

RESCUING AMERICANS FROM THE FAILED HEALTHCARE LAW AND ADVANCING PATIENT-CENTERED SOLUTIONS

HEARING

BEFORE THE

COMMITTEE ON EDUCATION
AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 1, 2017

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**RESCUING AMERICANS FROM THE FAILED
HEALTHCARE LAW AND ADVANCING
PATIENT-CENTERED SOLUTIONS**

**Wednesday, February 1, 2017
House of Representatives,
Committee on Education and the Workforce,
Washington, D.C.**

The committee met, pursuant to call, at 10:04 a.m., in Room 2176, Rayburn House Office Building, Hon. Virginia Foxx [chairwoman of the committee] presiding.

Present: Representatives Foxx, Wilson of South Carolina, Roe, Thompson, Walberg, Guthrie, Rokita, Messer, Byrne, Brat, Bishop, Grothman, Stefanik, Allen, Lewis, Rooney, Mitchell, Smucker, Scott, Grijalva, Courtney, Fudge, Polis, Wilson of Florida, Bonamici, Takano, Adams, DeSaulnier, Norcross, Blunt Rochester, Krishnamoorthi, Shea-Porter, and Espaillat.

Staff Present: Bethany Aronhalt, Press Secretary; Andrew Banducci, Workforce Policy Counsel; Courtney Butcher, Director of Member Services and Coalitions; Ed Gilroy, Director of Workforce Policy; Jessica Goodman, Legislative Assistant; Callie Harman, Legislative Assistant; Nancy Locke, Chief Clerk; Dominique McKay, Deputy Press Secretary; James Mullen, Director of Information Technology; Michelle Neblett, Professional Staff Member; Krisann Pearce, General Counsel; Brandon Renz, Staff Director; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Alissa Strawcutter, Deputy Clerk; Olivia Voslow, Staff Assistant; Joseph Wheeler, Professional Staff Member; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Austin Barbera, Minority Press Assistant; Michael DeMale, Minority Labor Detailee; Denise Forte, Minority Staff Director; Christine Godinez, Minority Staff Assistant; Carolyn Hughes, Minority Senior Labor Policy Advisor; Kevin McDermott, Minority Senior Labor Policy Advisor; Richard Miller, Minority Senior Labor Policy Advisor; Udochi Onwubiko, Minority Labor Policy Counsel; Veronique Pluviose, Minority Civil Rights Counsel; Arika Trim, Minority Press Secretary; and Elizabeth Watson, Minority Director of Labor Policy.

Chairwoman Foxx. Good morning. A quorum being present, the Committee on Education and the Workforce will come to order.

Before we turn our attention to this morning's hearing, I'd like to take care of an administrative matter. Today, both the Republicans and Democrats have completed assigning members to the

subcommittees. I ask unanimous consent on behalf of myself and Ranking Member Scott to submit those assignments for the record. Hearing no objection, the subcommittee assignments are made. [The information follows:]



VIRGINIA FOXX, NC
Chairwoman

MAJORITY – (202) 225-4527
FAX – (202) 225-9571

**COMMITTEE ON EDUCATION
AND THE WORKFORCE**
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

ROBERT C. "BOBBY" SCOTT, VA
Ranking Member

MINORITY – (202) 225-3725
FAX – (202) 226-5398

**Committee on Education and the Workforce
Republican Subcommittee Assignments
115th Congress**

February 1, 2017

Subcommittee on Early Childhood, Elementary, and Secondary Education

Todd Rokita, Indiana (Chairman)
Duncan Hunter, California
David P. Roe, Tennessee
Glenn "GT" Thompson, Pennsylvania
Luke Messer, Indiana
David Brat, Virginia
Tom Garrett, Jr., Virginia
(open seat)

Subcommittee on Health, Employment, Labor, and Pensions

Tim Walberg, Michigan (Chairman)
Joe Wilson, South Carolina
David P. Roe, Tennessee
Todd Rokita, Indiana
Lou Barletta, Pennsylvania
Michael D. Bishop, Michigan
Rick W. Allen, Georgia
Jason Lewis, Minnesota
Francis Rooney, Florida
Paul Mitchell, Michigan
Lloyd K. Smucker, Pennsylvania
A. Drew Ferguson, IV, Georgia

Subcommittee on Higher Education and Workforce Development

Brett Guthrie, Kentucky (Chairman)
Glenn "GT" Thompson, Pennsylvania
Lou Barletta, Pennsylvania
Luke Messer, Indiana
Bradley Byrne, Alabama
Glenn Grothman, Wisconsin
Elise Stefanik, New York
Rick W. Allen, Georgia
Jason Lewis, Minnesota
Paul Mitchell, Michigan
Tom Garrett, Jr., Virginia
Lloyd K. Smucker, Pennsylvania
(open seat)

Subcommittee on Workforce Protections

Bradley Byrne, Alabama (Chairman)
Joe Wilson, South Carolina
Duncan Hunter, California
David Brat, Virginia
Michael D. Bishop, Michigan
Glenn Grothman, Wisconsin
Elise Stefanik, New York
Francis Rooney, Florida
A. Drew Ferguson, IV, Georgia

Chairwoman Foxx. Next, I recognize myself for an opening statement.

I want to again say good morning to my colleagues and guests. I want to welcome our witnesses. We appreciate that you took time out of your busy schedules to be with us today.

It is no coincidence that our first hearing is focused on our efforts to rescue Americans from a fatally flawed healthcare law and transition to a patient-centered system. There's an urgent need to address the challenges facing working families and small businesses under ObamaCare, and that's exactly what this hearing is about.

For nearly seven years, Americans have struggled as they've seen their healthcare costs skyrocket, their plans canceled, and their choices and access to quality care diminished. That is why for nearly seven years Republicans have been fighting to provide the relief Americans desperately need.

This has never been about politics. The fight to repeal and replace ObamaCare has always been about people.

It has been about people like Steve from my congressional district. Steve resides in West Jefferson, and he and his wife are paying 225-percent-higher premiums than they were four years ago.

Scott from Hickory, North Carolina, has had his healthcare plan canceled three times because of the law and today has access to only one insurance provider.

Michael from Winston-Salem has an \$800 monthly premium for him and his daughter, and their deductible is over \$14,000.

Terry, a 70-year-old retiree from Advance, is working part-time just to help pay his wife's \$900 monthly premium.

These stories aren't unique to North Carolina. Working families across the country are suffering under a failed government takeover of health care.

Remarkably, the consequences extend beyond higher insurance costs and limited plan options to fewer jobs and suppressed wages. In fact, a recent study by the American Action Forum found ObamaCare has destroyed 300,000 small-business jobs and cost small-business employees \$19 billion a year in wages. An estimated 10,000 small businesses were even forced to close their doors because of the law's burdensome regulations.

All of these individuals, families, and small-business owners were promised far different. They were promised lower costs, more choices, and more competition. What they got was the exact opposite.

The reality is the 2010 healthcare law is completely unsustainable. It's collapsing as we speak. We cannot stand by as the law creates even more havoc in the lives of the American people. That's why we're on a rescue mission to deliver the relief people need, and this committee will play an important part in the process. We have already taken steps to repeal ObamaCare, and the Trump administration is actively working to stabilize health insurance markets.

Once the law is repealed, there will be a stable transition to a patient-centered system. At least 4.7 million Americans have already been kicked off their healthcare plans under ObamaCare, and the last thing Republicans want is to disrupt more people's coverage.

We're going to do this the right way. There won't be a massive bill that no one has read and is jammed through Congress in the dead of night. Instead, we will tackle the challenges of our broken healthcare system through step-by-step solutions that provide lower costs, more choices, and protect the most vulnerable among us.

We will put patients in control of their healthcare decisions. That means eliminating one-size-fits-all rules that drive up costs and restrict choices. All Americans should have the freedom to select a healthcare plan that meets their needs.

After years of costly federal mandates, we will empower small businesses to band together and provide affordable coverage for their employees. Additionally, we will preserve employee wellness plans that have been under attack in recent years by Washington bureaucrats.

Undoing the damage of ObamaCare and achieving real healthcare reform won't happen overnight. We will continue to hold hearings just like this one, and we will continue to receive input from Governors, insurance commissioners, workers, and employers across the country.

Today's discussion is an important step in this process. We look forward to hearing from all of you on how we can provide a better way forward on health care for the American people.

With that, I yield to Ranking Member Scott for his opening remarks.

[The statement of Chairwoman Foxx follows:]

Prepared Statement of Hon. Virginia Foxx, Chairwoman, Committee on Education and the Workforce

It is no coincidence that our first hearing is focused on our efforts to rescue Americans from a fatally flawed health care law and transition to a patient-centered system. There is an urgent need to address the challenges facing working families and small businesses under Obamacare, and that's exactly what this hearing is about.

For nearly seven years, Americans have struggled as they've seen their health care costs skyrocket, their plans canceled, and their choices and access to quality care diminished. That is why for nearly seven years, Republicans have been fighting to provide the relief Americans desperately need.

This has never been about politics. The fight to repeal and replace Obamacare has always been about people. It's been about people like Steve from my congressional district. Steve resides in West Jefferson, and he and his wife are paying 225 percent higher premiums than they were four years ago. Scott from Hickory, North Carolina, has had his health care plan canceled three times because of the law, and today he has access to only one insurance provider.

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In fact, a recent study by the American Action Forum found Obamacare has destroyed 300,000 small business jobs and cost small business employees \$19 billion each year in wages. An estimated 10,000 small businesses were even forced to close their doors because of the law's burdensome regulations.

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Once the law is repealed, there will be a stable transition to a patient-centered system. At least 4.7 million Americans have already been kicked off their health care plans under Obamacare, and the last thing Republicans want is to disrupt more people's coverage.

We're going to do this the right way. There won't be a massive bill that no one has read and is jammed through Congress in the dead of the night. Instead, we will tackle the challenges of our broken health care system through step-by-step solutions that provide lower costs, more choices, and protect the most vulnerable among us.

We will put patients in control of their health care decisions. That means eliminating one-size-fits-all rules that drive up costs and restrict choices. All Americans should have the freedom to select a health care plan that meets their needs.

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Today's discussion is an important step in this process. We look forward to hearing from all of you on how we can provide a better way forward on health care for the American people.

Mr. SCOTT. Thank you, Madam Chair.

And I'd like to first, before we begin, introduce one new member who's here, Adriano Espaillat, who represent New York's 13th Congressional District. He wasn't here when we introduced new members before. He represents the same district as the past chair of this committee, Adam Clayton Powell. He served in the State Senate and State Assembly in New York.

We have another member, Carol Shea-Porter, who was appointed to the Committee. She is from New Hampshire and previously served on this committee.

I'd like to welcome our witnesses and thank them for their testimony. This is our first hearing of the 115th Congress. Unfortunately, this hearing is part of a larger agenda to repeal the *Affordable Care Act* root and branch, despite the fact there's no credible plan to deal with the chaos that repeal would create.

I'd first like to remind our Republican colleagues once again where we were when we passed the *Affordable Care Act*. Healthcare costs were skyrocketing. If you lost your job or wanted to start a new business and had a preexisting condition, you were out of luck. Women were paying more than men. Seniors had no help for paying for prescription drugs when they landed in the notorious doughnut hole. The miners suffering from lung disease struggled to get access to health benefits because of complicated requirements that made it almost impossible to prove eligibility. And every year millions of people were losing their insurance altogether.

The so-called damage caused by the *Affordable Care Act* includes women no longer paying more for insurance than men. The costs have gone up but they've gone up at one-half the rate that they were going up before. Those with preexisting conditions can get insurance at the standard rate. We're closing the doughnut hole. We

have helped miners get their benefits. And instead of millions of people losing their insurance every year, 20 million more people have insurance. And all Americans, even if they had insurance before, are enjoying consumer protections. Small businesses were exempt from virtually all of the mandates in the bill.

And this progress will be reversed if the ACA is repealed. We know, for example, that 30 million Americans would lose coverage, with the vast majority in working families. Workers with job-based plans could lose out on ACA's consumer protections, such as prohibitions against annual and lifetime limits. They could lose out on access to free preventive services which keeps the American workforce healthier and on the job.

These meaningful protections have improved the lives of people around the country, protections that are being threatened.

The collateral damage won't stop there. The individual market could all but collapse if there's a repeal without a credible replacement, making it likely that nobody will be able to buy insurance at an affordable rate. Costs for uncompensated care will skyrocket, but those costs won't disappear. When people go to the hospital and don't pay, those costs have to be paid by somebody. When we passed the *Affordable Care Act*, that cost was about \$1,000 on a family policy, covering uncompensated care. Coal miners who now benefit from enhanced protections and benefits provided by the ACA could lose them.

Now, another important item to both workers and employers: employment. Repeal would devastate communities around the country, particularly rural areas that already face employment challenges. The American Hospital Association and the Federation of American Hospitals sent a letter to congressional leaders warning of massive job losses if the ACA is repealed. The letter noted a specific threat to rural communities, pointing out that hospitals are often the largest employers in many communities. Estimates show that repeal would result in a loss of 2.6 million jobs almost immediately.

Over the last seven years, we have heard a lot of complaints about the *Affordable Care Act*, but we haven't seen a plan that would actually make things better. Just last week, our colleagues on the Budget Committee held a hearing where healthcare experts from the Urban Institute estimated that, if the GOP were to replace the ACA coverage expansion with tax credits at the inadequate level pushed by the new HHS Secretary nominee, the healthcare deductibles could skyrocket to \$25,000 for individuals and \$50,000 for family plans.

Today, we are likely to hear about some other plans that, frankly, just won't work or won't do anything. And there's no strategy or interest in protecting the millions of Americans who now benefit from the ACA.

If a credible replacement plan were possible, we obviously would have seen it by now. But there's no legislation pending that has significant support, and there's no reason to believe that a replacement plan could be produced that would actually work.

Now, some of the initiatives already taken by this administration have been proven to be counterproductive. For example, the administration took action to threaten the marketplace by pulling adver-

tisements for coverage in the final days of the open enrollment period. It is well-known that those who wait till the last minute tend to be younger and healthier. And fewer of them signing up just means higher premiums for everybody else.

And I ask unanimous consent to insert into the record a letter sent by three ranking members of House committees with healthcare jurisdiction to the Department of Health and Human Services asking for further details on the impact of this decision.

Chairwoman Foxx. Without objection.

Mr. SCOTT. Thank you.

[The information follows:]

Congress of the United States
House of Representatives
Washington, D.C. 20515
January 30, 2017

Mr. Norris Cochran
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Secretary Cochran:

We are writing to request additional details regarding the Trump Administration's decision to halt advertising and outreach activities for Healthcare.gov in the final days of the open enrollment season, as well as to request information about the Administration's plans to continue Marketplace activities for the remainder of 2017. We are deeply concerned that the Administration's seemingly intentional efforts to sabotage enrollment in the Affordable Care Act (ACA) Marketplaces will result in adverse risk selection, destabilize insurance markets, and send premiums skyrocketing.

According to a report in the *Washington Post*, "the White House instructed the Centers for Medicare and Medicaid Services, which oversees much of the ACA's implementation, to withdraw all communications contracts, marketing plans, and advertising set for between Thursday and the end of January."¹ A Department spokesperson later confirmed that the Agency cancelled about \$4-5 million in ads set to run over the final weekend before the close of open enrollment, and claimed that these cost savings "will be returned to the U.S. Treasury."²

The White House's order could hamper overall enrollment in the Marketplaces, as the final deadline for open enrollment has in the past been the second-biggest day for signups.³ Research has shown that the last week of open enrollment tends to draw younger enrollees, whose participation is critical to the stability of the Marketplaces and to keeping premiums affordable.⁴ The White House's efforts to suppress enrollment will therefore weaken the risk pool, resulting in greater costs for everyone.⁵

¹ *White House stops ads, outreach for last days of 2017 ACA enrollment*, Washington Post (Jan. 26, 2017).

² *Reversing course, Trump administration will continue Obamacare outreach*, Politico (Jan. 27, 2017).

³ *Id.*

⁴ *Id.*

⁵ *Former Obamacare executive: Here's why Trump killed enrollment ads for Healthcare.gov*, CNBC (Jan. 27, 2017).

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January 30, 2017
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The suspension of outreach and enrollment activities prior to the closing of the 2017 open enrollment season, combined with the recent Executive Order instructing agencies to use their authority to waive, defer, grant exemptions from, or delay provisions of the ACA, creates the distinct impression that the Administration is attempting to sabotage enrollment in the Marketplaces. We therefore urge you to (1) reinstate the advertisements; (2) extend open enrollment for another two weeks, since enrollment may have been suppressed as a result of the Administration's decisions; and (3) take action to encourage Marketplace enrollment and maintain the stability of the Marketplaces for 2017 and beyond.

To better understand the Agency's recent decision to halt open enrollment advertising and outreach activities, as well as the Agency's plans to prepare for the next open enrollment season, we request that the Agency provide the following documents and information by February 13, 2017:

1. Who within the White House instructed the Agency to halt the paid media? Who at the Agency was responsible for implementing this directive? Please provide all documents or communications relating to the decision to halt advertising prior to the end of the 2017 open enrollment season.
2. Was any funding for advertising, communications, and marketing plans for the 2017 open enrollment season rescinded? If so, who provided the direction to do so? Please provide the General Counsel's analysis of the legality of this action.
 - a. Did the Agency terminate, suspend or otherwise modify any contracts for services relating to advertising, communications, marketing, or outreach for the 2017 open enrollment season? If so, who provided the direction to do so?
 - b. Please provide all documents and communications pertaining to any such terminated, suspended, or modified contracts, and documents and communications pertaining to any proposed terminations, suspensions, or modifications of open enrollment contracts.
 - c. Were any contracts terminated for services that were already paid for but not yet provided? If so, please provide the basis upon which the vendor was asked not to render services already paid for by tax dollars.
 - i. Please provide a copy of any such contracts, including the statement of work, the contract line item number (CLIN), and the name of the contracting officer.
 - ii. Please provide for each contract the dollar amount for services not rendered at the Agency's request, and an expected date at which the payment for these services will be returned to the U.S. Treasury.

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January 30, 2017
Page 3

3. Does the Administration plan to keep the call center that assists consumers with questions open and appropriately staffed throughout 2017, for consumers who may have to enroll during a special enrollment period?
 - a. Please provide a description of the expected staffing levels, and anticipated wait times, for the call center through the end of the year.
 - b. Please provide a description of expected expenditures for the call center through the end of the year, a copy of the contract currently in force for the operation of the call center, the name of the contracting officer, as well as any documents relating to any contract terminations, suspensions, and modifications.
4. Does the Administration plan to keep Healthcare.gov online throughout 2017 to allow consumers to find information regarding Marketplace plans?
 - a. Does the Administration plan to continue to provide Healthcare.gov with the basic technical staff it needs to operate and maintain the website?
 - b. Please provide a description of expected expenditures for technical support and operation of the website through the end of the fiscal year, a copy of the contract(s) currently in force, the name of the contracting officer(s), as well as any documents relating to any contract terminations, suspensions, and modifications.
5. Does the Administration intend to continue to award Navigator grants to provide high quality assistance to consumers to understand coverage options and financial assistance available at Healthcare.gov? If not, please explain why.
 - a. When will the Administration begin the process of awarding grants?
 - b. How many grants and what funding levels are expected?
6. Please provide a description of the Administration's outreach and enrollment strategy for plan year 2018, including an itemized list of all planned expenditures related to advertising, marketing, communications and outreach.
 - a. Please provide a copy of all contracts currently in force for such activities, the name of each contracting officer, and any documents relating to any contract terminations, suspensions, and modifications.
 - b. The previous Administration undertook specialized, targeted efforts to reach young adults without health insurance, such as targeting young adults on social media, working with partner organizations, sending direct mail to potential enrollees, and encouraging insurers to contact young adults before

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January 30, 2017
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they turn 26 to tell them about Marketplace coverage options. Please provide a description of the Administration's outreach and enrollment strategy for young adults aged 18-34 for the 2018 plan year.

Additionally, we request a briefing to discuss the above questions at your earliest convenience. Your prompt assistance on this matter is appreciated.

Sincerely,



Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce



Richard E. Neal
Ranking Member
Committee on Ways and Means



Robert C. "Bobby" Scott
Ranking Member
Committee on Education and the Workforce

cc: Dr. Patrick Conway
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Mr. SCOTT. Even President Trump's recent immigration order not only runs afoul of American values and our Constitution, essentially creating a religious test for entry into the United States and denying due process, but it also has an impact on health care in the United States. The Association of American Medical Colleges, one of the many groups to express concern over the Executive Order, released a statement explaining that the Executive Order could disrupt education and research and have a damaging long-term impact on patients and health care.

So we do have a few options moving forward. We could choose to move to a single-payer system, or we can improve upon the ACA. Going back to the days where a preexisting condition meant you couldn't get insurance should not be an option.

Now, since this is our first hearing in Congress, let me be clear about our shared priorities and the vision of Democrats on this committee. We are here to strengthen the economic security of Americans and to protect health care in this country. This is more that we need to do to improve access and affordability in health care, and Democrats are willing to work on a responsible improvement.

If the goal is to replace, then repeal, we can work together. But you cannot count on our support if the first step is to create total chaos by repealing without any replacement in sight.

In fact, Democrats are skeptical that there will ever be any replacement. We are reminded that the majority of the Republicans in Congress did not support Medicare. We know that over 60 votes have been taken in the House to repeal all or parts of the *Affordable Care Act* without any replacement in sight. And we have already missed the legislative deadline under the reconciliation. The two committees were given instructions to come up with changes in the *Affordable Care Act*, and they've missed that deadline. And so we're skeptical that there will be any replacement if there is a repeal.

So it is my hope that we can focus our efforts on the financial security of American families by working to improve health care instead of turning the clock backwards and ruining health care possibly for everybody.

Thank you, Madam Chair, and I yield back.

