you.

[The prepared statement of Mr. Harte follows:]

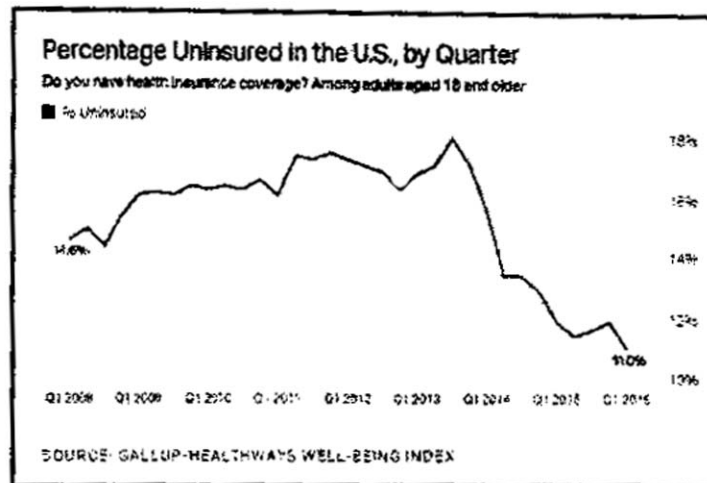
PREPARED STATEMENT OF THOMAS M. HARTE

Good afternoon. My name is Tom Harte and I am the president of Landmark Benefits Inc. in Hampstead, NH. I started my small business in 1997 and it has become one of the largest independent employee benefit companies in New Hampshire. Today, my company provides services to over 300 corporate clients and the majority are small to mid-sized businesses. Our primary goal for clients is to provide innovative solutions that address the continued increases in premiums by emphasizing both healthcare quality and healthcare cost containment.

I am proud to be here today on behalf of my professional association, the National Association of Health Underwriters (NAHU), which represents approximately 100,000 health insurance agents, brokers, general agents, consultants and other employee benefit specialists nationally. Last year, I completed 6 years of service as a member of our national Board of Trustees, including serving as the NAHU's national president for 2013–14. As an association member engaged on the national level since 1996, I know thousands of brokers from all over the United States who serve small businesses with health insurance challenges. Not only did I consult with my own clients about their most critical challenges and opportunities with small group coverage that they have asked me to communicate at today's roundtable, but I also reached out to my colleagues nationwide so that I could share their message today.

Prior to my responding to the primary topics for the consideration of the subcommittee, I want to share with you some of the successes within the market since my last visit in July 2015.

- The passing of PACE allowed States to determine if increasing the definition of small group to 100 was in the best interest of their small businesses.
- Delay of Excise Tax to 2020 (Thresholds: \$10,200 / \$27,500).
- To address the affordability issues in the market, both the Moratorium on Medical Device Tax of 2.3 percent and health insurance tax were suspended for 2017.
- Gallup has reported that the adult uninsured is at 11.0 percent, which is the lowest it has been in 8 years. (<http://www.gallup.com/poll/190484/uninsured-rate-lowest-eight-year-trend.aspx>).



At the same time, it is important to share with you that small businesses continue to face significant premium increases.

Client Location	Enrolled	Deductible	Rate Adj. (In percent)
Manchester, NH	65	\$5,000	29.96
Nashua, NH	46	\$5,000	29.96
Kittery, ME—SHOP	12	\$2,600 HDHP	12.61
Lowell, MA	2	\$2,000	29.22
Derry, NH	86	\$5,000	18.45
Salem, NH	10	\$500	11.47
Cambridge, MA	19	\$2,000	17.73
Methuen, MA	8	\$2,000	15.47
Chelmsford, MA	3	\$2,000	19.01

It is also important to understand that most small employers are faced with *mandatory* health plan changes from the health plans. For example:

- Primary care office copays are increasing from \$25 to \$30 or \$40;
- Specialist office copays are increasing from \$50 to \$60 or \$80; and
- Prescription drug copays are increasing dramatically and cost shares are increasing up to a monthly maximum of \$400.

Finally, the recent success of the adult uninsured rate at 11.0 percent does not take into consideration the “*under insured*.” For example, most employers are increasing plan deductibles and many have increased to as high as \$5,000 or \$6,000; however, most employees can’t afford a deductible event of \$1,000 let alone \$5,000 or \$6,000—this would result in a financial catastrophe.

With regard to the topics of interest to the subcommittee, I have focused my remaining remarks on these issues:

- (1) Factors driving healthcare costs for small businesses;
- (2) Health insurance market policies that have affected premiums for small businesses; and
- (3) Factors that small businesses must consider when assisting their employees in purchasing health insurance.

It is my and NAHU’s hope that now, 6 years into the implementation of the Patient Protection and Affordable Care Act (ACA), that Congress and President Obama will come together with bipartisan solutions to improve the outcomes of the ACA and resolve many of the unintended consequences that are making coverage more expensive and creating burdens for health insurance consumers.

FACTORS DRIVING HEALTHCARE COSTS AND HEALTH INSURANCE
MARKET POLICIES THAT HAVE AFFECTED PREMIUMS FOR SMALL
BUSINESSES

The leading causes of increased health plan premiums are increased utilization and government regulation.

Increased Utilization

In 2014, utilization increased in virtually every metric, with more physician visits, hospitalizations, and prescriptions filled than in 2013. Prior to the recession, higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments, defensive medicine, our aging population, and unhealthy lifestyles. As American consumers return to increasing use of healthcare services, including many newly insured individuals under the ACA, utilization has increased significantly.

Changes in the rate of utilization could also be attributed to plan design and the use of technologies in place of traditional medicine. To help offset the impact of increasing premiums, insurers and plan administrators have increasingly turned to higher deductibles. From 2009 to 2014, premiums increased by 26 percent in employer-sponsored plans while deductibles increased by 47 percent. In 2006, only 10 percent of employers offered plans with deductibles over \$1,000 and 3 percent had deductibles over \$2,000, compared to 40 percent and 18 percent in 2014, respectively.

Deductible Expenses	X > \$1,000	X > \$2,000
2006	10 percent of employers	3 percent of employers
2014	40 percent	18 percent

This increased out-of-pocket expense before coverage is deterring many individuals from seeking necessary healthcare services. This delay of care will exacerbate medical conditions, requiring more expensive care at a later date. Telemedicine is a way that some patients are seeking care without receiving more expensive care in person, as these services can be available at a significantly reduced first-dollar cost to the patient. Other plan design changes include value-based insurance design, which encourage chronic disease management while reducing the need for more expensive care.

Government Regulation

The ACA has imposed significant compliance burdens on employers, employees, individuals, and local and State government. Many of these compliance burdens discourage employer-sponsored coverage by adding onerous requirements and responsibilities that must be performed on behalf of employees. For small employers, many of the ACA's arbitrary provisions, such as narrow rating bands, limits on composite rating, new levels of minimum coverage, and employer reporting requirements, have resulted in higher costs. However, the compliance burden does not end with just employers, as individuals, providers, State and local governments, and all other elements of the healthcare delivery and financing system must meet the requirements of the law.

On June 14, 2016, the House Energy & Commerce Health Subcommittee held a hearing on "*Advancing Patient Solutions for Lower Costs and Better Care*," which included a discussion of the age rating bands. The age rating bands require insurers to charge their older policyholders three times that of younger policyholders while older policyholders tend to use up to six times as much healthcare in dollar value. This current 3:1 age band rating is a change from what was in effect in the States prior to the ACA when States were able to select their own age band rating, with the most commonly used rating being 5:1. The shift in age rating bands to 3:1 caused an increase in cost to younger policyholders, many of whom would rather drop coverage than pay the increase in premium; however, these are the same group of young, healthy policyholders that are needed in the market in order to avoid adverse selection. I believe that the policy in place prior to the ACA, which allowed States to determine the appropriate age rating bands to implement within their borders, is a far better way to control costs, and in the absence of State action, requiring a 5:1 age band rating would encourage young, healthy policyholders to maintain their coverage and support a far more sustainable health insurance market.

Further, final regulations concerning employer reporting have also burdened employers of all sizes. I can testify that some of my employer clients have spent 100's of hours in preparation, coordination, and deployment of these reporting demands. Additionally, the cost for reporting with either a payroll company or third-party administrator is excessive at best. In March 2014, the Department of the Treasury and the Internal Revenue Service (IRS) released final regulations on what health plan information all employers will be required to report to the Federal Government annually for enforcement of both the health reform law's individual and employer mandates. Unfortunately, the final regulations are confusing and extremely complicated for businesses of all sizes. I am concerned that many employers may stop offering health insurance coverage to their employees, especially small employers that are not mandated to do so, because the reporting compliance burden is too much for their business to bear.

There is legislation pending (H.R. 2712 and S. 1996) that will ease the compliance reporting requirements for employers offering health insurance coverage to their employees. The bill clarifies that any information regarding health insurance that is communicated to employees must be aligned with the processes that are already in place by employer or employee, including the use of electronic notification for all notification forms. We believe that providing employees with multiple and similar notices is confusing for employees and both costly and confusing to employers.

