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SMALL BUSINESS HEALTH CARE CHALLENGES AND OPPORTUNITIES

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

FIRST SESSION

ON

EXAMINING SMALL BUSINESS HEALTH CARE CHALLENGES AND OPPORTUNITIES

JULY 7, 2015

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C O N T E N T S

STATEMENTS

TUESDAY, JULY 7, 2015

SMALL BUSINESS HEALTH CARE CHALLENGES AND OPPORTUNITIES

TUESDAY, JULY 7, 2015

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:01 p.m., in room SD–430, Dirksen Senate Office Building, Hon. Michael Enzi, chairman of the subcommittee, presiding.

Present: Senators Enzi, Sanders and Murphy.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. I'll call to order this Subcommittee on Primary Health and Retirement Security Roundtable. I want to thank the witnesses for coming today, and I want to thank Senator Sanders and his staff for working to put together a bipartisan conversation about this important issue of small business healthcare.

I'd also like to thank the colleagues who have helped work on this, who will be interested in and appreciative of the testimony that all of you provided. That's been shared, and I appreciate the format that you used. You all answered the same questions. That's what we do at a roundtable.

Senator Kennedy and I used to do a lot of roundtables. One of the purposes of a roundtable is not so that the two sides can beat up on witnesses. It's so that we can actually get information from the witnesses that will help in making future decisions. It's OK for there to be a discourse between the people that are on the panel as well as with any questions from Senators.

Of course, what we're hoping—I've always had this 80 percent rule. I've found that we can talk civilly about 80 percent of the issues, and out of those issues, we can often pick an issue that we can agree on 80 percent. It always seems like there's 10 percent that each side has that they've been butting heads on sometimes for years.

Some of the legislation I've worked on—sometimes there's been 10 or 12 years of fighting through the same arguments. One of the problems is that the staff are so used to the arguments that when they hear a word, they can respond to that word without ever listening to the rest of the sentence. It's a challenge to get beyond that and actually get to the meat of the subject.

Sometimes we were even able to do 100 percent. That means that on that 20 percent that we'd been fighting over for years, we were able to find a third way that both sides could take credit for.

The purpose of a roundtable, of course, is just to have a discussion on the problem and the solutions for it. One of the first ones that I held with Senator Kennedy, when it was over, he said,

> "You know, it's kind of interesting to learn something about a subject before we do a bill on it." That's what we're hoping for today.

I appreciate the participants taking the time to put together the papers that you did. Those are very succinct and helpful. I think that we have a representation here at the table of a lot of different sectors, so there's a unique on-the-ground perspective of what is reality for small business. I will ask each of you to say a few words shortly after Senator Sanders finishes.

I'd like to welcome Tom Harte, who is the President of Landmark Benefits in New Hampshire. Mr. Harte's company, Landmark Benefits, provides employee benefit services to over 300 corporations and thousands of employees. He comes to the table with over 25 years of experience in designing, implementing, and managing the employee benefits.

Mr. Harte has built one of the most successful employee benefit companies in New Hampshire with a focus on contributions to the industry, charity, and community. In addition to his role at Landmark Benefits, Mr. Harte was the national president of the National Association of Health Underwriters from 2013 to 2014. He has consistently promoted the importance of reducing the cost of health insurance with a deliberate focus on improving the health of employees and increasing the transparency of the cost of healthcare services.

Sabrina Corlette is a Senior Research Fellow and Project Director at the Center on Health Insurance Reforms, CHIR, at the Georgetown University's Health Policy Institute. She directs research on health insurance reform issues as they affect consumers and patients. Her areas of focus include State and Federal regulation of private health insurance plans and markets and implementation of new insurance market rules under the Affordable Care Act.

Prior to joining the Georgetown faculty, Ms. Corlette worked at the National Partnership for Women and Families, and from 1997 to 2001 for the Senate Health, Education, Labor, and Pensions Committee—this committee.

Jim Scott is a local area small business owner. He is the president and CEO of Applied Policy, a company in Alexandria, Virginia, that he founded in 2009. It's a seven-person company, and you offer your employees a variety of fully insured products and a generous employer contribution.

Before founding Applied Policy, Mr. Scott worked for Hoffmann-La Roche, focusing on Medicare coding, coverage, and payment, and he served as the company's principal point of contact with the Centers for Medicare and Medicaid Services, CMS. Before joining Roche, Mr. Scott served as the senior legislative advisor at CMS.

Prior to his service with CMS, Mr. Scott was an assistant counsel with the Office of Legislative Counsel of the U.S. Senate. Mr. Scott serves on the Board of Directors of the Alliance of Aging Research, founded the Northern Virginia Health Policy Forum, and is a mem-

ber of the steering committee of the Partnership for a Healthier Alexandria.

Kelly Conklin is the owner of Foley Waite, an architectural woodworking company based in Bloomfield, New Jersey, and is here today to discuss his company's experience purchasing health insurance for his employees over the last few decades. Mr. Conklin lives in Glen Ridge, New Jersey, with his wife and business co-owner, Kathryn W. Schackner. In 1978, he and Ms. Schackner founded Foley Waite LLC.

The firm currently has 11 full time employees. Foley Waite fabricates cabinets, furniture, doors, paneling, and moldings in a 13,600 square foot facility in Kenilworth, New Jersey. Conklin attended Rochester Institute of Technology, the School for American Craftsman, and Schackner is a graduate of the Philadelphia College of Art.

Mr. Conklin is a member of the Executive Committee of the Main Street Alliance and is the Alliance for a Just Society board representative of MSA, a steering committee member of the New Jersey Main Street Alliance, and he served 14 years on the Glen Ridge Planning Board, leaving in 2014 as the chairman. From 1998 to 2010, he served on the board of the New Jersey Policy Perspective, a nonpartisan New Jersey based think tank.

I'll keep my remarks brief so we can get to the real discussion. I'd like to touch on the heart of what we hope we can get to today.

Small businesses have traditionally had some of the least competitive, most expensive health insurance options out there. I was in the shoe business. I know about that. Yet so many business owners still view it as a priority to assist their employees in purchasing health insurance. I know that when I was running my small business, I found out that any business looks easy to operate as long as you don't have to make the decisions for it.

A lot of people don't realize that in a small business, the owner might well have to wash the windows, sweep the sidewalks, clean the toilets, do the bookkeeping, and wait on customers, preferably not in that order. I also know there's no better feeling than seeing your dreams become reality with the success of your own business.

A big part of making all that happen is your employees. As the owner, you are linked to these people, and there are certainly market competitiveness reasons to provide health insurance, but also a sense of responsibility, knowing their family as being part of your enterprise together.

I'd like to touch on the issues that small businesses face. Government has tried many things to try to fix the market. I think there is a consensus that those efforts haven't gotten us over the finish line.

Today, I'd just encourage the group to think a little differently. There are a lot of changes that would improve things and meet a short-term need. We also need to think past the next plan year. We should try to ask the question of what this market should look like in the future and what do we need to do to get there. I think all of you have addressed that in your papers.

Just to clarify the process, once we finish our statements here, I'll ask each of you to give a brief introduction of yourself and any statement that you want to make on what you think should be

done to help small business, and then we'll begin the questions. When it is time for that, if you want to speak, just stand your card up, and that will help me to recognize you, although today it may be easy to do. We don't have 10 or 15 people on the panel.

With that, I'll turn it over to Senator Sanders for any comments he may have, and then we can get into a discussion.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Mr. Chairman, thank you very much for holding this hearing. Let me apologize to you and to our witnesses that I'm not going to be able to stay for very long, although this is a subject which interests me and the people of Vermont very, very much.

I think the point that I would like to throw out—I'm not going to be here for it, but maybe some of the panelists could get into it—is to maybe address the issue of how it happens that the United States of America, our great country, the wealthiest country in the history of the world, is, in fact, the only major country on Earth that doesn't guarantee healthcare to all people as a right. That's point No. 1. If we did that, a lot of aspects of this discussion might not be taking place.

What we all know is God didn't create a situation where businesses were obliged to provide health insurance to their workers. That's a public policy issue. I think it began in World War II for various reasons, dealing with the State of the economy in World War II.

What concerns me, Mr. Chairman, very much is that, No. 1, you have some employers, small and medium-sized employers, who feel a moral obligation to make sure that their employees have high-quality health insurance. Across the street, there may be another employer engaged in the exact same business who has a different point of view.

For no particularly rational reason, you have one guy who's trying to do the right thing and spending a lot of money on it. Another person is doing something different for his or her own reasons, spending a lot less money on it. That's issue No. 1. What rational sense is that?

No. 2, where I think we are at an international competitive disadvantage is that our small, medium-sized and large businesses spend an enormous amount of time—and it sounds like folks like Mr. Harte help them in this area. All right. I have 20 employees. What is my best deal? How do I provide health insurance to my employees in the most cost effective way?

That's kind of what you do, Mr. Harte. Right?

All right. Yet in other countries, small and medium-sized businesses don't particularly worry about that issue, because everybody in those countries has healthcare as a right. I live 100 miles away from Canada, and that's pretty much the story.

If you own a shoe store, Mr. Chairman, in one of those countries, what those businesses focus on is how you sell as many shoes as possible and not spend an enormous amount of time on a very, very complicated issue. I'm sure the panelists will agree with me that with the market changing every day, if one person in your 10-person company comes down with cancer, that changes the entire dy-

namics of what kind of premiums, what kind of costs you're going to have for your insurance policies.

Mr. Chairman, I think it is important for us to understand what the problems facing small and medium-sized businesses are today. I think what is even more important is that you and I who are on the committee, this committee that wrote the Affordable Care Act—God knows how many hearings we had on that, right, and how many meetings we had on that. The one simple question we forgot to ask for a reason is: Why are we the only country, major country on Earth, that doesn't guarantee healthcare for all people, and what can we learn from those other countries?

In the United States today, as all of us know—the chairman and I will disagree, I'm sure—the Affordable Care Act has had some modest gains in providing insurance for millions more people; doing away with the obscenity of pre-existing conditions; making healthcare available to younger people on their parents' policies, et cetera.

But despite the gains of the Affordable Care Act, we still have 35 million Americans who have no health insurance. Even more significant, I think, is that we have millions more people who are underinsured with high deductibles and high copayments. How does that impact the health of people?

If I have a $5,000 deductible, as is not uncommon, and I get sick, but I don't have the money, I'm not going to go to the doctor. Four months later, when I'm really sick, and I go crawling into the doctor's office, what will the doctor say? "Why weren't you here when you were sick?" And I say, "Well, I couldn't afford the deductible," and he says, "I'm sending you to the hospital." If maybe I had come in 4 months earlier, I would not have to go to the hospital.

I think you have a system which has 35 million uninsured, more than that underinsured, and here's the kick. For all of that, we end up spending far, far more per capita on healthcare as do the people of any other country—close to double, not quite double, but far, far more.

You're a businessman, Mr. Chairman. Do we get good value for what we're spending? We're spending a fortune. Do we get good value? Are you going to sit here and tell me—which you're not—that all of our people have health insurance? No, they don't.

Is our life expectancy as high as many other countries? Well, it's not. Is our infant mortality rate higher? Yes, it is. We do well in some diseases. We treat some diseases very well. Some diseases we don't treat particularly well.

If we are spending all of this huge amount of money, I think the end result is that we're not getting good value for what we are spending. What good value means is that everybody in America has quality healthcare as a right, and we do it in a cost effective way.

What is really significant is that we take that burden off of the backs of small business people and, by the way, millions of employees, Mr. Chairman, who stay at their jobs, not because they really enjoy their jobs, but who stay at their jobs because that job may provide good health insurance for them and their kids. That is not a good way to grow an economy. You want people to gravitate to the kind of work which they enjoy, where they feel passionate

about it, and not stay on a job simply because they get good healthcare.

I'm reminded that some years ago—you may have read the article—some fellow, I think, in his 50s, who rejoined the military—had been in the military and was out—rejoined. Somebody said, "Well, why are you going back to the military at the age of 50 or something?" He said, "Well, my wife has breast cancer. That's the only way that I can get treatment for her."

That really should not be the kind of healthcare system that we have. I think the best thing that we can do for small and medium-sized businesses is take the burden of an enormously expensive and complicated system off of their backs, allow them to go out and do their businesses, whether it's selling shoes or whatever it is, and focus on that business rather than getting mired down in the complexities and the cost of health insurance.

That is why I very strongly believe that the United States should join every other major industrialized country with a national healthcare program. In my view, it should be a Medicare for all, a single payer system.

With that, Mr. Chairman, I thank you very much for holding this hearing.

Senator ENZI. Thank you.

As I promised, now we'll go to our guests at this roundtable, and we'll just go from left to right. You may make a few comments, and if somebody wants to comment on the comments, stand your card up, and we can do that. Hopefully, we'll have about 3 to 5 minutes from each of you first, and then get into a discussion.

Another thing that happens with a roundtable, and particularly ones we hold on a Monday, is that a lot of the people will have additional questions based on the testimony that you provided and also things that their staff people will report to them based on what happens here today. I'm hoping that you'll be willing to answer those questions, too, to provide us with additional information, which then will be circulated to all the members of the committee. Again, thank you for being here.

Mr. Harte.

STATEMENT OF THOMAS M. HARTE, OWNER, LANDMARK BENEFITS, HAMPSTEAD, NH

Mr. HARTE. Senator Enzi, Senator Sanders, members of the committee, thank you so much for the opportunity to be here today. I look at this as a unique privilege for myself, my company, the professionals all over the country, in having an opportunity to talk about the challenges that we have in health insurance across the country.

What's interesting with Senator Sanders' comments is I share his frustration. I share your frustration, Senator Enzi. We've met before. We've talked about these challenges. The fact is that small employers across the country are paying premiums that are way too high. It's a reflection on the cost of healthcare.

People always are going after—and, quite frankly, healthcare reform went after health insurance as the issue. When you really think about it, if you think about medical loss ratio as one easy example, if 80 percent to 85 percent of our premium dollars are going

to the cost of healthcare, shouldn't our conversations be really more about healthcare, so we treat the cause, not the symptom?