[The statement of Mr. Scott follows:]

**Prepared Statement of Hon. Robert C. "Bobby" Scott, Ranking Member,
Committee on Education and the Workforce**

Thank you, Chairwoman Foxx. I would like to welcome and introduce the newest Democratic members to the Committee.

Congresswoman Carol Shea-Porter represents New Hampshire's first congressional district and is serving her fourth term in Congress, and I am pleased to welcome her back to the Committee.

Congressman Adriano Espaillat represents New York's thirteenth congressional district, the same district as the esteemed past-chairman of this Committee – Adam Clayton Powell, Jr. He previously served as a member of the New York State Senate and as a member of the New York State Assembly.

Welcome to the both of you.

I would now like to welcome our witnesses and thank them for their testimony. This is our first hearing in the 115th Congress and this hearing will likely lay out our Committee's agenda for the coming weeks and months. Unfortunately, this hearing is also part of a larger agenda to repeal the *Affordable Care Act*, root and

branch, despite the fact that there is no credible plan to deal with the chaos that this repeal will create.

I'd first like to remind my Republican colleagues once again of where we were when we passed the ACA. Health care costs were skyrocketing and if you lost your job, or wanted to start a new business and you had a preexisting condition, you were out of luck.

Seniors had no help paying for prescription drugs when they landed in the Part D "donut hole". Miners suffering from lung disease struggled to get access to health benefits because of complicated requirements that made it almost impossible to prove eligibility.

Yes, the cost of health coverage remains a challenge for both employers and workers. But although costs in employer-provided health coverage have gone up, they have gone up much more slowly than they were prior to the ACA. Today, we are releasing a report that highlights all of the ACA's benefits to the American people, particularly those with job-based health coverage, and why repeal is so dangerous for our country and families' health and economic security.

The ACA fixed many of these problems. Despite, Republicans' nonstop attacks on the ACA, we have made great progress in improving the nation's health care system. And because of those efforts, the rate of uninsured adults and the rate of uninsured children are at an all-time low.

If my Republican colleagues continue on the course to repeal, we know that thirty million Americans will lose coverage, with the vast majority of those millions in working families. Workers with job-based plans could lose out on the ACA's consumer protections – such as prohibitions on annual and lifetime limits. They could lose out on access to free preventive services which keeps the American workforce healthier and on the job. These are meaningful protections that have improved the lives of people in this country – protections that the Republicans are threatening to take away. And the collateral damage won't stop there. The individual market will all but collapse, making it likely that nobody will be able to buy insurance at an affordable rate. Uncompensated costs will skyrocket and those costs won't disappear – they will be absorbed by other payers. Coal miners, who now benefit from the enhanced protections and benefits provided in the ACA, could lose them.

Another item of importance to both workers and employers is jobs. Repeal would devastate communities across the country, particularly rural areas that already face employment challenges. The American Hospital Association and the Federation of American Hospitals sent a letter to Congressional leaders warning of "massive job losses" if the ACA is repealed. The letter noted the specific threat to rural communities, pointing out that, "hospitals are often the largest employer in many communities." Estimates show that repeal would result in a loss of 2.6 million jobs across all states almost immediately; while a third of those lost jobs would be in health care, the impact would be felt across industries.

Over seven years we have heard a lot of complaints about the *Affordable Care Act*, but we have not seen a plan that would make things better. Just last week, our colleagues in the Budget Committee held a hearing where a health care expert from the Urban Institute estimated that if the GOP were to replace the ACA coverage expansion with tax credits at the inadequate levels pushed by HHS Secretary nominee Congressman Tom Price, health care deductibles could skyrocket to \$25,000 for individual and \$50,000 for family plans. Today, we are likely to hear about some of the old, discredited, and highly inadequate ideas around health reform. But there is no strategy or interest in protecting the millions of Americans who now benefit from the ACA. If a credible replace were possible, we would have seen it by now, and yet there is no legislation pending that has Republican support and there is no reason to believe that a replacement would actually work.

Unfortunately, the conversation around health care has now taken on an even more troubling tone. The new Administration has taken action to threaten the Marketplace by pulling advertisements for coverage in the final days of the open enrollment period, making no secret about its intention to subvert Marketplace enrollment. I ask unanimous consent to insert into the record a letter sent by the three Ranking Members of the House Committees with health care jurisdiction to the Department of Health and Human Services asking for further details on the impact of this decision.

Further, President Trump's recent immigration executive order runs afoul of American values and our constitution by essentially creating a religious test for entry into the United States and denying due process to green card holders who have been unable to reenter the country. The impact of this order is being felt by communities across the country, and is particularly detrimental to students who wish to pursue their education in the United States. The Association of American Medical Colleges – one of the many groups to express concern over the executive

order – released a statement explaining that the executive order could, “disrupt education and research and have a damaging long-term impact on patients and health care.” I trust that my colleagues on the other side of the aisle are as outraged as I am at the executive order, both because of its lack of humanity and its detrimental impact on the health care sector in this country.

So we have a few options moving forward. We can choose to move to a single payer system or we can improve upon the ACA. Going back to the days where a preexisting condition meant you didn’t get insurance is not an option.

Since this is our first hearing of the Congress, let me be clear about our shared priorities and the vision of the Democrats on this Committee. We are here to strengthen the economic security of Americans and to protect the health of this country. There is more that we need to do to improve access and affordably in health coverage, but setting the stage for a repeal vote that will take benefits away from hardworking Americans is irresponsible and morally reprehensible. Similarly, banning the best and brightest talent in the medical community from studying at our universities and practicing medicine in our hospitals is irresponsible and morally reprehensible.

It is my hope that we can refocus our efforts to the financial security of American families, instead of turning the clock backward. Thank you.

Chairwoman Foxx. Thank you, Mr. Scott.

Pursuant to committee rule 7(c), all members will be permitted to submit written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

We will now turn to introductions of our distinguished witnesses.

Dr. Tevi Troy is the chief executive officer of the American Health Policy Institute. Previously, Dr. Troy held numerous positions in the Federal Government, including serving as Deputy Secretary of Health and Human Services beginning in 2007, where he oversaw all operations, including Medicare and Medicaid, public health, medical research, food and drug safety, welfare, child and family services, disease prevention, and mental health services.

Mr. Joe Eddy is president and chief executive officer of Eagle Manufacturing Company and will testify on behalf of the National Association of Manufacturers. In addition to his work at Eagle Manufacturing, Mr. Eddy also serves on the Advisory Board of the McDonough Center for Leadership in Business at Marietta College and the Foundation Board at West Virginia Northern Community College.

Ms. Angela Schlaack is a widow, mother of two children, and a student at Siena Heights University pursuing a bachelor’s degree in Communications. She is an educated grief group facilitator at Lori’s Place in St. Joseph, Michigan. Lori’s Place serves children and adults who suffered a death or are dealing with anticipatory grief. She is active also in fundraising for the Leukemia and Lymphoma Society.

Mr. Scott Bollenbacher is the creator and managing partner of Bollenbacher & Associates, LLC, a certified public accounting firm serving mainly small to midsize business in north-central Indiana and western Ohio. As a CPA, Mr. Bollenbacher provides accounting and tax services to clients in manufacturing, agricultural, retail, and professional services trades, as well as not-for-profits and individuals. Mr. Bollenbacher is testifying on behalf of the National Federation of Independent Business.

I will now ask our witnesses to raise your right hand.

[Witnesses sworn.]

Chairwoman Foxx. Let the record reflect the witnesses answered in the affirmative.

Before I recognize each of you to provide your testimony, let me briefly explain our lighting system. We allow five minutes for each witness to provide testimony. When you begin, the light in front of you will turn green. When one minute is left, the light will turn yellow. At the five-minute mark, the light will turn red, and you should wrap up your testimony.

Members will each have five minutes to ask questions.

Now I recognize Dr. Troy for five minutes.

TESTIMONY OF TEVI TROY, PH.D., CHIEF EXECUTIVE OFFICER, AMERICAN HEALTH POLICY INSTITUTE, WASHINGTON, D.C.

Mr. TROY. Chairwoman Foxx, Ranking Member Scott, and members of the committee, thank you all for the opportunity to testify today on the effects of the *Affordable Care Act* on large employers and their employees, as well as how to advance patient-centered solutions going forward.

My name is Dr. Tevi Troy. I am CEO of the American Health Policy Institute, a nonprofit research organization focusing on employer-sponsored healthcare benefits. I also served, as you mentioned, as a senior White House aide in the George W. Bush administration and Deputy Secretary of HHS.

While the public debate over the ACA appropriately focuses on the 20 million Americans who are receiving coverage through its exchanges, Medicaid expansion, and other provisions, the ACA also significantly and in many cases unnecessarily increased the regulatory requirements and burdens on employment-based health care that covers more than 177 million Americans.

Too little attention has been focused on this important aspect of the law. In this time of transition on health care, it is important to protect those who have gained coverage under the ACA, but it is also a critical priority to protect those who are covered by employers.

There is clear evidence that the ACA has both directly and indirectly increased the cost of employer healthcare benefits. In 2014, an American Health Policy Institute study found that over the next decade the cost of the ACA to large employers -- 10,000 or more employees -- will be about \$4,800 to \$5,900 per employee over a decade.

My written testimony includes other studies showing how the ACA has increased employer costs, and I ask that they be submitted for the record.

Furthermore, the regulatory burden the ACA imposes on businesses and individuals should not be underestimated. Since the ACA was enacted, 106 regulations implementing the law have been published. These regulations will cost the private sector more than \$51 billion and require 173 million hours of paperwork in order to comply. These cost increases come from a number of ACA provisions that have a direct impact on employees and employers and on the cost of their health plans.

Going forward, I believe that we should move toward a more patient-centered healthcare system and look to the private sector to lead transformation efforts. In order for the private sector to be innovative, it is imperative to protect the tax exclusion on employer-sponsored healthcare benefits as well as the ERISA preemption.

For more than 60 years, employer-provided health benefits have been excluded, without limit, from income and payroll taxes. Over time, this benefit has helped make employer-sponsored care a basic building block of our healthcare system. Given the role of employer-sponsored health insurance in providing stability and coverage to so many Americans, making a substantial change to the tax treatment of employer-provided health care could cause a significant disruption.

We strongly support the bipartisan effort to repeal the ACA's 40-percent Cadillac tax on employer-sponsored health benefits and urge Congress to repeal this tax, along with other ACA taxes and fees. We have seen how problematic the tax approach is by its opposition from both business and labor. We are glad that the tax has been delayed until 2020 and hope to see it repealed soon.

Reducing or eliminating the tax exemption on employer-sponsored health care would raise the same problems as the Cadillac tax. It would serve as a middle-class tax hike, drive up the health insurance costs for millions of American employees, and eliminate the strong incentives currently in place that constantly pressure large purchasers of health to demand more efficient, affordable, and effective health care from the marketplace.

Getting rid of or reducing the tax preference would also harm efforts to maintain strong risk pools and to cover the maximum number of people. As we have learned from experience with the ACA, encouraging people to get coverage is a costly and challenging endeavor, and risk pools are difficult to maintain as well. Employers, however, are both good at getting people covered and at maintaining manageable risk pools. Public policy should aim to encourage these important goals. As economist Peter Nelson has said, "Employers do get people covered -- they very successfully get people covered."

A second key issue is the ERISA preemption. ERISA is the foundation of employer-sponsored health benefits, and we encourage you to strengthen the protections in the law.

The longstanding preemption provision is vital to multi-state employers because it enables them to offer uniform, nationwide healthcare benefits at the lowest possible cost to employers no matter what state they live in. This leads to better benefit design and reduction in administrative costs through economies of scale, increased purchasing power, and greater innovation. Without it, an employer doing business in 50 different States would be required to comply with 50 different State healthcare laws, something that would make administrating a healthcare plan a complex nightmare.

In conclusion, I appreciate the opportunity to testify here today about the importance of employer-sponsored coverage and its importance to our system. Going forward, our policy should not be to increase the burdens or costs on employers and the 177 million employees and dependents who get coverage through the employer-

based system but to encourage that coverage for the benefit of our system as a whole.

Thank you for having me here today.

[The statement of Mr. Troy follows:]

**“Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions”
House Education and the Workforce Committee Testimony by Dr. Tevi D. Troy
Feb. 1, 2017**

Introduction

Chairwoman Foxx, Ranking Member Scott, and members of the committee, thank you all for the opportunity to testify today on the effects of the Affordable Care Act (ACA) on large employers and their employees, as well as how to advance patient-centered solutions going forward.

My name is Dr. Tevi Troy, and I am CEO of the American Health Policy Institute (AHPi), a non-profit research organization focusing on employer-sponsored health care benefits. I also served as a senior White House aide in the George W. Bush administration from March 2005 to July 2007 and Deputy Secretary of Health and Human Services from August 2007 until January 2009.

AHPi is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The ACA has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America’s largest employers.

While the public debate over the ACA appropriately focuses on the 20 million¹ Americans who are receiving coverage through its exchanges and Medicaid expansion, the Act also significantly, and in many cases unnecessarily, increased the regulatory requirements and burdens on employment-based health care that covers more than 177 million Americans². Too little attention has been focused on this important aspect of the law.

In this time of transition in health care, it is important to protect those who have gained coverage under the ACA, but it is also a critical priority to protect those who are covered by employers. Innovations in large employer-sponsored health care benefits are helping to significantly reduce health care costs for employees, retirees and their dependents – and leading the way for overall system reform. As health care reform moves forward, federal policies should leverage and encourage flexibility in employer-sponsored health care benefits to enable large employers to continue to make these innovations. Such policies will be critical for making the Nation’s workforce healthier and more productive and making the overall American health care system more fiscally sustainable – thereby enhancing American global competitiveness.

ACA Impact on Employer-Sponsored Health Care Benefits

There is clear evidence the ACA has both directly and indirectly increased the cost of employer health care benefits. In 2014, an American Health Policy Institute study³ found that over the next decade, the cost of the ACA to large U.S. employers (10,000 or more employees) will be \$4,800 to \$5,900 per employee, and over the same time period, the total cost of the ACA to all large U.S. employers will be \$151 billion to \$186 billion.⁴ In 2012, an Urban Institute study⁵ estimated the ACA would increase large employer (1,000 or more employees) health care costs by 4.3 percent, and mid-sized employers (101 to 1,000 employees) costs by 9.5 percent. More recently, a survey⁶ of employers by the International

Foundation of Employee Benefit Plans (IFEBP) found the ACA increased actual employer health care costs by an average of 5.8 percent.

Furthermore, the regulatory burden the ACA imposes on businesses and individuals should not be underestimated. Since the ACA was enacted, 106 regulations implementing the law have been published. These regulations will cost the private-sector more than \$51 billion⁷ and require 173 million⁸ hours of paperwork in order to comply. Moreover, hundreds of guidance documents regarding the ACA have been published by various federal agencies since 2010. According to a recent American Action Forum study,⁹ the cost of each ACA regulation published so far has averaged \$426 million and required 1.6 million hours of paperwork.

These overarching cost estimates come from a number of ACA provisions that have a direct impact on employees and employers and on the cost of their health plans. These provisions include benefit mandates such as coverage for adult-children up to age 26 as dependents; offering affordable coverage to part-time and seasonal employees; and the requirement for employers to cover 100 percent of a growing list of preventive services. Although these benefit mandates may be popular, they are not free, and are part of the reason employee health care costs are rising. Other direct ACA costs include the Patient Centered Outcomes Research Institute fee, and general ACA implementation and administrative costs associated with IRS reporting requirements.

The ACA also imposes a number of health care supply-chain taxes that are passed on to employees and employers, such as the medical device tax, the annual fee on the manufacturers and importers of brand-name drugs, and the health insurer tax for fully-insured plans.

According to the Centers for Medicare & Medicaid Services, employer-sponsored health benefits cost¹⁰ \$975.6 billion in 2016, or \$5,697 per covered life. Direct and indirect ACA provisions likely increased the cost of employer-sponsored health benefits by 5.8 percent¹¹ in 2016. This means the ACA likely cost employers \$56.6 billion in 2016, or \$330 per covered life.

Moving Toward Patient-Centered Reform

Going forward, we should move toward a more patient-centered health care system and look to the private sector for transformation. In order for the private sector to be innovative, it is imperative to protect the tax exclusion on employer-sponsored health care benefits as well as the ERISA preemption.

For more than 60 years, employer-provided health benefits have been excluded, without limit, from income and payroll taxes. And over time, this benefit has helped make employer-sponsored care a basic building block of our health care system. Given the role of employer-sponsored health insurance in providing stability in coverage to so many Americans, making a substantial change to the tax treatment of employer-provided health care could cause a significant disruption.

We strongly support repealing the ACA's 40 percent "Cadillac Tax" on employer-sponsored health benefits in the upcoming fiscal year 2017 Budget Reconciliation Bill and urge Congress to repeal this tax along with the other ACA taxes and fees. We have seen how problematic the Cadillac Tax's approach is to both businesses and unions. We are glad it has been delayed until 2020 and hope to see it repealed soon.

Reducing or eliminating the tax exemption on employer-sponsored health care would raise the same problems as the Cadillac Tax: It would serve as a middle-class tax hike; drive up health insurance costs for millions of American employees; and eliminate the strong incentives currently in place that constantly pressure large purchasers of health to demand more efficient, affordable, and effective care from the marketplace.

Getting rid of or reducing the tax preference would also harm efforts to maintain strong risk pools and to cover the maximum number of people. As we have learned from experience with the ACA, encouraging people to get covered is a costly and challenging endeavor, and risk pools are difficult to maintain as well. Employers, however, are both good at getting people covered and maintaining manageable risk pools. Public policy should be aimed at encouraging these important goals. As Peter Nelson, Director of Public Policy at the Center of the American Experiment has said, "Employers do get people covered— they very successfully get people covered."¹²

A second key issue is the ERISA preemption. The Employee Retirement Income Security Act of 1974 (ERISA) is the foundation of employer-sponsored health care benefits and we encourage you to strengthen the protections in the law. The long-standing preemption provision is vital to multi-state employers because it enables them to offer uniform nationwide health care benefits at the lowest possible cost to employees no matter what State they live in. This leads to better benefit design, a reduction in administrative costs through economies of scale, increased purchasing power, and greater innovation. Without it, an employer doing business in 50 different states would be required to comply with 50 different state health care laws, something that would make administering a health care plan a nightmare.

America's employers strongly believe that as Congress considers moves forward with health care reform, steps should be taken to strengthen the ERISA preemption, which provides the framework for the health care coverage on which millions of Americans depend.

In conclusion, I appreciate the opportunity to testify here today about the importance of employer sponsored coverage and its importance to our system. Going forward, our policy should not be to increase the burdens or costs on employers and the 177 million employees and dependents who get coverage through the employer based system, but to encourage that coverage for the benefit of our system as a whole.

Thank you for having me here today.

¹ "20 Million People Have Gained Health Insurance Coverage Because of the Affordable Care Act, New Estimates Show," Department of Health and Human Services, March 3, 2016. Available at:

<https://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>

² Jessica C. Barnett and Marina S. Vornovitsky, "Health Insurance Coverage in the United States: 2015," U.S. Census Bureau, Table 1, September 2016.

³ Tevi D. Troy and D. Mark Wilson, "The Cost of the Affordable Care Act to Large Employers," American Health Policy Institute, April 2014. Available at:

http://www.americanhealthpolicy.org/Content/documents/resources/2014_ACA_Cost_Study.pdf

⁴ *Id.*

⁵ "Implications of the Affordable Care Act for American Business," Urban Institute, October 2012. Available at:

<http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412675-implications-of-the-Affordable-Care-Act-for-American-Business.PDF>

⁶ "2016 Employer-Sponsored Care: ACA's Impact," International Foundation of Employee Benefit Plans, 2016.

Available at: <http://www.ifebp.org/pdf/aca-impact-survey-2016.pdf>

⁷ Sam Batkins, "\$1.8 Billion in Costs," American Action Forum, October 24, 2016. Available at:

<https://www.americanactionforum.org/week-in-regulation/1-8-billion-costs/>

⁸ *Id.*

⁹ Tara O'Neill Hayes, "The Regulatory Burden of the Affordable Care Act," American Action Forum, January 27,

2016. Available at: <https://www.americanactionforum.org/weekly-checkup/the-regulatory-burden-of-the-affordable-care-act/>

¹⁰ "National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar

Years 2009-2025," Centers for Medicare and Medicaid Services. Available at: [http://www.cms.gov/Research-](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015Tables.zip)

[Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015Tables.zip](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015Tables.zip)

¹¹ "2016 Employer-Sponsored Care: ACA's Impact," International Foundation of Employee Benefit Plans, 2016.

Available at: <http://www.ifebp.org/pdf/aca-impact-survey-2016.pdf>

¹² "Getting Beyond Employer-Sponsored Health Insurance: Some Fitful Starts," The American Enterprise Institute,

March 31, 2016. Available at: <https://www.aei.org/events/getting-beyond-employer-sponsored-health-insurance-some-fitful-starts/>

Chairwoman Foxx. Mr. Eddy.

TESTIMONY OF JOE EDDY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, EAGLE MANUFACTURING COMPANY, WELLSBURG, WEST VIRGINIA, ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. EDDY. Thank you. Good morning, Chairwoman Foxx, Ranking Member Scott, and distinguished members of the committee. I thank you for the opportunity to appear here today before you and for holding this hearing.

My name is Joe Eddy, and I am president and CEO of Eagle Manufacturing Company in Wellsburg, West Virginia. I'm currently on the board of directors of the National Association of Manufacturers, also known as NAM, and also serve on their Small and Medium Manufacturers Group. The NAM is the Nation's largest industrial trade association and a voice for more than 12 million men and women who make things here in America.

Eagle Manufacturing Company is a family-owned business established in 1894. We employ approximately 195 employees and are a prime manufacturer of safety cans, safety cabinets, secondary spill containment products, poly drums, and material-handling products. At Eagle, we design and manufacture all of our own products. We are a respected brand name across the world for consistent quality and value, and all of our products are still made in the United States.