Finally, the legislation requires that the Department of the Treasury, in consultation with the Department of Health and Human Services (HHS), Department of Labor, and Small Business Administration, write a report to Congress that would detail the processes necessary to develop a prospective reporting system. Greater sharing of employer plan information between the IRS and HHS to improve ex-

change subsidy eligibility determinations would work best if the Administration would also allow greater employer flexibility to provide information to employees and health exchanges regarding the employer health coverage offered on a prospective basis. Under a voluntarily prospective reporting system, employers could provide to the IRS information about coverage offered to employees electronically at the employer's open-enrollment period or by the January 31 statutory deadline at the employer's election. I believe if greater flexibility was provided and prospective reporting allowed, it will result in greater coordination between the exchanges and the IRS, leading to fewer faulty subsidy determinations and penalty assessments, which, in the long term, will aid in deterring the steady increase of premium costs.

FACTORS THAT SMALL BUSINESSES MUST CONSIDER WHEN ASSISTING THEIR EMPLOYEES IN PURCHASING HEALTH INSURANCE

It is no surprise that one of the leading factors in considering the purchase of health insurance is cost: cost to both the employee and to the employer. When I spoke to this subcommittee's roundtable last year, I spoke about the dangers of implementing the Cadillac tax. In contrast, today, I am going to shift to address a tax benefit that is in jeopardy, and I would like to take this opportunity to encourage the committee's support for the continuation of the "employer exclusion."

The employer exclusion is used to reference the tax benefit that excludes employer-provided contributions toward an employee's health insurance from that employee's compensation for income and payroll tax purposes. This exclusion makes employer-provided health coverage an attractive form of compensation for workers. According to a new poll from Accenture, three-quarters of workers see health benefits as a "vital reason" for continuing to work for their employers, and one-third would quit if their employers stopped offering insurance. A similar percentage said they wouldn't work as hard if their benefits disappeared.

Employer-sponsored coverage is the bedrock of private insurance coverage in the United States. According to the Bureau of Labor Statistics, about 175 million Americans have employer-sponsored coverage and are statistically more likely to maintain coverage year after year. Providing coverage through employers or other group arrangements offers controlled entry and exit in the health insurance market, which ensures the spreading of risk, federally guaranteed consumer protections, like portability rights, the ease of group purchasing and enrollment, and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

Several recent health insurance and tax-reform proposals have suggested eliminating or capping the tax exclusion provided to individuals who have employer-provided group coverage and perhaps substituting it for some other tax preference. Capping the exclusion for employees would degrade the benefit and serve as a tax increase for middle-class Americans. Eliminating the exclusion would mean that most of the advantages of employer-provided coverage would no longer exist: No longer would there be a potent means for spreading risk among healthy and unhealthy individuals; employers and individuals would lose many group purchasing efficiencies; workers would be less likely to have their employer as an advocate in coverage disputes; employers would be less likely to involve themselves in matters of quality assessment and innovation; and employers could suffer in terms of worker productivity and labor costs because employer-sponsored insurance leads far more workers to purchase health insurance than they would on their own. Some employers would not meet participation requirements for group coverage so the entire workforce would lose employer-sponsored coverage. This shift might seem minor, but it could compel employers to stop providing health insurance, according to the Congressional Budget Office and the Joint Committee on Taxation. Companies will expect their employees to secure affordable coverage in the individual market. For many people, particularly older and lower-income workers, that may be impossible, even with the implementation of the ACA.

One plan would eliminate the tax exclusion for employer-provided health insurance, preventing companies from purchasing coverage with pre-tax dollars, and instead provides individuals with a tax deduction of \$7,500 a year for buying insurance. Families would receive a deduction worth \$20,500. These types of tax deductions would encourage young, healthy workers to forgo employer-sponsored insurance because they could purchase cheaper plans elsewhere. Employers would be left with an older, sicker risk pool, thus higher costs—if they can get group coverage at all. As costs escalate, even the most generous employers may quit offering health insurance altogether. De-linking coverage from employment like this would make health insurance more expensive and less accessible, thereby contradicting the objectives of the ACA.

Adding to the threat to employer-sponsored insurance is the increase in cost to the employers. In a recent survey, almost 90 percent of businesses reported that their costs had increased because of the law. Employers are responding by laying off workers, making full-time employees part-time so the mandate doesn't apply or dropping coverage altogether. In all three cases, the result is fewer people with employer coverage.

Getting businesses out of the healthcare business would be a mistake. We urge you to maintain the system that has worked for Americans for decades, and preserve employer-sponsored health coverage through the continuation of the employer exclusion.

Small Group Market Policy Recommendations

We all have a stake in having a functioning, viable health insurance marketplace for small employers. While the ACA has brought many changes and market resources to consumers and employers, I am concerned about policies threatening the small group's viability that could lead to its erosion. The membership of the National Association of Health Underwriters feel that the following policy changes would have a significant impact on improving the cost and coverage options available today for our Nation's small employers and their employees:

- To address the affordability of health insurance we need:
 - Further delays of the Excise tax;
 - Continued suspension of the health insurance tax;
 - Continued moratorium on medical device tax; and
 - Legislation that allows States to increase the law's age rating bands from the current 3:1 spread to bands that more closely resembles the natural breakdown of age and meet the needs of a particular State. If a State does not set its own bands, the default should be 5:1.
- Preservation of the law's risk-adjustment mechanisms (often referred to as "The Three Rs") since they are crucial to preserving long-term private insurance market stability.
- To address the accessibility of health insurance we need:
 - To remove agent and broker commissions from the medical loss ratio calculation in the small and individual health insurance markets, to ensure small business access to agent and broker services and to economically help the hundreds of thousands of agent small business owners nationwide.
- To address the simplification of health insurance we need:
 - A repeal of the employer mandate, or failing, that establishes the eligibility threshold at 101 or more employees; and
 - To allow employers to set the definition of a full-time employee as one that works 40 or more hours a week for health coverage purposes.

In closing, I would like to thank Chairman Enzi, Ranking Member Sanders and all of the members of the subcommittee for the amazing opportunity to share information about the opportunities and challenges small business owners like me and my clients are having in today's health insurance marketplace. If you have any questions or need more information, please do not hesitate to contact me at either (603) 329-4535 or tharte@landmarkbenefits.com.

Senator ENZI. Thank you.

Ms. Lueck.

STATEMENT OF SARAH LUECK, SENIOR POLICY ANALYST, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Ms. LUECK. Thank you, Mr. Chairman, and thank you, members of the subcommittee, for having me here today. I really appreciate the opportunity to talk about issues facing small businesses with their healthcare.

As my other co-panelists have mentioned, there are longstanding system-wide trends in healthcare costs that absolutely affect small businesses, and that's a key question, obviously, one that we'll be discussing as we get into the conversation here today. As has been widely documented, also, the overall healthcare cost growth has slowed considerably in recent years with health reform likely a key

contributor. While we don't have all the answers, we certainly appear to be making some improvements in bending that cost curve.

Another piece of good news is that contrary to predictions, the ACA hasn't caused employers to drop coverage for their workers so far, and that's really good news. I'm impressed to hear those small business owners that are on this panel talking about how important it is to offer benefits. It's nice to hear the commitment that they have to their employees and the variety of considerations they make when they decide whether to offer benefits and what kind of benefits to offer.

As somebody who focuses a lot on the ACA and supports so many of the provisions that were in that law, I really wanted to mention the way in which the coverage expansions under the ACA have actually helped small businesses, the employees of those small businesses, by making sure that they have access to coverage and can maintain their health regardless of whether a small employer that they work for is able to offer them coverage. That's very important, if they're a low-wage worker, that they have access to Medicaid in a State that has taken up the coverage expansion and that they can also access subsidized coverage through the marketplace, where they both get assistance with affording the coverage and then reductions in the high deductibles and other cost-sharing so that they can also have some access to healthcare.

Notably, many self-employed people have also newly obtained insurance as a result of the ACA, and it's just worth thinking about—the situations that people used to face before the law was in place. Self-employed people might have had trouble getting access to coverage if they had a preexisting health condition, and now they can get access to coverage in the individual market.

The essential health benefits were mentioned as something that was sort of bad news. In some ways, I think, for many people, it's good news to have some minimum standards about the benefits that are covered under small group plans. Before the ACA, there might have been gaps in the coverage that small employers were able to choose from in their State. Their employees, just like individuals that don't have employer coverage, want access to maternity benefits, for example, or mental health treatments, and those sorts of things may not have been covered in their policies before in some cases.

Another story we used to hear before the law was in place is those cases where a small business might have a sick employee, somebody diagnosed with a very expensive illness or an employee who has a baby that's born with a lot of challenging health problems and has to be hospitalized. Those sorts of huge costs that one person in a small firm could face could really impact the cost of coverage for that small business just the following year.