Senator Enzi, I represent about 100,000 agents and brokers across the country. I also represent 25 individuals who I insure back home in small businesses, like mom and pop stores, colleges, healthcare, local stores. We do it every single day.

I've been in this business for 25 years. I've heard all the stories. I've seen people canceled for health insurance. I've seen people subject to preexisting conditions. The market is not perfect.

What I hope I can share with you today and members of the committee and my colleagues with the opportunity here today is what are the real challenges that Americans are facing with regard to their health insurance? Why are their premiums increasing so significantly? Why is the shop exchange not working? It's a great idea, but it's just not working.

What is the issue with migrating groups of 51 to 100 over into the small group marketplace, and what kind of profound effects will that have on those businesses and their economic viability? Senator Sanders is right that we are at an international disadvantage when it comes to the cost of our healthcare.

That's really what I want the conversation to start going toward, so that when you look at competition in the United States of America, there's competition with health insurance companies, but there's very little competition among healthcare.

What I want to do and, hopefully, convey to you today is to think about—well, look at the State of New Hampshire. In the State of New Hampshire, a CT scan of your head from the least expensive facility to the most expensive facility is 446 percent different. The consumer doesn't know that. We need to fix that problem so that we can reduce the long-term cost of healthcare.

Again, I sincerely appreciate the opportunity to be here today, and I look forward to your questions, Senator Enzi.

[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.; located 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 of them are small to mid-sized business owners. My primary goal for my clients is to provide innovative solutions that emphasize both 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. Just last week, 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 the 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.

As requested, I have focused my remarks on three topics of greatest interest to the subcommittee:

(1) Status of the small group health insurance market today,
(2) Tools, resources, and options available to small employers, and

(3) What is working and not working for small employers, and the policy ideas my NAHU colleagues and I have that could improve the small group health insurance market for consumers.

It is my and NAHU's hope that now, 5 years into the implementation of the Patient Protection and Affordable Care Act (PPACA), that Congress and President Obama will come together with bipartisan solutions to improve the outcomes of ACA and resolve many of the unintended consequences that are making coverage more expensive and creating burdens for health insurance consumers.

The Status of Today's Health Insurance Marketplace for Small Business Owners and Their Employees. As a benefit broker from southern New Hampshire, virtually all of my clients and my professional experience are within New England. However, thanks to my resources from NAHU and my colleagues from across the country, I hope I can effectively communicate the options small business owners in other States now have available.

Currently the small employer marketplace is defined as employers with between 1 to 50 "eligible" employees for coverage. Every employer is different and, of course, many of my clients offer very different benefit options. However, my clients in the small employer market always purchase fully insured coverage and, in New Hampshire, we are able to provide four carrier options, of which two of these plans comprise over 95 percent of the small business market.

One option for small employers is the SHOP exchange and has four provider options with a total of 18 plan choices (5 Bronze, 7 Silver, 5 Gold, and 1 Platinum) and many of these plans have limited networks—as a result, many that enroll on the SHOP will be forced to lose their doctor. Most of the small employers I represent purchase "silver level plans" for their employees and have an employer contribution of between 50 percent and 80 percent of the employee and dependent premium. In New Hampshire, our typical health plan design provides a $3,000 deductible with office co-pays of $25 for primary care and $50 for specialist and a prescription benefit of varying out-of-pocket expense depending on the tier (generic, preferred brand, and brand name).

For the types of plans that I described, the total monthly premium for our clients will vary considerably. In recent health plan renewals, our small employer clients have been faced with renewals of as high as 46.60 percent with monthly premiums for a single employee as high as $726 and $2,168 for a family.

Client Location	Enrolled	Deductible	Renewal Single	Renewal Family	Rate Adj. [In percent]
Merrimack, NH (9.1)	51	$3,000 to $4,000	$601 to $688 (tiered)	$1,835 to $2,099	23.32
Wrentham, MA (7.1)	8	$500	$760	$2,168	7.95
Salem, NH (7.1)	5	$2,000	$297 to $573 (list bill)	none	3.46
Lawrence, MA (7.1)	36	$1,500	$550	$1,569	12.45
Berwick, ME (8.1)	3	$2,500	$931	$2,795	21.66
Bedford, NH (6.1)	29	$4,000	$778	$2,296	46.60
Derry, NH (6.1)	38	$3,000	$585	$1,781	10.84
Chelsea, MA (5.1)	2	$2,000	$639 to $726	$1,823 to $2,070	11.92
Derry, NH (6.1)	81	$4,000	$540	$1,756	19.50

An unintended consequence of the ACA, with exception of certain State statutes (e.g., Massachusetts) or the allowed "Grandmother" transaction, which varies by State, is that carriers are often not able to present small employers with a "composite rate" for health plan premiums. As a result, the small employer now has to adjust for the fact that every single employee and dependent has a separate and varying monthly health insurance coverage premium based on their age.

Additionally, small employers are now challenged with economic impact with the hiring of new employees and the significant variance of health insurance premiums of one employee versus another. By example, if my company elected to have a "NON-Grandmothered" plan for our health plan, the rate differential for one employee to another would be as high as a 300 percent and thousands of dollars in additional expense.

Single, Age 25	Single, Age 60	Annual Difference	Increase (In percent)
$385.57	$1,046.44	$7,930.44	273

Family, Age 30, 30, 6, and 4	Family, Age 55, 24, and 23	Annual Difference	Increase (In percent)
$1,364.92	$2,490.75	$24,768.26	183

While the pricing of coverage varies significantly by State, or even within geographic areas of particular States, my NAHU colleagues indicate that the plan design options and available carrier choices are becoming more and more limited. State-by-State pricing varies not only due to medical care cost variations by State and region but also because health reform implementation has varied by State. Some States still allow small groups to maintain plans that do not include all of the ACA reforms and related costs via "grandmothered" plans. Other States have essentially required small employers to drop the coverage they had before and purchase plans that include all of the ACA-related changes and their associated costs by phasing out or never allowing "grandmothering." When employers in the States with widespread "grandmothering" are eventually forced to shift to post-ACA plan designs, then their rate increases will be significant.

The marketplace I just described is the small group market as it exists right now. Today, employers with more than 51 employees have significantly different coverage options available to them as they are considered "large groups" for health coverage purposes. These employers are not bound by the age rating or composite rating restrictions we see in today's small group market and their benefit design options and associated price points are much more flexible than in the small group market. Some will elect to self-fund, that is to pay their own claims, but most prefer the security of a fully insured health plan. These employers also have more benefit from the implementation of meaningful wellness programs and the incorporation of innovative and cost-saving benefit designs. Although the rates vary widely for employers in this market, those employers that have a deliberate focus on having an impact on the health plan utilization will generally have lower premiums compared to employers that do not. As the employee benefit broker for these companies; we have deployed nutrition, exercise, and health challenge programs that have allowed for the sustainability of premiums for many corporations. With a migration to the small group market, the benefit these employers receive today with reduced premiums will be lost.

My colleagues and I are very concerned about the planned expansion of the small group market in 2016 to employers with 100 employees or less. We anticipate this expansion will result in clients of 51 to 100 employees receiving significant premium increases in 2016. Furthermore, these clients will not be able to keep the plan OR the plan options they have today and, in some cases, their current health plan may not serve the small group market. They will also have to adapt their plans to the "metal plan" design options, which means that their covered services may change and be forced to either reduce benefit offerings or increase them to meet the actuarial values tied to the metal plans.

For example, an employer with a plan actuarial value today of 76 percent would have to either reduce coverage to a 70 percent silver plan or raise it to an 80 percent gold in 2016. As you would expect, there are coverage and cost consequences to either option. These employers will have to follow the age rating requirements and will lose the ability to receive a true composite rate in most circumstances, so their pricing for employee premium cost-sharing will need to change dramatically. Furthermore, by forcing these employers into the small group market they will lose some of their flexibility to create meaningful wellness, cost-containment, and quality components within their plan offerings. Finally, this employer segment will have to follow the employer mandate in 2016, meaning that these smaller but vibrant companies that drive local economies will be the only group of employers subject to both the employer responsibility and reporting requirements and all of the small group reform requirements and associated costs. These are significant changes in a market that is exceptionally price sensitive and least able to effectively manage the new compliance requirements.

TOOLS AND OPTIONS FOR SMALL EMPLOYERS

The most important tool any employer has in the management of their health plan is a health insurance agent or broker. That's why, nationwide, more than 90 percent of small businesses rely on brokers and, according to a Society for Human Resources Management (SHRM), 78 percent look to their broker as their No. 1

source of health reform information. Agents and brokers support their small business clients in choosing and making the most of coverage options by providing assistance, trusted advice and service. Some of the services that I and my colleagues provide for our small employer clients include:

- Comprehensive wellness programming to improve the health and wellness of the employees and their dependents.
- Deploy health care cost transparency tools to educate the employees of the wide variance of cost between health care providers.
- Assist employers with the management to the increased complexity of compliance.
- Manage enrollments, terminations, and COBRA process.
- Negotiate renewal rates and identify items that should be considered by carriers when determining renewal premiums (i.e., turnover of personnel, addition of new hires, etc.).
- Recommend healthcare financing options best suited for the client (i.e., fully insured, self-funded, health reimbursement arrangements, flexible spending accounts, health savings accounts).
- Provide online and written communication for plan administration.
- Advise about new and pending legislation, new plan designs, and premium changes.
- Assist clients with claim issues and advocate on their behalf.
- Analyze the performance of the medical plan and identify key areas of utilization.
- Assist clients with requests to doctors and hospitals to improve health care outcomes.
- Assist employee family members with the selection of coverage.
- Meet with employers/employees to explain benefits, plan designs, and optional coverage.
- Assist the employer in selecting the appropriate plan(s) that best meets the employer and employee objectives and goals.
- Assist employers with billing issues.
- Provide or assist with employee Web sites to facilitate access to plan information.
- Research and advise on financial viability, credibility, and value of various insurance companies and plan offerings.

Employers of every size rely heavily on agents and brokers for advice and assistance. The health insurance marketplace has become so complicated with changes in legislation, plan design and benefit offerings that my colleagues have become an invaluable resource. Whether the large pizza chain in Boston, the colleges we represent in New Hampshire, the manufacturing facility in Nashua, or the construction company in Maine—employers don't have the resources or expertise to take this task on by themselves.

SMALL GROUP MARKET POLICY RECOMMENDATIONS

We all have a stake in a 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:

- Passage of the bipartisan S. 1661 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.
- Restoration of a state's ability to set its small group market size at 1–50 employees.
- Efforts to reduce the new tax burdens on small employers and their employees, including the new national health insurance premium tax that adds more $500 a year to the average premium for a small group employee and only affects the fully insured marketplace and the coming excise tax.
- A repeal of the employer mandate, or failing that, establishing the eligibility threshold at 101 or more employees and a simplification of the eligibility criteria so that employers cannot be subject to both the small group market reforms and costs and the mandate requirement at the same time.
- Allowing employers to set the definition of a full-time employee as one that works 40 or more hours a week for health coverage purposes.

• Legislation which allows States to increase the law's age rating bands from the current 3 to 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 to 1.
• Restoration of the ability of health insurance carriers to issue employers a composite rate for employee coverage, just as they did prior to the ACA
• 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.
• Reviewing the essential benefit and other coverage requirements to ensure that they allow individuals and employers the opportunity to buy affordable coverage.
• Improvements to the SHOP exchange and the small business tax credit to make SHOP a more viable coverage option for small employers and to provide more small businesses with free-market purchasing assistance.

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.
Mr. Scott.

STATEMENT OF JAMES G. SCOTT, OWNER, APPLIED POLICY, ALEXANDRIA, VA

Mr. SCOTT. Senator Enzi, Ranking Member Sanders, and members of the committee, thanks for the opportunity to participate in today's roundtable discussion. Today, I'm here in my capacity as a small business owner, but I also work on health policy.

As you mentioned, Senator, in 2009, I founded Applied Policy to help healthcare organizations navigate the Centers for Medicare and Medicaid Services. When I started Applied Policy, my biggest worry was whether I would generate enough income to feed my family. My second biggest worry was how I would find health insurance for myself and my family, because I had always relied on my employer to provide that coverage.

As a health policy consulting firm, I believe we need to walk the walk. We work to encourage healthy lifestyles among our employees, and we also want to provide good health insurance. As Applied Policy, we have to make sure that all our employees have access to high-quality health insurance, and that was the first benefit we added.

To do this as a small business, like you mentioned, you have to wash the windows and update your website and all that kind of thing nowadays. I needed outside help, so I relied on our insurance broker to help us compare a number of options and select a range of options for our employees.

We decided that, as a health policy consulting firm, I should ensure that everybody that worked at Applied Policy had health insurance. We paid the full cost of the HMO option so everybody had access to a zero premium plan, and we allowed them to provide that premium subsidy toward other options that we provided.

By 2014, there were seven of us, and six of us have chosen health insurance options offered by Applied Policy, and one retains their spouse's coverage. That year, we received two checks from our carrier because of the medical loss ratio. One was for 36 cents, and the other was for 12 cents. Those refund checks were accompanied

by a stern letter directing us to distribute these funds equitably among our employees. I gave them each a dime.

In 2014, when it came time for us to renew our plans for 2015, I told our broker that we were happy with what we had. We just wanted to renew. They said that now our plans were designated as platinum plans, and the premium had increased by 40 percent. The HMO option that we had based our subsidy calculation on increased by 48 percent. The year before that, we had also seen double digit increases.

Our desire to give a premium subsidy to each plan enrollee has been affected by the new member-level billing-premium calculation requirements. Instead of being able to have an office-wide meeting and say,

> "Look, these are our health insurance policy options. Here's our contribution, and here's the options you have to choose from,"

our broker has to have seven individual conversations because of the age rating, and the cost of plans varies widely between the younger and older employees.

Generally, we don't discuss the ages of staff at work, and I believe compensation should be tied to the work the employee does and not how old they are. However, this new system requires us to tie compensation to age, at least as far as our health insurance benefits go.

We realigned our plan options, and we took advantage of some of the new wellness options, and we continue to provide employees with a zero dollar plan. I've changed my family dental and vision coverage to coverage for my wife and I, because now, pediatric vision and dental is embedded in our medical plan. We continue to be concerned about what levels of increase we are going to see next year and how we can manage the unpredictable changes in benefits and rates from year to year.