Manufacturers have a proud tradition of providing health insurance for their employees. At Eagle, our tradition has been to cover 100 percent of medical costs. We have done this because it's the right thing for our employees and our community. No government policy or mandate leads us to provide this generous benefit. We often hear that people specifically want to come to work at Eagle because of our reputation for taking care of our employees. We live by our mission statement: Protecting people, property, and the planet.

Unfortunately, the last few years under the *Affordable Care Act* have made it more difficult to live up to our own standards. Rising healthcare costs have forced us to make some difficult choices, and the ACA has further limited our options.

In 2009, prior to the ACA, we were paying about \$13,500 per year per employee, and by 2013 those costs increased to over \$15,800 per year per employee. The additional taxes, paperwork, fees, and mandates of the ACA cost us nearly \$1,000 per year per employee. As much as we work to keep costs down, our plan now costs over \$22,800 per year per employee.

We do not think that our benefits are excessive. They are necessary to attract, retain, and maintain a strong, quality, and healthy workforce. And I am not alone. Ninety-eight percent of NAM members offer health insurance to employees, and the cost of health care remains a top business concern for both large and small manufacturers. These rising healthcare costs impact all facets of any company: hiring new workers, maintaining competitive pay rates, making capital investments, as well as our decisions in researching and developing new products.

Part of the challenge that the ACA ushered in was the paradigm shift in healthcare choices available to manufacturers and other businessowners. More specifically, the insurance that we had for more than 10 years was no longer available. Many of our employees had to find new doctors, and we had to learn to manage an entirely new system. Furthermore, the new product we purchased was more expensive, driving our healthcare costs up that year an additional \$4,000 per year per employee.

Unhappy with the outcomes of this change, we switched carriers again to another insurer. We are hopeful that our situation has stabilized, but businesses such as ours need flexibility and competitive options so that we can always find the best and most cost-effective plan for our employees.

Perhaps the most challenging part of the ACA is the effect that it's had on our employer-employee relations. As I mentioned earlier, Eagle has 195 employees, but it should be noted that 150 of those are unionized through the United Steelworkers Union. We have traditionally had a strong relationship with the union and our employees. However, last year, during contract negotiations, for the first time in our history, we had to negotiate a cost-sharing arrangement with the union. The union members now have to contribute \$35 per pay, or \$910 per year, towards monthly healthcare premiums. As you would imagine, those were not easy negotiations, tending to break down the trust and partnership that we had established through the many years between the company and our employees.

The years following the passage of the ACA have been costly, disruptive, and distracting from the things that we are really good at doing as manufacturers. Moreover, the dose of uncertainty delivered to us over seven years ago still has not been fully resolved.

Eagle is very proud of our 123 years in West Virginia, manufacturing innovative, quality products for our customers. As a leader in the Wellsburg community, we strive to provide healthcare benefits that allow for a strong, healthy workforce, but it is a struggle given the limits, restrictions, and mandates of the *Affordable Care Act*.

I know that my struggle is not unique and that many manufacturers across the country are facing the same challenges. I very much look forward to working with you to find a workable solution that will help control outrageous costs and provide the flexibility for employers to continue to provide the benefits their employees deserve.

Thank you for inviting me to testify before you today, and I am happy to answer any questions. Thank you.

[The statement of Mr. Eddy follows:]



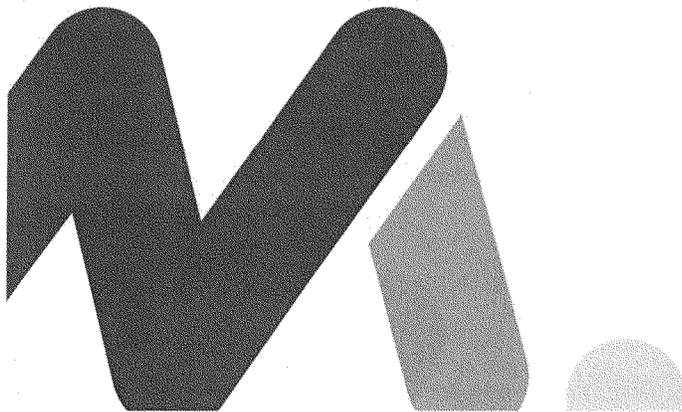
Testimony

of Joe Eddy
President and CEO
Eagle Manufacturing Company
On Behalf of the National Association of Manufacturers

Before the U.S. House Committee on Education and the Workforce
115th Congress

Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions

February 1, 2017



**TESTIMONY OF JOE EDDY, PRESIDENT AND CEO, EAGLE MANUFACTURING COMPANY
ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS
BEFORE THE U.S. HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE**

Hearing on Rescuing Americans from the Failed Health Care Law and Advancing
Patient-Centered Solutions

FEBRUARY 1, 2017

Good morning Chairwoman Foxx, Ranking Member Scott and distinguished members of the committee. Thank you for the opportunity to appear before you and for holding this hearing today.

My name is Joe Eddy, and I am president and CEO of Eagle Manufacturing Company in Wellsburg, West Virginia. I am on the Board of Directors of the National Association of Manufacturers (NAM) and also serve on its Small and Medium Manufacturers Group.

The NAM is the nation's largest industrial trade association and a voice for more than 12 million men and women who make things in America. The NAM is committed to achieving a policy agenda that helps manufacturers grow and create jobs. Manufacturers appreciate your attention to the burdens of the Affordable Care Act (ACA) that are impacting the competitiveness and growth of manufacturers around the nation. My story is not unique; it is one of many experiences that manufacturers have experienced over the past several years.

Eagle Manufacturing Company is a family-owned business established in 1894. We employ 195 employees and are a prime manufacturer of safety cans, safety cabinets, secondary spill containment products, poly drums and material-handling products. At Eagle, we design and manufacture all of our own products. We are a respected brand name for consistent quality and value, and all of our products are "Made in the USA." We supply nearly every industrial and commercial sector: contractors, manufacturers, utilities, military, professional, government, printing, chemical, fabricators, transportation, textile mills, automotive, agricultural, medical, oil and gas and electrical. In 2015, Eagle received the NAM's Sandy Trowbridge Award for Excellence in Community Service, and last year, Secretary of Commerce Penny Pritzker awarded us the President's "E" Award for Exports, the highest recognition any U.S. entity can receive for making a significant contribution to the expansion of U.S. exports.

Manufacturers have a proud tradition of providing health insurance for their employees. More than 98 percent of NAM members offer health benefits to their employees. At Eagle, our tradition has been to cover 100 percent of medical costs for our employees. We have done this because it's the right thing to do for our employees and our community. No government policy or mandate leads us to provide this generous benefit. We often hear that people specifically want to come to work at Eagle because of our reputation of taking care of our employees. We live by our mission statement: "Protecting People, Property and the Planet."

Unfortunately, the past few years under the ACA have made it more difficult to live up to the standards we have set for ourselves. Rising health care costs have forced us to make some difficult choices, and the ACA has further limited our options. In 2009, prior to the ACA, we were paying about \$13,500 per year per employee, and by 2013, those costs increased to more than \$15,800 per year per employee. At that time, I was

tasked with specifically looking at the added costs to the company resulting from the impacts of the ACA because our health care costs were on the rise and posing a risk to the company's financial health. The taxes, paperwork, fees and mandates cost us almost \$1,000 per year per employee, and this does not include the hiring of an additional human resources professional who specifically manages health care and all the new requirements. As much as we work to keep costs down, our plan now costs more than \$22,800 per year per employee, so we are at even more risk if the "Cadillac" tax is not repealed. In addition, as a fully insured company that works directly with insurance brokers to purchase employee health plans, we are exposed to the health insurance tax in 2018.

We do not think our benefits are excessive; they are necessary to attract, retain and maintain a strong, quality and healthy workforce. Unfortunately, the cost of health care remains a top business concern for both large and small manufacturers based upon quarterly survey results conducted by the NAM that focus on manufacturing sentiment. While the overall business outlook is improving, there has been limited relief in sight to address escalating health care costs. Since being added to the NAM survey two years ago, it has been listed as a primary business concern each quarter. Rising health care costs impact all facets of any company—hiring new workers, maintaining competitive pay rates and making capital investments as well as researching and developing new products.

Part of the challenge that the ACA ushered in was the paradigm shift in health care choices available to manufacturers and other business owners. Options that were once available to us became more limited over time. More specifically, the insurance that we had for more than 10 years was no longer available. It put a whole new meaning to the oft-repeated words of the previous president, "If you like your health care plan, you

can keep it." Many of our employees had to find new doctors, and we had to learn to manage a new system. Furthermore, the new product we purchased was more expensive, driving our health care costs up an additional \$4,000 per year per employee. Unhappy with the outcomes of this change, we switched carriers again to another insurer. We are hopeful that our situation has stabilized. Businesses such as ours need flexibility and competitive options so that we can always find the best and most cost-effective plan for our employees.

But the most challenging part of the ACA is the effect it has had on our employer–employee relations. As I mentioned earlier, Eagle Manufacturing has 195 employees, but it should be noted that 150 of those are unionized through the United Steelworkers Union. We have traditionally had a strong relationship with the union and those employees. However, last year during contract negotiations, for the first time, we had to negotiate a cost-sharing arrangement with the union because of the untenable rise in health care costs facing Eagle. It was a difficult choice, and I am proud that for the competitiveness and well-being of the company, the union agreed. Employees now contribute \$35 per pay period (\$910 per year) toward monthly health insurance premiums. As you would imagine, those were not easy negotiations. It broke down the trust and partnership between the company and our employees. For our non-union employees, we now have to charge \$50 per pay period (\$1,200 per year) for their co-share.

The years following ACA passage have been costly, disruptive and distracting from the things we are good at doing as manufacturers. Moreover, the dose of uncertainty delivered to us more than seven years ago still has not been fully resolved. We look forward to working with you to help address these mounting issues, and I appreciate the opportunity to share my experiences on behalf of my company and other

manufacturers. In speaking for myself and others, we urge Congress to focus its efforts on solutions that will successfully eliminate the costliest and most problematic aspects of the ACA. The challenges ahead—a continued escalation of health care costs paid by employers and employees through the anticipated “Cadillac” tax on comprehensive health plans, an excise tax on medical devices, a health insurance tax and other administrative burdens—all demand immediate and thoughtful attention from Congress.

Eagle is very proud of our 123 years in West Virginia, manufacturing innovative, quality products for our customers. As a leader in the Wellsburg community, we strive to provide health care benefits that allow for a strong, healthy workforce, but it is a struggle given the limits, restrictions and mandates of the ACA. I know that my struggle is not unique and that other manufacturers around the country are facing the same challenges.

I very much look forward to working with you to find workable solutions that will help control outrageous costs and provide the flexibility for employers to continue to provide the benefits their employees deserve. Thank you for inviting me to testify before you today, and I am happy to answer your questions.

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Chairwoman Foxx. Thank you very much.
Ms. Schlaack, you are now recognized for five minutes.

TESTIMONY OF ANGELA SCHLAACK, ST. JOSEPH, MICHIGAN

Ms. SCHLAACK. Good morning, Chairwoman Foxx, Ranking Member Scott, and the members of the committee. Thank you very much for inviting me to attend the session today.

My name is Angela Schlaack, and I am originally from central Texas but have been a longtime resident of St. Joseph, Michigan. I'm here today to share with you a little bit about how the *Affordable Care Act* has impacted my life and the lives of my family. Never could I have imagined the life-changing events that would bring me here today.

In November 2013, my husband, Michael Schlaack, suddenly had three days of extreme fever, headaches, and sweating. Michael was diagnosed with the most aggressive form of acute myeloid leukemia, and he had mere days to live. He was 44, exercised, did not smoke, got routine medical checkups, and had no prior health issues.

He was admitted to the University of Chicago Medical Center's Leukemia Intensive Care Unit that night, as our local hospital does not have the ability to treat this type of disease.

The University of Chicago is about 90 miles from our home, and the distance created an additional hardship on our lives. This diagnosis meant he was forced to take an extended leave from work, as living with AML is a full-time job in itself. His employer, Whirlpool Corporation, was supportive and, thankfully, very generous in their benefits. Little did we know at that point the cost of treating leukemia and how valuable our health insurance would be.

The only cure as of now for AML involves chemotherapy and donor stem cell transplant. Not only were we responsible for Michael's medical expenses, but patients are also responsible for those of their donor.

After six weeks of chemotherapy to keep the leukemia under control and preparation for transplant in place, Michael was able to return home for a few weeks before returning for another minimum six weeks inpatient. In those weeks at home, we still had to return to his hematology oncologist two to three times per week. At this point, we were beginning to realize the financial magnitude of what treatment for leukemia entails. Our bills were exceeding a million dollars already.

Within three months of his stem cell transplant, Michael's leukemia relapsed with a vengeance. At this point, the only options were clinical trial therapies. We spent the next four months in and out of the hospital in Chicago, and he needed blood transfusions every few days. One bag of blood, which he was receiving multiple units of per week, was over \$1,500 each. In addition to the 20 or so prescriptions he was taking, the constant trips for doctor visits to Chicago, we still had to maintain our household financially.

With the extreme physical, mental, and emotional stress that came with this journey, one thing we did not have to worry about was the fact that we knew our insurance would not cut us off after any lifetime maximum. Hoping Michael would survive, we knew,

despite this now preexisting condition, he would stay covered and not be discriminated for something he had no control over.

The provisions of the *Affordable Care Act* kept us from filing bankruptcy and losing what we had built up in our over 20-year marriage. The expenses incurred in a matter of 10 months were nothing any health savings account could properly fund. We had peace of mind knowing Whirlpool's insurance would take care of us.

In September 2014, Michael died at age 45 of AML. As I had been a full-time caregiver to him, in addition to trying to maintain some normalcy for our family, I was not employed. I was a stay-at-home mom to our then-10-year-old daughter. Our young adult son was in graduate school at the time and was entering the Peace Corps after graduation. Whirlpool graciously covered the three of us under their insurance for the rest of the calendar year.

Though offered COBRA benefits beginning in 2015, the premiums were beyond anything I could afford. I was able to take advantage of something I never expected to need, the healthcare marketplace.

Knowing I needed to continue to provide for myself and daughter from here on out, I decided to go back to college to complete my degree. Having access to the marketplace gave me the ability to provide excellent coverage for us at an extremely low monthly rate and not have to return to work yet simply to have the benefit of health insurance. We were able to keep our same doctors, and while dealing with our grief and this new life, the ability to have full coverage, including mental health benefits, was one less worry.

Though I am just a common person from a small town in the Midwest, I know my experience with devastating health issues and having my whole world turned upside down in the blink of an eye is not uncommon, and anyone can be one illness away from losing everything they have. Our bills were nothing a health savings account could have remotely covered. Had Michael survived, he would have had a major preexisting condition. And being that AML has genetic links, our family is at risk for facing similar situations down the road.

The *Affordable Care Act* has helped keep my life moving forward. It's given me the ability to continue a healthy life with access to routine care and without worry that one hospital admission could cost me everything.

I implore you to please consider the benefits that the *Affordable Care Act* has provided. Whether through an employer or the marketplace, everyone deserves that peace of mind.

Thanks for your willingness to hear my voice.

[The statement of Ms. Schlaack follows:]

Good morning Chairman Foxx, Ranking Member Scott, and the members of the Committee. Thank you very much for inviting me to attend this session today and share with you some of my story that has greatly impacted my life. My name is Angela Schlaack and though I am originally from central Texas, I am a long-time resident of Saint Joseph, Michigan, a lovely beach community on the shores of Lake Michigan.

The reason I am here today is to share with you a little about my recent experience with unforeseen medical issues and how the Affordable Care Act has impacted my life and the lives of my family. Never could I have imagined the life changing events that would bring me here today.

In November 2013, my husband Michael Schlaack had three days of extreme headaches, fever, and sweating. Just days before he had been on his usual 5 mile walk on the beach, had been busy with his supply chain job at Whirlpool Corporation, and our life was quiet and routine. Knowing something just was not right, he went to his physician and unsure of what was wrong, he ordered blood work. Within hours we were given the diagnosis. Michael had leukemia. Due to the extreme white blood count level, the doctors realized he had mere days to live and he was admitted to the University of Chicago Medical Center's leukemia Intensive Care Unit that night as our local hospital does not have the ability to treat this type of disease. Thus began our journey that no one ever saw coming. Michael was the picture of health. He was 44, exercised, did not smoke, got routine medical check ups, and was never sick.

After further tests were done at the University of Chicago, it was determined that Michael had one of the very most aggressive types of Acute Myeloid Leukemia (AML). The life expectancy for his diagnosis is grim and the chance of recurrence is high. The only cures as of

now for AML involve chemotherapy and stem cell transplants, what were formerly more commonly known and processed as bone marrow transplants. Michael was initially an inpatient from the night of his diagnosis for six weeks in preparation for his stem cell transplant. Though the University of Chicago hospital is about 90 miles from our home, we were grateful to be in such good care, despite the distance that created an additional hardship on our lives. His diagnosis also meant he was forced to take an extended leave from work. Living with AML is a fulltime job in itself. His employer, Whirlpool Corporation, was supportive and thankfully, very generous in their benefits. Little did we know at that point the cost of treating leukemia and how valuable our health insurance would be.

Stem cell transplant therapy requires a donor and fortunately a great match was found for Michael from a young man in Germany. Not only are we responsible for Michael's medical expenses, patients' are also responsible for their donor's medical expenses. After six weeks of chemotherapy to keep the leukemia under control, having the preparation for stem cell transplant in place, Michael was able to return home for a few weeks before returning for another minimum of six weeks inpatient. In those few weeks at home, we still had to return to his hematology oncologist two to three times per week. Around this time is when the first medical bills started rolling in to us. We were very thankful that his employer considered him a fulltime employee and our insurance stayed intact. At this point we were beginning to realize the financial magnitude of what treatment for leukemia entails. Our bills were exceeding a million dollars already.

Unfortunately within three months of his stem cell transplant, Michael's leukemia mutated around the donor's cell and the disease was back with a vengeance. At this point the only options are clinical trial therapies. We spent the next four months in and out of the hospital

in Chicago for fevers, doctor visits, and blood transfusions every few days. A simple bag of specially processed blood, which he was receiving multiple unit of per week, was over \$1500 each. Cancer does not discriminate between economic abilities. In addition to the 20 or so prescriptions he was taking, the constant trips for doctor visits to Chicago, we still had to maintain our household financially. With the extreme physical, mental, and emotional stress that came with this journey, one thing we did not have to worry about was the fact that we knew our insurance would not cut us off after any lifetime maximum. In looking forward and with hopes that Michael would survive, we knew despite this now pre-existing condition, he would stay covered for the rest of his life and not be discriminated for something he had no control over. The provisions of the Affordable Care Act kept us from filing bankruptcy and losing everything we had built up in our over twenty year marriage. The expenses incurred in a matter of 10 months was nothing any health savings account could properly fund. To this day I am eternally grateful for the peace of mind we had knowing Whirlpool's insurance would take care of us.

In September 2014, Michael died at age 45 from AML. I had been a stay at home mom for the past 10 years to our then 10 year old daughter and young adult son who was in graduate school at the time. Whirlpool graciously covered us under their insurance for the rest of the calendar year. As I had been a fulltime caregiver to Michael in addition to trying to maintain some normalcy for our children, I was not employed. I found myself as a young widow with a child still at home. Thankfully I still had access to insurance for all of us, including my son who was still under 26 years old. He had signed on to join the Peace Corps immediately after graduating and again, thanks to the ACA, knowing he was still covered under the employer's policy was just that much more of a relief to me.

Though offered COBRA benefits beginning in 2015, the premiums were far beyond anything I could afford. At that point I was able to take advantage of something I never expected to need, the healthcare marketplace. My income was comprised of a pension from Michael's employer, life insurance, and social security benefits. Knowing I needed to continue to provide for myself and daughter from here on out, I decided to go back to college to complete a degree that I never had. Having access to the marketplace for our insurance gave me the ability to provide excellent coverage for my daughter and myself at an extremely low monthly rate and not have to return to work just yet simply to have the benefit of health insurance. We were able to keep our same doctors and while dealing with our grief in this new life we had, being able to have full coverage including mental health benefits was one less worry.

Though I am just a common person from a small town in the Midwest, I know my experience with devastating health issues and having my whole world turned upside down in the blink of an eye is not uncommon. I realize anyone can be one illness away from losing everything they have. Our bills were nothing a health savings account could have remotely covered, had Michael survived he would have had a major pre-existing condition forever, and being that AML has genetic links, our family is at risk for facing similar situations down the road. The Affordable Care Act has helped me keep my life moving forward. It has given me the ability to continue a healthy life with access to routine care and without worry that one hospital admission could cost me everything. I implore you to please consider the benefits that this Affordable Care Act has provided to every single person in the United States. Whether through an employer or the marketplace, everyone deserves that peace of mind.

Thank you for your willingness to hear my voice.

Chairwoman Foxx. Thank you very much.
Mr. Bollenbacher, you're recognized for five minutes.

TESTIMONY OF SCOTT BOLLENBACHER, CPA, MANAGING PARTNER, BOLLENBACHER & ASSOCIATES, LLC, PORTLAND, INDIANA, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. BOLLENBACHER. Good morning, Chairwoman Foxx, Ranking Member Scott, and members of the committee. My name is Scott Bollenbacher, and I'm a managing partner of Bollenbacher & Associates, a CPA firm serving individuals and small-business clients, most of which are family-owned.

I started the business in 2004 with six employees serving 400 clients. We have grown to 11 full-time employees and six part-time employees serving 1,600 clients. I am pleased to be here on behalf of the NFIB to discuss how the ACA has impacted our business and our clients at today's hearing.

As a small business, we are a close-knit family. Our employees are much more than employees; they are our friends. We care deeply for them. We care for their families. We want to provide for them -- provide benefits and help in any way we can. We know that our success as a business depends on our team. Most of our employees have been with us for 10 or more years.