That might put a small firm, a small business owner, in the position of thinking, "Can I even offer coverage now that I have this expensive claim on my books?" That is not an issue now under the ACA. There's broader pooling and limits on the way that the insurers can rate small groups, just as there are with the rules in the individual market.

I think with that, I'll pause. I'll just say, also, that there's a lot of good news here. I think that there's a lot of flexibility, also, for

States that want to take some opportunities to do things in their own markets to stabilize it, to make things more competitive, and, hopefully, we will get into some of those issues as we continue our discussion today.

Thank you very much.

[The prepared statement of Ms. Lueck follows:]

PREPARED STATEMENT OF SARAH LUECK

Chairman Enzi and Ranking Member Sanders, thank you for the opportunity to discuss the challenges and opportunities for small businesses that want to provide health benefits to their workers.

What factors are driving health care costs for small businesses?

Longstanding system-wide trends in health care costs and utilization affect all health care payers, including small employers that offer health insurance to their workers. For example, the entry of high-cost specialty drugs into the market can raise premiums for small businesses and the workers they cover. Other trends, however, can slow growth in health care costs and premiums, including adoption of new payment models that encourage the use of high-value services and efforts to increase competition among insurers based on price and quality of care.

As has been widely documented, overall health care cost growth has slowed considerably in recent years, with health reform likely a key contributor. Premium increases for employers have been similarly modest in most States since the Affordable Care Act's (ACA) enactment; average job-based premiums rose only 4 percent between 2014 and 2015. Premiums between 2010 and 2015 rose 27 percent, which was significantly lower than the 69 percent increase from 2000 to 2005.¹ There has been, however, a long-term trend toward workers paying a growing share of premiums and cost-sharing charges under employer-sponsored plans. For example, annual deductibles continue to rise, and more workers are enrolled in plans that include deductibles.

Contrary to predictions, the ACA hasn't caused employers to drop coverage for their workers. From 2014 to 2015, the percentage of employees who reported that their employers offer health coverage increased slightly, as did the share who reported being eligible for the coverage offered, according to a new analysis of Census data. Overall coverage rates remained stable for people working at both small and large employers during that period.²

Smaller employers remain less likely than larger ones to offer coverage, however. In fact, the smaller the firm, the less likely it offers coverage. For example, in 2015, 37 percent of firms with three to nine workers reported offering coverage, as compared to 63 percent of firms with 10 to 24 workers, 82 percent of firms with 25 to 49 workers, and 92 percent of firms with 50 to 199 workers. Firms that do not offer health benefits cite cost as the main reason.³

The ACA's coverage expansions have undoubtedly helped small business employees by ensuring that more people have access to coverage through Medicaid and the marketplaces. Many small business employees and their family members who may have been uninsured in the past can receive needed medical care and maintain their health. Notably, many self-employed people have also newly obtained insurance as a result of the ACA. Self-employed people often could not get coverage before the ACA, when insurers in most States' individual markets could deny coverage or charge far higher rates based on pre-existing health conditions. For example, more than one-fifth of the enrollees in California's individual-market exchange (known as Covered California) were self-employed as of June 2016.⁴

What Federal insurance market policies have affected premiums for small businesses?

Federal policies under the ACA have produced a much better functioning small-group market than existed prior to health reform. Some of these policies have enabled small employers to improve the coverage they offer, while others have lowered premiums, particularly for firms with older workforces in poorer health.

¹ Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits 2015 Annual Survey," September 2015.

² Joelle Abramowitz and Brett O'Hara, "New Estimates of Offer and Take-up of Employer-Sponsored Insurance," June 2016, forthcoming publication in *Medical Care Research & Review*.

³ Kaiser Family Foundation and Health Research Educational Trust, *op cit*.

⁴ Covered California data is available upon request.

Insurers offering coverage in the small-group market must now cover a package of “essential health benefits,” which includes critical benefits like maternity services and treatment for mental health and substance abuse disorders; before health reform, these benefits were often omitted from small-group plans, even if small employers wanted to offer them. The ACA also bans annual and lifetime dollar limits on the benefits that insurers pay out and requires plans to limit enrollees’ out-of-pocket costs each year for deductibles, copayments, and other cost-sharing charges. While these reforms made small-group coverage more comprehensive and hence pushed up premiums somewhat, they also enabled small firms to offer coverage more similar to the offerings from large employers, a choice that many small firms did not have before the ACA.

Other Federal policy changes affect how insurers set premiums for the small-group market, including a prohibition on charging higher premiums based on employees’ health status, gender, industry type, or the overall claims history of a small business, as well as a limit on how much more insurers can charge older employees than younger ones. While some small businesses have seen premium increases due to these changes (for example, those whose workers are mostly younger, healthier, or male), other firms have seen premium decreases (for example, those whose workers are mostly older, sicker, or female). As a result, all small employers covered by ACA-compliant policies, including those with younger and healthier workers, can rest easier now that a sudden illness among their workers or their workers’ families will not result in a sudden spike in the firm’s premiums the following year, which was a substantial risk for small businesses prior to 2014.

The ACA also requires each insurer in the small-group market to pool their enrollees in that market when determining what they will charge for coverage. Advocates for small businesses have long wanted the ability to pool small firms together to get more affordable and stable premiums, similar to large employers, rather than having each small firm looked at independently when setting premiums. Broader pooling, too, has allowed some firms to see their rates decrease or to stay the same. Other firms (such as those with healthier and younger workers) may have seen higher premiums as a result, but in the long run, premiums in the small-group market will likely be more stable over time due to this single risk pool requirement than they would otherwise have been.

The ACA also required insurers in the individual and small-group markets to spend 80 percent of the premiums they charge on patient care and quality improvement efforts. Prior to health reform, only about 70 percent of insurers in the small-group market met this “medical loss ratio” (MLR) standard, which means that more than 20 percent of small business premiums were going to overhead and profit rather than medical care. The MLR requirement helps ensure that small businesses get good value for their premium contributions. In addition, ACA-mandated improvements in information transparency for small businesses make it far easier for business owners to compare plan and coverage options. For example, a standard form called a Summary of Benefits and Coverage (SBC) allows apples-to-apples comparison of virtually any plan’s benefits and cost-sharing charges. The ACA’s standards for plan benefits and cost-sharing charges, including the “metal levels” that small-group plans must meet, also help consumers compare coverage options, promoting competition based on price and quality among insurers—which can help reduce premiums.

While health reform established some minimum Federal standards for State small-group markets, States remain primarily responsible for their markets. States have a number of tools to improve affordability for small businesses (as well as individuals) and create more affordable, competitive, and stable markets. For example, States that have the authority to review and either approve or disapprove health insurers’ proposed rates have helped reduce premium increases compared to what insurers wanted to charge. Some States operate Small Business Health Options Program (or SHOP) marketplaces, which offer a choice of plans and carriers to small business employees and allow some small employers to receive Federal tax credits for offering coverage.

A few States have taken additional steps to ensure that their risk pools are well-balanced and as competitive as possible. For example, Vermont and Massachusetts each merged their individual and small-group markets. Vermont includes small businesses with up to 100 employees in its merged market, rather than up to 50 employees as in most States.

Many States also decided not to extend the availability of non-ACA-compliant plans for small businesses. In States that allowed such plans to continue (under an Administration policy), some degree of adverse selection likely occurred that weakened the stability of the small-group market. Firms with healthier workers are likely disproportionately enrolled in those plans. States that did not continue to make

those plans available likely helped create more balanced risk pools more quickly in their small-group markets, with more stable premiums.

What factors must small businesses consider when assisting employees in purchasing health insurance?

Small employers have a number of options for assisting workers with purchasing insurance. The first question is whether to offer health benefits at all, if the employer is small enough to be exempt from the “shared responsibility” penalty. Clearly, many small employers view health benefits as critical to attracting and retaining high-quality workers and will continue offering them even if not required to. Other small firms may decide not to offer health coverage, recognizing that the reformed individual market is far more accessible due to the ACA. Workers and their family members with pre-existing health conditions now have guaranteed access to an individual-market plan that covers a comprehensive set of benefits and protects against very high out-of-pocket costs.

Many small business employees may also qualify for Federal premium tax credits and cost-sharing subsidies for coverage purchased through an individual-market exchange or marketplace if they are not offered employer-sponsored coverage or the coverage is not affordable or comprehensive.

Another option for small employers is to offer small-group health coverage to their workers, possibly by working with an insurer or a broker, much as they did before the ACA. Some may use private exchanges to access small-group coverage.