With those comments, I'd be happy to answer any questions you have.

[The prepared statement of Mr. Scott follows:]

PREPARED STATEMENT OF JAMES G. SCOTT

Chairman Enzi, Ranking Member Sanders and members of the committee: Thank you for the opportunity to participate in this roundtable discussion regarding small business health care challenges and opportunities.

I am here today in my capacity as a small business owner, but I also work on health policy. In 2009, I founded Applied Policy to help health care companies, including providers, manufacturers, suppliers, insurers, trade associations and specialty societies navigate the Centers for Medicare & Medicaid Services. We are not lobbyists, rather, we take our clients concerns into account, explain the opportunities and threats posed by new legislation and current and proposed changes to regulations that apply to those concerns. We then work with them to find solutions that not only benefit the client, but also foster a government that serves the people as intended.

When I started Applied Policy, my biggest worry was whether it would generate enough income to feed my family. My second biggest worry was how I would find health insurance for my family because I had always relied on my employer to provide that coverage.

When I first hung out my shingle, I had to buy health insurance for myself and family and go through the underwriting process. Fortunately, I worked with an insurance broker who helped us navigate the process and we were able to secure good coverage. After completing that process, I realized why that process caused so much angst among others and how we were fortunate to get a good result.

As I began to hire staff, I had to consider not only what salaries I would offer, but also what benefits highly qualified staff would expect. Moreover, working as a health policy consulting firm, I felt that Applied Policy should make sure all its employees had access to good health insurance. The first benefit I tried to add was health insurance.

The first person I hired was in 2010 and the Affordable Care Act had just passed and allowed all individuals under age 26 to remain on their parents' health insurance plan. The first person I hired was under age 26 and chose to stay on her parents' insurance. The implications of this were that I did not yet meet the "group" criteria and had to maintain my individual insurance at underwritten rates until I hired an employee willing to sign up for a group health insurance policy.

Then, I hired my second employee. Our insurance broker helped me compare a number of options and select three plan options: an HMO; a point-of-service (POS) plan; and a PPO. Applied Policy decided to pay a larger subsidy than the law required so its employees could have access to a $0 premium plan. Therefore, I paid the full cost of individual coverage for the HMO and allowed the employee to elect to have additional funds withheld from their paycheck to upgrade to the POS or PPO options. We also provided optional vision and dental insurance.

As we added more staff, Applied Policy continued its policy to provide its employees with access to a $0 plan. By 2014, there were seven of us, with five electing one of our plans and the other two choosing to remain on other health care insurance through their spouse or parents.

That year, Applied Policy received two checks from our carrier because of the Medical Loss Ratio calculation. One was for 36 cents and the other was for 12 cents. Stern instructions accompanied the checks stating the law required Applied Policy to share the funds with our employees. Therefore, I gave each of the plan enrollees a dime.

In July 2014, when it came time for us to renew our plans for 2015, I told our broker that we would like to keep the same plans as we currently had. She informed us that the plans had been recently designated as "Platinum Plans" and the insurance premiums increased by 40 percent. The HMO option that we had based our subsidy calculation on increased by 48 percent. The year before, we had also seen double-digit increases in our rates.

Our desire to give a premium subsidy to each plan enrollee sufficient to enroll in a $0 premium plan was affected by the new age-rating requirements. Instead of being able to have an office-wide meeting, explain the health insurance options, show the 2015 rates and Applied Policy's contribution toward them, our broker had to have seven individual conversations. This is because the cost of the plans varies widely between young and older subscribers, and results in a greater premium subsidy the older the employee is. We do not discuss the ages of our staff at work and I believe compensation should be tied to the work the employee does, not how old they are. However, the age-rating system forced us to tie compensation to age, at least for our health insurance benefits.

We realigned our plan options, taking advantage of some of the new wellness options, and continue to provide employees with access to a $0 premium plan, but I have changed my family vision and dental coverage to coverage just for my wife and I, since pediatric vision and dental coverage is now included in our health insurance plan. I have not been able to determine whether the 40 percent increase was the result of additional benefits being required by law, the new rating rules, an opportunistic rate hike by the insurer, or a combination of all three.

With that as background, I would like to answer the questions you provided to me before this roundtable:

What is the current status of the health insurance market for small businesses, specifically plan options and costs in the small group market?

The current status is uncertain. Small employers are receiving mixed messages regarding what a "good" employer should do. Am I expected to continue to make employer-sponsored coverage available to its employees, should I use the SHOP exchange to make coverage available to their employees, individuals should obtain their own coverage through the individual Exchanges, or should I be able to do whatever I feel is best for my business?

In addition, the changes in rates are unpredictable from year-to-year, and one major aspect of running a business is to have recurring expenses like health insurance premiums be predictable.

I get the feeling that the rules are being developed with the assumption that small businesses do not want to provide health insurance benefits to their employees or are aiming toward the minimum requirements.

What tools and options are available and useful for small employers to offer some assistance to their employees?

Our insurance broker has been an invaluable resource. In addition to helping us renew our plans and analyze options that offer us a robust provider network, a good benefit package and the best value in terms of premiums and cost-sharing, she helps us identify and comply with legal requirements like the section 125 plan, helps us welcome on-board new employees, and answers questions about providers, benefits and cost-sharing for my employees.

What has worked, what hasn't worked and what policy recommendations do you have for the committee?

I encourage the committee to recognize in its policymaking that small businesses are all different. Some want to provide health insurance to their employees that exceeds Federal standards and others will take a different approach.

My employees want access to providers, a good benefit package and fair premiums and cost-sharing. As an employer, I want to provide that to them. More could be done to help employers and employees compare the total costs of coverage rather than choose the lowest premium plan and be surprised by the high out-of-pocket expenses when they visit the doctor.

Please keep in mind that our employees want stable and predictable coverage so they can keep their doctor from year-to-year, become comfortable with benefits and the cost-sharing obligations, and have confidence that if they have to go to the hospital, their insurance coverage will help pay the costs. I want my employees to have that kind of coverage so that they can focus on work, get healthcare services when they need to, and not worry about their health insurance coverage.

Thank you again for the opportunity to participate in this roundtable. I would be happy to answer your questions.

Senator ENZI. Thank you.

Mr. Conklin.

STATEMENT OF J. KELLY CONKLIN, OWNER, FOLEY WAITE LLC, KENILWORTH, NJ

Mr. CONKLIN. Thank you, Senator Enzi, and I too appreciate the opportunity to be heard here today. I'm here representing not only my small business but my colleagues in the Main Street Alliance, both the national organization and the New Jersey organization.

Let me start by saying that I, with the utmost affirmation, support the Affordable Care Act. I do that because I think it provides fundamental cornerstones for establishing a fair and reasonable standard for healthcare insurance, and through that establishes the doorway for access to health insurance. Without those standards—and I'll probably reiterate this several times today—it's impossible to know, from the perspective of a small business owner, what you're buying.

I've said before that in order to make an informed choice in purchasing health insurance, you need to be an actuarial to understand what the real risks are. You need to be a doctor to understand what the formularies provide. It wouldn't be bad to be an attorney with a background in business contract law and, specifically, health. To top it off, it might not be a bad idea to be Nostradamus so you could predict the future and actually know what you needed to buy.

To imply that I, as a cabinet maker from New Jersey, can make an informed decision for myself and my employees about what health insurance is best for them is a stretch. Consequently, what it means to me is that—I'm lucky because I live in New Jersey and work in New Jersey, and we had protections built into New Jersey insurance law. Things like essential health benefits were established before the Affordable Care Act.

Our experience has been as the Affordable Care Act came into place, aside from the significant adjustment that occurred with age banding—and I have several older employees, and that was kind of a shock—we've experienced between 10 percent and 15 percent increases in our premiums. A reasonable person and I think a sound businessman would say, "Wow, that's significant," and I wouldn't argue with them. We've absorbed increases in the past of 38 percent and 40 percent.

One year when we tried to maintain our plan, we got a 138 percent increase from Aetna insurance. By the way, we're back on Aetna, and Aetna, this year, provided a plan—again, I can't speak specifically to the quality per se of the plan, but we were able to, with our insurance agent, buy a plan that was 2 percent less in premium costs and actually reduced deductibles by $500.

It came at a cost—$6,000 a year total exposure because of coinsurance for an individual and $12,000 a year as a potential exposure for families. That doesn't sound like a great plan to me if you're unlucky. It's the plan that we can afford, and it's the plan that provides a window or a doorway into care that might, as Senator Sanders enumerated earlier, avoid a catastrophic event for a family.

Having said that, I'm going to skip right to the bottom line and say that access to care, in my view and over my years of experience in purchasing healthcare and paying attention to this issue, is the key. We have to ask ourselves today and every day going forward what it is we're trying to accomplish. Are we actually trying to accomplish affordable, reliable, accessible healthcare for the American people? Or is there an alternative at work here, an alternative motivation that we don't understand?

Personally, I think at some point about 30 years ago, we made a decision to monetize healthcare. When we did that, we changed the entire relationship between doctors and patients, insurance companies, premium buyers, the whole deal, and we did it without really understanding long-term what the consequences are.

Now we know what the consequences are. The consequences are a very high cost for what is an inefficient—I won't even use the word, system—approach to delivering healthcare to the American people that results in poor quality outcomes and higher costs. Until we come up with a way—I don't know whether I agree with Senator Sanders entirely that it's a single payer system.

Until we all agree that every American should have a card in their pocketbook or wallet that gives them access to a physician when they need a physician wherever they need a physician, my employees and I are going to spend too much for healthcare.

[The prepared statement of Mr. Conklin follows:]

PREPARED STATEMENT OF J. KELLY CONKLIN

Chairman Enzi and Senator Sanders, thank you for the opportunity to participate in today's roundtable to discuss the experience of small business owners purchasing coverage in the small business health insurance market. My colleagues and I at the Main Street Alliance, a national network of small business owners, proudly supported the passage of the Affordable Care Act. Today, I am eager not only to discuss how the law currently works for small business owners, but also to discuss how the law should be developed to ensure that it works for all small business owners.

What is the current status of the health insurance market for small businesses; specifically plan options and costs in the small group market?

Let me start by reiterating that I am a strong supporter of the Affordable Care Act and believe that the ACA is an important and crucial step forward for millions of Americans in gaining access to affordable healthcare coverage. Today, I'm here to discuss the ways in which I believe that the ACA should be improved to strengthen the program for small business owners.

Small business owners' experience in the small business market varies from State to State. From our perspective as a New Jersey company, we purchase health insurance in the small group market as we always have, through an agent. There is little appreciable difference between now and before the ACA in terms of options. There are many plans available to choose from and there is the same confusing, arcane language in the policy documents and in how the various plans are presented. That makes meaningful comparison among the plans almost impossible beyond the most basic considerations: premium cost, co-pays, deductibles and maximum annual out-of-pocket costs. As a small company with tight margins the first consideration is always premium cost.

Premium Increases. Premium increases over the previous 2 renewals, 2013/2014 have been in the neighborhood of 10 to 15 percent. That said this year's is down about 2 percent and we reduced deductibles for the individual to 2,000 from 2,500. That did come with an annual increase in total maximum out-of-pocket from 5,000 to 6,000 per individual and 12,000 per family.

Age Banding. There was an initial "shock" when the new price schedules were implemented using age as the determinant factor of premium rates. In that initial adjustment we had the biggest rate increase in some time as a result of our older population of employees participating in our plan. As I recollect that was around 18 percent.

Weak Rate Review. New Jersey does not have a strong rate review process nor does the Federal exchange that serves New Jersey. It would help consumers like me if a strong rate review policy were set in place. Strong rate review has helped dampen down premium increases elsewhere. The ACA review process is weak. It only requires insurers to file rates if they exceed 10 percent and then it has no enforcement. A rate review where the exchange could deny rates before they are used would be much more useful.

Active Purchasing. Furthermore, the exchanges are not what we call "active purchasers." They do not negotiate price and quality on behalf of the consumers. All exchanges should be required to do this.

Premium Aggregation. Some exchanges around the country are abandoning premium aggregation. This is an important tool for small businesses because it permits us to send premium dollars to the exchange and they pay the insurers. This eases the administrative burden. It appears to be a technology problem in some exchanges and it needs resources to fix it.

Increase Competition. One other thing would help with cost—very robust competition. I talk to my fellow small business owners around the country and discover that many of the SHOP exchanges have very little competition. Insurance companies that offer in the individual market should be required to offer in the SHOP exchanges also.

What tools and options are available and useful for small employers to offer some assistance to their employees?

This is a difficult question to address. There is more information than ever available to anybody with enough time to investigate the available plans in their respective areas. In New Jersey with its high density, well-off population, the market is relatively rich affording options on the individual market that did not exist prior to the ACA through the exchange. Choosing a plan can be a daunting experience, filled with uncertainty and anxiety. Thankfully the comprehensive consumer protections I mentioned previously are in place to reduce the actual risk to individual consumers.

Tax Credits. It would help enormously if the small business tax credits were available to more small businesses. Currently only those with under 25 employees qualify. This should be expanded to at least 50. The salary limitations also should be increased. Small businesses want their employees insured and better credits would be a great help.

Cost of Older Dependents. We recently had our oldest employee move to Medicare. His younger wife could no longer be covered under our plan. In the exchange they were able to purchase a slightly higher quality plan, lower deductible, lower co-pays, for about $50 more per month than the coverage she had under our plan. Medicare with part D and the additional supplements making his coverage complete, saved us enough in premium cost to raise his compensation to cover his additional out-of-pocket expenses and his wife's coverage, while saving us about $200 per month.

What has worked, what hasn't worked, and what policy recommendations do you have for the committee?

From my perspective, the ACA has been an incredibly important program for individual consumers. It's time to take the next step and ensure that the ACA also works for small business owners and their employees.

In terms of next steps for improving the ACA, there are a number of things that might be done. Repeal is not one of them. Nor is a piece-by-piece alteration of the law that will have the same effect as repeal. Congress must act to restore faith that changes to the ACA come by way of improving access to care and by means resulting in affordable quality health care, not political victory laps.