From 2004 to 2014, our firm maintained a high-deductible health insurance plan accompanied by a health savings account. The firm paid the entire premiums and funded up to \$3,000 per year to the employees' HSA. This plan worked well for the business and our employees. We saved tax-preferred funds for predictable and unforeseen medical expenses.

In late 2014, we learned that our policy no longer qualified under the ACA because it did not cover the essential health benefits package, specifically pediatric dental coverage. I requested the benefit be added but was unable to do so, and we lost our plan.

We did not know what to do, and we had little time to choose a new option, but we explored all the available options with a consultant. We considered purchasing insurance through the SHOP exchange. However, the plan would have cost over 50 percent more than our previous plan with less coverage. We considered dropping health insurance altogether and increasing the employees' salary to help them purchase insurance on their own. IRS restrictions made this very difficult. We considered a healthcare sharing ministry called Medi-Share, and we considered self-insuring.

The only feasible option at the time was a partially self-funded plan. I believe our firm was the smallest group they accepted at the time. The premiums were similar to our previous plan, but the coverage was not as good. It carried a higher deductible and did not cover vision care. It did not cover my family doctor.

We have maintained this coverage for two years. In the fall of 2016, we learned that our carrier no longer wanted to offer self-funded health plans to small businesses, so they proposed to raise our premiums by 156 percent. We could either pay the increase or leave. We left. Essentially, our plan was canceled again. As with most small businesses, we must watch our expenses. A 156-percent increase is not possible.

Once again, we worked with our benefit consultant to explore all options. Shopping for the right plan is complicated for us because the firm is close to the Indiana and Ohio border. Our employees live in both states. We must find a policy that is accepted by doctors and hospitals on both sides of the state line.

We finally settled on another fully insured plan at a 78-percent increase. It was our only available option. Most of our employees liked the HSA option we maintained for 12 years, but this plan is not HSA-eligible.

The experience has been frustrating and stressful. The increases and cancellations are unsustainable for a small business like ours.

Many clients experience similar disruption with premium increases and plan cancellations:

A church could no longer provide three ministers with tax-preferred money to purchase coverage in the individual market due to IRS guidance. The pastors ended up purchasing coverage on the individual exchange that was twice as expensive because they did not qualify for a subsidy.

A cabinet manufacturer with 25 employees could no longer contribute the entire premium to their employees after a 44-percent increase to their 2017 plan.

A pallet manufacturer with 110 employees who could neither afford the \$500,000 insurance nor the \$70,000 employer mandate penalty was forced to terminate 80 employees and subcontract some of the work.

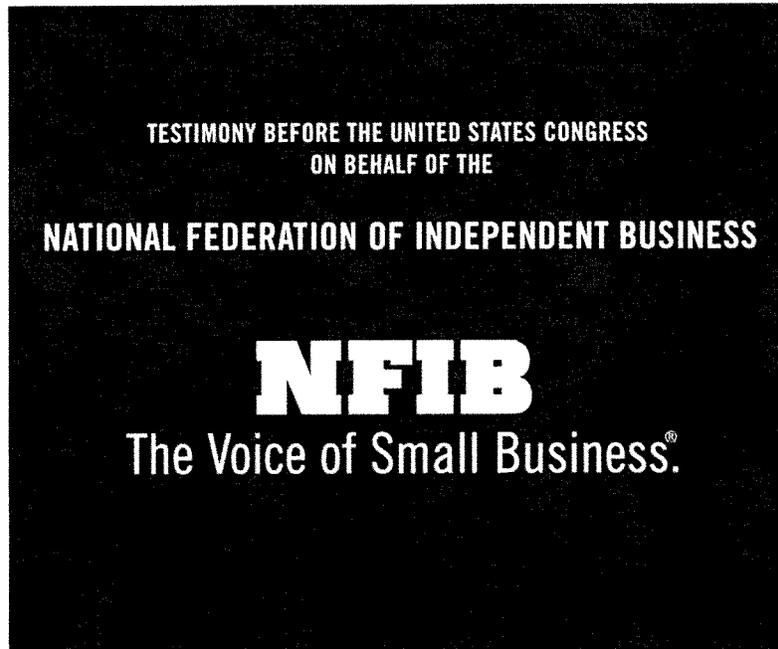
A farmer couple who earns just above the subsidy had to pay a 38-increase after their plan was canceled.

And a single, female businessowner suffered a policy cancellation, forcing her onto the individual exchange marketplace, where her premiums doubled without a subsidy.

I want you all to know what's going on in the real world with average Joes and Janes. We work very hard. I brought a picture of our team today so that you see that we're real people. We've been hurt badly by the cost increases caused by the ACA and request your assistance in fixing this. As you consider repealing and replacing ACA, I encourage you to focus on lowering the costs and increasing flexibility for small businesses.

Thank you again for allowing me to share my story today, and I'm happy to answer any questions.

[The statement of Mr. Bollenbacher follows:]



Testimony of Scott Bollenbacher,
House Committee on Education and the Workforce
February 1, 2017

*Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered
Solutions*

Good morning, Chairwoman Foxx, Ranking Member Scott, and members of the Committee on Education and the Workforce. My name is Scott Bollenbacher. I am a Certified Public Accountant (CPA) and the managing partner of Bollenbacher and Associates, a CPA firm serving individual and small business clients, most of which are family owned.

I started the business in 2004 with six employees serving 400 clients. We have grown to 11 full-time employees and six part-time employees serving 1,600 clients. Even though we are in the middle of our busy season, I felt this issue is so important that I accepted the invitation to testify. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB) to discuss how the Affordable Care Act (ACA) has impacted our business and our clients at today's hearing.

NFIB is the nation's leading small business advocacy organization. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB represents about 325,000 independent business owners located throughout the United States.

As a small business, we are a close-knit family. Our employees are much more than "employees." They are our friends. We care for them deeply. We care for their families. We want to provide for them, provide benefits, and help them any way we can. We know that our success as a business depends on our team. Most of our employees have been with us for ten years or more.

From 2004 to 2014, our firm maintained a high-deductible health insurance plan accompanied by a health savings account (HSA). Many of our clients maintained a similar benefit. The firm paid the entire premium and funded up to \$3,000 per year into employees' HSAs. This plan worked well for the business and our employees. We saved tax-preferred funds for predictable and unforeseen medical expenses.

During that period, our premiums increased eight to twelve percent annually. These premium increases impacted raises and rates but were manageable.

In late 2014, our benefits consultant informed us that our policy no longer qualified under the ACA because it did not cover the entire Essential Health Benefits package, specifically pediatric dental coverage. Despite the lack of children on the plan, I requested adding that benefit but we were unable to do so. We lost our plan.

We did not know what to do and had little time to choose a new option, but we explored all available options with our consultant.

No Good Options

- 1) We considered purchasing insurance through the Small Business Health Options Program (SHOP) exchange. However, that plan would have cost over 50 percent more than our previous plan with less coverage.
- 2) We considered dropping health insurance altogether and increasing employees' salaries to help them purchase insurance on their own. IRS restrictions made this option difficult.
- 3) We considered a health care sharing ministry called Medi-Share.
- 4) We considered self-insuring.

The only feasible option at the time was a partially self-funded plan with a \$25,000 stop loss policy. I believe our firm was the smallest group they accepted at the time. Self-funding came with increased compliance responsibilities and increased risk, but it seemed like the best option. The premiums were similar to our previous plan, but the coverage was not as good. It carried a higher deductible and did not cover vision care. It did not cover my family's doctor. We maintained this coverage for two years.

In the fall of 2016, our benefits consultant informed us that our carrier no longer wanted to offer self-funded health plans to small businesses, so they proposed to raise our premiums by 156 percent. We could either pay the increase or leave. We left. Essentially, our plan was canceled again.

As with most small businesses, we must watch our expenses. A 156 percent increase was not possible. Once again, we worked with our benefits consultant to explore all options.

Shopping for the right plan is complicated for us because the firm is close to the Indiana-Ohio border, and our employees live in both states. We must find a policy that is accepted by doctors and hospitals on both sides of the state line.

We finally settled on another fully-insured plan at a 78 percent premium increase. It was our only available option. Most of our employees liked the HSA option we maintained for 12 years, but this plan is not HSA eligible.

The experience has been frustrating and stressful. The increases and cancellations are unsustainable for small businesses.

Similar Client Experiences

I don't know of any clients who were uninsured previously. Many clients suffered plan cancellations, forcing them into the exchange marketplace. Some anecdotes include:

- A church could no longer provide three ministers with tax-preferred money to purchase coverage in the individual market due to IRS guidance. The pastors ended up purchasing coverage on the individual exchange that was twice as expensive because they did not qualify for a subsidy.
- A cabinet manufacturer with around 25 employees could no longer contribute the entire premium to their employees after a 44 percent increase for their 2017 plan.
- A pallet manufacturer with 110 full-time equivalent employees, who could neither afford the \$500,000 insurance costs nor the \$70,000 employer mandate penalty, was forced to terminate 80 employees and subcontract out some work.
- A farmer couple, who earn just above subsidy-eligibility, had to pay the entire 38 percent increase after a plan cancellation at the end of 2014.
- A single female small business owner suffered a policy cancellation, forcing her into the individual exchange marketplace where her premiums doubled without a subsidy.

I want you all to know what is going on in the real world with "average Joes and Janes." We work hard every day. I brought a picture of our team so you can see we are real people. We have been hurt badly by the cost increases caused by the ACA and request your assistance in fixing this issue.

As you consider repealing and replacing the ACA, I encourage you to focus on lowering costs and increasing flexibility for small businesses. Thank you again for allowing me to share our story today. I am happy to answer any questions.

Chairwoman FOXX. Thank you very much.

Thanks to all of our witnesses.

And now we'll recognize members for five minutes of questioning, and I'll begin with Dr. Roe.

Mr. ROE. Thank you, Dr. Foxx.

And, first of all, Ms. Schlaack, I want to offer you my condolences for your loss. Two years ago today, I was sitting home with my wife, who was dying of cancer. So, certainly, my sympathy goes out to you and your family, and I share your grief.

Ms. SCHLAACK. Thank you.

Mr. ROE. You know, we had a promise from the administration, when we started debating the *Affordable Care Act*, to increase access and lower cost. And I think certainly everybody agreed with that. I know on our side of the aisle I did. And you all don't know me, but I'm a doctor that practiced medicine for over 31 years before I ran for Congress.

And so what did we get? We got some increased access, but at what cost? And I know at our local hospital at home, 60 to 70 percent of the uncollectible debt -- now, it's a billion-dollar healthcare system -- are people with insurance.

And, certainly, we agreed on the preexisting conditions -- everybody on this dais agreed with that -- and lifetime limits. I think that certainly was something that we all agreed on, because health care is more sophisticated and costs more money than it used to.

And we created this incredibly complex plan. And I said this seven years ago in an article I wrote. I could have done three-fourths of what the ACA did in two paragraphs. And I've just heard the data that once again proved that. Mr. Scott pointed out that 20 million people who weren't covered are. Over half of them are Medicaid. We could have expanded Medicaid and allowed 26-year-olds to stay on their parents' healthcare plan. That would have covered, along with the 5 million people, almost, who lost their insurance, including me -- I had perfectly good healthcare insurance and lost it and had to go on the ACA. You ended up with 80 percent. All these regulations and things that these three witnesses have talked about could have been avoided easily.

In my own state, almost as many people pay a penalty, a tax, a fee, whatever Judge Roberts labeled it, as get a subsidy. And for the people who get a subsidy, it's a good deal. The problem with it is there are millions of other people out there with small businesses who are being harmed by this.

I was a mayor of my local community before I got elected, and we had to pay a \$180,000 fee so that insurance companies would stay in the market. Eighteen of the 23 co-ops, one in the state of Tennessee, went broke to the tune of billions of dollars of costs of -- really, no health care got provided. Just the taxpayers were on the hook for this.

And I can tell you flatly, we went through this over 20 years ago in our state, healthcare reform. I could have written the epitaph of what's happening. We don't do something, we cannot not do something, because no one is going to be able to afford health insurance coverage any longer if we don't. I mean, Bill Gates won't be able to buy a health insurance policy. When you're talking about

\$22,000, that makes you not competitive with other people in foreign countries, and eventually you will lose your business.

And, Mr. Bollenbacher, you mentioned one of the things you want to do is go across the state lines. I have a city in my district, Bristol, Tennessee/Virginia. I mean, the center street of that, one side you're in Virginia, one side you're in Tennessee, but you can't purchase health insurance.

Mr. Scott mentioned there are no plans. There are. I've written one, and it has 130 cosponsors. It's been submitted, and we'll have some version of that.

What I want to know from you all at the dais is what can we do, what would you expect us to do. When we rewrite this policy, what could we do to help you lower the cost and increase access, which was the premise of the ACA to begin with?

Anyone can take it.

Mr. TROY. I'll step in. Thank you for your statement, Mr. Roe.

So we believe that the way to approach this is to try and incentivize the purchase of health care by lowering costs overall. What the ACA did, as you so cogently said, was to increase the costs for everyone and subsidize a select few. I think a better approach would be to try and make it cheaper overall to reduce costs.

And there have been a number of Republican plans that have done this: the HSAs, health savings accounts, purchase across State lines, tort reforms, and association health plans that would allow people to get the tax benefits not just through their employer. And a combination of those things have been scored by the Congressional Budget Office as having the effect of reducing overall premiums.

Mr. ROE. And Ms. Schlaack mentioned -- I use a health savings account and have since the day they came out. And for most people -- for her, she's right; it would only have covered part of the cost of that, not this astronomical cost. But for most of the care, it would work just fine.

And the cost of the ACA -- a personal testimonial. I had major back surgery in September of this year. I looked at all the bills I got for the doctor, for the hospital, for the anesthesia, the MRIs, all of that. At the cost of the ACA, they still made money on me this year. My premiums were that expensive. And so I can pay that, but the average person where I live in rural Appalachia, which is what I represent, cannot.

With that, I'll yield back.

Chairwoman FOXX. Mr. Scott, you're recognized for five minutes.

Mr. SCOTT. Thank you, Madam Chair.

Madam Chair, I'd like unanimous consent to enter into the record a report prepared by the committee staff on the Democratic side showing the benefits of the *Affordable Care Act*.

Chairwoman FOXX. Without objection.

[The information follows:]

What's at Stake for Working Families?

Highlighting the Progress of the Affordable Care Act

Prepared by the Democratic Staff of the U.S. House Committee on Education and the Workforce
Ranking Member Bobby Scott (D-VA) | February 2017

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, was enacted to improve and expand access to health insurance for all Americans. This historic law represents an important step toward full coverage for every individual, working family, and child across the country, and it has affirmed the belief that quality, affordable health care is a right, not a privilege. The ACA preserves and builds upon the current employer-sponsored insurance system – where most Americans get their health insurance – and also creates a Marketplace where individuals and families can compare private insurance plans and purchase coverage that fits their needs. Whether workers access health coverage through their employers or in the Marketplace, the ACA benefits all types of consumers.

The law's comprehensive approach to health insurance reform rests on its requirement that everyone buy insurance. Some studies of state markets indicate that health care costs skyrocket in the absence of this requirement. If families and healthy individuals wait until they get sick to buy insurance, that drives costs up for everyone. So, the ACA's requirement that every person have coverage helps keep costs down.

In the seven years since the ACA was signed into law, 20 million previously uninsured Americans have gained access to health care insurance and the uninsured rate is the lowest on record.^{1,2} More specifically, the uninsured rate has dropped from 16.3 percent in 2010 to 8.6 percent today.³ This is a truly historic

accomplishment. Many of these newly insured Americans are working people – some work part-time, some work for themselves, and others simply could not buy health insurance through their job. With the assistance of tax credits, these workers and others can now purchase private insurance through the Marketplace, making health care more affordable for everyone.

However, the ACA did much more than expand insurance coverage. To ensure that more Americans receive higher quality services, the ACA introduced stronger consumer protections. This has made a tangible improvement in the lives of millions of Americans. Many of the consumer protection provisions of the ACA enjoy widespread popularity. For example, more than 80 percent of Americans, both Democrats and Republicans, support allowing young people to stay on a parent's insurance plan until they turn 26, as well as the protection that lets women and families access preventive services without a co-pay or deductible.⁴ Despite this, Republicans in Congress are committed to repealing the law without a replacement plan that improves health care security for working families.

1. Department of Health and Human Services, *New Report Details Impact of the Affordable Care Act*, December 13, 2016, available at: <https://www.hhs.gov/about/news/2016/12/13/new-report-details-impact-affordable-care-act.html>

2. Centers for Disease Control and Prevention, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015*, available at: <https://www.cdc.gov/nchs/data/press/earlyrelease/insur201605.pdf>

3. Id. & The Office of the Assistant Secretary for Planning and Evaluation, *Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey*, September 13, 2011, available at: <https://aspe.hhs.gov/basic-report/overview-uninsured-united-states-summary-2011-current-population-survey>

4. Kaiser Family Foundation, *Kaiser Health Tracking Poll: November 2016*, December 1, 2016, available at: <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>

SOME OF THE WAYS WORKING FAMILIES WITH JOB-BASED COVERAGE BENEFIT FROM THE ACA

Access to health insurance remains a popular job-based benefit for both workers and employers. By recognizing the importance of employer-provided insurance, the ACA strengthens job-based coverage for the more than 155 million Americans who are already covered through their employers.⁵

The ACA provides that:

- **Young adults can stay on a parent's plan until age 26**
- **There are no limits on care**
- **Doctor-recommended wellness visits and preventative care are now covered without cost sharing**
- **Insurance companies are required to spend premium dollars on health expenses**
- **Prohibitions on long waiting periods before coverage kicks in**

Democrats in Congress remain committed to full implementation of the ACA and have offered ways to improve the law, including increasing quality of care and making health services even more affordable for America's working families.

This report highlights ten of the most important ways in which the ACA has improved the lives of, hard working Americans and their families. The report also illustrates why efforts to repeal the ACA are dangerous for students, families, and working people. Lastly, it outlines ways in which working families without job-based health insurance, benefit from access to comprehensive coverage in the Marketplace.

5. Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, 2015*, available at: <http://kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0>

1 *Strengthening Health Coverage Rights and Protections for Working Families*

Before the ACA, many families struggled to manage chronic health conditions that required regular or expensive treatment. All too often, families would “cap out” – hitting an annual or lifetime limitation on benefits. After the cap, working people commonly ran out of health care benefits and were left to pay for the services they desperately needed. This led to financial instability for many families, who were forced to make tough choices, such as whether to pay for health care or pay rent.

However, under the ACA’s elimination of lifetime and annual benefit caps, working people – including those with job-based insurance – are protected from these coverage limits. Workers are now safeguarded from incurring unreasonable out-of-pocket expenses, which can be financially crippling for many families, especially those struggling to make ends meet while recovering from a major health issue. While affordability of coverage is still a concern for some workers and Congress can do more in this area, the improvements made through the ACA provide important protections for families with job-based coverage. Repealing the ACA would strip away the protections that benefit so many families across the country now. Without the ACA, our nation’s workers would be susceptible to paying unlimited costs for their health care.

Repeal of the ACA would leave working people susceptible to paying unlimited costs for health care.

“I have Multifocal Motor Neuropathy which is a very expensive disease to treat. There is no cure. Fortunately, I have great insurance from my employer and they have fully covered my illness without exception. I would have reached the \$2 million lifetime maximum payout at the end of December 2010. By some miracle, as of January 2011, lifetime maximum payout limits became illegal. I’ll now be able to continue treatment which allows me to work and be a productive member of our society...”

– Sue, Powell, WY
Moms Rising “Healthcare is a Lifesaver” Storybook

2 *Putting Money Back into the Pockets of Working People*

Thanks to a provision in the Affordable Care Act, Americans have already saved \$9 billion dollars in the form of rebates from insurance companies. If an insurance company isn't spending at least 80 percent (85 percent in the large group market) of premium dollars on quality medical care, they are required to send some money back to families.⁶ This protection has put money directly back into the pockets of working people when their insurance company spends too much money on administrative costs – such as marketing, advertising, and executive bonuses – and not enough on actual health care expenses. With the ACA in place, consumers get a rebate check or some other form of payment from their insurer. The concept is simple: health insurance premiums should pay for actual health-related expenses.

While many working families continue to face challenges with health care costs and cost-sharing, such as deductibles and co-payments, the progress we have made under the ACA is quite meaningful. It is time to move forward, not backward, in addressing these affordability challenges. If Republicans successfully repeal the ACA, this progress will be rolled back – eroding transparency in health coverage and undoing the requirement that health premiums be used for health benefits and quality of care. Repeal of the ACA means insurance companies will once again be able to use workers' hard-earned money on frivolous expenses, taking us back to the days when insurers could spend an enormous amount of premium dollars on CEO bonuses, instead of working families' health care.

Americans have
SAVED \$9 BILLION
in the form of rebates.



Repeal would take us back to the days when insurers spent a huge chunk of premiums on CEO bonuses, instead of working families' health care.

6. Department of Health and Human Services, Consumers Have Saved a Total of \$9 Billion on Premiums, July 24, 2014, available at: <http://www.hhs.gov/about/news/2014/07/24/consumers-have-saved-total-of-9-billion-on-premiums.html>

3 *Enabling Financial Security for Young Workers*

Many young people often find themselves in difficult financial positions before they establish their place in the workforce. For example, many young adults have student loan debt and other financial demands such as rent, transportation, and living expenses. Before the ACA, they had limited insurance options, leaving them at the edge of financial risk when faced with illness just when they are about to begin adulthood.

However, the ACA changed this. The law has allowed 6.1 million young adults to obtain or remain on their parents' health plans until the age of 26. Young adults qualify for this coverage even if they are not living with their parents. Allowing dependents under the age of 26 to remain on their parents' health care plans establishes important protections for young adults, including college students and recent graduates, as they prepare to enter the workforce. The benefit also provides peace of mind and reduced financial strain for many parents. Before the ACA, approximately 30 percent of young adults were uninsured, representing more than one in five of all the uninsured.⁷ Thanks to the new age 26 provision – along with the other coverage expansion provisions in the ACA – the uninsured rate among young adults ages 19-25 has fallen by more than 50 percent.⁸ This expansion is important for young adults who need coverage, and in general, younger and healthier enrollees also help to keep health insurance costs down for everyone.