One additional option created by the ACA within the small-group market is SHOP, as noted above. SHOP gives small businesses an easier way to comparison shop for insurance options, receive tax credits, and offer multiple plan options to their workers. The SHOP exchanges got off to a slower start than the individual marketplaces and have suffered from some technical and operational problems, so enrollment remains low. However, it appears the technical issues have largely been resolved. In 2016, employee choice—which allows employers to select a metal tier and employees to choose any SHOP plan in that tier—became available in all States served by the federally run SHOP. This was an important advance; previously, small firms typically could offer only one insurance plan from one carrier. In addition to reducing the effort involved with offering coverage, the SHOP enables small businesses that want to contribute to the cost of a small-group plan on a tax-advantaged basis to do so.

Yet another option in many States—and one that raises significant concerns for the stability of premiums in the small-group market—is the possibility that small businesses will increasingly decide to self-insure, meaning they would bear the risk of employees’ medical claims. Some small employers might find this attractive, at least at first, because it would allow them to offer coverage that doesn’t meet many of the ACA’s requirements for the small-group market. Insurers offering to help small employers self-insure also provide a reinsurance or stop-loss policy to cover unexpectedly large claims. However, self-insurance would most likely attract employers with workers that tend to be healthier and cost less to cover. If a large share of small employers with lower cost employees opt to self-insure, this would disrupt the newly balanced risk pools in States’ small-group markets and make premiums less affordable and stable over time.

Finally, the House recently passed a bill allowing firms with fewer than 50 workers to use a health reimbursement arrangement (HRA) to contribute to the cost of workers’ premiums on the individual market. Currently such “standalone” HRAs are not permitted because they cannot meet ACA standards for group health plans offered by employers, such as the requirement to cover certain preventive services at no cost and the prohibition against annual benefit limits. Similar to self-insurance by small groups, standalone HRAs for small employers (which have been banned for all employers since 2014) could have a negative impact on States’ small-group markets. It is unclear how many small businesses that now offer coverage might shift their workers to the individual market using an HRA and how that might affect workers and the risk pool in a given State. However, large numbers of small firms could decide to make this jump. If they tend to be firms with healthier workers, this could leave the small businesses remaining in the small-group market with higher premiums and possibly fewer coverage options.

Supporters of the HRA proposal claim that it would free up more low-income workers to get subsidized coverage through the marketplace, rather than requiring them to take an employer offer of coverage that might not be as affordable or comprehensive. But it isn’t clear how employers would structure their offers in response to the HRA proposal. Employers have significant flexibility to define the terms of the HRA they offer, and many low-wage workers might not be better off. Such an

option, if made available to small employers, seems ill-advised because of its risks for the small-group market.

Senator ENZI. Thank you.

We'll get into a little discussion. As I mentioned, this is a round-table, so if somebody wants to make a comment, if you'll stand your name tag up, you can comment on anything that's been said or any of the questions that might come up. Of course, one of the things we're concentrating on here is cost, and I'd be interested in any suggestions that you might have—you may have already stated them—on ways to bring those costs down for small businesses.

Does anybody want to answer that question?

Mr. Glause.

Mr. GLAUSE. Thank you, Senator Enzi. One thing we need to focus on is that healthcare determines the cost of health insurance. Health insurance doesn't dictate the cost of healthcare. I think we need to really take a look at how we're going to control our healthcare costs and our pharmacy costs.

When you talk to the health insurance companies, the No. 1 driving factor for increase in rates is continued prescription cost. I think that our discussion, if we're going to really look at focusing on controlling the cost of insurance, has to include looking at the delivery of healthcare.

Senator ENZI. Thank you.

Mr. Harte.

Mr. HARTE. I figure I'll be a great segue to Commissioner Glause, because a lot of what we talk about at the Health Underwriters is something that I've been preaching from the rooftops for a very long time, and that is that health insurance is expensive because healthcare is expensive. As a matter of fact, within the ACA, it talked a lot about the medical loss ratios, and we've talked about that issue for years.

When you think about the medical loss ratio from a cost of healthcare perspective, when formulating healthcare reform, when medical loss ratio came out, finally, it came out at 85 percent for large group and 80 percent for small group. That speaks volumes to me about healthcare, because a lot of what we talk about across the country are health insurance premiums, but people are bundling it all together to say that the problem is health insurance premiums.

In fact, when 80 percent to 85 percent of the cost of the premiums goes toward healthcare, a lot of our focus should be more on the healthcare side of the delivery equation. When I reflect back and I look at statistics going back to 2014, when we look at metrics—and we look at metrics as inpatient hospital care, physician visits, hospitalization—since that time, all of those metrics have gone through the roof. As a result, healthcare costs have exploded, which leads to higher health insurance premiums.

Then, of course, like I mentioned before, the deductibles for the individuals are making it unaffordable for them to have access to care. A 47 percent increase in deductibles from 2009 to 2014 makes healthcare unaffordable for a lot of people. Yes, they're insured, and that's what we wanted to do. That's what we wanted to accomplish with accessibility. But in the end, we're making healthcare very unaffordable.

As it relates to prescriptions, what a lot of people don't know is when we talk to an employer, 26 percent to 28 percent of their premium goes toward prescription cost expenses. We tend to set that aside because we're simply paying a \$10 or \$25 co-pay. But in the end, we have insureds who have prescriptions that cost \$100,000 per month, \$100,000 a month for one prescription. We need to address the cost of prescriptions.

Then we move into high-cost claimants. Historically, Health Underwriters—we look at the total healthcare dollar, and it's commonly known that 5 percent of the claimants produce 50 percent of the total utilization of an employer plan. That's a challenge for us, because as a health underwriter myself, as a compassionate individual, I desperately want to make sure that we take care of those people who are suffering from chronic illness. But we need a solution to address the 50 percent of the healthcare equation.

I will yield my time over to Sarah.

Ms. LUECK. I think he was next.

Mr. HARTE. Oh, I'm sorry.

Senator ENZI. Mr. Hudak.

Mr. HUDAK. Fundamental to shaving the cost of care is transparency. Americans are great consumers. We consume better than anybody else. We know how to shop. One could argue under the Affordable Care Act that there's less transparency, not more transparency. There's less options, not more options. In our area, we have three viable options. We are paying \$200 a month more for our family coverage just to keep our doctors, to stay in—so that my wife can keep her doctors.

Consumer-based health plans gives the flexibility and allows us to be consumers. I have some stories about being a consumer. When going to the doctor and they see that you have a high-deductible health plan, they'll negotiate the price with you. "Mr. Hudak, if you pay today, we'll give you a 20 percent decrease in the bill."

But it's more than that. It's how I get my care, what care I get. I had to have a procedure done on my back. The doctor deemed it elective. I said, "No, I have a tremendous amount of pain. It's affecting my work. It's affecting my ability to run my business." The doctor said, "I can't justify it with the insurance company." I had an HSA. I said, "I'll pay for it. It's not a big deal." We negotiated our price. I had the procedure done.

In 2 months, I lost 30 pounds, 30 pounds in 2 months. I felt better than I had in a decade. My productivity went up. My business thrived. Today, I need to have the procedure done again. Guess what? They don't want to do it. I don't have the flexibility. I don't have the options I had when I was a consumer. I'd like to be a consumer again.

Senator ENZI. Ms. Lueck.

Ms. LUECK. Thank you. I think one thing I wanted to point out is there is a lot of discussion about consumer-driven healthcare, and I think there are some things, particularly, as you mentioned, related to transparency that can help consumers be better informed. There are now standard forms called SBCs that exist for virtually every plan.

If you are trying to decide what plan you want to buy, whether it's maybe your spouse's plan and yours from two different employers or you're in the marketplace and you're shopping for individual market coverage, you can lay these documents side by side, and this is the first time you've ever been able to compare apples to apples, sort of. What is the cost sharing for this plan versus this plan? Which benefits are excluded? The insurers provide those and the employers provide those for almost every plan. That's a really helpful thing for people to begin to understand their plans and how they work and to try to make wise choices about coverage when they're looking for coverage.

But when it comes to consumer-directed healthcare, I think we're often talking about very high-deductible plans, which, as we've already said, are difficult for people. The problem with a very high-deductible plan is that it can be kind of a blunt instrument that makes the person perhaps decide not to get care and they may not be making the best decision in terms of whether to get high-value care or low-value care. They may just sort of be deciding "I'm not going to get this care because I can't afford my deductible," and that's not something we want to see.

Some of the more sophisticated and perhaps impactful things that are starting to go on, I think, to deal with healthcare costs have to do with driving provider behavior, because providers have a lot of power in the system. When they're dealing with consumers, as the anecdote showed, making decisions about cost and value of care and deciding how to proceed with treatment, often that's something the consumer can't do on their own or can't do enough to make a difference in healthcare costs, because a lot of things either aren't elective for them or they don't have enough information about the specific medical benefits and costs to make a decision or about the prices of the treatment.

I think that we have a lot of work to do. But I think that there's a lot of promise in trying to change payment structures in order to drive higher-value care, reduce inefficient care, and to maybe encourage providers to talk with patients about how best to proceed with treatments.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Mr. Chairman.

Senator ENZI. Tim.

Senator SCOTT. These folks are fairly active with these name tags going up and down, so I figured I'd just jump in here now.