Let's start with what is working. The consumer protection and community rating provisions of the ACA have been a success and must be preserved.

Consumer Protections. New Jersey's robust consumer protections prior to ACA, including EHB's and no exclusion for pre-existing conditions, made cost increases in our market tolerable. The uniform consumer protection standards contained in the ACA for health insurers, along the lines of New Jersey's, is a critical piece of the ACA that cannot be tampered with. No lifetime limits and no exclusions for pre-existing conditions are cornerstones of increased access and financial security and should not be altered as well. These features along with the MLR have had the expected effect of containing both premium increases and cost shifting by providers. This along with other features of the ACA is working to decelerate the rate of health care cost increases.

Community Rating. Another critically important piece of the ACA that must be preserved is Community Rating. Community rating is enormously important to small businesses. If a little business has a plan and an employee gets cancer or renal disease, we need to be protected from disaster. We also need to be protected from the simple process of aging. The community rating system should be improved by placing stricter limits on age banding.

Improvements to ACA. I also believe that there are some basic policy measures that would dramatically improve the ACA for small business owners.

Tax Credits. As mentioned previously, Congress should expand the tax credits available to small business owners so that businesses with larger workforces or higher paid workers have access to those incentives. Currently these incentives are only available to business owners who employ 25 or fewer employees. This should be expanded to at least 50 employees. The salary limitations should be increased. Small business owners want their employees covered and better tax credits would help.

Require SHOP Participation. Insurers who participate in the individual market in a given State should also be required to participate in the SHOP exchange in that State. This would ensure much needed competition in the exchanges.

Rate Review. Congress and the States should implement stronger rate review, including "prior approval" policies.

Technology. More investment should be directed toward technological improvement in the SHOP exchange market places. This should be done in a way that eases the administrative burden for participating small businesses.

Active Purchasing. Congress should require that the exchanges become active purchasers who negotiate rates and quality for their customers. This is an important bargaining measure that ensures better consumer costs.

Medicaid Expansion. I urge you to do everything in your power to foster the expansion of Medicaid. This program undergirds the market by assuring that cost shifting is reduced and many at-risk populations are covered. Our businesses draw their customers from the neighborhoods that surround them. If there are huge coverage gaps in those neighborhoods, we lose business. Not having Medicaid expanded is costing us all.

The ACA is the first major step toward providing universal access to health care, an as yet unmet goal of the reform effort. As long as access is determined by one's ability to pay, whether at the point of service or in the purchase of insurance, our health care costs will continue to climb while quality and availability of care continues to decline. Voluntary charity care remains an inadequate alternative to mainstream access and that shortfall continues to contribute substantially to cost shifting and deferred care, leading to expensive and poor outcomes. We can do better.

I don't live in a Magical Market Place where innovation and quality are always rewarded and fraud, abuse, incompetence and inefficiency are always weeded out. In the long run, the best way to ensure that the American healthcare system works for small businesses is to take the employer out of the health insurance provision business all together. Not by cutting people off, but by ensuring that everyone in America has access to quality care. Until every American has a card in their purse or wallet that guarantees access to a doctor—any doctor, anywhere, until emergency

rooms only serve emergency patients and not emergency patients and the uninsured, I and my employees will pay too much for too little.

Our goal must be a comprehensive, all-inclusive health care delivery system in the United States. We should get on with it.

Thank you, Chairman Enzi and Senator Sanders. It has been a pleasure speaking with you today.

Senator ENZI. Thank you.

Ms. Corlette.

STATEMENT OF SABRINA CORLETTE, J.D., SENIOR RESEARCH FELLOW AND PROJECT DIRECTOR, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Ms. CORLETTE. Thank you, Chairman Enzi. It's a real honor to be here today. I'm going to be very, very brief, because I think the questions that you provided us in advance are really just right to allow us to really dive into the details of this issue. I'll save the substance of my comments for those.

I would just like to say, I want to thank you for having this roundtable. I think the moment is a timely one. It may be hard for some of us to believe, but we're a little bit more than 5 years after enactment of the Affordable Care Act. It's a great moment to sort of pause and sort of do a temperature check to see where is the small group market.

We at the Center on Health Insurance Reforms have been doing some research looking at changes in the small group market in the wake of the Affordable Care Act, and the incentives for many small businesses have changed. I think policymakers and those that are concerned about employees and employers' ability to recruit and retain a healthy and productive workforce need to assess where we are and where we're going. I look forward to the discussion.

Thank you.

[The prepared statement of Ms. Corlette follows:]

PREPARED STATEMENT OF SABRINA CORLETTE, J.D.

Chairman Enzi, Ranking Member Sanders, thank you for the opportunity to participate in today's roundtable discussion of issues confronting the small business health insurance market. The three questions you've asked us to discuss today can help you and your colleagues hone in on policies to help support small businesses' efforts to recruit and retain healthy and productive workers at an affordable cost.

What is the current status of the health insurance market for small businesses, specifically plan options and costs in the small group market?

For a number of years now, employer-sponsored insurance has been eroding, and the decline has been more pronounced among small businesses. Small business owners have long struggled with high and often volatile premium costs relative to large businesses, a lack of market power when negotiating premiums, and high administrative costs associated with covering a small number of workers. In addition, minimum participation requirements used by insurers to safeguard against adverse selection used to mean that small employers often could offer only one plan and had to contribute a hefty portion of employees' premiums in order to encourage enough employees to enroll in the plan. These pressures have contributed to the steady decline in the number of small businesses offering coverage, from 44.5 percent in 2002 to 35.2 percent in 2012, leaving their employees disproportionately more likely to be uninsured compared to larger firms. Furthermore, even small business workers who were fortunate enough to receive insurance have historically had less generous coverage than their large business peers and have faced significantly higher deductibles and lower employer contributions for dependent coverage. Small employers have also been less likely to offer their employees a choice of insurers or plans.[1]

[1] Blavin F, Garret B, Blumberg L, Buettgens M. *Monitoring the Impact of the Affordable Care Act on Small Employers: Literature Review*, October 2014 (Washington, DC). Available at

The small group market provisions of the Patient Protection and Affordable Care Act (ACA) were designed with the goal of making it easier for small businesses to offer adequate and affordable coverage to their employees. Key pillars of the strategy included changes to insurance rules, which for example broadened risk pooling for small businesses and ensured that minimum participation requirements do not have to be a barrier to small firms offering coverage to their workers. In addition, the new "SHOP" marketplaces offer small businesses a range of group health plans, including the ability for employees to choose their own plan.

What tools and options are available and useful for small employers to offer some assistance to their employees?

In many ways, small employers have some of the most coverage options of any other group, and their options have expanded under the ACA. They can choose to offer coverage or not, without facing a penalty. They can choose whether or not to enroll in the SHOP, in a private exchange, or directly with an insurer. They can also decide whether to offer their employees a choice of plans, and, through the SHOP or a private exchange, set a defined contribution level.

The ACA created new options and insurance standards in order to address some of the most glaring problems with small business coverage, including unpredictable premium increases because of changes in an employer group's health status, limited benefits, pre-existing condition benefit exclusions, and high out-of-pocket costs. Consistent with the changes effected for the individual market, the small group insurance reforms thus included new rating rules prohibiting variation in premiums based on health status, required minimum essential health benefits and first-dollar coverage of approved preventive services, ended limits or exclusions from plan benefits based on pre-existing conditions, and capped enrollees' annual out-of-pocket liability.

In addition, insurers offering products in the small group market are now required to set rates using a single statewide risk pool that includes both healthy and sick enrollees across all of their small group plans in the State. Small employers can also avoid having to meet minimum participation and contribution thresholds if they obtain coverage during an open enrollment period running from November to December each year.

NEW OPTIONS FOR SMALL EMPLOYERS

SHOP marketplaces and tax credits

The ACA created the Small Business Health Options Program (SHOP) to provide new, State-based exchanges, or marketplaces, where small businesses can more easily shop for health insurance.[2] Responding to small business owners' concerns about their inability to give employees a choice of health plans,[3] SHOPs are designed to provide an "employee choice" option. As envisioned, instead of having to make a "one-size-fits-all" plan decision for their employees, the employer sets its contribution level and lets each employee choose the plan that best suits his or her needs.

With few exceptions, the SHOPs have been slow to get off the ground and enrollment has been low.[4] During the first year of operation, only a minority of States had the technical capability to offer on-line enrollment, and fewer still prioritized the SHOP in their marketing and outreach campaigns.[5] In addition, mandatory implementation of employee choice was delayed in both 2014 and 2015, resulting in uneven rollout of this option across States. This year, 32 States are providing some form of employee choice; the feature is expected to be available nationwide in 2016.[6]

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http://www.urban.org/UploadedPDF/413273-Monitoring-the-Impact-of-the-Affordable-Care-Act-on-Employers.pdf. (Derived from Medical Expenditure Panel Survey—Insurance Component (MEPS–IC) summary tables, AHRQ 2002–12).

[2] 42 U.S.C. § 18031(b)(1)(B) (2010).

[3] Kingsdale J, *How Small-Business Health Exchanges Can Offer Value to Their Future Customers—And Why They Must*. Health Aff (Millwood). 2012;31(2):275–83.

[4] U.S. Government Accountability Office, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, Nov. 2014 (Washington, DC). Available at *http://www.gao.gov/assets/670/666873.pdf*.

[5] Blumberg LJ, Rifkin S, *Early 2014 Stakeholder Experiences with Small-Business Marketplaces in Eight States*, August 2014 (Washington, DC). Available at *http://www.urban.org/UploadedPDF/413204-Early–2014-Stakeholder-Experiences-with-Small-Business-Marketplaces-in-Eight-States.pdf*.

[6] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Small Business Health Options Program (SHOP) (Washington, DC). Available at *http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html* (accessed February 12, 2015); *see also* Dash SJ, Lucia

Continued

A growing number of private exchanges offer another entrée into the market, generally allowing one-stop shopping, defined contributions and employee choice, much like the SHOPs.[7] These exchanges may be run by insurance carriers, insurance brokers, or in some cases by employee benefit firms.

The ACA also included small business premium tax credits to help make insurance more affordable for some very small employers with moderate-income workers. These tax credits are available only to businesses that enroll through the SHOP, and only through 2016. To date, few small businesses have made use of these credits, likely due to the narrow and complex eligibility requirements and relatively low credit amounts.

Non-compliant plans

Under the ACA reforms, many small employers—and their employees—will benefit from the new rating and benefit standards and cost-sharing protections. Others, particularly those with younger and healthier workers, may face premium increases as they are brought into a single risk pool that includes older and sicker workers. Several alternative coverage options currently enable such employers to circumvent the single risk pool, leaving the higher risk people who remain in the pool to face higher premiums than would otherwise have been the case and threatening the long-term viability of the small group market.

Many small group plans are exempt from the ACA market reforms. Some are considered "grandfathered" because they were in existence before the law was passed in 2010 and have not made significant changes to benefits.[8] Over time, the importance of grandfathered plans is expected to diminish as benefits and cost-sharing are inevitably updated. Other small group plans were granted a reprieve under a transitional rule that allows small employers and individuals to remain on the health plans in which they were enrolled before the ACA reforms went into effect in 2014[9]—the so-called "grandmothered" or transitional plans. Not all States implemented these transitional rules, and some required small employers to transition to ACA-compliant plans in 2014.[10] While comprehensive data on how many small employers have remained on their pre-ACA plans are lacking, anecdotal evidence suggests a good many did.[11] In most States, these employers will be permitted to hang onto their old plans until October 1, 2016 (for coverage extending into 2017).[12] If, as expected, it is mainly employers with younger, healthier workers that are remaining in transitional plans, the risk pool for ACA-compliant small group plans and the SHOP exchanges is likely less healthy than it otherwise would have been, putting upward pressure on premiums for employers on these plans in the short term. However, as healthy groups transition off their pre-ACA plans, the overall risk profile of the small group market should stabilize.

Self-funding

Small employers with healthy groups may also find it tempting to self-fund coverage, meaning that they bear the risk of employees' medical claims. As with the non-compliant plans, such a move exempts them from many of the ACA's rating and benefit reforms and could help lower their costs, at least initially. However, self-funding can also pose significant financial risks for employers and is usually accom-

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KW, and Thomas A, *Implementing the Affordable Care Act: State Action to Establish SHOP* Marketplaces, March 2014 (Washington, DC). Available at *http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/mar/1735__dash__implementing__aca__state__action__shop__marketplaces__rb.pdf*.

[7] Alvarado A, Rae M, Claxton C, Levitt L, *Examining Private Exchange in the Employer-Sponsored Insurance Market*, Sept. 2013, Kaiser Family Foundation (Menlo Park, CA). Available at *http://kff.org/private-insurance/report/examining-private-exchanges-in-the-employer-sponsored-insurance-market/*.

[8] 5 C.F.R. § 147.140 (2015).

[9] U.S. Department of Health & Human Services, *Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016*. Center for Consumer Information & Insurance Oversight, Mar. 5, 2014. (Washington DC). Available at *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies–03–06–2015.pdf*.

[10] Lucia KW, Corlette S. *Update: State Decisions on the Health Insurance Policy Cancellations Fix*, Jan. 8, 2015, The Commonwealth Fund Blog (New York, NY). Available at *http://www.commonwealthfund.org/publications/blog/2013/nov/state-decisions-on-policy-cancellations-fix*.

[11] U.S. Government Accountability Office, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, Nov. 2014 (Washington, DC). Available at *http://www.gao.gov/assets/670/666873.pdf*.

[12] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016 (Washington, DC). Available at *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies–03–06–2015.pdf*.

panied by a reinsurance or stop-loss policy to cover unexpectedly large claims. Increasingly, these stop-loss policies are incorporating very low thresholds (or attachment points) above which claims are covered; self-funding employers purchasing these policies can mimic traditional health insurance while avoiding health insurance regulations. Researchers have projected that use of such low-risk stop-loss policies can lead to large premium increases for employers remaining in the regulated small group market,[13] undermining stability. A few States have moved forward to protect their small group market from the risks of self-funding, primarily through the regulation of very low-attachment point stop-loss coverage.