Enhanced coverage options give young people much-needed stability and peace of mind while they are making health, career, and financial decisions that will impact their lives for decades to come. If Republicans successfully repeal the ACA, young people will have limited health care options that could put their health, finances, and even their careers at risk.

Repeal limits options for young people, which could put their health, finances, and even their careers at risk.

“Because of health care reform, our son will now have health care insurance as a graduate student. He was due to lose it because of his age, and now we can keep him on our policy until he finishes school. Given his health care needs, this is a tremendous relief. Healthcare reform is impacting us all now for the better...”

— Patricia, Morgantown, WV
Moms Rising “Healthcare is a Lifesaver” Storybook

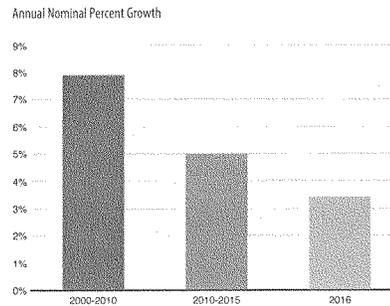
7. Centers for Medicare & Medicaid Services’ Center for Consumer Information & Insurance Oversight, *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses*, available at: https://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet.html
8. Council of Economic Advisers, *The Economic Record of the Obama Administration: Reforming the Health Care System*, December 13, 2016, available at: https://www.obamawhitehouse.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform_chartbook.pdf

4 *Controlling Health Insurance Costs for Working Families*

For decades, working families were hit hard by the rising costs of health coverage. Increasingly, people paid more and more for plans with less generous benefits.⁹ While the cost of health insurance has continued to increase, since the enactment of the ACA the rate of growth for premiums has gone up by less than half the rate that it was before the law was enacted. The cost growth in employer-based coverage has actually decreased, relieving the financial burden many hard-working Americans experience when dealing with their health care.¹⁰ Workers enjoy this slowed cost growth on top of added consumer protections, such as the elimination of annual or lifetime caps.

The average premium for employer-provided family coverage rose only 3.4 percent in 2016 – compared to an average annual rate of 7.9 percent in 2000-2010.¹¹ This decrease in premium growth means working families are spending less on health insurance premiums than they would have if the ACA had not been enacted. In fact, the Council of Economic Advisers has found that families are saving more than \$3,000 a year because of the slowed premium growth.¹² ACA repeal would threaten the progress made in controlling the cost of health insurance on many levels. Repeal would also increase the number of people without insurance and escalate the cost of uncompensated care.

Growth in Premiums for Employer-Based Family Coverage



Source: KFF/HRET Employer Health Benefits Survey

Repeal threatens the progress made in controlling the cost of health insurance, increasing the number of uninsured and escalating the cost of uncompensated care.

9. Kaiser Family Foundation, *A Comparison of the Availability and Cost of Coverage for Workers in Small Firms and Large Firms: Update from the 2015 Employer Health Benefits Survey*, February 5, 2016, available at: <http://kff.org/private-insurance/issue-brief/a-comparison-of-the-availability-and-cost-of-coverage-for-workers-in-small-firms-and-large-firms-update-from-the-2015-employer-health-benefits-survey/>

10. Council of Economic Advisers, *New Data Show that Premium Growth in Employer Coverage Remained Low in 2016*, September 14, 2016, available at: <https://obamawhitehouse.archives.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016>

11. *Id.*

12. *Id.*

5 Creating a Healthier Workforce

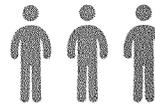
One of the most important elements of the ACA is its robust focus on prevention. The ACA expanded access to free preventive services with no co-pay for 137 million Americans, including 55 million women and 28 million children.¹³ Simply, this means that if families go to the doctor for a preventive service, such as annual physicals or blood pressure screenings, they won't pay a penny. Before the ACA, the cost of preventive care could dissuade many Americans from getting important screenings. But now, the share of adults who report forgoing a needed visit to the doctor because of the cost of has dropped significantly across the country and more people are taking advantage of routine checkups.¹⁴

This focus on prevention can keep workers healthy, while saving them money.¹⁵ Increasing access to preventive care decreases the likelihood of disability, and individuals who are healthier enjoy increased productivity on the job, generating higher incomes for themselves and their families.¹⁶

Productivity losses linked to absenteeism cost employers **\$225.8 BILLION** (or \$1,685 per employee).



People going to work when they're sick (presenteeism) accounts for nearly **TWO-THIRDS OF THE TOTAL COSTS** of worker illness.



Source: CDC, International Monetary Fund, Harvard Business Review

Research has shown that more than 90 percent of employers link good health to high employee productivity and performance.¹⁷ This is a win for both employers, who benefit from a healthier and more stable workforce, and workers, who can stay healthy while providing for their families. Repeal of the ACA endangers workers' access to free preventive services and may force workers to forego important doctor visits and screenings, sacrificing their health and productivity in the process. In short, repeal of the ACA puts the health of the American workforce at risk.

Repeal puts the health of the American workforce at risk.

13. Department of Health and Human Services, *About 137 Million Individuals with Private Insurance are Guaranteed Access to Free Preventive Services*, May 14, 2015, available at: <http://www.hhs.gov/about/news/2015/05/14/about-137-million-individuals-with-private-insurance-are-guaranteed-access-to-free-preventive-services.html>
 14. The Commonwealth Fund, *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013-2015*, December 2015, available at: http://www.commonwealthfund.org~/media/files/publications/issue-brief/2016/dec/1922_hays_long_way_state_coverage_access_ib.pdf
 15. The White House, *The Economic Benefits of the Affordable Care Act*, April, 2, 2015, available at: <https://obamawhitehouse.archives.gov/blog/2015/04/02/economic-benefits-affordable-care-act>
 16. The National Center for Chronic Disease Prevention, *The Power of Prevention*, 2009, available at: <https://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf>
 17. Society for Human Resource Management (SHRM), *Employers See Wellness Link to Productivity, Performance*, February 2, 2015, available at: <https://www.shrm.org/hrdisciplines/benefits/articles/pages/wellness-productivity-link.aspx>

6 Helping Working People Afford Coverage

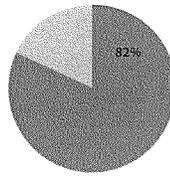
While employer-sponsored insurance is an important benefit for those who have access to it, the Marketplace creates a coverage option for those who don't. If workers' jobs do not offer affordable or adequate health coverage, workers have the option to purchase an insurance plan in the Marketplace and can potentially benefit from a tax credit to help pay their premiums. The Marketplace creates additional options for workers and their families to afford coverage. It also encourages job mobility and entrepreneurship. As a result of the ACA's Marketplace, those who are self-employed have better and more options. In 2014, one of every five consumers – well over one million people in total – who purchased Marketplace coverage was self-employed, a small business owner, or both.¹⁸

According to the Urban Institute, 80 percent of the individuals who receive premium tax credits for coverage in the Marketplace are employed.¹⁹ Also, the vast majority of those who buy Marketplace coverage get financial help – in 2017, more than 8 in 10 Marketplace consumers will receive tax credits that bring down the cost of coverage.²⁰

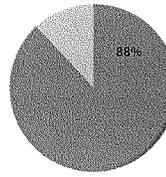
The Marketplace exists to fill an important gap in coverage for workers and its stability is important for workers, employers, and the overall insurance market alike. If Republicans succeed in repealing the ACA, this would collapse the Marketplace and financial assistance for individuals and families, taking away affordable health care options from workers.

Working Families Caught in Repeal Crossfire

Percent of Those Who Lose Coverage and are in Working Families



Percent of Children Who Lose Coverage and are in Working Families



Source: Urban Institute

Repeal would collapse the Marketplace and financial assistance for individuals and families, taking away affordable health care options from workers.

18. The Department of the Treasury Office of Tax Policy Analysis, *The Risk of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage*, January 2017, available at: <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/WP-17-14.pdf>

19. Urban Institute, *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell*, January 2015, available at: <http://www.urban.org/sites/default/files/center/publication/pdfs/000008-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf>

**Note: The analysis included 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but which have taken responsibility for plan management nonetheless (8).

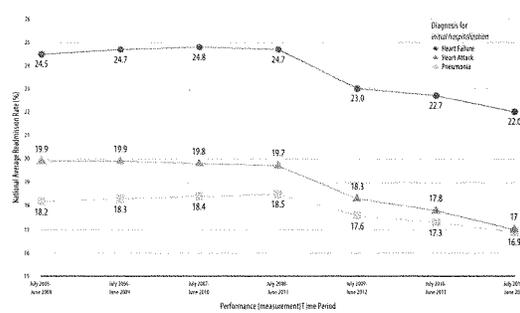
20. Centers for Medicare & Medicaid Services, *Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report*, January 18, 2017, available at: <https://downloads.cms.gov/files/first-marketplace-mid-year-2017-enrollment-report-1-18-2017.pdf>

7 Improving the Quality of Coverage for Families

In order to keep people healthier, the ACA created health care quality improvement programs, including programs aimed at preventing costly, unnecessary, and avoidable hospital readmissions. Between April 2010 and May 2015, approximately 565,000 hospital readmissions were prevented, compared to the year prior to the passage of the Affordable Care Act.²¹ That equates to 565,000 instances where a patient avoided having to go into the hospital.²² This notable reduction in hospital readmissions does more than save taxpayers' money through reduced health care spending—it has improved the quality of care for patients.

Improved health care quality is important for both workers and their family members. The stakes are particularly high for workers who must balance the demands of caregiving with their outside employment. For example, if a child or parent is sick, a worker may need to stay home from work to provide care to that family member. For those workers who are also the primary caregiver, staying at home may have an impact on their job performance or limit their availability to keep a regular work schedule. Repeal of the ACA threatens the quality improvements that have prevented thousands of unnecessary and costly medical complications. At the same time, repealing the ACA would place unnecessary financial stress on working families by forcing them to choose work over the health of their family members—a choice no one should have to make.

National Medicare Readmission Rates Started to Fall in 2012



Repeal places unnecessary financial stress on working families by gambling with their health and the health of their family members.

21. Department of Health and Human Services Blog Post, *Reducing Avoidable Hospital Readmissions to Create a Better, Safer Health Care System*, February 24, 2016, available at: <https://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html>
22. *Id.*

8 *Creating More Job Flexibility*

Prior to the ACA, individuals struggled to access affordable coverage if they lost their job or lost access to their employer-provided health plan. Many workers felt “locked in” to jobs, due to the lack of affordable health care options outside of the insurance coverage provided by their employer. This led to inefficiencies in the labor market – workers stayed in jobs where they were not satisfied or where their skills were not fully used because they could not afford to go without their employer’s health insurance plan.²³

Thanks to the ACA, the problem of “job-lock,” has improved significantly because workers have health care options outside of their employers through the Marketplaces.²⁴ This means that millions of Americans with pre-existing health conditions no longer have to worry about going without coverage if they want to leave their jobs, reduce their hours, or start new businesses. Workers who recognize that their skills may be better used in an entrepreneurial environment now have the flexibility to make career decisions without fear that they will lose vital health care benefits.²⁵ Some workers can choose to invest more time in their families and careers. Parents of young children have the option to work part-time or temporarily leave the labor market in order to spend more time with their kids. Older workers may take advantage of the opportunity to retire early before they are eligible for Medicare. If the ACA is repealed, this freedom goes away. Workers – particularly those who have pre-existing conditions – will be robbed of the flexibility to make choices based on what is best for their careers and families.

Repeal robs workers of the freedom and flexibility to make choices based on what is best for their careers and families.

“Joshua Lapp left a full-time job with health benefits in 2014 to launch an urban planning firm with two partners... There’s no way Lapp, 27, would have considered starting his own business before the Affordable Care Act took effect because he has a congenital heart condition... He hasn’t had to worry about insurers denying him coverage – as they could before the law – for his condition, which requires a \$100,000 operation every five to 10 years to replace his cardiac pacemaker. His two business partners and their significant others also have ACA coverage as self-employed people. “Being able to buy my own affordable plan on the exchange allowed me to step out on my own,” he said. “It’s a big enabler for all of us.”

– Article Excerpt, *Modern Healthcare*, December 28, 2016

23. AARP, *Job Lock and Employer-Provided Health Insurance: Evidence from the Literature*, March 2015, available at: <http://www.aarp.org/content/dam/aarp/ppi/2015-03/JobLock-Report.pdf>
 24. Center for Economic and Policy Research, *The Affordable Care Act: A Family-Friendly Policy*, September 2014, available at: <http://cepr.net/documents/publications/aaca-pt-2014-09.pdf>
 25. Urban Institute, *The Affordable Care Act: Improving Incentives for Entrepreneurship and Self-Employment, Timely Analysis of Immediate Health Policy Issues*, May 2013, available at: <http://www.urban.org/sites/default/files/afca/publication-pdfs/412830-The-Affordable-Care-Act-Improving-Incentives-for-Entrepreneurship-and-Self-Employment.PDF>

9 *Improving Health Benefits for our Nation's Coal Miners*

The Black Lung Benefits Act provides monthly income and health care benefits to coal miners with black lung disease, an illness caused by the inhalation of coal mine dust. This disease impairs lung function, which can lead to disability and premature death.²⁶ Before the ACA, many deserving miners who applied for black lung benefits were denied benefits due to the high burden of proof of eligibility. The ACA reinstated a presumption of eligibility of benefits for miners who worked at least 15 years in underground or comparable surface mining, and those who suffer from a totally disabling respiratory impairment. The ACA also granted deceased miners' survivors an automatic entitlement to benefits if the miner was eligible to receive them. As a result of the ACA, a survivor is no longer required to prove that the miner died due to black lung disease.

Named after former Senator Robert Byrd (WV) who ardently advocated for coal miners, these provisions – commonly known as the “Byrd Amendments” – removed barriers that coal miners and their families’ had faced in securing benefits by shifting the burden of proof away from the coal miners who worked much of their lives in mining to mining companies.

Many more miners receive benefits today thanks to Byrd Amendments in the ACA. If the law is repealed, miners’ and survivors’ eligibility for benefits will be slashed. Repealing the ACA will reduce the liability for coal operators and insurers, at the expense of disabled coal miners and their families – jeopardizing the health and financial benefits owed to ill coal miners and their survivors.

“I am 60 years old and I worked in underground coal mines from 1974 to 2001. I ran a scoop, bolted the mine roof, cut coal with a continuous mining machine longwall machine. I was constantly breathing coal mine dust. When I stopped working my breathing was bad. The Black Lung Benefits which I get every month helps me and my wife to pay our bills and it means a lot to us. The “Byrd Amendments” to the Black Lung Benefits Act in the Affordable Care Act made it possible for me to receive benefits. Without the Affordable Care Act, I would have faced a very difficult burden of proving that my disabling lung impairment was caused by coal mine dust exposure and not some other condition. The Affordable Care Act also made it automatic that if I die my wife, Thelma, will continue to receive Black Lung Benefits and will not be required to prove that black lung caused my death. This gives me peace of mind.”

– Danny, Cumberland, KY
Correspondence Sent to the Education and the Workforce
Committee Minority Staff

Repeal jeopardizes the health and financial benefits owed to ill coal miners and their survivors.

26 Centers for Disease Control and Prevention, *Pneumoconiosis*, available at: <https://www.cdc.gov/niosh/topics/pneumoconiosis/>

10 *Creating a Better Economy for Working People*

Before the ACA was signed into law, some speculated at length about how the ACA would impact jobs. In 2010, former Speaker of the House John Boehner asserted that, “economists are warning that the tax hikes, mandates, and regulatory costs in the [ACA] bill will only accelerate America’s jobs crisis.”²⁷

Despite the abundance of doomsday predictions about the ACA’s impact on jobs and the labor market, the ACA has had a positive effect on jobs and the economy. The positive impact is twofold. First, by increasing the demand for health care, the ACA is creating jobs in the health care sector.²⁸ This sector is seeing a sizable increase in demand, with 43,000 health care jobs added in December 2016 alone.²⁹ Most of the revenue earned by health care providers is used to hire and pay staff and to purchase goods and services, such as clinic space or medical equipment. In turn, those vendors pay their employees and buy additional goods and services, creating even more jobs.³⁰ As of November 2016, U.S. businesses have added 15.6 million jobs since early 2010 and the unemployment rate is down to 4.6 percent – its lowest level since August 2007.³¹ This means that jobs were added in places such as hospitals, dentists and physician offices. Second, in order to bolster the health care industry so that it can respond to increased demand for products and services, the ACA invested nearly \$230 million in efforts to train 1,700 primary care medical residents, nurse practitioners, and physicians assistants.³²

Repeal could devastate communities across the country, particularly rural areas that already face employment challenges. The American Hospital Association and the Federation of American Hospitals sent a letter to Congressional leaders warning of “massive job losses” if the ACA is repealed.³³ The letter noted the specific threat to rural communities, pointing out that “hospitals are often the largest employer in many communities.”³⁴ Estimates show that repeal would result in a loss of 2.6 million jobs across all states; a third of those lost jobs would be in health care though the impact would be felt across most industries.³⁵ Repeal threatens jobs in every state and every Congressional district.

Repeal of Both Premium Tax Credits and Medicaid Expansion: Potential National Impact

	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	-139.5	-150.0	-161.5	-172.0	-184.0	-587.0
TOTAL EMPLOYMENT LOST (thousands of jobs)	-2,599	-2,854	-2,978	-2,924	-2,857	N/A

Source: George Washington University analysis

Repeal threatens jobs in every state and every Congressional district.

27. Speaker’s Press Office, Press Release, March 17, 2010, available at: <http://www.speaker.gov/general/economists-agree-government-takeover-health-care-initiative-job-killer>

28. The White House, Expanded Prepared Remarks of Jason Furman, April 2, 2015, available at: <https://obamawhitehouse.archives.gov/blog/2015/04/02/economic-benefits-affordable-care-act>
Brookings, *Employment Impacts of the Affordable Care Act*, March 20, 2015, available at: <http://www.brookings.edu/blogs/health360/posts/2015/03/20-aca-five-year-employment-impact-business>

29. Bureau of Labor Statistics, *Current Employment Statistics highlights*, December 2, 2017, available at: <https://www.bls.gov/web/empsticeshghighlights.pdf>

30. The Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States*, January 5, 2017, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform>

31. Council of Economic Advisors, *The Employment Situation in November*, December 2, 2016, available at: <https://www.whitehouse.gov/the-press-office/2016/12/02/employment-situation-november>

32. Department of Health and Human Services, *Creating Health Care Jobs by Addressing Primary Care Workforce Needs*, available at: <http://www.hhs.gov/healthcare/facts-and-figures/fact-sheet/creating-health-care-jobs-by-addressing-primary-care-workforce-needs/index.html>

33. Letter to Congressional Leaders from the American Hospital Association and the Federation of American Hospitals, December 8, 2016, available at: <http://www.aha.org/advocacy-issues/letter/2016/161208-let-aha-fah-congress-healthagenda.pdf>

34. *Id.*

35. The Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States*, January 5, 2017, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform>

CONCLUSION

In the nearly seven years since its passage, the ACA has done much to improve the quality, access, and affordability of health care in America. The ACA, building on the employer-sponsored insurance system, has expanded health coverage to 20 million Americans and decreased the uninsured rate to historically low levels. Whether accessing their coverage through their employers or in the Marketplace, workers now benefit from more affordable and better quality coverage.

Access to free preventative services and prohibitions on annual and lifetime benefit caps mean more Americans can now access much needed, and often lifesaving, care. Financial assistance provided through the Marketplace and slowed cost growth in employer-based coverage premiums has made health care coverage more affordable. Requirements in the ACA that insurers now use payments for medical costs instead of excessive overhead, have put more money back into the pockets of many Americans. Provisions designed to decrease the number of hospital readmissions have also improved the quality of health care. The ACA has provided more coverage options so workers, including young adults, have increased financial security and job flexibility. And our economy as a whole benefits from a healthier, more productive workforce.

Despite this demonstrable progress, there is more work to do. While seeking to repeal the ACA, Republicans have failed to offer a plan that matches the comprehensive approach of the ACA and ensures that Americans have access to quality coverage. As Republicans continue with their efforts to repeal the ACA, they not only jeopardize the significant progress made under the law, but also threaten to make millions of Americans worse off than before its passage. America's families and working people deserve better. Now is the time to support changes that improve the law and increase health care access and affordability for children, families, and working people.

What's at Stake for Working Families?

How Repeal of the Affordable Care Act Threatens the Health & Economic Security of Working Families

Additional Graphic Sources

1 Strengthening Health Coverage Rights and Protections for Working Families

Story excerpt from Moms Rising, Healthcare is a Lifesaver, available at: https://s3.amazonaws.com/s3.momsrising.org/images/Lifesaver_Book_-_Final_1.5.17.pdf

3 Enabling Financial Security for Young Workers

Story excerpt from Moms Rising, Healthcare is a Lifesaver, available at: https://s3.amazonaws.com/s3.momsrising.org/images/Lifesaver_Book_-_Final_1.5.17.pdf

4 Controlling Health Insurance Costs for Working Families

Chart generated by the Council of Economic Advisers, New Data Show that Premium Growth in Employer Coverage Remained Low in 2016, September 14, 2016, available at: <https://obamawhitehouse.archives.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016> (underlying data sourced in line)

5 Creating a Healthier Workforce

Graphic generated by CDC Foundation, available at: <http://www.cdcfoundation.org/business-pulse/healthy-workforce-infographic> (underlying data sourced in line)

7 Improving the Quality of Coverage for Families

Chart generated by Kaiser Family Foundation, Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program, September 30, 2016, available at: <http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/> (underlying data sourced in line)

8 Creating More Job Flexibility

Story excerpt from Modern Healthcare, Self-employed fear repealing Affordable Care Act will bring back 'job lock', December 31, 2016, available at: <http://www.modernhealthcare.com/article/20161231/MAGAZINE/312319968>

9 Improving Health Benefits for our Nation's Coal Miners

Story obtained through correspondence sent directly to Education the Workforce Committee Minority Staff

10 Creating a Better Economy for Working People

Chart generated by the Commonwealth Fund, Repealing Federal Health Reform: Economic and Employment Consequences for States, January 5, 2017, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-healthreform>

Mr. SCOTT. I'd like to ask all the witnesses if any support a total repeal of the *Affordable Care Act* without any credible replacement. Anybody?