Senator ENZI. Yes.

Senator SCOTT. Thank you.

Senator ENZI. We'll come back to that.

Senator SCOTT. Yes, we certainly will, because I'm going to focus on the issues, because I think if we take a step back and realize what we're having a conversation about, we're having a conversation about healthcare affordability for small businesses, but really for employees of small businesses, for average families, who in the last several years have seen their real income go down, not up. We've seen more small businesses closed last year than opened. There's a reason why.

In the economy that we are facing today, we have 12 million more Americans who are living in poverty. We have a 40 percent increase in Americans who are eligible for food stamps. There's something going wrong in our economy, and if you look at one of the primary challenges we face, especially as a former small business owner for 15 years, the regulatory environment that exists today is unparalleled in the history of our country.

Six of the last 7 years, we've seen the greatest increase in regulatory burden: 80,000 new pages proposed last year with an economic impact of \$1.8 trillion. We're asking small businesses to do what they've never had to do before. If you look at two of the primary causes for the regulatory burden that we see today—Dodd-Frank and the ACA.

When you focus specifically on the ACA and you ask yourself the question between healthcare costs and health insurance, perhaps it's the wrong debate, because I would tell you that the ACA may actually be increasing the actual cost of healthcare, because what you talked about for a moment there, Mr. Harte, was what I call healthcare rationing. You may have a card that gives you access, but because of providers—and in South Carolina, we've had two rural hospitals closed. Yes, you have a card, but do you have access to healthcare?

With higher deductibles—and we may be talking about HSAs, where your deductible is \$5,000. But, actually, in South Carolina and throughout this country, it is difficult for the average American to put \$400 together, not \$5,000, but \$400. We're talking about people working paycheck to paycheck, who are struggling to make a \$1,000 deductible or a \$500 deductible. In November, we're going to hear about higher health insurance costs, not lower.

Mr. Hudak, who had to negotiate for his healthcare cost because of the challenges of health insurance, may not always be in the position to negotiate again for the necessary back surgery that increases his productivity, not decreases it. I would love for us to continue the conversation on how small employers can better afford to provide healthcare coverage for their employees. But I want to make sure that we do so, looking through the prism of reality.

Anyone who believes that when 12 out of 23 co-ops fail, 740,000 more folks looking for coverage because of the failure, when the exchanges are challenged, when health insurance coverage is becoming more expensive, and when United Healthcare, one of the largest providers, is saying, "No, I can't do that anymore. I'm pulling out"—for us to think that reducing competition somehow lowers prices, it's only in Washington where that makes sense, to be honest with you.

Mr. Hudak, I do have a few questions for you and Mr. Harte as well, and the panel can answer the questions. I'll start with you, Mr. Hudak.

Sixty percent of small employers suggest—and I would say states—that the reason why they don't have health insurance for their employees 52 percent of the time is because of cost. What are some of the reasons that you've seen, as an accountant, with folks that you're insuring? You're having a lot of interaction with folks financially. What are some of the things that you're hearing from the folks that you work with on the cost issue, if you can answer

that question? No. 2, how will increased premiums—we see they're coming in November of this year—impact the number of folks that you think will be providing health insurance in the future?

Then for the panel, I think—and I can't prove this yet—but I think the employer mandate and the penalty will actually create a perverse incentive to provide less healthcare through your employer, not more healthcare—2,000 versus 10,000 might be an easy conclusion to reach for many employers. The actual burden on taxpayers will go up, not down.

First, healthcare costs from the small business perspective—what have you seen? Mr. Hudak and Mr. Harte as well, I know that you are in the business. I sold health insurance for about 5 years and realized, OMG, I need to do something else. So I went into the property and casualty business and the financial services business.

I see the pain. I've seen the pain that an increase has when someone who could barely afford their health insurance could see doubling of their health insurance costs, even though they have an HSA. In South Carolina, a guy in Greenville went from \$425 a month to \$800 for his family with a \$25,000 deductible, family deductible.

Mr. HUDAK. The small business community has always struggled with healthcare premiums. That's why we always liked the flexibility of consumer-based products. In order to compete with the State of Pennsylvania, because of our proximity to the capital, we provided an HRA, an allowance, allow our employees to have a certain dollar amount that we could afford. We can budget for it. We can plan. We can figure it into our growth plan.

What we found, particularly amongst young people, millennials, is they love that flexibility. They love to be able to take that money—and maybe their wife has a medical plan at her employer, but maybe they don't have dental, or maybe they need help with their co-pays, or maybe they need help with their co-insurance. This enables us the flexibility to compete for that labor. All big businesses become big businesses with the help of great people, and we need to attract and retain those. Sure, we'd like to provide health insurance.

You asked about what's happening. We have a business on our board, on the NFIB board in Pennsylvania. He had been providing health insurance for 40 years. He was prideful. It was a bragging point. Do you know that last year, he announced that he can no longer afford coverage for his firm anymore, and those individuals ended up in the marketplace? It's unfortunate. It made him less competitive. It made his business, some may argue, less attractive to young talented people that can maybe bring his business to the next level.

What we've found with the Affordable Care Act is we have greater costs. We went from \$1,200 a month for our family plan to \$1,900, if we include my wife's prescriptions, which went from \$100 to \$600 a month. When we signed up for the plan, we specifically asked about the formulary for that drug. They assured me—but because of the confusion, even the insurance company got it wrong. We signed up for a plan, and they couldn't even—when we signed

up, they didn't truly represent the cost to us. There's not less confusion. There's more confusion.

Senator SCOTT. Mr. Harte.

Mr. HARTE. Thank you. Off testimony, because you were a broker yourself at one time—yes, maybe you were the smart one. You got out after 5 years. I've been doing this for almost 30 years.

Senator SCOTT. Let us pray.

Mr. HARTE. I would say brokers across the country—we struggle every single day. We struggle because those who become our clients become our family. We take them under our wing. We help them every single day, not just with the price increases that they are so fearful of every 12 months, but having access to care and the other challenges with their health insurance plan.

Before I flew down here, I took a sampling of my most recent renewals that I've had, and I gathered 12 of them just so that I can share with you the insights from my employers. It's hard for me to walk into a small business and say, "Your rate has increased by 29.96 percent," or 18.45 percent, 17.73 percent, 15.47 percent. The fact is small businesses have to make a critical decision—How much of this am I going to pass on to my employees? How much of it can I absorb on my own? What must I cut? What type of cost shifting do I need to do? Do I need to reduce my prescriptions, increase the hospital co-pays? What do I need to do?—because they can't afford a 30 percent rate increase.

As you indicated earlier, with the struggles within our economy, employers are struggling—small, medium, large businesses, and individuals who are purchasing insurance on the marketplace. It's unsustainable for us to continue to be faced with these significant rate increases.

I know we talked briefly about transparency, and I believe transparency is one of the success factors that we really need to focus on. Anecdotally, it always helps me when I share numbers. On my phone, I have this really cool app. It's not available to you, Senator Scott, because you're in South Carolina. But I have this app in New Hampshire. It's called My Medical Shopper, and I can scroll through, and I can find out what the cost is within 30 miles of my home of any particular service that I need, and it's all bundled up. It brings one particular care together.

For your interest, I threw together a couple of examples. I'll give you four, and they were picked at random for me when I was out in New Mexico yesterday. For an MRI of a lumbar spine without dye, the least expensive facility within 30 miles of my home is \$485. The most expensive is \$2,114. The percentage is 436 percent. Colonoscopy—the least expensive is \$458. The most expensive is \$3,031. The percentage is 661 percent.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Does that include facility fees?

Mr. HARTE. Yes, it is.

Senator CASSIDY. Is that soup to nuts?

Mr. HARTE. Soup to nuts. This particular app will actually show you all of the other underlying care that happens with that particular colonoscopy. The one that's up on my phone right now is with a biopsy. It can drill down to a very specific and deliberate

procedure. The MRI categories that are on this app go into maybe 30 or 40 different categories of MRIs, with dye or not, neck, back, legs, arms.

Senator CASSIDY. Is it the provider who is publishing that, or is it the insurance company which is publishing that rate schedule?

Mr. HARTE. For this particular app, they are doing a technology platform called scraping, where they're going in to the back end of the website for the health insurance company and pulling the data from the health insurance company.

Senator CASSIDY. That's pretty cool.

Senator SCOTT. One last question before we hear more on this. One of the things that I think escapes us at times is the impact of the medical loss ratio on a small business person's opportunity to have an expert come in, because, essentially, you're shaving commissions, and, frankly, in a world that's becoming more complicated, you're having fewer experts come in to provide assistance, which makes it more likely that a small business owner will opt out of providing care. Remember that 60 percent of employees work for a company with 20 or fewer employees.