At this time, there is limited evidence that small employers are transitioning to self-funding in significant numbers.[14] However, employers moving off of transitional plans over the next couple of years may have greater incentives to self-fund. In addition, when the ACA's small group market reforms are extended to employer groups with 51–100 employees, more mid-sized employers may look to self-funding as an option.

Discontinue offering coverage

Small employers are not subject to the ACA's employer mandate and some, particularly those of very small size (less than 10) or with low-income employees, might find it advantageous to drop coverage (perhaps raising wages to compensate) and encourage workers to seek premium subsidies and enroll in a plan through the individual health insurance marketplaces. Evidence of this is anecdotal at this point, and reductions in offer rates appear to be modest so far.[15] While a shift out of employer-sponsored coverage reduces employers' health-related costs, workers lose the benefit of pre-tax contributions to their premiums and would have to pay taxes on any higher wages. For lower income workers however, many may benefit from Federal premium and cost-sharing subsidies.

What has worked, what hasn't worked, and what policy recommendations do you have for the committee?

WHAT'S WORKING

All employers, including small employers, are benefiting from the unprecedented slowdown in health care cost growth. Since the ACA was passed, we have seen the slowest growth in health care prices in 50 years. And the three slowest years of growth in real per capita national health expenditures on record were 2011, 2012, and 2013. In employer-based coverage, the average annual family premium was approximately $1,800 lower in 2014 than it would have been if premium growth since 2010 had matched the 2000–10 average rate of growth.[16]

Employers—and their employees—are also benefiting from the ACA's prohibition on discrimination due to pre-existing conditions. No longer can an insurer refuse to cover the care for a new employee because he or she had a medical condition before being hired. Nor can those small employers with a higher proportion of older workers or women be charged a higher premium than competitors with a younger or predominantly male workforce. And small employers no longer have to worry that an employee with cancer, or a difficult pregnancy, will cause their premiums to spike.

For those many small employers who have not been able to offer their workers coverage, they now know there is a viable, high quality alternative coverage option for their employees. Whether through the ACA's health insurance marketplaces or in States adopting the Medicaid expansion, many lower-wage employees may be able to find affordable coverage for themselves and their dependents for the first time. Even when they cannot afford to offer coverage to their workers, small business employers know that health coverage is critical to maintaining a healthy and productive workforce.

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[13] Buettgens M and Blumberg LJ, *Small Firm Self-Insurance Under the Affordable Care Act*, November 2012 (Washington, DC). Available at *http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2012/nov/1647__buettgens__small__firm__self__insurance__under__aca__ib.pdf*.

[14] Kaiser Family Foundation and Health Research & Educational Trust, 2014 Employer Health Benefits Annual Survey, September 2014. (Menlo Park, CA). *http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report*.

[15] Blavin F, Shartzer A, Long SK, Holahan J, *Employer-sponsored Insurance Continues to Remain Stable under the ACA: Findings from June 2013 through March 2015*, June 2015 (Washington, DC). Available at *http://hrms.urban.org/briefs/Employer-Sponsored-Insurance-Continues-to-Remain-Stable-under-the-ACA.html*.

[16] Furman J, *The Economic Benefits of the Affordable Care Act*, White House Council of Economic Advisors Blog, April 2, 2015 (Washington, DC). Available from: *https://www.whitehouse.gov/blog/2015/04/02/economic-benefits-affordable-care-act*.

What is not working

Without question, the SHOP exchanges have been slow to get off the ground. At this time, they are not able to provide a sufficient "value add" to convince small employers—and (more importantly) their brokers—that a move to a SHOP exchange is worthwhile. Premiums for the same plans inside and outside the SHOP are required under the ACA to be the same, and as noted previously, the small business tax credits are narrowly drawn and difficult to apply for. As a result, the SHOP has not been able to offer small businesses a price advantage. Perhaps even more challenging, the commissions for brokers inside and outside the SHOP are the same, yet enrolling a business in the SHOP currently takes more time than direct enrolling them with an insurer. As a result, brokers have no financial incentive to propose SHOP as an option to their clients.

Policy recommendations

1. Discourage self-funding among employers with fewer than 50 employees. Allowing healthy and younger small groups to self-fund will cause adverse selection and premium increases for those employers in the regulated small group market. Yet insurers are increasingly using low-attachment point stop-loss packages to entice smaller and smaller groups to self-fund (knowing they can dump them back into the small group market if their risk deteriorates). Such products make a farce out of the term "self-funded." When a product looks, acts and breathes like health insurance, it should be regulated as such. Congress should define "self-funding" to exclude these low-attachment point products.

2. Encourage the administration to delay implementation of the ACA's requirement that employer groups of 51–100 become part of the small group market, and commission a study of the potential benefits and risks of such a change. While some employer groups will undoubtedly benefit from the small group market insurance reforms, the most immediate concern is that premiums for younger, healthier groups of this size could face a significant premium increase. Over the longer term, some of these mid-sized groups could face a greater incentive to self-fund, leaving sicker, older groups in the traditionally regulated small group market. At a minimum, policymakers need better data about the impact of this policy change.

Thank you Mr. Chairman, Senator Sanders and members of the subcommittee for the opportunity to join this discussion today.

Senator ENZI. You were really brief.

Ms. CORLETTE. I told you I'd be brief.

Senator ENZI. Did you want to make any comments at this point?

Senator MURPHY. No, I don't. I'm good.

Senator ENZI. OK. I appreciate all those comments. You've given me a lot to think about already. I would mention that Senator Sanders was referring to the World War II effort that changed healthcare. All salaries were set during World War II. Nobody could increase salaries.

There was a little area there where they could provide a little different benefit for their employees, and that was in healthcare. There were no limits on that. At that point, the companies could provide healthcare and give credit for that and attract the employees that they wanted to attract.

Later, we decided that was such a good idea that we'd make it tax deductible for the companies. That changed the face of healthcare at that point. For small businesses, I wish that healthcare were the only regulation that they had to handle. Several of you have mentioned the different talents that a person has to have as a small businessman, and there are continually more things that they have to worry about.

On the issue of having single-pay, government-run healthcare, that had a lot more favorability before we ran into the little Veterans Administration problem that we had a little over a year ago, and we still haven't worked through that one.

Of course, our goal would be to have portability that Senator Sanders mentioned so that nobody is locked into a business. I think if they're working for a major corporation that pays for their insurance, they're still kind of locked into that because there isn't probably a better offer out there anywhere. The benefits are still eliminating some of the flexibility that an employee might be able to have.

As a few things of clarification that I'd like to do here to start with, Mr. Harte, you mentioned the 46 percent difference in costs. Are you referring to a need maybe to have costs at different medical facilities posted so that we could see if they change it? Could you expand on that?

Mr. HARTE. Yes. The reference I gave to you earlier—you can refer to the website of *nhhealthcost.org*, and on that website in the State of New Hampshire, it will publish the different reimbursements to each provider based upon certain categories of service. In my testimony, I shared with you that from the least expensive facility to the most expensive facility, for a CT scan of your head, the cost differential is 446 percent.

Senator Sanders' comments earlier were he was referencing a high deductible plan. Those people who are on a high deductible plan—it does them so much justice to make sure they have access to that information. The fact is that information has very little access today.

The health insurance companies have that information. They know how much their providers are charging. We need to, as an industry, make sure that that information becomes available to individuals.

In New Hampshire, we have access to that information on all forms of diagnostic imaging, MRIs, CT scans, PET scans, normal childbirth, cesarean childbirth, x-rays, labs—the list goes on. However, my colleagues all across the country are envious of New Hampshire, that we have access to some information. The fact is we can make a huge difference in the cost of healthcare if we simply made healthcare costs more transparent.

Senator ENZI. Thank you. That's been a suggestion that we've had from different places, and some companies have done that, where they provide the amount of deductible based on whether people pick the average or above or below average.

Mr. HARTE. Exactly.

Senator ENZI. If they go below average, I guess they get the extra money. That is one of the suggestions, to have more prices posted.

Mr. Scott, you mentioned the separate meetings because of age. Could you expand on that a little bit more?

Mr. SCOTT. Yes, Mr. Chairman. The employees in our office range from in their 20s to in their 50s. That the premiums are age rated, we had to make a decision, because when we were group rated, it was basically $300 a person, and the health insurance options cost the same if they picked the low, medium, or high option.

I could tell everybody,

> "You have $300. Shop for a plan, and that amount pays the full cost of the HMO option. If you want more than that, we'll withhold the additional from your check and you can get a more expensive plan option."

The plans are a different price for every individual. On the low end, the premiums are still about $300. On the upper end, they're closer to $500, and I think maybe even a little bit more for the subsidy amount.

In order to keep my promise to the employees that they'll have access to a zero premium plan, now I need to give them all a different subsidy to start with so they can actually have access to a zero premium plan. That's what we did.

Senator ENZI. Thank you.

Mr. Conklin, you mentioned monetized insurance. Could you give a little broader explanation of that?

Mr. CONKLIN. Well, actually, Mr. Chairman, I think I said monetized healthcare.

Senator ENZI. Oh, OK.

Mr. CONKLIN. What I mean by that is we turned the relationship, the basic relationship between a physician and their patient, into a transaction. We all know the stories—or perhaps some of us are too young to know the stories—about the Depression, when people would walk in with a chicken or perhaps in my case a small cabinet or a chair, and the doctor would take care of us because we didn't have money.

That idea, that concept of "first do no harm" has been, in my opinion, badly dented by the relationship that has to do with who gets paid and how they get paid and all the middle men in between.

I'd like to just speak briefly for a moment to your earlier question about costs and posting costs. Two brief anecdotes: This winter, I was walking my dog and slipped and fell, hit my head pretty hard on the sidewalk, went home, reported to my wife that I was feeling a little dizzy and I had tingling in my hands but I was going to go to work, and she said, "No, you're going to go to the hospital."

I went to the nearest hospital. The likelihood that I was actually going to check the price posting on my way in the door to see a physician is pretty low. About 2 weeks ago, my daughter called me at 1 o'clock in the morning to report that she was on her way to the hospital—she had been hit by a car in Boston—and did she have insurance, which is how I knew she was concussed. Again, she was in no condition to make a shopping expedition at the emergency room.

Those are, I admit, fairly extreme examples. They go to an underlying reality of the whole approach we have to providing care, that it's based on one's ability to pay, and one has the capacity in any given situation to make a decision based on what makes the most economic sense.

What we really should be doing, in my opinion, is we should be focusing on what makes the most medical sense. If we did that, if we did a better job of that, I think we would have lower costs of delivery of service at the point of service.

Senator ENZI. I appreciate that, and I think Mr. Harte was talking about the things that you have a little bit more pre-planning on than your concussion or her car wreck. One of the things that we're finding right now is that some people go in for the prevention, which is supposed to be free, and if they find anything at all,

then it's not free. That's a little bit of a surprise to them, and that ought to be posted a little bit better, I think, for all concerned.

Ms. Corlette, in your testimony, you talked a lot about the shop exchanges and had some suggestions about what could be done. Could you expand on that a little bit more?

Ms. CORLETTE. Sure, Chairman. We are, I guess, about 18 months into the launch of the shop exchanges. In concept, the shop could be a terrific option for small employers. It tries to address a couple of the primary concerns and frustrations that small employers have had in the past.

For example, many small employers are not able to offer their employees a choice of insurers or a choice of plans. The shop was designed to provide a marketplace for small employers to go to say to their employees, "This is my contribution. You can take this contribution and shop among different plan choices." It's a very appealing idea.

The other issue that I think the shop was designed to address is employers' desire for some predictability around the premium contribution. It allows employers to make what's called a defined contribution to their employees' premiums, which, hopefully, will give them some predictability in what they can contribute.

I think there's a couple of reasons why the shops have been slow to get off the ground. No. 1, the IT systems. Just as with the launch of the individual marketplace last year, the IT systems for the shops have been—it might be kind to say nonfunctional in many States. That's a barrier.

The other issue—and I'll be interested in Mr. Harte's perspective on this as well. Most small employers purchase their health coverage through a broker. What we have heard from most brokers is that the time and effort it takes to enroll somebody through a shop—it's just not worth it to them, because the commission that they get is the same whether they buy direct from a carrier or through the shop, and because the shop is taking a considerable amount of time and effort on the part of the broker, it's just not profitable for them.

Then last, but not least, the tax credits. The Affordable Care Act created a small business tax credit for employers with fewer than 25 employees with average salaries of under $50,000. From what we are hearing in talking to both brokers and small employers is that the tax credit that they get is just not worth the time and effort it takes to apply for it, and it's just not a sufficient incentive for employers to try to enroll through the shop.

I think the jury is still out. I think we want to see if they can get their IT systems smoothed out and make it a much quicker and smoother process and get employee choice rolled out in every State. It's not rolled out in every State yet. I think maybe if we could make the tax credit easier to apply for and get, that might make it a more appealing option for employers.

The other thing is, frankly, there are a lot of private exchanges that are now being established to directly compete with the shop in offering many of the same benefits. If we're going to fix the shops, we have to do it quickly, because the private market is also recognizing that there's a need that needs to be filled.

Senator ENZI. Thank you.

Mr. Harte, did you want to comment on that?

Mr. HARTE. Oh, I'd love to. Thank you. Her comments are spot on. The shop, by intent, is an incredible opportunity for small business, an incredible opportunity. It is a dismal failure, and I'm going to explain to you why.

We do try to enroll small groups onto the shop. Here's what happens. No. 1, the maximum waiting period on there is 60 days, which completely contradicts the Affordable Care Act, whereas the Affordable Care Act says it's 90 days.

The reason why that is is because it's a backstop, because if an individual is hired on a given date in the month, they don't receive their correspondence from the shop until their last day of eligibility. Based upon that last day of eligibility, that person only has 2 days to enroll, because they only enroll on the 1st or the 15th. They must process before the 1st or the 15th. They have to wait an entire other month to get their health insurance.

Myself and my own small business—if I am on the shop, and I tell my employee, "You're going to be on the health insurance plan on August 1st," and if they don't respond within the 2-day period to enroll in the plan and select their plan, they're going to get on the plan September 1, and that becomes my burden. That's No. 1.