Let the record reflect that nobody volunteered.

Does anybody propose -- we have a mandate that individuals buy coverage. Do any of the witnesses propose to eliminate that individual mandate?

Mr. TROY. I don't think the individual mandate is effective, sir.

And then, also, on your previous statement, I want to make sure that it's the -- we oppose the repeal without any alternative, but I think there will be an alternative.

Mr. SCOTT. Okay. Well, if you eliminate the mandate for individuals, could you cover those with preexisting conditions?

Mr. TROY. I think there are a number of proposals that look at covering people with preexisting conditions, especially those who maintain continuous coverage, and then also having high-risk pools to address those people, if it's designed correctly.

Mr. SCOTT. Has that ever worked anywhere, covering those with preexisting conditions, without an individual mandate?

Mr. TROY. We are obviously going into new places in health care and new directions, so I'm not aware of any --

Mr. SCOTT. Well, that's not a new direction because they tried it in New York, and when the *Affordable Care Act* came in, the individual prices in the individual market were cut 50 percent. The Governor of Washington State has indicated they tried it in Washington, and they had to repeal the whole thing because nobody could buy insurance if you didn't have the individual mandate. So it's not real new.

Now, some of the witnesses have talked about the costs going up since the *Affordable Care Act*. We didn't hear much about the costs going up before the *Affordable Care Act*.

If the witnesses could present, Mr. Eddy and Mr. Troy, what your cost increases were the 10 years before the *Affordable Care Act*, I would appreciate to see that. Because all the studies have shown that the cost increases since the *Affordable Care Act* have been on average about half of what the increases were before.

Could you provide that for us?

Mr. TROY. Yes. We actually prepared that, sir. From 1999 to 2005, employer-provided healthcare costs for family coverage were increasing by an annual average of about 11.1 percent.

From 2006 to 2010, we saw a number of steps by employers to reduce costs, including the implementation of CDHPs, consumer-directed health plans, wellness programs, and other benefit plan innovations. And, as a result, the annual increase dropped to 4.8 percent -- still high, but much lower.

And then in the intervening period from 2010 to 2016, the annual increase has been 4.7 percent. And this reflects the net costs increases and decreases from the ACA and additional cost savings innovations by employers. And we believe that without the cost increases by the ACA that 4.7 percent figure would be even lower.

So it is absolutely true that costs have been going up over time, and we're looking for ways to continue to moderate those costs through innovative programs.

Mr. SCOTT. Okay. Well, if you could show us that 11 percent, because that's consistent with what most increases were before the *Affordable Care Act*. And the 4 percent is consistent with what most of the -- closer to what the increases have been since the *Affordable Care Act*.

So complaining about the costs going up without pointing out that they were going up a lot faster before the *Affordable Care Act* tends to be a little misleading.

Some of the plans that have been referred to point out that you can reduce costs, but all of those plans appear to just shift the cost to the patient by cutting benefits, that the patient's going to be just as sick, probably going to get the same kind of treatment, just have to pay more.

Ms. Schlaack, can you say where you would be without the *Affordable Care Act*?

Ms. SCHLAACK. I'd probably still be paying bills from three years ago. My daughter and I wouldn't have been able to afford any health insurance if we wouldn't have had the marketplace to go to. Where my COBRA payments were going to be \$1,000 a month for the two of us, with the marketplace our premiums were under \$100 a month. We had deductibles that were possibly \$500 a month the first year, and the second year they were lowered.

We very well could have been bankrupt from well over the million dollars that my husband's medical expenses racked up in, again, just 10 months' time.

Mr. SCOTT. You mentioned the lifetime cap. What did you mean by that?

Ms. SCHLAACK. I know prior to the ACA, some insurance companies, once you hit a million dollars, you could be penalized and not be able to get insurance ever again. And had he survived, he could've possibly not ever been able to get coverage from anyone.

Chairwoman FOXX. The gentleman's time has expired.

Mr. Walberg, you're recognized for five minutes.

Mr. WALBERG. Thank you, Madam Chairman, and I appreciate this hearing.

Of course, what we desire is that people, in general, across the spectrum, be covered and have better opportunities for health care. We appreciate the fact that some have had good results, but we want to do this for all. And so we need to take this seriously here.

Dr. Troy, you cited several studies in your testimony predicting that the ACA would increase the cost of offering coverage for large employers. These studies were conducted in 2012, 2014, and even 2016. Has this prediction come to be?

Mr. TROY. Thank you for that question, sir.

So two points on that. First, number one is the study in 2012 and our study in 2014 that I mentioned that would increase costs \$4,800 to \$5,900 for an employee over a 10-year period, these were numbers that were produced by teams, benefit teams, at large employers that were reflecting what the CEOs and CFOs were looking at in making their determinations. So it is very important to look at those projections in saying that these affected how employers looked at the plans going forward.

The second thing, there has been a recent study that found large costs associated with general ACA administrative costs, reporting

disclosure and notification costs, costs associated with benefit plan design changes related to the ACA, costs of adjusting benefits to keep up with the ACA affordability requirements, and PCORI fees. So those are some of the biggest recurring costs.

One cost that has not come to fruition at this point is the Cadillac tax, which was delayed in a bipartisan effort, which we applaud, and would impose extremely large costs on employers if it were to be instituted going forward. And so we would like to see its repeal.

Mr. WALBERG. So, basically, costs did increase, as you suggested in the studies. What were the biggest contributing factors to those increases?

Mr. TROY. So I mentioned a number of those, so I'll be a little more specific.

So the H26 dependent coverage, which I recognize is popular, one company said that it could cost about \$69 million over 10 years. Another one estimated about \$56 million over 10 years.

In terms of the transitional reinsurance fee, estimated cost of \$15.3 million from 2014 to 2016.

One-hundred percent coverage of prevention services and other benefit mandates, one company said that this would cost them about \$36.5 million over 10 years.

And, again, the big five are the ACA administrative costs, the reporting disclosure and notification costs, the costs associated with plan design changes, the costs of adjusting benefits, and the PCORI fee.

Mr. WALBERG. Okay. These are things we need to work on.

Mr. Eddy, thank you for your testimony, and it's admirable that your company traditionally paid 100 percent of the medical costs for your employees. And it was your desire to continue doing that, as a good number of businesses I've interviewed in my district as well, who literally at times with tears in their eyes, with their insurance agent sitting next to me, talked about what this would mean to them, to change a process that they felt they wanted to continue because of the family, as they called it. It was the right thing to do.

It's understandable that it was not sustainable under ACA. And it's no surprise that your colleagues in the manufacturing business continue to cite the cost of health care as a top business concern, according to the National Association of Manufacturers.

Could you tell the committee more about the difficult choices ACA forced you to make in breaking with the tradition of providing this type of coverage for your employees?

Mr. EDDY. Yes, sir. Thank you, Congressman.

You know, the difficult decisions really started with the implementation of the ACA during the tough times of a really bad recession, and it couldn't have been a more worse time. And the decisions that we've had to make, now we seem to focus more on how we're going to try to manage things like hiring people that we need and, you know, how soon people have to retire now. Every decision that we make now revolves around the costs and the uncertainties really afforded to us by the *Affordable Care Act*.

So the tough thing we had to do -- we always like to try to take care of our employees, and that's not only with good salary but also

good benefits. We've always had that as a company philosophy. Asking them to participate in health care, as you said, it has really disrupted the relationship between management and union, management and the salary group, as well, because they pay more than the union does for their health coverage now. It's just a matter of trying to keep them accountable and realize the additional burdens that we've had to take on here.

Really, the bad part for the union and the company is I truly believe we could have added another 20 to 25 people in the last five to seven years if we didn't have the additional burden of the *Affordable Care Act*. I'm not sure where the increases would have taken, but we didn't see the major increases.

Now, as an employer, we look for flexibility. That's all we can ask you, as you're working on the ACA, to give us some more flexibility as an employer, as well as options. And without that, the uncertainty going forward, it really delays any options for hiring people, developing new products. It's really created a major burden.

Thank you for your question.

Chairwoman FOXX. Thank you.

Mr. WALBERG. Thanks for your response.

And my time has expired.

Chairwoman FOXX. The gentleman's time has expired.

Mr. Polis, you're recognized for five minutes.

Mr. POLIS. Thank you, Madam Chair. I thank the chairwoman for yielding and the witnesses for coming.

We're here today to discuss the *Affordable Care Act* and its repeal. This committee has held a number of hearings in this area, in particular to highlight the dangers of repealing the *Affordable Care Act* without a replacement that improves and builds upon it.

Of course, I would note that the title of the hearing is somewhat deceptive. It's called "Rescuing Americans from the Failed Healthcare Law and Advancing Patient-Centered Solutions." Obviously, we hope that we can move forward in way to improve upon the healthcare law and leave something in its place that's better.

It has been six years since the law passed. Before the passage of the *Affordable Care Act*, about 48 million Americans had no insurance, and now that number has fallen to 28 million. For the first time, being a woman is no longer a preexisting condition; a diagnosis in childhood doesn't preclude coverage as an adult; and cancer survivors can't be sent a bill for their radiation after hitting their coverage ceilings for the year. As was indicated in the testimony, medical bankruptcies can be avoided. The statistics bear that out as well.

In my home state of Colorado, I'd like to submit a letter from our Governor Hickenlooper urging this body to protect healthcare coverage for 600,000 Coloradans. Without objection, Madam Chair, I'd like to add that to the record.

Chairwoman FOXX. Without objection.

[The information follows:]



COLORADO
Gov. John Hickenlooper

January 4, 2017

The Honorable Kevin McCarthy
Majority Leader
U.S. House of Representatives
H-107, U.S. Capitol Building
Washington, DC 20515

Dear Majority Leader McCarthy,

In response to your letter from December 2nd, we urge you to protect health care coverage for the over 600,000 Coloradans that have gained coverage under the Affordable Care Act. We simply cannot support efforts to repeal current law without a plan to immediately protect Coloradans.

We share your commitment to putting patients first, and Coloradans have a history of coming together to improve health care. In 2008, our bipartisan, blue ribbon commission on health care reform made key recommendations, many of which have now been adopted by state and federal policymakers. Colorado's Accountable Care Collaborative program is saving money and improving the quality of care in our Medicaid program. Bipartisan efforts to expand Medicaid and create our state-based marketplace have driven coverage to historic levels. Our offices of the State Innovation Model and eHealth Innovation are helping to make it as easy to access mental health care as it is to see your primary care doctor, while making sure your health records are accessible to you no matter where you seek care.

Colorado's businesses and their employees have benefited from slower growth in health care costs that have resulted from the Affordable Care Act. When more Coloradans are uninsured, the costs of uncompensated care are borne by employers, as providers must raise their prices and insurers pass these costs on to businesses and their employees. Since the passage of the Affordable Care Act, annual increases in premiums and out of pocket costs for employer sponsored insurance have been cut in half nationally. As a result of expanding Medicaid, Colorado has added an additional 31,000 jobs and household earnings are up more than \$600 a year.



Because of the progress Colorado has made, repealing the Affordable Care Act without an immediate replacement may be disastrous. In the wake of “repeal and delay,” Colorado’s individual health insurance market may collapse, as insurance companies abandon our market in the face of market uncertainty. Over 160,000 Coloradans, including 27,000 children, who receive coverage through our public exchange, Connect for Health Colorado, will be without protection.

In response to your questions, we welcome conversations about giving states additional flexibility to improve health care for our citizens. Our state has had discussions about Section 1332 waivers and believe that such waivers could be vehicles to drive innovation at the state level. Coloradans have discussed potentially using such a waiver to align income eligibility rules between Medicaid and our state-based marketplace or to eliminate the “family glitch.” Unfortunately, greater flexibility cannot make up for a lack of funding. Should the federal government pull back its financial commitments, we simply cannot afford to make up the difference.

We are interested in discussing new and innovative ideas for improving the Medicaid system. Coloradans are striving to lower costs and improve health by making sure that patients get the right care, in the right setting, at the right time. Our state is in the process of improving upon its successful Accountable Care Collaborative program, an innovative approach to Medicaid that focuses on data driven, coordinated primary care. We look forward to continuing an open collaboration with our federal partners that will grant Colorado the flexibility to move this program into the next phase.

At the same time, we are concerned that block grant and per capita cap proposals will make it difficult to maintain coverage and benefits for Coloradans over the long term. Many proposals would force us to make impossible choices in our Medicaid program. These proposals would shift the cost of providing health care to Colorado’s most vulnerable citizens on our limited state budget or force us to make difficult cuts. We should not be forced to choose between providing hardworking older Coloradans with blood pressure medication or children with their insulin.

We have heard from countless Coloradans who are concerned about the future of their health care. More than 100 groups representing all 64 of our state’s counties, businesses, patients, people with disabilities, consumers, doctors, hospitals, insurers and others have asked us to protect the progress we have made on coverage, access, and quality. They agree that the ACA should not be repealed without a clearly identified and carefully considered replacement plan in place. They have asked us to reject proposals that put vulnerable populations at risk and shift costs onto our state.

We stand ready to work with you, in a bipartisan manner, to improve upon the advances we have made and continue to protect Coloradans. We look forward to discussing these

issues with you in person and attending your convening of Governors and Commissioners on this topic later this year. Feel free to contact the Governor's Senior Health Policy Advisor, Kyle Brown (kylem.brown@state.co.us; 303-866-5361), with any questions.

Thank you for your efforts to improve the health of Coloradans and all Americans.

Sincerely,



John W. Hickenlooper
Governor



Marguerite Salazar
Commissioner of Insurance

Mr. POLIS. And I would also like to share a couple stories as well.

A few weeks ago, Elizabeth Robinson, a constituent of mine, called my office in Boulder. She works as a homeless navigator for Boulder Municipal Court. For Elizabeth, the expansion of Medicaid that Colorado and 31 states took advantage of has been absolutely critical for serving the homeless population with which she works. She urged me specifically to oppose repealing the law because of the dramatic consequences to the most vulnerable.

I also received an email from Dorothy, who shared her story. She's from Louisville, Colorado, 63 years old, self-employed, earns less than \$20,000 a year. Thanks to the subsidies on the individual marketplace, she finally has coverage that's affordable as she waits for her Medicare eligibility.

Elizabeth is an advocate, Dorothy is a patient, but both of them believe strongly the *Affordable Care Act* is working for them.

My first question is for Ms. Schlaack.

According to January reports from The Commonwealth Fund, repeal would cost \$54 million in gross State product and \$1.8 million for Michigan alone in local and state tax revenues.

In addition to your personal responsibilities, are you also concerned about this negative fiscal impact on your State the repeal would produce?

Ms. SCHLAACK. Well, sure, Michigan being a lot of manufacturing facilities that struggle as it has been for a while. Also, like, the area where I live is right on Lake Michigan, and it's a heavy tourist economy. And when people don't have jobs, they don't have extra money to spend, and the tourist economy is going to suffer. And the small community where I live, a lot of it is based around tourism.

Mr. POLIS. Thank you.

And, Dr. Troy, I appreciated in your written testimony where you said it's important to protect those who've gained coverage under the ACA. What concerns me is the CBO has made clear that repealing the ACA would cause over 30 million Americans to lose their insurance.

Would your organization oppose legislation that doesn't maintain those coverage gains made by the *Affordable Care Act* in some way, shape, or form?

Mr. TROY. Thank you, Congressman, for the question.

As I said earlier in my testimony, I do believe it is important to protect the 20 million who have coverage via the ACA. I think the CBO study suggests that just if you repeal it and do nothing in its place, you would have a number of people without coverage, and I think that would be a problem.

So we want to build on the existing building blocks of American health care, the successful ones, such as employer-sponsored care, and make sure that we can expand coverage and maintain coverage for all.

Mr. POLIS. So I think you said it would be a problem if it didn't maintain that coverage. Is that what you said?

Mr. TROY. We absolutely would like to maintain coverage levels, yeah.

Mr. POLIS. Mr. Eddy, you mentioned some of the -- this is on the pay-for side, the way that the *Affordable Care Act* was paid for.

You mentioned in particular the so-called Cadillac tax. There's other aspects, like a tax on unearned income, medical device tax. I'm not aware of your organization's position on all of those, but certainly you've made it clear you oppose the Cadillac tax.

Do you have other ideas for how to pay for an ACA replacement? And whatever takes the place of it, have you put other potential pay-fors on the table that are acceptable to you?

Mr. EDDY. No, Congressman, I have not seen anything else that's

--

Mr. POLIS. Does your organization propose any, or do you simply oppose the current ones?

Mr. EDDY. There are some provisions of the ACA that --

Mr. POLIS. Pay-fors, pay-fors. The ways that it's paid for. The revenues.

Mr. EDDY. Well, I don't support the fact that it's a mandate and has to be paid with penalties if not. And I understand why there are the mandates and the health insurance industry fees. The fees are really what -- the pay-fors, the additional --

Mr. POLIS. Right.

Mr. EDDY. -- where that amount could have gone to health coverage for our employees.

Mr. POLIS. My time has expired, but, in concluding, I would just say, you know, it's fine to oppose particular ways of paying for it, like fees and certain taxes, but, obviously, something has to be paid for. So maybe you can put, in the future, some on the table -- we'll be happy to submit that to you in writing after the hearing -- as to how you would like to pay for the replacement for the ACA.

And I yield back the balance of my time.

Chairwoman FOXX. The gentleman's time has expired.

Mr. ROKITA, you're recognized for five minutes.

Mr. ROKITA. I thank the chairwoman.

I also thank the witnesses for your testimony today. I learned a lot from each of you.

I want to start by commenting on some of the comments made by the Ranking Member, a dear friend of mine, Mr. Scott, who talked in his opening statement about a Budget Committee hearing. I happen to be an officer on that committee. And I just want to say, while I don't dispute that there was some testimony given at that committee hearing along the lines of what Mr. Scott was talking about, the overwhelming testimony last week in the Budget Committee was that -- and these were experts in the field of health care and the economy and both -- was that ObamaCare was roundly criticized, that, in fact, if it was left to go on, it would implode, that the fact that you had another major government control in people's lives only meant that costs were going up and choices were going down.

So that was the takeaway from the Budget Committee witnesses last week when we examined this. And it's not any different than the other examinations we've had on ObamaCare over the last several years.

Mr. Scott also talked about some misleading figures, about the increase in costs and whether or not the increase in costs actually went down with ObamaCare or whether, if we didn't have

ObamaCare, the costs would've continued to increase at a higher rate.

What I find to be misleading about the 6 years or so that we've had ObamaCare is statements like this: If you like your doctor, you can keep your doctor. That, in fact, is wrong. If you like your healthcare plan, you can keep your healthcare plan. That, in fact, is wrong. There are over 1,000 counties in the United States right now that have one choice on the exchange for a healthcare provider. In fact, it's gotten worse.

Then the cost was told to us to not be more than \$2,500 per family or something along those lines. And, of course, we've blown through that figure almost immediately.

So where are we today?

I'd like to recognize my fellow Hoosier, Mr. Bollenbacher. I'm glad to see you here. I'm very familiar with your area of the State from when I served as Indiana Secretary of State.

Can you explain a little bit about how a small accounting firm owner from northern Indiana winds up testifying before this committee on this issue? Did you ever think that would be the case? And can you go into a little bit more detail?

Mr. BOLLENBACHER. Thank you.

In the fall of 2016, we received a renewal for our health insurance of 156 percent, and it just blew me away. Many of my clients -- I was expecting a 40- to 50-percent increase based on the number my clients had been receiving. When I received 156, I just shook my head. I had no idea what we were going to do.

My team members are my family. You know, I want to care for them, I want to take care of them. So I wrote a letter to President Obama just explaining to him about our 156-percent increase. And I sent that also to the NFIB, and they contacted me to come speak today, which I'm grateful for.

Mr. ROKITA. Well, you're not alone. I mean, in Indiana alone, 31 percent of small businesses offered coverage in 2010, and by 2015, the most recent year that I could find data, only 23 percent of those same businesses were able to offer coverage, a decrease of 26 percent in the number of offerings.

And your reason, just to be clear for the record, for this reduced coverage among small-business owners?

Mr. BOLLENBACHER. The costs have been increasing. It's just increasing out of control.

Mr. ROKITA. When you described how your insurance was canceled the first time, you said there were some less ideal options. One of those was Medi-Share, I heard from your testimony, and some other things. Could you go into a little bit more detail there?

Mr. BOLLENBACHER. We looked at a number of options. Medi-Share is called a church plan. I have a number of clients that have gone to that. It's usually a half or a third of what even on the exchange it would cost them. And that was one of the options that we looked at.

Mr. ROKITA. But that's not working?

Mr. BOLLENBACHER. For those clients that have gone to Medi-Share, they are still on it. It is working for them.

Mr. ROKITA. Okay. Thank you.

And then, Mr. Troy, I think with the 30 seconds I have remaining, I'd just like to ask you, at the risk of this committee losing jurisdiction over the issue, why do employers have to be involved in the insurance market? I mean, I understand the history and all that, but why couldn't if we changed or modified the Tax Code could we not incentivize individuals to enter directly into a competitive marketplace? Why does the employer have to be involved?

Mr. TROY. I don't think the employer has to be involved per se. I just think that is the way the system has evolved, and to change it precipitously would be to cause large disruptions. As we saw with the *Affordable Care Act*, the disruptions are often quite problematic. Somebody mentioned the 5 million people who lost their individual plans via the ACA.