Mr. HARTE. You're talking my language, Senator Scott. So, yes, and within healthcare reform, between small group and large group, the medical loss ratios must be 80 percent or 85 percent, dependent upon where you fall as an employer. Broker compensation must be included within the administrative costs. We have argued for years that that should be pulled out, because there's no greater value to an employer than accessing the expertise of an employee benefit professional who can help small businesses like Mr. Hudak.

The fact is purchasing health insurance is not like going down to your appliance store and buying a refrigerator. Purchasing health insurance is overwhelmingly complicated. Whether you talk about deductibles or co-insurance or transparency or bifurcated networks, it is likely the most complicated product that you will ever have to purchase, and you need the expertise of an employee benefit professional to help you navigate those challenges.

Senator SCOTT. Thank you.

Thank you, Mr. Chairman, for your indulgence.

Senator ENZI. Thank you for your questions.

Senator Cassidy, I know, has questions, because he's been working on this a lifetime, and since he's gotten to the Senate, he's spent another lifetime working on it.

Senator CASSIDY. And my hair has turned your color.

[Laughter.]

Senator CASSIDY. It used to be, shall we say, blond.

Ms. Lueck, you had a critique of consumer-driven healthcare that their high deductibles make perhaps less advantageous. Often-times, I think of consumer-driven healthcare as a health savings account associated with that catastrophic policy. On the other hand, the exchange policies typically have a \$6,000 deductible without the HSA component.

Now, it seems as if you're OK with the one, but have kind of a negative critique of the other. How do you reconcile that impression that I have?

Ms. LUECK. On the exchanges, for people who are low-income, who are under 250 percent of the poverty line, there are cost shar-

ing reductions available, and it varies in terms of how that affects the deductible under a Silver Plan, but it can affect it quite significantly. For the people that are lowest income, the deductibles are substantially reduced, and that's important because there's a lot of research to show that lower-income people are really sensitive to price, and they would possibly avoid care that they should be getting because they can't afford to pay the fee that they owe.

Senator CASSIDY. Though what we're hearing from Mr. Hudak and others is that, really, a single woman who's earning \$70,000 a year would not qualify for a subsidy. Mr. Harte, how much does a single woman in New Hampshire who is 45 years old pay for an individual policy, Silver policy?

Mr. HARTE. Approximately \$600 a month.

Senator CASSIDY. She is paying \$7,200 a year on a pretax income of \$70,000. She's paying probably roughly 15 percent of her after-tax income, if not more, and I find that if she has a \$6,000 deductible, she also is foregoing care. Again, if you're limiting your comments to those who are getting subsidized, I guess I see your point. If we're going to be more inclusive of the middle class and these people who are typical employees, they're getting punished, and I'm not sure how—they have a \$6,000 deductible with a pretax income of—you see where I'm going with that. Any comments on that?

Ms. LUECK. Yes. I mean, I think that we definitely need to look closely at the affordability of cost sharing and how it's impacting people and whether the HSA-style plan with a high deductible is the best route to go, regardless of your income, and whether people are able to make the decisions about how to spend that money, when, as Senator Scott pointed out, a lot of people have trouble even spending \$400 out-of-pocket if they needed to in a pinch.

Another point I should make about the ACA compliant plan design is what we've seen over time. A trend that's different than what was there before in terms of plan design is that, often, even a plan that has a very high deductible of \$6,000, like you're mentioning, may cover a lot of services that people commonly use without charging them that deductible.

Senator CASSIDY. It will for a colonoscopy, but it will not for the car accident or the trip to the urgent care center with their daughter's earache, and that is where they are foregoing care, anecdotally, in order to still put food on the table. That seems inherent in the rate structure that is part of the ACA exchanges.

Ms. LUECK. There's a variety of ways that they design plans. When there's a car accident, people aren't able to decide one way or the other, right, and if they don't have the money to pay—

Senator CASSIDY. But they are left with that hanging over them, and although the ACA was supposed to eliminate medical bankruptcy, I gather it is actually a worse problem now. Let me ask as well—sitting here, it's like you're hearing two different conversations.

From you, sir, I heard dramatic increases in premiums, and from you and from you, and then—or at least out-of-pocket exposure and the inability to afford. From Ms. Lueck, I heard from you that premiums are only rising 4 percent. It really is a kind of discordance as we listen.

The way I reconcile that—but tell me if you disagree, Ms. Lueck, because people who defend the ACA mention that 4 percent. But that's not out-of-pocket exposure. That is premium cost. Premium costs may be only rising 4 percent, but network is narrowing and out-of-pocket exposure is increasing. That 4 percent rise means the policy now has a higher deductible, a higher co-pay, tiered benefits for pharmacies—I could go on.

You're nodding your head, Mr. Harte.

Ms. Lueck, do you agree even though premiums are not rising, that patients' out-of-pocket exposure has increased substantially?

Ms. LUECK. Premiums are rising more slowly in recent years. They're still rising, and I think that's a longstanding trend, obviously. Then there's a longstanding trend toward individuals bearing more of their own out-of-pocket costs compared to the employer in things like deductibles and cost sharing. I don't point at the ACA. That's a trend that predates the ACA, and I think that the key thing that the ACA did is expand coverage for people so there are actually a lot fewer people that are facing the kind of bankruptcy that you're talking about.

Senator CASSIDY. I've seen the statistics. The statistics show that medical bankruptcies have not declined. Imagine a family in a wreck in December—they have complete exposure—then they're in the wreck, so there's still pain through the next year. That's actually an unfulfilled promise, if you will.

Ms. LUECK. We continue to have affordability issues. You mentioned the woman with a higher income level who's not subsidy eligible trying to buy her own policy. We should definitely be looking at the way that you described it, that global number of what percentage of people's income are they spending to get their health insurance coverage and to pay for their out-of-pocket costs for their healthcare and consider what's affordable and recognize that people at the lower end don't have the ability to pay as high a percentage of their income toward that care and that coverage as people with a higher income.

Senator CASSIDY. Mr. Hudak, you have a comment?

Mr. HUDAK. Yes. I want to just point out as part of our business of advising small businesses, as an accountant, more than 10 years ago, we probably did a financial analysis on HSAs hundreds and hundreds of times, and the way it worked is when you buy an HSA compliant plan, it provided no first dollar benefits except for the exception of prevention. Because of that, the way the HSA was cost, the savings in premiums would allow those contributions by the employer into an HSA account on behalf of the employee to give them the flexibility to use those dollars.

Today, that's impossible to do. An employer not only has to deal with the insanity of the premium increases, but they don't have the ability to assist the employees in that way again, because the Affordable Care Act says—mandates that an HSA plan must provide those first dollar benefits. It's priced where an HSA no longer makes any sense. Some can argue that some of these plans—none of them make any sense from a financial perspective except for people who are running away from the tax penalty for not having a compliant plan. That's unbelievable to me.

Senator ENZI. Mr. Glause, did you want to comment?

Mr. GLAUSE. Thank you, Chairman, yes. The deductibles for ACA plans are, in my opinion, extremely high—\$6,350. The average person in Wyoming only spends \$7,000 on healthcare annually, almost equal to the cost of the deductible. In many cases, these high deductibles are directly related to uncompensated care. Individuals just do not have the money to afford that deductible. Our healthcare facilities are then having to absorb that cost, and in many cases, it's raising the cost of healthcare.

The providers are pretty sure that they're not going to get that first \$6,000. They're building that into their rates, and it's caused the rates of healthcare to go up and uncompensated care to go up, which is threatening the existence of the sparse healthcare facilities that we do have in Wyoming.

Senator ENZI. When we were first discussing healthcare changes, there were 49 million people that were uninsured. Today there are still approximately 30 million people uninsured. It's a different group of uninsured people. The ones that couldn't get insurance before have insurance, and the ones that had insurance can't afford the insurance.

One of the things that comes up in the discussion is the effect of changing the bandwidths. Have any of you noticed an impact from that or have any suggestions for solving that?

Mr. Harte.

Mr. HARTE. I didn't integrate a lot of my comments with regard to age bands, but for the edification of the committee, I will say that ACA declares that a three-to-one ratio is appropriate for small businesses across the United States. Most people would first ask me, "Well, what does that really mean?"

What you can't see right now is what the rate grids look like. The rate grids that are handed to a small employer start off with the age of 21 and go up through the age of 65, and every individual on the health insurance plan follows by that grid. That individual who is 21 versus the one who is age 65. It's a multiple of three or a 300 percent differential.

The majority of healthcare is consumed by those who are older. Those over the age of 50 consume a lot more healthcare than those individuals who are younger than the age of 50. What we're seeing is the premiums for the younger population—and one of the objectives of healthcare reform was to insure the younger population—their premiums are too high. A five-to-one ratio would give greater flexibility to the insurance companies to make sure that they're collecting enough money for the older population to provide for their care while at the same time trying to provide more affordable options for the younger population.

Senator ENZI. Mr. Glause.

Mr. GLAUSE. Thank you, Senator Enzi. What we've observed in Wyoming is with the—is that me?

Senator ENZI. That's just us giving ourselves permission not to speak on the floor.