No. 2, lockouts. If in the event that your employer submits your information for your census and says, "My date of birth is 12-5-66," and if in the event that my employer put in 12-5-65, if I go in to change my date of birth, the system locks you out, and you cannot proceed any further. You cannot enroll for health insurance.

The testimony you've heard today talks about the brokers. We try to call the shop. My staff members call the shop, and they'll be on the phone for an hour to 2 hours waiting for someone to pick up the phone to unlock it. There's no mechanism in place to unlock their enrollment.

By the way, thanks for backing me up about the emergency and urgent care, because I have three kids myself, and I'd never pick up an app to shop for my emergency care.

The fact is our access to healthcare is my priority to my clients. The shops, their networks, are bifurcated. In my State, we have five different plans. We have 26 hospitals. Some of the plans have only half the hospitals in the network. When you enroll in the shop, there's a good chance you might actually lose your physician.

One other comment I wanted to make for you is about the tax credits—100 percent. We run the analytics. We try to see if someone qualifies for the tax credits. I don't have any clients who have been approved for the tax credits.

If you would indulge me for just one moment—because Mr. Scott referred to this list billing issue that we have out there—I really want to give you some real numbers so you can take these back to the other members of the committee.

I brought one example with me, a client called River Valley Development. It's a small business with less than 10 employees. Their single rate for a 21-year-old annually is $4,500. For the 64-year-old, it's $13,000.

Senator ENZI. Say both of those again, would you?

Mr. HARTE. The single rate for a 21-year-old is $4,579. The same plan for a 64-year-old is $13,725. That total difference on an

annualized basis is $9,146. To Mr. Scott's point—and although he didn't say this—this is the struggle with employers all over the country. They're saying,

> "I want to hire an experienced employee who understands my business, who understands healthcare policy, who wants to make a difference in their client's lives."

The economic decision, as Mr. Scott said, is "Do I really want to pay them an extra $9,000 off of my books?"

In essence, the way we look at this in a grid format, every single employee, regardless of age, all the way from 21 to age 64, has their own rate. Each of their dependents, their spouse, has another rate. Each of their children has another rate. You can have some families who are in your employ who pay $20,000 a year, and you can have other families who pay $30,000 a year because they have an older spouse or more kids.

This all comes down to—and I know you have this question coming up, Mr. Chairman. When it gets to the 51 to 100, imagine the nightmare when we roll out 51 to 100, putting them into the small group marketplace, and, using an employer with 75 employees, having 75 different rates, and an individual rate for every single one of your dependents. It's a nightmare to manage for small business. It'll be more of a nightmare for businesses with 50 to 100.

Ms. CORLETTE. I do, though, want to clarify that age rating is nothing new in the small group market. The Affordable Care Act simply compressed the age rating band to three to one. What is new is that the differences from employee to employee are now transparent to the employer where, before, they were aggregated. Is that correct?

Mr. HARTE. Yes, correct. However, the big difference is—and, Mr. Scott, you may have had this in your own business, and you can share this if this is the case. We always had what we call composite rates. If we had a group that had 10 employees, even my own company—I have 17 employees—even though I was individually—my rates were individually created by an underwriter, I would still have a single, a two-person employee-child, and a family rate. If you move 51 to 100 over to a list bill system, it'll be an administrative nightmare.

Mr. SCOTT. Right. That's why I referred to the change as sort of the member level billing, because these rates were always going on in the background, but I didn't have to divide it up for each employee to tell them, "OK, well, you're older so you cost more so I'm giving you more money so that you can have access to a zero premium plan." It was a big change, and it was disruptive and not helpful.

Senator ENZI. Mr. Conklin, I think you wanted to comment?

Mr. CONKLIN. I do. I concur that the—like I said, the age band rating was a shock, but only because it exposed how our rates were structured previously and more opaquely. The bottom line is my premium did not increase significantly as a result. Our cohort remained fairly constant. We did hire a younger guy. His premiums were around $300 a month, and my oldest employee's premium is about $725 a month for a single person.

Yes, I can imagine with little difficulty how ridiculous it would be to expand to the 50 to 100 or even from the 25 to 50 and keep

that format in place. It seems to me—and I'm a cabinet maker from New Jersey. I work from plans. When we get a plan that doesn't work, we change it, we alter it, we redraw it so that it does work. Believe me, we've had plenty of drawings from architects and designers that don't work, and that's part of our job.

These guys' hands are tied. My hands are tied. You folks can help untie them. I want to reiterate that that can't come at the cost of the fundamental building blocks of the Affordable Care Act that are in place that do work.

I think there are pieces here that would allow us, over time and with careful adjustment, to do all kinds of imaginative things to broaden the small group market, to increase access, to allow us to aggregate, to do all kinds of interesting things. Those fundamental underpinning consumer protections that are built into the act must remain in place. They can't be compromised.

I'm sitting here deathly afraid, frankly, Senator, that Congress will get their hands on this and just rip it to pieces. That's not something that I could tolerate. I can tolerate a 10 percent increase in our premiums, but going all the way back to square one and starting over again is just unimaginable to me at this point.

Senator ENZI. Of course, I remember Senator Sanders' comment that there are 35 million people who are still uninsured. When we were doing the discussion on the Affordable Care Act, there were 49 million uninsured. What we've done is shifted who is uninsured. We haven't gotten the job done, and we're actually kind of having our hands tied on being able to make any changes.

There's been a number of changes that have been suggested, and, hopefully, out of this exercise that we're having this morning, we'll be able to come up with some ways that small business can be helped through the process, because I think the reason we're holding this hearing is I think they're the main ones that are having difficulties with it. Part of it is because they're small and they don't have all the expertise that the big companies have. How do we fix it so that their expertise can lend itself to getting the insurance for their employees?

Almost all of them that I know are interested in having healthcare for their employees and themselves. They kind of have to include all of them in the family that way.

Were you going to make a comment, Senator Murphy?

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Yes, if I could just jump on board here.

Senator ENZI. Sure. Go ahead.

Senator MURPHY. Let me very briefly just insert a couple of thoughts on this running dialog about how much we can ultimately rely on consumers to reset these marketplaces. I agree with the comments about the moments of interaction with the healthcare system that are most appropriate to make informed decisions. That's an important caveat.

There's also all of this literature around the inequity of knowledge that exists in the healthcare system that makes consumer-oriented marketplace decisions difficult when you've got such a different amount of knowledge in the hands of the person who is providing the service versus the person who is buying the service. It

makes market-based decisionmaking difficult when there's that much of a gap. Count me as amongst the skeptics that that ultimately is how you continue to bend the cost curve.

I wanted to stay on this topic of the change going from 1 to 50 to 100, because there seems to be unanimity of opinion that there's danger lurking here and that we should be counseling for at least a postponement of that decision.

I maybe wanted to see if, Ms. Corlette, you would help us understand the pitfalls of not moving forward. You say that we should take the time to weigh the costs and the benefits, and I've heard pretty clearly what the costs potentially are. Why should we be careful about just walking away completely from stretching all the way out to 100 in terms of what we consider for a small group rating?

Ms. CORLETTE. Sure. Thank you, Senator, for the question. I should say just for the record—and it's in my statement—I'm an advocate for delaying the change in definition from 51 to 100 in terms of defining a small group market, largely because I just don't think we really know what the consequences of that change will be, and it could cause some market disruption.

The benefits, I think, are fairly straightforward. Essentially, what it does is extend the small group market protections that are included in the Affordable Care Act to these mid-sized groups, so 51 to 100. For example, the requirement to offer an essential health benefits package of the 10 prescribed categories in the statute—that will be required of groups 51 to 100.

Another example is health status. Gender rating will be prohibited as well as the age bands will be tightened down to 3 to 1. 0n the plus side, for employers that have older workers or sicker workers or a predominately female workforce, they could see some improvement in their rates, and some employees who may not have had the full breadth of benefits that are currently required in the small group market could benefit from that as well.

The bottom line for me, however, is I don't think we understand this market well enough to really know who's going to benefit, but also on the flip side, who's going to suffer. There will be some groups that will see some premium increases that they may not face if we kept the markets the same. Some of those groups could be faced with incentives to self-fund their coverage, which will take them out of the regulated market entirely, and that poses a whole new set of risks.

For those reasons, I would say if this provision is implemented, proceed with caution.

Senator MURPHY. I'll ask this of Mr. Harte. I would appreciate your comment on this risk toward more people self funding. I'm sorry that I missed some of the testimony. You may have already covered this. Are you seeing clients showing an interest already in moving toward self funding? I assume that if we do make this change come January 1st, you'll have more and more companies interested in taking the risk upon themselves.

Mr. HARTE. Yes, 100 percent, and it will be disastrous, and I'll explain to you why. First of all, I support my own Senator, Senator Shaheen's bill, Senate bill 1099—she has bipartisan support with Senator Scott—which will allow individual States to define where

those 51 to 100 eligible employees will fall. I fully support that. As well, the NAIC, the National Association of Insurance Commissioners, has issued their support for that.

That being said, this is what the real world will look like. If I have an employer today that is a 51 to 100 life group, and they have favorable claims experience, favorable meaning there's less than 70 percent—some of those employers might be 30 percent or 40 percent. Well, if in the event they are in a fully insured market today, they're receiving a benefit for having lower claims utilization, but also protected on the back end should they have a shock loss.

I can guarantee you that that healthy group will leave the small group marketplace at this transition. Why is that so important? Well, that's just one group. If you take all of the healthy groups that have favorable risks that are losing the ability to be rated based upon their claims experience, they're going after, as Mr. Scott said, the economic viability of their own company.

They're going to say,

> "I can save money by avoiding the essential health benefits, by avoiding the nightmares of the 3 to 1 ratio, which will lead to list billing. I will lose my discounts. I will lose my plan,"

because if you move over to small group, you're not going to have the same plan that you had as a large group. The consequences for those businesses, 51 to 100, will simply be disastrous. I wish there was a better way to put it.

Senator MURPHY. There's still significant risk. Any time you're choosing to self insure——

Mr. HARTE. Absolutely.

Senator MURPHY. That will mitigate those decisions to an extent. It will depend on how risk averse you are.

Mr. HARTE. You're absolutely correct. You're talking my language. I've been doing this for 25 years, and that's what insurance is all about. It's the risk against the peril. Oliver Wyman came out with a report, and they said 64 percent of the groups that are in that marketplace of 51 to 100 will be faced with rate increases, on average, of 18 percent simply for the migration over to small group.

Those companies that already have favorable risk and want to keep their plan, they are more than willing, as they have told me—my clients have told me—we insure some 300 corporations that are small businesses. They've told me that they will be migrating to the self-funded marketplace.

Senator MURPHY. Thank you. I have to run to another committee meeting, but thank you for holding this. This has been really fascinating.

Senator ENZI. Thank you for your questions, and, of course, if you or your staff have more, we can get some written responses, too.

Many of the people on the committee are involved in the education debate that started this afternoon, about 30 minutes after we started. No Child Left Behind has been out of authorization now for about 8 years, and it came out of committee unanimously to make some changes, and those are the changes that are being debated on the floor right now. There'll be some additional amendments.

There were a lot of amendments in committee. There'll be more on the floor, I'm sure. There's intense interest from this committee, which is in charge of that, for doing that.

We haven't lost sight of the need to make sure that insurance works, and times change, and some of the new regulations come into play, and we want to make sure that we're adjusting to those.

I want to ask, particularly, Mr. Scott and Mr. Conklin, what kind of flexibility you'd like to see for yourself in the way of possible changes, things that would be beneficial to you. I know in your testimony you mentioned some things that ought to be changed.

Mr. SCOTT. Thank you, Mr. Chairman. First of all, I think one of the recognitions in making broad national policy is to recognize the diversity of U.S. business, and that when you open a small business, it's very personal, and after you go from being a solo practitioner to going to, say, "Well, I'm going to start to hire additional employees," you realize that they're not only depending on you, but their families are depending on you as well. It's very personal in the way that you run that business.

There are a lot of small businesses that value providing high-quality health insurance to their employees. If a business across the street were to open up and do the same kind of business as ours and not offer health insurance, we'd want to be able to leverage that as a competitive advantage of why work for us.

We want a range of options. We also want access to good networks of physicians. We want access to care when we need it. I don't want my employees afraid to go to the doctor because they don't know how they're going to pay for it. I want them to go to the doctor when they should and need to. I want to provide that environment so our employees can focus on work and that Applied Policy is a good place for them to come work.

Senator ENZI. Mr. Conklin, do you suggest any changes for kinds of flexibility or changes at all?

Mr. CONKLIN. Yes. Well, for us, personally, again, because of our location in New Jersey and the availability in a dense market with relatively high income availability, insurance companies are working pretty hard to get everyone's business. There are innumerable options. My broker comes in with a stack of spreadsheets about that thick to run through with me.

Unfortunately, when I get the policy and start looking through it, that's where the arcane and confusing language comes in. Very often, I don't fully appreciate—that hit on the head, for example. That was billed out by the hospital at $12,000. The insurance company paid $4,800, and I was on the hook for somewhere between $700 or $800.

I called my broker and I said, "Is this legit?" He called me back and he said,

> "Yes, this is completely above board. These costs that you're paying here are part of your co-insurance, and there's a formula to determine what your share of the final bill is."

We start out with $12,000, get $4,800, we're up to $5,200. It's a complete mystery as to how anybody arrives at any of this, and when I spoke to my broker, he said, "Oh, yes, it's a complete mystery to me. I can't explain it to you." If we want to have a real conversation about what would be helpful, real transparency would be

helpful, for me to be able to understand in plain language, really, what's going on.

At the bottom of all of this, I think we need to maintain—I keep saying this, but I absolutely believe it. We need to maintain robust consumer protections. We need to have real oversight of the insurance industry, and I have absolute respect for both of my colleagues on the panel today, and I know from my own insurance agent—he's a small businessman, too, and I'm not looking to kill the for-profit insurance industry or harm their businesses.

We do need that oversight, and we also need to put some time and money into figuring out how it is this actually works, because nobody really seems to know. Until we have a better understanding of that—and, honestly, Senator, I went into the effort to reform healthcare in 2009 with rose-colored glasses on, and they quickly dimmed to fogged over.