So I think the best way to go forward is to try and avoid disruptions and focus on what is working. And you have 177 million people getting health care through employers. If you were to disrupt that, the government would have an even larger hole to fill in terms of covering people.

Chairwoman FOXX. The gentleman's time has expired.

Ms. Bonamici, you're recognized.

Ms. BONAMICI. Thank you, Chairwoman Foxx and Ranking Member Scott.

And thank you so much to all of our witnesses for being here today and testifying.

I wanted to just follow up on what Mr. Rokita said about employer-provided health care. And also Dr. Roe mentioned, as well, that insurance costs make us noncompetitive with other countries. And I want to point out that that's not necessarily a function of the *Affordable Care Act*.

I was born in Detroit, Michigan, many years before the *Affordable Care Act*. And everyone knew in Detroit, Michigan, that if you make something in Detroit or if you go across the bridge and make it in Windsor, Ontario, you have very different cost considerations, because in Windsor, Ontario, they don't have employer-provided health care, because Canada, like basically every other industrialized country, has universal health coverage.

So it's not necessarily a function of the *Affordable Care Act* that healthcare costs are making us unaffordable. And if we want to have a conversation about that in another hearing, I'd welcome that.

Madam Chairwoman, I ask unanimous consent also to insert into the record a letter from the AARP supporting the *Affordable Care Act* and expressing concerns about the effects of repeal.

Chairwoman FOXX. Without objection.

[The information follows:]



601 E Street, NW | Washington, DC 20049
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

December 28, 2016

Dear Representative:

On behalf of our nearly 38 million members in all 50 states and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, I am writing to express our views on health care reform. AARP supports the Patient Protection and Affordable Care Act (ACA) because on balance it addresses health care priorities that are important to all Americans age 50 and older: protecting and improving Medicare's benefits and financing; providing access to affordable quality coverage; preventing insurers from engaging in discriminatory practices; lowering prescription drug costs; providing new incentives to expand home and community based services; and strengthening efforts to fight fraud, waste, and abuse. As Congress considers legislation to repeal and replace the ACA, it will be important for any health care legislation to include older Americans' priorities.

Medicare

Our members and other older Americans believe that Medicare must be protected and strengthened for today's seniors and future generations. The average senior, with an annual income of under \$25,000 and already spending one out of every six dollars on health care, counts on Medicare for access to affordable health coverage. We will continue to oppose changes to current law that cut benefits, increase costs, or reduce coverage for older Americans.

According to the 2016 Trustees report, the Medicare Part A Trust fund is solvent until 2028 (11 years longer than pre-ACA), due in large part to changes made in ACA. We urge you to maintain provisions in current law that have strengthened Medicare's fiscal outlook without shifting costs to beneficiaries or cutting benefits, including savings from provider payments and Medicare Advantage plans, the 0.9 percentage point Medicare Part A payroll tax on earnings of higher-income workers (incomes more than \$200,000/individual and \$250,000/couple), and the fee for the Part B trust fund on the manufacturers and importers of branded drugs. Together, these provisions of the health law have improved Medicare's fiscal outlook without harming beneficiaries.

With this in mind, lowering prescription drug costs for seniors by closing the Medicare Part D coverage gap, or "doughnut hole," also remains a critical priority for AARP. The

Alabama | Alaska | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia | Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virginia | Washington | West Virginia | Wisconsin | Wyoming

ACA would eliminate the coverage gap in 2020. Since 2010, more than 11 million Medicare beneficiaries have received over \$23.5 billion in savings while they were in the coverage gap. The average savings has been \$2,127 per beneficiary.

In addition to the ACA provisions above, we urge Congress to further help those enrolled in Medicare with high drug costs. For example, any new legislation could also provide the Secretary of Health and Human Services with the authority to negotiate drug prices on behalf of millions of Medicare beneficiaries to further ensure that seniors can afford the prescription drugs they need. Further, similar to what existed prior to Medicare Part D, drug manufacturers could be required to provide Medicare with the same rebates or discounts that Medicaid receives for prescription drugs purchased by beneficiaries who receive the Medicare Part D Low-Income Subsidy.

In addition to lowering drug costs, any health care changes should maintain Medicare improvements such as cost-free access to preventive benefits and additional steps to crack down on fraud, waste, and abuse.

AARP also supports efforts to reduce health care costs over time, including many of the payment and delivery system reforms designed to improve quality and make Medicare more efficient. Among these is giving the Secretary authority to test, evaluate, and expand new payment and delivery models. Complete repeal of the ACA could undermine Medicare's ability to innovate and adapt, as well as undermine health care providers' ability to implement high-value, quality care in the new Medicare reimbursement system. Additionally, while we did not support enactment of the Independent Payment Advisory Board, we do strongly support its requirements that Medicare savings not come on the backs of seniors through higher cost-sharing or cuts in benefits.

We also strongly urge efforts to improve Medicare's low-income programs, such as raising asset limits that perversely penalize people who did the right thing by saving a small nest egg for retirement, as well as ensuring assignment to prescription drug plans that meet their needs. In addition, we objected to the ACA's provisions to freeze the Part B and Part D income-related premium thresholds -- which penalize both work and savings and, like the Alternative Minimum Tax, will increasingly tax middle-income earners over time -- and urge that the thresholds at least be indexed.

Prescription Drugs

Older Americans use prescription drugs more than any other segment of the U.S. population, typically on a chronic basis. In 2015, retail prices for 268 brand name prescription drugs widely used by older Americans increased by an average of 15.5 percent. In contrast, the general inflation rate was 0.1 percent over the same period. For older adults, affordable prescription drugs are critical in managing their chronic conditions, curing diseases, keeping them healthy and improving their quality of life.

AARP urges that any changes to the health law retain an approval pathway for less expensive generic versions of biologic drugs, and modify the provisions in current law that force consumers to wait 12 years or more for these important products. Biologic drugs can cost tens of thousands of dollars a year. Longer waits for less expensive versions cost both taxpayers and consumers billions of dollars we cannot afford, and may force consumers to forgo needed drugs because of costs. A more rapid 7-year exclusivity pathway would improve health and bend the cost curve for everyone. Congress should also consider reducing barriers to better pricing competition worldwide by allowing for the safe importation of lower priced drugs. We also support prohibiting agreements between brand and generic manufacturers that delay timely access to affordable drugs.

Private Insurance Market

Beyond Medicare, we are concerned that many of our members and other older Americans age 50-64 could be adversely affected by changes in the health insurance market. About 6.2 million older Americans currently benefit from improvements in the individual insurance market, including 3.3 million who receive subsidy assistance. Affordability of premiums and cost-sharing is essential to the success and long term sustainability of health reform. Critical to that goal is prohibiting insurers from charging older Americans unaffordable rates because of their age. The current law's 3:1 age rating -- already a compromise that requires uninsured older Americans to pay three times more than younger individuals, even though their incomes are not significantly higher -- should be retained in any new legislation. Prior to the ACA, many insurers were permitted to use ratings of 5:1 or higher. Maintaining 3:1 age rating is a critical consumer protection for older Americans age 50-64 to ensure that they will have access to affordable coverage.

In addition to limits on age rating, a strong combination of insurance market reforms, broad risk-pooling, restrictions on gender discrimination, subsidies, and cost-sharing limits are needed to make coverage affordable and accessible. We strongly support maintaining existing insurance market rules relating to guaranteed issue and prohibitions on preexisting condition exclusions. In addition, AARP believes the ban on annual and lifetime coverage limits is essential. AARP also urges Congress to keep children on their families' policies until the age of 26. Any legislation should also require ongoing assessment of affordability and provide for stricter limits on age rating or enhanced subsidies if coverage proves to be too costly for older Americans.

Medicaid and Long-Term Services and Supports

Medicaid is the only safety net for millions of children with disabilities, adults and seniors in need of critical long-term services and supports. We urge you to keep this vital safety net in place.

We are concerned that efforts to block grant or cap Medicaid funding will endanger the health, safety, and care of millions of individuals who depend on the essential services

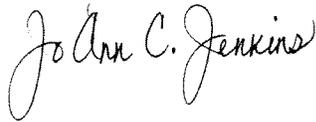
provided through this program. Furthermore, caps would likely result in overwhelming cost-shifts to state governments unable to shoulder the costs of care without sufficient federal support. As Congress considers changes to Medicaid, we urge that states be afforded enhanced flexibility to access funding for generally more cost-effective home and community-based services in the same way they can access nursing home funding

In addition, the ACA provided states with new options and enhancements to existing provisions to provide home and community-based services. We urge that any health law changes retain and enhance these provisions to enable more individuals to receive services in their homes and communities rather than costly institutional care.

Finally, Congress could further help seniors and other Americans with long-term care costs by returning the medical expense itemized deduction threshold from 10 percent to 7.5 percent of adjusted gross income. The tax increase caused by the higher threshold has fallen disproportionately on the sick — even those at more moderate income levels — especially since the deduction provides help to those with large medical costs that often include expensive long-term care costs.

We look forward to working with you to ensure we maintain a strong health care system that strengthens Medicare, ensures insurance market protections, controls costs, improves quality, and provides affordable coverage to all Americans. If you have any questions, please feel free to contact me, or have your staff contact Joyce A. Rogers, Senior Vice President, Government Affairs at (202) 434-3750.

Sincerely,

A handwritten signature in black ink that reads "Jo Ann C. Jenkins". The signature is written in a cursive, flowing style.

Jo Ann C. Jenkins
Chief Executive Officer

Ms. BONAMICI. The AARP also mentioned in the letter that Medicaid is the only safety net for millions of children with disabilities, adults, and seniors in need of critical long-term services and supports.

I want to point out that, in Oregon, the Kaiser Family Foundation estimates that more than 546,000 Oregonians could lose coverage if the ACA Medicaid expansion is repealed. Also, in Oregon, we have been doing some great innovations with care. We have CCOs improving care and reducing costs with patient-centered primary care homes. It's really working well to provide that preventive care.

And I've heard from hundreds of constituents in Oregon. In fact, thousands showed up recently at a townhall meeting that I did with our Senators about this issue. They're terrified about losing their coverage.

And Debra from Rainier shared her story with me. She called my office. She's worried that she's going to lose her care if the ACA is repealed. She's in the final stages of pancreatic cancer. She's not yet eligible for Medicare. She's worried that her cancer will prevent her from obtaining coverage without the *Affordable Care Act*. So she's spending her remaining time advocating for those who have benefited from health reform and doing what she can to prevent the repeal of this important law.

And I know her fears are shared with millions of Americans in districts all across the country. And I hope my colleagues will keep her, as well as you, Ms. Schlaack, in mind as we debate this repeal.

And, Ms. Schlaack, thank you so much for being here to share your story. I know it's not easy to come forward and talk about something so personal.

But you mentioned that the type of leukemia your husband was diagnosed with has genetic links so your family might be at risk. Can you discuss how the repeal might affect your family if individuals with preexisting conditions are no longer protected under the ACA? And if you might mention, what would a high-risk pool do? Do you think that's an acceptable alternative for your family?

Ms. SCHLAACK. No, not -- I mean, a high-risk pool, not at all. I mean, actually, the University of Chicago continues to work with samples from my husband to further educate themselves. And I've learned from my own family about some of the genetic links.

And being that I have a young daughter who previously was almost a preexisting condition for being a female, the thought that 30, 40 years down the road, if she sees the same thing, she won't possibly have the choice of buying prescriptions or paying for groceries.

Ms. BONAMICI. Thank you, and I hope we can keep your story and others in mind.

Mr. Eddy, you stated in your testimony your business had experienced some significant challenges as the health coverage you offered your employees changed, but you are hopeful your situation is stabilized. So can you talk a little bit about how the repeal of the *Affordable Care Act* without a credible alternative would affect your current situation?

There's a lot of uncertainty now. I know the President has said there's going to be insurance for everybody. I don't know how that

plan would work. We haven't seen that yet. But how would the uncertainty of repeal and replace, how would that affect your business and business owners like you?

Mr. EDDY. Thank you, Congresswoman.

For the answer to that, I will reference a study that the NAM has completed called "Shaping Up." The NAM took a hard look at the challenges as well as the opportunities for employers concerning healthcare insurance coverage. They were really looking at three broad themes with that: controlling costs, such as eliminating burdensome taxes and paperwork; expanding coverage options, such as providing flexibility for employers to cater their health insurance options; and access to better information in the form of improved healthcare IT and information sharing.

I think that document would maybe tend to give some additional, broader perspective than my own personal. I think that I would reference that, and that would be made available to you.

Ms. BONAMICI. Thank you, Mr. Eddy.

And I see my time has expired. Thank you, Madam Chairman.

Chairwoman FOXX. Thank you. The gentlewoman's time has expired.

Mr. Guthrie, you are recognized for five minutes.

Mr. GUTHRIE. Thank you, Madam Chairman, for the recognition. Thank you all for testifying. I appreciate you all being here.

And, Mr. Bollenbacher and Mr. Eddy, you mentioned in your testimony about your small businesses. And I have heard from families in my district. Right when we first got back to the session, a lot was going on in January, and I got a call, my office got a call from a young lady. And I called her back. I wanted to talk to her personally. And she has a special needs son, and she was really concerned -- and she's on the exchange in Kentucky -- extremely concerned about the idea that she might lose her health care as a lot of stuff has been reported. So I wanted to assure her, we're going to have a transitional plan and an ability for her to move forward.

But then we started talking about her plan. In Owensboro, Kentucky, on the exchange, you have one insurance choice. She said her husband works for a small business, less than 50 people, didn't get health care now through that business, had to go on the exchange, only one choice. Her child has special needs. We have great physicians in Kentucky, all over our state, but there was a particular physician for her child's needs in Cincinnati at the Children's Hospital and he was not in network.

So we started walking her through, after we talked about you're going to be able to continue your current coverage, the things that we want to do in our replacement plan that will have her have better coverage. One is, well, if it's a small business, associated health plans for small business will have better opportunities to provide health insurance, if she can buy out-of-state plans, if she needed a doctor in Ohio, because they had special skills for her child.

So we started walking through that, and she became more confident as we moved forward that we can improve the situation that she's in instead of being stuck in an exchange with one plan.

But my question. So I've actually put the *Employee Protection Act* that would allow small businesses, because what we are going to

do with small business -- because the people who are really trapped in this are people that are single employers, small businesses trying to buy on the individual market or small market. And what I want in this bill, and I want to see how this would help you, that you could actually offer pre-ObamaCare plans, pre-ACA plans. If you could go back and offer a plan like that to your employees, would that help you?

I think, Mr. Bollenbacher, you're a smaller business, I believe.

Mr. BOLLENBACHER. Yes, sir. It sure would. We feel like we have no options right now. We have a cookie-cutter plan that we have to pick, and that's it. And before the ACA, we had the ability to pick the plan that best fit our particular needs.

Mr. GUTHRIE. Mr. Eddy.

Mr. EDDY. Yes, Congressman, we run into the same issues. We are in the northern panhandle of West Virginia, so we are about a mile from Ohio and five miles from Pennsylvania.

One of the issues as far as going backwards is the fact that we don't have several of the carriers that used to represent West Virginia. The ACA has weakened and some of them have actually been taken over. So our options now are somewhat limited to three carriers in the northern Ohio Valley. And we would like to maybe move some of the provisions back that would give us more options and flexibility that we talked about. So, yes, that would be important.

Mr. GUTHRIE. And we think what we want to propose will give her more options for her son, and that's what we hope to certainly accomplish.

Mr. Bollenbacher, I think Mr. Rokita -- I was out but just coming back -- asked you about a letter that you sent to the President. Can you talk about the response you got on the letter -- or from the administration? I didn't expect him to personally respond, but from the administration what did you?

Mr. BOLLENBACHER. Sure. A month or so after I sent the letter, somebody from the SHOP Marketplace called me, just to talk about the plans that they had available on the SHOP network, which really wasn't any benefit to us.

Mr. GUTHRIE. Okay. Well, thanks.

And then, Dr. Troy, in your testimony you mentioned that innovations in large employer-sponsored healthcare benefits helped to reduce healthcare costs for employees, retirees, and dependents. Can you share with the committee some of the ways employer coverage is reducing costs?

Mr. TROY. Thank you. So as I was saying earlier, that we were seeing reductions in employer-sponsored costs in that period, 2006 to 2010, before the ACA went into effect, and it was a result of program design changes and plan design changes on the part of employers, which included the implementation of consumer-directed health plans, wellness programs, which have been shown in many cases to reduce costs and actually improve the health of employees, which is really what we are trying to get at, and other significant plan innovations.

And, again, combined, these really dropped the annual increase from 11.1 percent in the period before 2006 to from 2006 to 2010 to 4.8 percent. And we believe that additional innovations by em-

ployers could reduce costs even further in the years ahead. Employers are now taking this issue very seriously.

Mr. GUTHRIE. Thank you.

Thank you, Madam Chair. I yield back my time.

Chairwoman FOXX. Thank you so much.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Madam Chair.

Madam Chair, before I begin, I would like to ask unanimous consent to insert into the record a letter from the American Hospital Association and Federation of American Hospitals raising grave concerns with repealing the *Affordable Care Act*.

Chairwoman FOXX. Without objection.

[The information follows:]



December 6, 2016

The Honorable Paul Ryan
Speaker
U.S. House of Representatives
U.S. Capitol Building, H-232
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
U.S. Capitol Building, S-230
Washington, DC 20510

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
U.S. Capitol Building, H-204
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader-Elect
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

Dear Speaker Ryan, Majority Leader McConnell, Minority Leader Pelosi and Minority Leader-Elect Schumer:

The American Hospital Association (AHA) and the Federation of American Hospitals (FAH) stand ready to help as the Congress and new Administration take shape and develop the health agenda moving forward. As you know, hospitals and health systems provide essential medical services and assume a critical public health and safety role across the nation in every single state and congressional district.

We appreciate your commitment to ensuring access to affordable health care for all Americans. We also recognize that the 115th Congress is committed to a thorough reconsideration of the Patient Protection and Affordable Care Act (ACA). At the same time, we value statements you have made about the importance of protecting health care coverage – a goal we strongly support. Health coverage is key to ensuring patients have access to the care they need.

According to reports, it appears that the Congress is moving to reconsider the ACA in the early days of the new year without enacting accompanying legislation specifically guaranteeing similar coverage for those who will lose it. If that approach is taken, we respectfully urge you to also include in such legislation the prospective repeal of funding reductions for Medicare and Medicaid hospital services for patient care that were included in the ACA for purposes of helping fund coverage for the insured. Specifically, we seek your support for the restoration of the Medicare hospital inflation update, as well as Medicare and Medicaid Disproportionate Share Hospital (DSH) payments that support those facilities that take care of high volumes of uninsured, poor and disabled Americans.

December 6, 2016
Page 2 of 3

Restoring these cuts for the future is absolutely essential to enable hospitals and health systems to provide the care that the patients and communities we serve both expect and deserve.

ACA repeal and replace legislation sponsored by Department of Health and Human Services Secretary-nominee Tom Price is an example of providing a “clean slate,” which would protect hospitals from destabilizing cuts that would jeopardize access to high-quality services. In contrast, The Restoring American’s Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762), which passed the Congress, and was ultimately vetoed by President Obama, effectively repealed the coverage and many other funding provisions of the ACA, but left in place hundreds of billions of dollars in cuts to payments for hospital services originally intended to help fund the coverage that the bill would repeal.

Further, we want to bring to your attention critically important information that we hope will inform the deliberations on ACA repeal and replace. Today, we are releasing two reports prepared by the health care economics consulting firm Dobson | DaVanzo on hospital payment cuts that require the attention of policymakers. The first analysis estimates the financial impact, from 2018 – 2026, on hospitals of repealing the ACA under H.R. 3762 without any replacement. Dobson | DaVanzo finds that the loss of coverage under H.R. 3762 would have a net negative impact on hospitals of \$165.8 billion, after accounting for the restoration of the Medicaid DSH cuts that H.R. 3762 contemplates. Dobson | DaVanzo also finds that hospitals would lose \$289.5 billion in inflation updates if the payment cuts in the ACA are not restored. Finally, Dobson | DaVanzo finds that the full restoration of the Medicare and Medicaid DSH payment reductions would amount to \$102.9 billion. Losses of this magnitude cannot be sustained and will adversely impact patients’ access to care, decimate hospitals’ and health systems’ ability to provide services, weaken local economies that hospitals help sustain and grow, and result in massive job losses. As you know, hospitals are often the largest employer in many communities, and more than half of a hospital’s budget is devoted to supporting the salaries and benefits of caregivers who provide 24/7 coverage, which cannot be replaced.

As Dobson | DaVanzo point out in their analysis, the total net losses hospitals would suffer under repeal is nearly 100 percent more than the hospital reductions in the Balanced Budget Act of 1997 (BBA), which was the largest ever reduction in federal payments for services provided by hospitals for patient care. In fact, due to these extreme cuts, hospitals had to cut back staff, services, education, research, investments in new technology, and modernization and upgrading of aging facilities. As a result of this overreach, Congress was compelled to pass several subsequent measures to remediate the BBA’s damage. These measures were enacted under both Democratic and Republican administrations. The Dobson | DaVanzo report cautions that “this magnitude of cuts would threaten hospitals’ ability to serve their patients and communities.”

The second Dobson | DaVanzo analysis estimates the cumulative federal payment reductions to hospital services that have been imposed through other Congressional and Executive Branch actions subsequent to and independent of the ACA. These cuts alone total another \$148 billion from 2010 – 2026, and come on top of the ACA cuts.

As you can appreciate, the cuts detailed above will create challenging and potentially unsustainable financial circumstances that could ultimately reduce patients’ care options. And they highlight only part of the problem. A recent analysis by the Congressional Budget Office (CBO), titled

December 6, 2016
Page 3 of 3

“Projecting Hospitals’ Profit Margins Under Several Illustrative Scenarios: Working Paper 2016-04,” also should give policymakers pause as they consider the future of hospital care. The September 2016 report found that, even accounting for the benefits of ACA coverage expansion (which is at risk of repeal), nearly half of all hospitals – between 40 and 50 percent – are likely to suffer negative margins in 2025. The results could be devastating to hospitals and our patients.