[Laughter.]

Mr. GLAUSE. With the three bandwidths in the ACA as compared to the five bandwidths in our high-risk pool, we've actually found that the rates for young males with a five bandwidth in our high-risk pool is actually cheaper than getting coverage on the ACA. I

think that that has constricted the bandwidth and has led to increased costs for the younger, healthier population.

Senator ENZI. Ms. Lueck.

Ms. LUECK. The other side of that would be if you changed it, it would obviously increase rates for the older population. Overall, we really want to make sure that there are healthier people of all ages in the risk pool so that we have as well balanced a risk pool as possible. But if you're talking about changing the age rating rules now from what they are, you're definitely going to see rate increases for certain groups of people.

When the rating rules went into place, things changed for people as well. Women used to be rated more than men. That's a big change. There are some people that saw lower rates as a result of the changes and some people that saw higher rates, and I think they're just different groups of people.

Senator ENZI. That's the 30 million I was talking about.

Mr. Hudak.

Mr. HUDAK. I'm not an economist, but before the ACA, younger people weren't so interested in healthcare. Raising their prices hasn't made them more interested in healthcare.

I do want to mention one thing. Connecticut some years ago had an exchange. The Chamber of Commerce had a small business exchange. If you were an employer, you could sign up for the exchange, and participating in there were all the different carriers, the insurance companies. The employee could select any company and any plan, and it would be billed as a group plan. It was fully medically underwritten. If you fell outside of the medical underwriting guidelines, you went into the risk pool.

I always felt the best way to fund a risk pool would be based on market share of the insurance companies. If Anthem of Connecticut had a 30 percent market share, they would be responsible for funding 30 percent of the risk pool. This was a system set up by the Chamber of Commerce.

I think it's a viable solution. I think it adds flexibility and choice, transparency, and, most importantly, one-size-fits-all wouldn't have to be mandated. In other words, employees could have their choice of flexibility and the employer could be the true hero and provide the coverage that's needed.

Senator ENZI. Just to followup on that, you were talking about the high-risk pool that the State had before?

Mr. HUDAK. Correct.

Senator ENZI. Could you just go into that a little more? I must have missed part of it or something, but I think it was important.

Mr. HUDAK. It was fully underwritten, and if you fell outside the underwriting guidelines and didn't qualify for the plan, you would go into the risk pool, and your plan would be subsidized by the risk pool. Everybody—all comers would get—it really addressed the adverse selectivity issue, because now you're dealing with a group plan where the qualifying event is new employment, marital change. You didn't have to worry about people jumping on and off, or if you lost your coverage for some reason. Right now, if for some reason, someone for whatever reason missed a premium bill, and their coverage lapsed, good luck trying to get it back. It's a very scary situation right now.

Senator ENZI. Thank you.

Mr. Glause.

Mr. GLAUSE. Thank you. In response to Ms. Lueck's response, I'd also like to point out that open enrollment without regard to pre-existing conditions every year also increases cost to all consumers, whether you're young or old or middle aged. When the individuals elect not to obtain coverage until they have a need for it, costs are driven up, whereas if the bandwidth was wider and those individuals that were healthier had the opportunity to get into the insurance market at less cost, we may be able to get them coverage for when they need it without waiting until they had a condition that necessitated insurance.

Senator ENZI. Ms. Lueck.

Ms. LUECK. I just wanted to mention, since the guaranteed availability in the individual market and the open enrollment period issue came up, that it's one of the most important changes that's happened since 2014. One of the most popular changes, frankly, if you ask the public, is the fact that people can get access to coverage in the open enrollment period and that they don't get denied or that they don't pay higher premiums because of the fact that they have a preexisting condition.

That was obviously something that was very concerning before to people who had those conditions, and it wasn't just people that had really expensive conditions that experienced those kind of problems. It was people that had taken antidepressants or had had chronic sinus infections. It was really a lot of us that would have faced barriers in the individual market.

Now, we have a situation where small employers have a little bit of the pressure taken off, right, because they don't have to feel like they have to provide coverage. That used to be the case, right? They used to feel especially responsible to provide coverage because they may have employees that have health challenges and that wouldn't have been able to get coverage in the individual market, and now there's a backstop there, that people can get access to that coverage, and the open enrollment period is just a way of making sure that people can't actually enroll whenever they want to. They have to do it at a defined time.

Senator ENZI. Thank you.

Back to Mr. Hudak, did you ever look into the SHOP exchanges?

Mr. HUDAK. We did, and it appeared that the plans weren't very price competitive. Selections weren't very abundant, and in our area, my wife would have had to change her doctors, and she's had a preexisting condition for more than 15 years. We've always struggled with keeping coverage, but we've always maintained coverage. It's always been expensive. But I will say today our monthly costs are far above anything that we've ever faced in the past.

To answer your question about the SHOP exchange, I think the selections aren't there, the choices aren't there, and the networks are limited.

Senator ENZI. Anyone else want to comment on that?

Mr. HARTE. I would say to you, Senator Enzi, that I mentioned earlier that we represent 300 companies throughout New England, and it may be helpful to know that only two of our clients are involved in the SHOP. When I testified before you last year, I shared

with you some significant challenges that the SHOP has had. I will share with you today that under the leadership of Mr. Counihan, the SHOP is better today than it was a year ago.

However, it still presents the challenges outlined by Mr. Hudak, that sometimes you're going to find within certain States lack of options. You will find bifurcated networks, and sometimes you just don't find the solutions. It does attract a certain employer with less than 25 lives and an average income of less than \$50,000 so you can take advantage of tax credits. But the ultimate question for a small business owner like Mr. Hudak will be: Is the aggravation going to be worth it?

Senator ENZI. Thank you.

Ms. Lueck.

Ms. LUECK. I just wanted to say something, because I happen to agree with a lot of the panelists—I thought I would take my chance while I could—that the SHOP has obviously experienced a lot of challenges across the country in terms of getting started on time and working well. It had a lot of technical and operational problems when it first started. The reports that I've heard since, in the last year, are that it's better, and that a lot of those problems are resolved. But, of course, the enrollment still remains quite low.

Small employers still have a lot of different options. They can keep buying coverage as they always have done on the open market directly from insurers through their brokers. That's still an option, and they don't have to go to the SHOP. It remains to be seen whether enrollment picks up there, whether there are more concerted efforts to educate employers, or to continue to bring more brokers into the SHOP marketplace, because that's another area where things have gotten better, but perhaps the brokers could have a larger role in the SHOP and that would help get more employers enrolled.

The verdict is still out on the SHOP, and we'll have to wait and see what happens. Clearly, the enrollment has skewed toward those that are eligible for the tax credit that you can get when you're in the SHOP. If we want to assist the very small employers that are eligible a little bit more, maybe that's something to consider.

Senator ENZI. Thank you.

Mr. Glause.

Mr. GLAUSE. I'd just like to reiterate what I said in my opening comments, that in Wyoming, we have less than 300 lives covered in the SHOP, and the employers are telling us it's difficult to determine what the tax benefits are. It's convoluted, and they just aren't able to figure out what advantage, if any, there is to providing coverage under the SHOP. At least in our small State, we just haven't seen the benefits to date of the SHOP program.

Ms. LUECK. Just one benefit I'll mention, for what it's worth. There is the ability in the SHOP to offer a defined contribution toward coverage. There's the ability to compare different plans. Obviously, the options are variable, depending upon the market and the State that you're in and the number of carriers that you have access to. But a number of SHOPS do have access to—they present access to multiple carriers so that small businesses can choose from those.

They also have the advantage of not requiring, at least in the federally run shop, a contribution requirement from the small business. So often, we hear this idea that, oh, small businesses just want to provide a little assistance with the premium cost or to help their employees a little bit with the cost. That's an option in the SHOP, and those were the kinds of things that the SHOP was created for, and then, of course, the option to do employee choice and let employees choose either different plans in the same level or among different carriers on their own without the employer making those choices for them. That's a huge change and a new benefit, especially for small employers who haven't been able to do that in the past.

Senator ENZI. Mr. Hudak.

Mr. HUDAK. I do want to mention that being able to provide healthcare in a flexible way is very important to small businesses. The No. 1 issue is, right now, one in three businesses have a position open that they can't fill. Trying to attract and retain key people is critical to our success. Great businesses are built with great people. We need to see flexibility in the healthcare system so that we can be inventive. We are finding that younger people like choices, like to be able to spend money—allow them to be true consumers.

We hear this time and time again, and when the little guy is up against the big guy, it's very difficult for us to compete, and the only way we can compete with the limited dollars we have is with flexibility. That's why we believe HRAs are really critical to this puzzle. HRAs allow us to have the flexibility to let them purchase premiums, insurance plans, and a whole host of other benefits. But they are in the driver's seat, and there's a perceived and real value to being in the driver's seat when it comes to your healthcare.