I concluded at the end that what I really hoped for from the Affordable Care Act is some window into what it really costs, because from the perspective of the small business owner, I need to know what my costs are. When I know what my costs are, if there's something that's a little out of line, well, I can focus on that and fix it. If I have no idea what my costs are, then I really don't know whether I'm running a profitable business or not.

The bottom line is what are we trying to achieve? Are we trying to achieve affordable access to healthcare for all Americans, or are we trying to preserve a system—and I use that term loosely—that doesn't work, that just is not really going to work based on people's ability to pay? Because at the end of the day, they will make bad healthcare decisions that feel like good economic decisions when they make them, and I'll do it, too. No one is immune from that tendency.

Senator ENZI. Well, one of the things that we have changed is health savings accounts. I know that I had quite a few people on my staff that were young and healthy, and they looked at the Federal plans, and they looked at the health savings accounts, and they said,

> "You know, if I go with the health savings account and put the difference in cost into a savings account so that I have this stop loss from the health savings account so that there's a maximum that I have to pay in deductibility, in a maximum of 3 years, I can have that minimum—that stop loss already covered, and I'm going to be healthy probably for 3 years."

That's not necessarily going to happen, but I think in a lot of the cases—I had a lot of people that were young and went into the health savings accounts, and that's one of the things that we've decreased now. People are finding out that their deductibles are considerably greater than they were before.

We just made some changes in the flex accounts for people who want to put some money aside for health insurance, things that come up during the year. We made a change in that, that some of that can actually roll over. I'm sure that hurt the eyeglass industry. A lot of people bought glasses at the end of the year because they still had some money left in their account. Now they'll be able to roll some of that over.

Do any of you have a feeling for what we ought to do more to encourage health savings accounts and the flex plans?

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. What we have found is that allowing young people, at least who are working for us, to stay on their parents' plans until they're 26 delays their need to acquire sort of basic health insurance literacy. One of the great things our broker has really helped us with is educating the new people that we hire that are younger and that are picking their health insurance for the first time, just teaching them about health insurance and how it works and what a deductible is and the difference between co-pay and co-insurance so that they're capable of having a basic understanding.

You can't be an expert in everything, and I can't be an expert in everything it takes to run a small business. We have to rely on outside help like from our broker, who has been spectacular.

For the health savings account, I think that besides more being done to encourage health insurance literacy broadly, people have to understand that they're comparing not the cost of what the premium for their health insurance policy is, but they need to look at the value of the overall policy. What's the premium plus what's the co-insurance and co-pays plus the deductible and what do I expect to use during a year, so they can make the best decision they can. When you look at that, then you can actually see the value of an HAS coupled with a high deductible health plan.

Right now, we're still at the place where we're trying to show the young people that this is health insurance, and here's a deductible and a co-pay, and here's what—yes, the premium is cheap, but that means that if you go to the hospital, you're going to have to pay the $1,500 deductible. There's a lot of work, I think, that can be done there. I think that would increase the appeal of HSAs together with high deductible health plans.

Senator ENZI. Mr. Harte.

Mr. HARTE. The expectation, of course, is that when you have the health savings account, it's your money, and if it's your money, you want to spend your money wisely. I'm actually coming full circle back here because when you have the health savings account, and you know that you have to spend that money on a particular product or service, that being healthcare, you want to choose wisely.

When you don't have access to the transparency tools to know that—I need to go in for lab work. I'm not sure how much it's going to cost here. Maybe I should be going to a freestanding lab. Does it really make a difference if I go to a hospital? I really don't know. For those on your staff that may have migrated to a high deductible health plan, they will find out quickly that that money can be burned up very quickly without having access to that information.

That being said, I also want to share with you that my professional trade association, the National Association of Health Underwriters, has been talking about health savings accounts since before they were popular. We recognize that it's one of the most powerful consumer-driven tools to effect behavior. In order for it to work, you have to have a system that supports the purchase of those products.

We can look at the data as it relates to healthcare services that are not covered by insurance, so you can talk about services such as Lasik eye surgery. Over the past 10 years, Lasik eye surgery has come down dramatically because it's been a part of competition, because people are looking at that price. The same could also be true for other services as we come to a more transparent world.

That also being said, my trade association supports the Affordable Care Act. We're here today and recognize that it's here to stay. The Supreme Court has made its decision. We're beyond the debate. We're here to make sure that we can collectively work together for the accessibility and affordability of health insurance for all Americans and fix the problems for those 35 million that Senator Sanders talked about that he says are uninsured.

The only other comment I'll say about health savings accounts which no one is talking about, but it's a significant concern for myself and my trade association as well as employers who recognize this issue, is when we start talking about the excise tax in 2018, employer-sponsored health savings accounts and employer-sponsored health reimbursement accounts and wellness programs, as well as the premiums that they pay for the health insurance, are all included in that calculation.

What might surprise you is that employers or their employees will be paying substantial tax on their health savings account because it's over a threshold.

Ms. CORLETTE. If I may, on health savings accounts—a couple of concerns. As you probably know, Senator Enzi, the health savings accounts involve several tax advantages that accrue, particularly to people who are healthy and who are wealthy. Contributions are obviously tax deductible. The money as it accrues in investment accounts accrues tax free or grows tax free, and then withdrawals are tax free if they're used for medical purposes. They are great tax sheltering devices for people with a lot of disposable income or for people who are healthy.

Frankly, that comes at a cost to the Federal Government. If you are expanding eligibility for HSAs, and they become more widely used, that costs money, Federal taxpayer dollars, to support that. Quite frankly, when I look at the finite Federal resources that we have, I would far rather see scarce Federal dollars go to support people at the lower end of the income scale to help make coverage more affordable for them both in terms of the premiums that they pay as well as the cost sharing.

If we're looking at—you know, it's a finite pie, our Federal tax dollars. I would far rather see those go to people of lower incomes who are, frankly, more vulnerable. If we're going to do something with Federal tax dollars, let's not give a government handout to the people who need it the least.

Mr. CONKLIN. If I may, I'd like to tag on to what Ms. Corlette said and give you a practical example. I can tell you right now that if I went out to my employees—and our average income at Foley Waite LLC is $45,000 a year. In the New York metropolitan area, there was a time when that was actually a pretty solid middle class income. No one could support a family on $45,000 a year and have savings for college, have savings for the down payment on a new car, having savings for a house—that's just completely out of the

question—have a little money set aside for a family emergency. It's just not possible.

You can make the very compelling argument that my colleagues made for health savings accounts, but it's going to be a no-sale for my employees. I think that to hang a significant alteration of the Affordable Care Act on that is going to lead to some disappointment. Clearly, it's going to help some people, but there's going to be a significant portion of the workforce that just is not going to be able to access it or take advantage of it. That's where the real rubber hits the road.

In New Jersey, the small businesses that are getting absolutely hammered are the 25 to 50s. We need to expand both that income threshold to allow small businesses to take advantage of the tax break, and we also need to expand the—in doing that, increase or reformulate the calculation for those businesses that would qualify. Once you go over 10 you've got to be paying people $3 an hour to have any sort of significant tax refund from your insurance—subsidy is the word I'm struggling for here—for the subsidy to represent any significant advantage.

We need to increase the subsidies for businesses between 10 and 25. I think we should do that immediately. I also think we need to raise the threshold. When the Affordable Care Act was first being formulated, one of the things that we advocated for at Main Street Alliance was figuring out a way to calculate into the subsidies the cost of living, because an across the board national threshold didn't make sense to us.

Senator ENZI. The cost of living then would vary by State?

Mr. CONKLIN. Region is probably more accurate. You could have, for example, Washington and Boston. You might have one standard for that entire area, and for the fly over country, incomes might be somewhat lower, and therefore you might have a different threshold in that part of the country.

Mr. HARTE. Senator Enzi, could I make one quick comment?

Senator ENZI. Yes, sure.

Mr. HARTE. Mr. Conklin is just like many of my other clients back home, where he clearly appreciates his employees and wants to do what he feels is best for them. We deal with those struggles every single day. I appreciate his comments about how savings accounts are not the solution for my employees. When I walk into a client, I don't assume that a health savings account or a high deductible plan or an HMO plan or a PPO or a POS or all the other acronyms that we have is a one-size-fits-all for all of our clients.

We believe in choice, and that goes back to Senator Sanders' comments earlier, when we talk about a public option or national healthcare. The employers that I talk to every single day, the 300 that we represent and the 25,000 employees—they don't want to not have choice. I know Mr. Conklin and I agree, but we disagree in certain matters.

I believe that what's most important for small employers out there, myself included, is we want to do what we feel is best for our employees. Although our system is broken and it needs repair, we shouldn't replace that with a system that will take that choice away from business owners and their employees.

Senator ENZI. Anybody else want to comment on that?

Mr. CONKLIN. I'll go, because I think it's important that we do have an understanding, and I'm not sure we do yet. I said earlier that I'm not sure I agree with Senator Sanders, as much as I admire him, about a single payer system. He did mention that there are multiple models.

My concern is the 35 million people that are uninsured, and I look at it, really, from a standpoint of a business owner. I know that's probably not the best way to look at it, but I don't have much of a choice. As long as those folks are out there, and they're accessing healthcare, my employees and I are picking up the tab if they can't pay the bill.

That has a lot to do—and I'm sure these folks to my right know this—with that crazy pay—that crazy cost differential in delivery, at the point of delivery, because there's all this cost shifting going on. There's all this—how does the hospital or this medical group cover the cost of folks who showed up that we didn't leave on the sidewalk?

I don't think we live in a country where we're prepared—I have employees from Central America. Very quickly, years ago, if you went to the hospital in El Salvador—I had an El Salvador employee—and you were injured, the doctor would come in or a nurse, and they would give you a list of all the things they needed to treat you, and then a family member would go down to the Pharmacia and get them.

If you could afford it, you got care. If you couldn't, they patted you on the back and said, "I hope you survive." And I said, "I can't believe that." They said, "No, no, no. That's the way it works. That's the way it works."

I don't think that's where we want to go as a country, and we're not going to. I'm not suggesting that we would. In a sense, it is where we are. If you don't have the money to pay, somebody's going to pay, and it's going to come through this convoluted, incredibly complicated system that we have that increases cost and reduces outcomes.

Ms. CORLETTE. One comment—oh, I'm sorry.

Senator ENZI. Go ahead.

Ms. CORLETTE. Mr. Chairman, I don't disagree that small employers want choice and to be able to give their employees choice. However, that choices come with consequences, and one of the things that policymakers, particularly national level policymakers, need to think about is what might be the right choice for an individual or small employer if it's done at a critical mass could be the wrong choice for the market as a whole.

As policymakers, I think it's incumbent on you all and those of us who try to support you to think about not just let's have unfettered choice for everybody, but also what are the consequences of those choices for those who may not be able to take advantage of them. For employers who have sicker, older workers for whom, for example, self funding is not an option, what are the consequences if a critical mass of small employers self-fund. These are really critical things that policymakers need to think about before just opening the door to unfettered choice.

Senator ENZI. Thank you.

Mr. CONKLIN. One more anecdote. About a year ago in New Jersey, some legislation came up to open MEWAs up. I had never heard of a MEWA. I didn't have any idea what that was. One of the things that was included in the MEWA was a modified essential benefits model. You could sort of cull out some of the more expensive essential benefits and offer this as a plan for what I would describe as medium-sized small businesses.

The consequences of this, had that legislation passed, would have been the collapse of the small market in New Jersey. It would have just destroyed it. We do need to tread carefully, and one guy's solution is another guy's disaster.

Senator ENZI. Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. I think it's important for me to answer Senator Sanders' opening question about access to healthcare in the United States and why it might not be viewed as good as other countries in the world. I think that everyone in the United States should have access to high quality healthcare.

I also think an American solution to the problem should recognize that Americans, or at least myself, value freedom, opportunity, and self determination, and part of the American dream is being able to open a small business and take that risk and have that opportunity. With that opportunity, there's no guarantee that it's going to work out. If you can't fail, it's not really a challenge.

I think Americans also value access to the latest and best care, and I'm not sure if that's what they value in the rest of the world. You should look at the other countries and see what their models do, but I don't think you should wholesale adopt any other country's particular model and say that that's good for America. I think that America has some important differences and that the American solution should ensure that everyone has access to high quality healthcare.

While there are 35 million uninsured, I think it's important to acknowledge that there's more than 300 million Americans. While you're fixing the 35 million uninsured problem, don't mess up the 200 million part of people who do have access to health insurance.

Senator ENZI. Thank you. Again, I'll mention that the 35 million are a different 35 million, but still 35 million that were uninsured when we started the whole discussion several years ago. What we've done is shift who's insured. What I'm trying to do with this panel and with this effort is to figure out how to insure the other 35 million people.

In Wyoming, we have limited insurance company options. We don't have the raft of them that could provide you with all of those documents and spreadsheets. Last week, one of them said they're going out of business. We're only looking at even more limited choices. That's not choice. That's really a monopoly. We could have some problems based on that.

Another experience that I've had—I was in India. I was primarily looking at education. They promise that every kid gets an education through sixth grade. We found out that they kick out most of them in fourth grade. They're the ones that get a dollar a day the rest of their life sweeping the streets, and then they kick out more in sixth grade, and they get $2 a day the rest of their life—no opportunity to change.

They have healthcare for everybody, the one that makes $1, the one that makes $2, and the one that makes—well, $25,000 is considered a real high wage there. We went by a hospital, and there was this line that went way around the block, and I said, "What's that?" They said, "Well, that's the people waiting to see a doctor." And I said, "Will the doctors get to all of those people today?" "No."

They're all guaranteed healthcare, but they can't get to see a doctor. In my opinion, they don't have healthcare, and we certainly want to avoid that in this country.

At this point, I've run out of questions. I'll let each of you do a concluding statement, if you have some more suggestions for us. There may be some legislation that comes out of this. Again, I'm concentrating on that—because of the statements that you provided beforehand, instead of looking at 1 to 25 or 1 to 50, I'm looking at 1 to 100 where we can make changes, and I think that's probably the real small business market, even though the Small Business Administration says it's 500 employees.

We're just picking random numbers anyway. Since most of you mentioned 1 to 100, I would be interested in any concluding remarks you might have for improving the coverage in that area. You don't even have to give them all right now. You can include that in anything additional, written, based on what we've done here today. That might be helpful to us.

We'll go in reverse order this time. I'll start with Ms. Corlette.

Ms. CORLETTE. Sure. Thank you. I'll just close with my two main policy recommendations. The first is—and we've already alluded to this a little bit. I would encourage the committee and the Congress to discourage self funding among small employers. When the risk of self funding is really borne by an insurance company and not the employer, that's not true self funding.

When you have a functionally equivalent product that's allowed to compete on a different set of rules, that sets up an unleveled playing field and creates risk of adverse selection. This is something that, actually, the administration could do independent of Congress by simply defining what self funding means and to say that if it walks, talks, and breathes like traditional insurance, it should be treated as such.

Then the second policy recommendation is—again, I think we've touched on this. I would suggest that there be a delay in the definition of small group market extending not to 100. I think we need to understand the consequences of that and really understand who's in this market, what do the groups look like, what do their rating structures look like, what would the premium impact be before that definition change goes into effect.

Senator ENZI. Thank you.

Mr. Conklin.

Mr. CONKLIN. Yes, Senator Enzi. I really sincerely want to thank you for this opportunity and for the way you've conducted this meeting. I appreciate very much your interest, which I believe is genuine and heartfelt, and I think we both share some very significant and important goals, not the least of which is trying to figure out how we get everybody access to real healthcare.

Your example of India is certainly frightening. My daughter's best friend just graduated for the last time, and now she is a full-

fledged OBGYN working in Boston. She is, without question, the smartest person I know and perhaps the hardest working person I know.

That combination of brilliance and drive is rare. Among the many things we're going to have to figure out is how we provide a broad-based healthcare system that provides adequate access and allows doctors like my daughter's best friend to do her job as well as she possibly can. No one pretends—I certainly don't—that this is not a daunting undertaking.

When the Affordable Care Act was being initiated, I had, I think, very reasonable expectations that it would be a first step and that there are many steps to go. I don't think there is another model that we can duplicate in the United States.

I believed then and I believe today that whatever we come up with, it will be uniquely American, and that it will probably involve for-profit insurance, and it may involve some nonprofit insurance components. It will certainly involve a great deal of support at the bottom of the pyramid for people to be able to access healthcare.

I would beg you, Mr. Chairman, to focus on the goal. What is it that we are trying to accomplish? I think you and I share that goal, that is, to make sure that every American has access to healthcare.

Senator ENZI. Thank you.

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman, for the opportunity to participate in the roundtable today. As a small business owner, the current status is uncertain for us of access to health insurance because we don't know what the premium rates increase will bring.

At the same time, we have a desire to keep consistency in the health insurance plans we offer from year to year, so employees who get comfortable with the coverage and co-pays are able to keep the physician that they're used to, they learn how the plan works, and then they cannot worry so much about healthcare and health insurance and focus more on their work and have that comfort that insurance should provide.

In considering reforms, we would like less help from the government. When the government enacts new programs and innovative changes for us, it usually means a lot of new bureaucratic requirements and risks and stern letters, like we got with the MLR. Also, government-run programs seem slow to change and adapt to changing circumstances, and, frankly, we think we do better on our own, being able to shop for health insurance coverage under the current system. We'd just like more predictability in what we're getting and not see double digit premium increases every year.

That's all I have. I'm happy to respond to questions after the hearing in writing or in any way we can. Thanks again for the opportunity to participate.

Senator ENZI. Thank you.

Mr. Harte.

Mr. HARTE. Mr. Chairman, as I said earlier, I truly consider this an honor and a privilege to be here today to represent my clients, to represent the members of NAHU. With all heartfelt thanks and gratitude, thank you for the invitation. Also thank you to your staff for all they did to assemble an amazing panel of individuals who are exemplar in their own rights and passions, which I sincerely

appreciate having the opportunity to share this opportunity with them. They did a great job.

I will share with you four final policy recommendations from me. The first, as the testimony from the other panelists discussed, the role of the employee benefits broker has transformed itself during my career of 25 years. Today, I spend more of my time dealing with compliance and underwriting and evaluation and taxes and fees and regulations and legislation more than I ever would have imagined.

Certainly, I didn't wake up in college one day and say, "I'm going to be an insurance broker." I know that my clients, much like their own personal experience, sincerely appreciate the hundreds of thousands of agents and brokers out there who are working tirelessly as the first line of defense in the understanding of the complexities of healthcare reform.

With that, we've been talking about MLR for a very long time, and agents and brokers are going away in some States because their compensation is included within the MLR. Senate bill 1661 addresses that issue and, hopefully, will provide a strong foundation for those who are considering to leave the business in hopes of other opportunities. They want to be able to help their clients. That's No. 1.

No. 2, we've talked about the 51 to 100, but the one part that we haven't talked about is the employer reporting. All I will say to you today is this, that large businesses, over 100 employees, are having a very challenging time embracing the employer reporting on the 6056 and the 6055. We really have to delay the reporting for those medium-sized groups of 51 to 100.

There's another Senate bill out there, Senate bill 1415 from Senator Heitkamp, and that's a repeal of the employer mandate for group sizes 51 to 100. That will remove the penalties or remove the mandate entirely. We fully support that. We're putting a lot of pressure on those groups, and whatever we can do to mitigate the potential damage with the continued rollout of 51 to 100 will be welcomed by them.

The last thing I'll say to you—and I know some have commented on the 3 to 1 age bands. If we can somehow reduce those restrictions so that maybe we can go to 4 to 1 or leave it to the individual States to make the decisions of what's best for their communities. Leave it to the insurance commissioners and let them make the decision, because every State is unique in how they should be developing their rates.

In my closing comments, I'll say to you, as in my first speech in front of NAHU back in 2001 and close with the same remark. I say this, that health insurance is expensive because healthcare is expensive, and that has to be part of the solution.

Again, Mr. Chairman, thank you for the opportunity.

Senator ENZI. Thank you. I'm glad you mentioned the healthcare being more expensive. We're the inventors for all of the things for the rest of the world, and I know of a lot of things that are coming through the pipeline now that will make a difference to people. I've noticed that the cost goes up, and we don't want those things denied to people, either.

I appreciate all the suggestions that you've given today. I've been working on healthcare for a long time. I got to work with Senator Kennedy for years, and we did a lot in other bills. The Needlestick bill was the first one that I got to work on so that there is protection for the nurses and the janitors and stuff that they wouldn't accidentally get stuck by a needle that had been used on somebody and then maybe have to wait a year or two to find out if there was going to be a complication from it.

Consequently, he and I worked on a lot of things. One of the things we were working out was a 10-step plan for providing healthcare for everyone. That is on my website, and I've been talking about it for a long time, and some of those would be changes that might help, particularly, the small businessman, because I always look at it from that position because that's all I understand. I was a small businessman. We had three shoe stores, and I know that that's most of America.

I appreciate it. Your comments have been very helpful today. Like I said, people will be allowed to submit questions. I think they'll have to have those in by tomorrow night. If you'd answer those, we'd appreciate it. Any other suggestions that you have for things that might improve the healthcare system, for small business, we'd be appreciative of. If you'd limit it to that, we'd also appreciate it.

Thank you for being here today, and I thank the people who came to listen as well, and all the staff members who, of course, will get back to their Senator to get additional questions and to share this information.

Thank you.

[Additional Material follows.]

ADDITIONAL MATERIAL

RESPONSE BY J. KELLY CONKLIN TO QUESTIONS OF THE HELP COMMITTEE

Question 1. What is the status of the health insurance market for small businesses, specifically plan options and costs in the small group market?

Answer 1. From our perspective as a New Jersey company purchasing health insurance in the small group market as we always have, through an agent, there is little appreciable difference between now and before the ACA in terms of options. There are many. There is the same confusing, arcane language in the policy documents and in how the various plans are presented. That makes meaningful comparison almost impossible beyond the most basic considerations: premium cost, co-pays, deductibles and maximum annual out-of-pocket costs. As a small company with tight margins the first consideration is always premium cost.

Premium increases over the previous two renewals, 2013–14 have been in the neighborhood of 10 to 15 percent. That said this year's is down about 2 percent and we reduced deductibles for the individual to 2,000 from 2,500. That did come with an annual increase in total maximum out-of-pocket from 5,000 to 6,000 per individual and 12,000 per family.

There was an initial "shock" when the new price schedules were implemented using age as the determinant factor of premium rates. In that initial adjustment we had the biggest rate increase in some time as a result of our older population of employees participating in our plan. As I recollect that was around 18 percent.

Question 2. What tools and options are available and useful for small employers to offer some assistance to their employees?

Answer 2. This is a difficult question to address. There is of course more information than ever available to anybody interested enough to investigate the available plans in their respective areas. In New Jersey with its high density, well off population, the market is relatively rich affording options on the individual market that did not exist prior to the ACA through the exchange. Choosing a plan can be a daunting experience, filled with uncertainty and anxiety. Thankfully the comprehensive consumer protections, essential health benefits, no exclusion for pre-existing conditions and medical loss ratio oversight are in place to reduce the actual risk to individual consumers.

We recently had our oldest employee move to Medicare. His younger wife could no longer be covered under our plan. In the exchange they were able to purchase a slightly higher quality plan, lower deductible, lower co-pays, for about fifty dollars more per month than the coverage she had under our plan. Medicare with part D and the additional supplements making his coverage complete, saved us enough in premium cost to raise his compensation to cover his additional out-of-pocket expenses and his wife's coverage, while saving us about $200 per month.

Question 3. What has worked and what hasn't worked and what policy recommendations do you have for the committee?

Answer 3. New Jersey's robust consumer protections prior to ACA, mentioned above, made cost increases in our market tolerable. The uniform consumer protection standards contained in the ACA for health insurers, along the lines of New Jersey's, is a critical piece of the ACA that cannot be tampered with. No lifetime limits and no exclusions for pre-existing conditions are cornerstones of increased access and financial security and should not be altered as well. These features along with the MLR have had the expected effect of containing both premium increases and cost shifting by providers. This along with other features of the ACA is working to decelerate the rate of health care cost increases.

There are any number of things that might be done to improve the ACA. Repeal is not one of them. Nor is a piece by piece alteration of the law that will have the same effect as repeal. Congress must act to restore faith that changes to the ACA come by way of improving access to care and by means resulting in affordable quality health care, not political victory laps. I suggest correcting the sentence in the ACA recently adjudicated by the Supreme Court would be a good first step. Done without filibusters and amendments, this symbolic gesture would send a powerful signal to the people that Congress is at long last ready to attend to the people's work.

The ACA is the first major step toward providing universal access to health care, an as yet unmet goal of the reform effort. As long as access is determined by one's ability to pay, whether at the point of service or in the purchase of insurance, our health care costs will continue to climb while quality and availability of care continues to decline. Voluntary charity care remains an inadequate alternative to main-

stream access and that shortfall continues to contribute substantially to cost shifting and deferred care, leading to expensive and poor outcomes. We can do better.

Basic access as established by essential health benefits under the ACA should be available to every American. If that requires a universal expansion of Medicare to make that access available to the unemployed and working poor, then we should do that. If it requires excluding for-profit insurers from those income earners at 400 percent of the poverty line to an established income level that makes for profit coverage affordable, we should do that. We should at minimum increase both the number of employees that establishes a business as small and the average income per employee that qualifies an employer for subsidies. We should do that now, without delay or fan fair.

I abhor the word fair, my heart is not bleeding and I don't care about level playing fields. I don't live in The Magical Market Place where innovation and quality are always rewarded and fraud, abuse, incompetence and inefficiency, broadly shared characteristics of all human enterprise, is always weeded out. That is why I know that until every American has a card in their purse or wallet that guarantees access to a doctor—any doctor, anywhere—until emergency rooms only serve emergency patients and not emergency patients and the uninsured, I and my employees will pay too much for too little. This is a practical problem requiring the completion of the critical step forward that is the ACA. Our goal must be a comprehensive, all inclusive health care delivery system in the United States. We should get on with it.

RESPONSE BY SABRINA CORLETTE, J.D. TO QUESTIONS OF SENATOR WARREN

Question. Under current law, the 40 percent excise tax on high cost health plans, known as the Cadillac Tax, will go into effect in 2018. In determining the cost of repealing the Cadillac Tax, the Congressional Budget Office assumes individuals that have their health benefits reduced due to the tax will experience an increase in taxable wages. Some groups have expressed skepticism that reduced benefits will lead to increased wages. A 2014 study by Harvard researchers published in the Journal of Health Economics and a 2013 study from the National Bureau of Economic Research, which both focused on public sector employees, found that when employer health care costs increased, employees paid for some of that increase through reductions in wages.

If employers decrease the amount they spend on employee health plans in order to avoid the Cadillac tax, would you expect an increase in employees? wages? If so, would the increase in wages be expected to fully offset the reduction in benefits?

Would a requirement that employers must offset any reduction in benefits with wage increases change the responses of employers to the Cadillac Tax?

Answer. Many economists believe that on average and in the long run, employees bear the full cost of coverage. In other words, economic theory suggests that workers pay for higher health care costs via lower wages. However, that theory is dependent on the notion that employers get no independent benefit from offering coverage. Some economists have posited that providing health insurance coverage has benefits that accrue to employers, such as improvements to worker productivity or reductions in job terminations.[1] A 2005 study found that firms offering benefits (including health and pensions) have higher productivity and higher survival rates.[2] If these analyses are correct, it suggests that a reduction in benefits would not necessarily be fully offset by an increase in wages, at least in the short term. It is not clear how employers would respond to a requirement to offset a reduction in benefits with wage increases. More research on this question is needed.

[Whereupon, at 3:41 p.m., the hearing was adjourned.]

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[1] Garret B, Chernew M. Health Insurance and Labor Markets: Concepts, Open Questions, and Data Needs. Inquiry 45: 30–57 (Spring 2008). Available at *http://inq.sagepub.com/content/45/1/30.full.pdf+html*.

[2] Decressin A, Lane J, McCue K and Stinson M. Employer-Provided Benefit Plans, Workforce Composition and Firm Outcomes. Technical Paper No. TP–2005–01 (2005). Suitland, MD.: U.S. Census Bureau, LEHD Program.