Senator ENZI. Ms. Lueck, in your opening comments, you mentioned the need for transparency of cost. Mr. Harte mentioned that in New Hampshire, they have transparency of cost. Does anybody know if that's available in any other States that way?

I know of a couple of companies that testified before us before that were big enough that they could do those kinds of comparisons within their company. But I'd like to know more about this transparency.

Mr. Harte, you talked about that app.

Mr. HARTE. In answer to your question, do other States have transparency tools, I want to answer that question, definitively, yes. However, I thought it might be helpful to also help you understand how New Hampshire was a bit of a pioneer in healthcare cost transparency, because approximately 10 to 13 years ago, the State of New Hampshire Insurance Department under the leadership of Roger Sevigny came up with www.nhhealthcost.org, and it was a limited healthcare cost transparency tool.

The first thing I'll share with you, Mr. Chairman, is that the first step could be that some of the States, through the insurance departments, can learn from the model in the State of New Hampshire, whereby the transparency conversation can start. That being said, the insurance industry is embracing the concept of helping their health plan members to have access to this information. As I shared with you before, the differentials can be greater than 600

percent from one facility to another, and, quite frankly, the lower cost facility can possibly be the higher quality of the two.

There are some significant large companies who are in this marketplace right now, which I will share with you after today's hearing. But, also, health plans across the country are starting to get into the business of healthcare cost transparency.

Senator ENZI. Mr. Glause.

Mr. GLAUSE. I was just going to echo Mr. Harte's comments. There are a number of States that have created either an all-claims database or a multi-claims—multi-payers claims database. The problem is that research has not borne out that these all-payer claims databases or multi-payer claims databases have reduced cost. Even in certain instances, in California, we've seen them increase cost.

I think the real challenge with the all-payer claims database is figuring out how to incentivize that for individuals. For instance, there is a Neiman Marcus approach to it, that if someone charges more, they must be better. It has to have a quality concept tied to it. And, as well, the individuals who have fulfilled their deductible—they no longer have any skin in the game. We have to figure out how to incentivize it.

The other issue it creates is the providers have access to it as well, and you sometimes see providers bringing up their cost to meet the higher cost rather than bringing them down in limited competition areas.

Senator ENZI. Thank you.

I'll have some other questions that are probably a lot more specific, and so I'll submit those.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator ENZI. But does anybody want to make a closing comment?

Mr. Harte.

Mr. HARTE. Thank you, Senator Enzi. Again, thank you for having me here today. I don't want this hearing to end without me talking about a couple of issues that are of great concern to my employer clients, one of which is the employer mandate and the management and administration of the employer mandate. Many employers issued their first tax forms just a few months ago, and the burden on employers from 50 and up is overwhelming at best.

The volume of hours, administration, and management for any employer, regardless of size, to administer the employer mandate is overwhelming. Many employers, large employers, went to their payroll company last July and said, "I need to start preparing for the employer mandate and my reporting. Can you help me with that?" Now, as we know, a lot of healthcare reform reporting requires that hours be submitted on a monthly basis for individual employees. The clearinghouse for that is a payroll company.

Many payroll companies shut down their clients and said, "I apologize. We cannot do your employer reporting," which left thousands of employers across this country looking for a third party solution without access to all that data, and they didn't talk to each other. My hope is that in this coming year, there will be better solutions so that the employers are not so overwhelmed.

My other comment to you, Senator Enzi, is I wanted to share some concern that I have with regard to the consideration of eliminating the employer exclusion. As many of us know, the employer exclusion says that if a small business, like Mr. Hudak, contributes premiums toward their employees' health insurance benefits, then that benefit, the dollar benefit of the health insurance plan, is excluded from an individual's income.

I will share with you, anecdotally, some of my clients. One of my clients is a large State employees union, and all of their employees will be subject to a significant tax increase absent the employer exclusion. In addition, as we're here today talking more about small businesses, since the rate grids came out, we have seen some significant discrimination in local businesses, because they look at these rate grids, and they say, "It costs more to hire someone and provide benefits to someone who is age 55 and older."

What you'll also find by eliminating the employer exclusion is that there will be further discrimination amongst people who are my age and older, because when you work for a small business, if the volume of premium paid for that individual is higher than others, then, conversely, the tax to the business, for the payroll tax, as well as the individual tax to the employee, will be significant.

I actually have some examples here that one taxable income for a 25-year-old will be an additional \$12,900—and this is a real-life example from one of my clients—versus a \$29,000 additional income, almost like imputed income. Take their Federal tax rate of anywhere from 10 percent to 39.6 percent, and you're going to have a substantial tax burden to individuals.

My concern, Senator Enzi, as you've known me through the years, my platform is we need to make health insurance more affordable. If in the event that we eliminate the employer exclusion, we will absolutely see an increase in the number of uninsured, because it will be significantly more unaffordable than you have it today. You'll also have employers who say, like Senator Scott said earlier, why don't employers just pay the \$2,000 penalty?

In my conversations with my clients every year, when I sit down and share with them a 10 percent to 30 percent increase, they're already considering walking away from their health insurance plan. By eliminating the employer exclusion, I can assure you that we will see a massive exodus from the small employer marketplace and the large employer marketplace by employers who are desperately concerned about the impact of losing the employer exclusion.

Senator ENZI. Thank you.

I appreciate all the comments today and all of the suggestions. I've got five pages of things circled here to followup on and see if we can work them into, again, making things more affordable for people that work for small businesses, because that's what we're trying to do, and I know a lot of people want to do that.

I want to thank you all for your testimony and the ideas and suggestions. I hope I got them right. But they're very good. You're a knowledgeable group, and perhaps we'll have some more questions submitted for you. They have to be given to my office by close of business on Tuesday, July 5, 2016.

Thank you very much. The roundtable is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR HATCH

Small businesses in Utah, and across our Nation, are an important source of employment and economic activity while serving as the foundation of our communities. According to the Small Business Administration, Utah small businesses employ more than 520,000 individuals, which is nearly half of the private sector workforce. Firms with fewer than 100 employees make up the largest share of small businesses in Utah. Small businesses spark innovation, create jobs and complement the economic activity of large organizations. However, small business creation and growth is faltering in Utah and throughout the country because of the Affordable Care Act and its increased costs.

According to a study conducted by the National Federation of Independent Business Research Foundation, “the cost of health insurance is the most critical concern for small business owners in operating their business ...” This is further exacerbated by mandates and taxes imposed by Obamacare. It is time for the Federal Government to stop this assault on small businesses and hard-working Americans. Through my work as a member of this committee, as Chairman of the Finance Committee, and as a Utahn seeking common sense solutions to unnecessarily complex problems, I have fought to decrease health care costs for small businesses in a variety of ways.

At the end of 2015, I ensured that Obamacare’s 40 percent excise tax on high cost employer-sponsored health benefits—referred to as the Cadillac Tax—was delayed until 2020. Similarly, I worked to enact a 1-year moratorium on the health insurance tax, which is estimated to increase premiums on average for small employers by more than \$200 per employee. While these are small steps to address the rising cost of health care, they provided meaningful relief in the short term.

As Chairman of the Finance Committee, I have also worked with my colleague, Senator Chuck Grassley, to support the Small Business Health Care Relief Act (S.3060). This measure would allow small businesses that have no more than 50 employees to offer stand-alone Health Reimbursement Accounts (HRAs) to their employees if certain conditions are met without subjecting them to an onerous excise tax that went into effect last July. HRAs are an important tool used by employers to help employees pay for health insurance premiums and medical expenses. I will continue to work with Senator Grassley on avenues to advance this important piece of legislation.

Many of the other ideas I believe will help to decrease health care costs for small businesses are included in the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act I proposed with my colleagues, Senator Richard Burr and Congressman Fred Upton. The Patient CARE Act would repeal Obamacare, and instead build the economy, empower the individual, and reduce health care costs. Of particular interest for employers should be the repeal of the employer mandate that imposes a one-size fits all requirement on small businesses that offer health insurance coverage to their employees. Small businesses know their employees and

their health needs better than Federal bureaucrats in Washington, and should have flexibility to design benefit packages that work best for them. Furthermore, this proposal would allow small businesses to join together to negotiate small business health plans to leverage purchasing power, which could help expand access to coverage and lower health care costs.

Another component of the Patient CARE Act is giving employers and employees more access to Consumer Directed Health Plans, also known as HSA-Eligible Health Plans. As the lead sponsor of the Health Savings Act of 2016, I feel strongly that giving employees more choice and greater control of their earnings will enable smarter, more personal decisions about their health needs.

Starting, maintaining and growing a small business demands hard work, dedication, and focus. The Federal Government should do all it can to support small business employers and employees, rather than increasing burdensome regulations that make it difficult for businesses to grow and hire more workers. I will continue to advocate for ways to bend the cost curve for small businesses purchasing health insurance coverage, and I invite anyone—Republican or Democrat—to work with me to address rising health care costs, which is a top issue facing the economic engines of our country.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