As you begin reconsideration of the ACA, we want to be a constructive partner in this discussion. We strongly believe that any repeal legislation must be accompanied by provisions that protect the coverage for those currently receiving such protection. However, if that is not the legislative path to be pursued, then it is vital that such legislation provide a true clean slate and also include repeal of the reductions in payments for hospitals services embedded in the ACA – specifically the substantial reductions to hospitals’ annual inflation updates and the cuts to Medicare and Medicaid DSH payments. If the coverage associated with the ACA disappears, the importance of these payments would be heightened – they are vital in helping defray the costs of treating our most vulnerable patients.

In addition, restoring these cuts is consistent with Congressional action aimed at repealing a variety of ACA-related taxes that were imposed to help fund coverage expansion. It stands to reason that, if the funding and cost of the ACA is repealed, all sources of funding for that legislation, including cuts to payments for hospital services, should be rolled back as well.

We want to reiterate our commitment to working with you on legislation that achieves our shared goal of improving America’s health care system through patient-centered care, and believe strongly that empowering Americans through health coverage is key to success.

Thank you for your consideration of our views.

Sincerely,

/s/

Richard J. Pollack
President & CEO
American Hospital Association

/s/

Charles N. Kahn
President & CEO
Federation of American Hospitals

Mr. TAKANO. Thank you, Madam Chair.

I'm disappointed that my colleagues are yet again seeking to undermine a law that has helped millions of Americans get health coverage while creating a more just and compassionate healthcare system for hundreds of millions more through consumer protections.

Before I get to my questions, I want to speak briefly about the impact of the *Affordable Care Act* on my constituents. When I took office in 2013, a quarter of my constituents were uninsured. By 2015, the uninsured rate was cut in half to less than 12 percent, and nearly 90,000 people were newly insured.

People like my constituent and childhood friend Heather Froehly. Heather had a preexisting condition, and for years before the ACA she was priced out of the insurance market and denied coverage. She contacted me during the first enrollment period in 2014 to let me know that she had successfully purchased a plan and was thrilled to be covered for the first time in years. The law's subsidies ensured here coverage was not only accessible but affordable.

Soon after, Heather was diagnosed with stage two breast cancer. In the following months she underwent treatment, and I'm happy to report Heather is now cancer free and doing well. Heather has told me without hesitation that the *Affordable Care Act* saved her life. Had she not been able to obtain coverage, she would not have been able to go to that appointment where the doctors first discovered her cancer. She was fortunate to catch the cancer before it progressed further. I don't want to think what she would have done without the ACA.

Now, we know the costs of repealing the ACA: 30 million people will lose their insurance, including nearly 5 million Californians. It would cost my State nearly 150,000 jobs. But more than that, we know that stories like Heather's or Ms. Schlaack's can be found in every district represented here today. Democrat and Republican districts share the same predicament.

Cancer does not recognize red states and blue states. We have to take off our partisan blinders and acknowledge where the ACA has succeeded and where it must be improved. And I hope we can agree that it would be a terrible mistake to repeal a law that has saved so many American lives.

Now, Ms. Schlaack, first of all, I want to thank you for your courage this morning and sharing your family story. And I'm incredibly sorry for our loss and appreciate your willingness to speak here today.

Now, my colleagues on the other side of the aisle seem to be in a great rush to repeal a law that insures millions of Americans and that they have any access at all to lifesaving care. And it seems in their illogical haste to score political points and make good on an ill-informed promise to repeal the ACA that they have ignored the impact of their actions, especially for families who are dealing with a significant healthcare crisis.

Can you help us understand what it must be like for those families, on top of the deep concern for their loved one's health, to be scared about Republican attempts to dismantle a law that is working to ensure that they maintain lifesaving care? Can you help us understand?

Ms. SCHLAACK. Thank you.

Well, like I had mentioned before, I mean, when you're going through this treatment, whether you're the patient or caregiver or family friend, your focus is on wellness. And the bills keep coming in regardless of what's going on, and the fact that you don't have to worry about whether you're going to be covered or not is one less worry.

Mr. TAKANO. Tell us more about the annual or lifetime caps, the fact that there were no caps annually.

Ms. SCHLAACK. Right.

Mr. TAKANO. How would that have affected you and your husband?

Ms. SCHLAACK. Well, for instance, my husband had to have -- in a 10-month period he had 12 bone marrow biopsies. Those are four grand apiece. Blood transfusions multiple times a week. An ambulance arrived from our house to the hospital, which happened three times, \$2,000. This is not counting the doctors, the medical staff, the hospital admissions. Easily before he was even halfway through his treatment would have maxed out a lifetime million-dollar maximum like it used to be.

Mr. TAKANO. So this consumer protection was key. And if I had more time, I would want to ask Mr. Eddy and Mr. Bollenbacher whether their policies had any lifetime or annual caps and that might have made them more affordable to them. But I don't have the time. My time expired. So I don't want to yield back, but my time has expired.

Chairwoman FOXX. Thank you very much.

Mr. Rooney, you are recognized for five minutes.

Mr. ROONEY. Thank you, Chairwoman Foxx, and thank the witnesses for being here today. I've got questions for Dr. Troy and Mr. Eddy.

People throughout southwest Florida have expressed many of the frustrations shared here today. According to Forbes magazine, an average 64-year-old woman in Lee County, Florida, has seen her insurance premiums and costs jump 135 percent. Under these exchanges, due to the failure of competition, most southwest Floridians now have one choice for their health insurance. Many of them are on a fixed income.

So my question for Dr. Troy is, if the failed experiment of ObamaCare continues as is, what chance do our average southwest Floridians have to see their healthcare costs go down?

Mr. TROY. I am, too, sir, concerned about the lack of choices on the ACA exchanges, and we are having an increasing number of exchanges with only one option, as you were saying. The cost trend suggests that the chance for the average Floridian of seeing cost reductions under the ACA are very low.

Mr. ROONEY. Thank you.

Mr. Eddy, thank you for being here as well. Glad to see another businessperson here who has firsthand experience with this disaster on our employees.

According to the American City Business Journals, Lee County, Florida, is the third-best place for small businesses. Employer mandates have prevented many of our small-business owners from hiring new employees. And as I think you've mentioned as well, many

have had to reduce the hours worked to deal with the cost increases of ObamaCare.

Can you share with us some insights on how the employer mandates have curbed jobs and wage growth?

Mr. EDDY. Yes, Congressman. Thank you.

The obvious first one is the cost. As it restricts our hiring capability, the costs per year, if you look at just the costs related to the mandates and the health insurance industry fees, those two alone really represent about three full-time equivalent employees for us.

The restrictive parts of the ACA really, as I said earlier, dictate a lot of different business decisions that we make, including capital investments. Looking to the future, we have to, any time we make a capital investment for growth, we have to hire and plan on hiring new employees.

So this has, as I said, become one of our most critical decision-making parts. And it's not just the costs and fees, it's the future. It's the uncertainty. The Cadillac tax, for example, is of critical concern because of our -- the curve on the costs right now by 2018 would possibly put us into that 40 percent additional tax rate.

So it's fully encompassing, to say the least, for all of our business decisions.

Mr. ROONEY. Well, I appreciate that response. Like I say, I'm an employer too, and I'm used to satisfying customers, as you are. And maybe we ought to think about a system that puts the patient first, patient-centric care, where they get to make the choice instead of a top-down government mandate. What do you think about that?

Mr. EDDY. I can tell you, I'm no healthcare expert, but without change -- and I want everybody to know that we are all compassionate to the needs of the people. That's why we employ and try to take great care of our employees. But I'm very concerned about the long-term sustainability of health care in general if we don't make a major change. I'm supportive of that, yes. Thank you.

Mr. ROONEY. Thank you very much.

Again, thank you all for being here.

And I yield back.

Chairwoman FOXX. Thank you very much.

Mr. Espailat, you're next for five minutes.

Mr. ESPAILLAT. Thank you, Madam Chair.

Dr. Troy, I appreciate in your written testimony that you stated, and I quote, "It is important to protect those who have gained coverage under the ACA." However, I am concerned that about 30 million individuals are projected to lose health insurance if the ACA is repealed. Specifically, New York State Governor Cuomo, Andrew Cuomo, has stated that over 2.7 million New Yorkers would lose coverage, with Republicans offering no guarantee to protect this coverage.

I ask for unanimous consent to include Governor Cuomo's statement announcing the impact of the ACA repeal on the record.

Chairwoman FOXX. Without objection.

[The information follows:]

For Immediate Release: 1/4/2017

GOVERNOR ANDREW M. CUOMO

**GOVERNOR CUOMO ANNOUNCES IMPACT OF POTENTIAL AFFORDABLE CARE ACT
REPEAL IN NEW YORK**

Over 2.7 Million New Yorkers Would Lose Coverage

Estimated State Budget Impact of \$3.7 Billion

Counties Across New York Would Lose Over \$595 Million in Direct Spending

New York Residents Would Lose \$250 Million in Health Care Savings Tax Credits

Governor Andrew M. Cuomo today announced the impact of potential repeal of the Patient Protection and Affordable Care Act on health care coverage of New Yorkers and the state budget. If the repeal of the Affordable Care Act were enacted, an estimated 2.7 million New Yorkers would lose coverage and New York State would experience a direct state budget impact of \$3.7 billion and a loss of nearly \$600 million of federal funding that goes directly to counties, which they use to help lower property taxes.

"The cost of a repeal of the Affordable Care Act, to state and local budgets and to the New Yorkers who depend on its health care coverage, is simply too high to justify," **Governor Cuomo said.** "Since its implementation, the Affordable Care Act has become a powerful tool to lower the cost of health insurance for local governments and New Yorkers, and it is essential that the federal government does not jeopardize the health and livelihoods of millions of working families."

The NY State of Health exchange has successfully cut the percentage of uninsured New Yorkers in half, from 10 percent to 5 percent. It has also significantly expanded eligibility and access to health coverage, allowing hundreds of thousands of previously uninsured New Yorkers to achieve economic and healthcare security. Based on current enrollment levels, the repeal of the Affordable Care Act would result in over 2.7 million New Yorkers losing health coverage. The estimated number of individuals at risk of losing coverage, based on current enrollment levels, is broken down by counties below:

County	Individuals at Risk of Losing Coverage
Albany	25,552
Allegany	4,608
Bronx	300,012
Broome	20,231
Cattaraugus	8,310
Cayuga	7,665
Chautauqua	15,270

Chemung	9,160
Chenango	5,184
Clinton	7,787
Columbia	6,827
Cortland	4,606
Delaware	4,461
Dutchess	25,074
Erie	93,403
Essex	3,660
Franklin	5,110
Fulton	6,038
Genesee	5,074
Greene	4,971
Hamilton	522
Herkimer	6,932
Jefferson	10,955
Kings	540,320
Lewis	2,932
Livingston	4,972
Madison	5,861
Monroe	75,512
Montgomery	5,473
Nassau	133,324
New York	218,937
Niagara	21,287
Oneida	24,781
Onondaga	45,682
Ontario	9,355
Orange	37,851
Orleans	4,522
Oswego	12,568
Otsego	5,785
Putnam	7,006
Queens	493,058
Rensselaer	12,540
Richmond	56,882
Rockland	38,526

Saratoga	16,340
Schenectady	16,056
Schoharie	3,079
Schuyler	2,065
Seneca	3,145
St. Lawrence	11,063
Steuben	10,039
Suffolk	152,631
Sullivan	9,668
Tioga	4,560
Tompkins	7,827
Ulster	19,850
Warren	6,796
Washington	6,689
Wayne	9,354
Westchester	91,844
Wyoming	3,700
Yates	2,515
Total	2,715,807

The estimated direct state budget impact of the repeal is \$3.7 billion. New York's counties have been able to use the additional federal Medicaid funding through the Affordable Care Act, which goes to directly to counties and helps to lower property taxes. A repeal of the Affordable Care Act would result in a total loss of \$595 million in funding. A county by county breakdown of the allocated annual funding that each county would lose is available below, based on the most recent year:

County	2016-17 Funding
Albany	\$4,738,862
Allegany	\$786,300
Broome	\$3,049,122
Cattaraugus	\$1,211,333
Cayuga	\$1,098,606
Chautauqua	\$2,443,709
Chemung	\$1,491,573
Chenango	\$686,373
Clinton	\$1,292,531

Columbia	\$833,957
Cortland	\$786,023
Delaware	\$666,830
Dutchess	\$2,974,044
Erie	\$17,149,148
Essex	\$400,176
Franklin	\$681,442
Fulton	\$879,897
Genesee	\$691,774
Greene	\$832,298
Hamilton	\$68,800
Herkimer	\$956,261
Jefferson	\$1,601,068
Lewis	\$294,378
Livingston	\$686,242
Madison	\$842,891
Monroe	\$13,023,431
Montgomery	\$797,695
Nassau	\$17,866,829
Niagara	\$3,849,704
Oneida	\$4,169,425
Onondaga	\$7,871,592
Ontario	\$1,042,122
Orange	\$5,021,173
Orleans	\$667,917
Oswego	\$2,281,144
Otsego	\$729,112
Putnam	\$561,094
Rensselaer	\$2,307,076
Rockland	\$3,867,080
St. Lawrence	\$1,564,073
Saratoga	\$1,864,638
Schenectady	\$2,462,377
Schoharie	\$475,760
Schuyler	\$312,126
Seneca	\$369,493
Steuben	\$1,514,370

Suffolk	\$18,310,813
Sullivan	\$1,439,822
Tioga	\$589,433
Tompkins	\$1,015,126
Ulster	\$2,935,566
Warren	\$787,632
Washington	\$746,252
Wayne	\$910,595
Westchester	\$15,243,258
Wyoming	\$382,781
Yates	\$282,426
Upstate Total	\$162,405,572
New York City Total	\$433,294,428
New York State Total	\$595,700,000

George Gresham, President, 1199SEIU United Healthcare Workers East, said, "New York's healthcare workers see the positive impact of the Affordable Care Act every day. Our patients are able to access preventative care instead of coming to emergency rooms in states of advanced illness. Our employers have reduced losses from uncompensated care. Our friends and relatives are relieved of the fear that getting sick equals financial ruin. Repealing the Affordable Care Act without an adequate replacement would have immediate and devastating consequences for millions of our fellow New Yorkers and for state and local budgets. We applaud Governor Cuomo's leadership in educating New Yorkers about costs and are proud to stand with him to advocate for the health all New Yorkers."

Greater New York Hospital Association President Kenneth E. Raske said, "These deeply troubling numbers are only the tip of the iceberg if the Affordable Care Act is repealed. It will also severely harm the hospital community. 27 hospitals across New York State are on a 'watch list' for financial stress and many more both public and private face similar fiscal challenges. Repealing the Affordable Care Act without an immediate and adequate replacement plan will make things dramatically worse for safety net hospitals and the vulnerable communities they serve. I applaud Governor Cuomo for his leadership and look forward to working with the bipartisan members of the New York Congressional delegation to ensure that the health care of all New Yorkers is protected."

Bea Grause, President of the Healthcare Association of New York, said, "In addition to providing care to those in need, hospitals are major employers in communities all across the state. Repeal of the ACA could have tremendous consequences for the delivery of healthcare and also in terms of jobs and economic activity. It's imperative that Congress be mindful of this reality. I'm pleased to join the Governor in this important effort to protect New Yorkers."

Mr. ESPAILLAT. Dr. Troy, I appreciate that in your written testimony, you stated that employers, and I quote, “however, are both good at getting people covered and maintaining manageable risk pools. Public policy should be aimed at encouraging these important goals.” You also mentioned the risk pools are difficult to maintain. Employer risk pools for the chronically ill is a central tenet of Speaker Ryan’s “A Better Way” paper.

I would like to know how you will separate the healthy from the ill. And considering that high-risk pools are more expensive to buy by consumers, more expensive to administer, and generally provide less coverage, how do you propose to implement these high-risk pools without taking a real hit on consumers and patients across the country?

Mr. TROY. Thank you, sir, for your question. And as a native New Yorker, I congratulate you for your joining Congress and joining the committee.

In terms of risk, managing risk is a crucial part of how to handle any possible healthcare plan going forward. It’s a crucial part of healthcare reform. One of the things about employers and why I said in my testimony that they are good at managing risk is that they have large pools of people who work for them and therefore the risk pools generally tend to be better. You don’t have the same kind of options such as you have in the ACA exchanges in which you have the young and healthy people choosing not to participate. And we, too, have evidence that the percentage of the young people in the ACA exchanges are younger than needs to be to maintain an acceptable risk pool. So I think --

Mr. ESPAILLAT. Aren’t they generally more expensive to buy? Aren’t they more expensive to administer and provide less coverage?

Mr. TROY. Are you saying employer-sponsored plans? No, we have not found that to be --

Mr. ESPAILLAT. High-risk pool.

Mr. TROY. We have not found that to be the case.

In terms of high-risk pools, the idea is to minimize the number of people who would be in them. And that’s why employer-sponsored health care is an important building block, as would be, perhaps, association health plans that would allow other people to join what are effectively risk pools by joining with their civic organization or their union or their religious organization and then get the tax-preferred benefit. So the idea is to minimize the number of people in high-risk pools.

But, yes, of course, you are right that the specific high-risk pools that these programs that would establish, the specific high-risk pools programs would establish are more expensive because we’re dealing with a group by its nature that is high risk. The idea is to minimize the number of people in those pools.

Mr. ESPAILLAT. Dr. Troy, the Trump administration’s recent immigration executive order has made it impossible for many foreign-born physicians and students to enter the United States. On your blog in December 2013, you discussed the worrisome expected doctor shortages. And in 2012, while a fellow at the Hudson Institute, you wrote a piece that commented on the physician shortage that this country already faces.

As a healthcare policy matter, does it make sense for the administration to make it more difficult for the United States to meet the health needs of our population by restricting the number of doctors we recruit and train?

Mr. TROY. Thank you very much for that question. As a healthcare policy nerd, I guess, as you said, who wrote this paper four years ago, I'm flattered that people are reading the paper, and I hope it has an important public policy impact. I absolutely think that we do have concerns about a doctor shortage. I've always been in favor of an immigration system that works to bring in people who are willing to work and willing to help improve our economy, and I worked in the Bush administration on the immigration reform plans that would have helped bring more doctors into the country.

Mr. ESPAILLAT. So you support an exemption for doctors and healthcare professionals from those countries that are currently being hit with the ban?

Mr. TROY. I would like to see our immigration policy have plans to allow more doctors to come into the country, absolutely.

Mr. ESPAILLAT. Madam Chair, the statement from the Association of American Medical Colleges expresses deep concerns about this new immigration policy. I ask unanimous consent to insert this in the record.

Chairwoman FOXX. Without objection.
[The information follows:]

Press Releases
Monday, January 30, 2017

AAMC Statement on President Trump's Executive Order on Immigration

AAMC (Association of American Medical Colleges) President and CEO Darrell G. Kirch, MD, issued the following statement regarding President Trump's executive order on immigration:

“The nation’s medical schools and teaching hospitals are dedicated to promoting a diverse and culturally competent health and biomedical workforce that supports improvements in health care, breakthroughs in medical research, and, ultimately, improved and equitable health for all patients.

We are deeply concerned that the Jan. 27 executive order will disrupt education and research and have a damaging long-term impact on patients and health care.

The AAMC strives to ensure medical education and training is accessible for students and physicians from all backgrounds. The United States is facing a serious shortage of physicians. International graduates play an important role in U.S. health care, representing roughly 25 percent of the workforce. Current immigration pathways—including student, exchange-visitor, and employment visas—provide a balanced solution that improves health care access across the country through programs like the National Interest Waiver and the Conrad 30 J-1 Visa Waiver. In the last decade, Conrad 30 alone has directed nearly 10,000 physicians into rural and urban underserved communities. Impeding these U.S. immigration pathways jeopardizes critical access to high-quality physician care for our nation’s most vulnerable populations.

Our ability to attract top talent from around the world also enriches the research laboratories at medical schools and teaching hospitals that are working toward cures and has helped position the U.S. as a global leader in medical research, strengthening our economy and bolstering the public's health. Because disease knows no geographic boundaries, it is essential to ensure that we continue to foster, rather than impede, scientific cooperation with physicians and researchers of all nationalities, as we strive to keep our country healthy.

The AAMC is committed to a workforce that serves all patients and urges the administration to carefully consider the health care needs of the nation.”

The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and

groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians. Additional information about the AAMC and its member medical schools and teaching hospitals is available at www.aamc.org.

Chairwoman FOXX. And the gentleman's time has expired.

Mr. ESPAILLAT. I yield my time.

Chairwoman FOXX. Mr. Brat, you're recognized for five minutes.

Mr. BRAT. Thank you very much, Madam Chairman.

Thank you all very much for being with us today.

I'm on the Budget Committee, and so I like to kind of zoom in on the mandatory spending problem this country faces, and a lot of that is going to be impacted by increasing healthcare costs over the years. And so that's where I'm headed.

And so we all appreciate the concerns shared across the aisle on uninsured, the costs. We want to get it right. But the amazing thing I never hear and that the media, unfortunately, never covers is the impact on our children with the programs, Medicare, Social Security, *et cetera*, going forward. So I'll just share a few facts.

And then I don't know whether you all have this in your planning horizon or not, because it is 10 to 20 years off. But just the basic fact, everyone -- I taught economics for a 18 years -- everyone wants everything in the short run, right? I mean, utility maximization, *et cetera*, and we're pushing stuff off when it comes to the debt, *et cetera*. So in Virginia, healthcare costs are going up by 20 percent, and that's pretty typical. Some States, 50 or more percent increase in premiums. So, number one, is that sustainable?

Two, Kaiser recently has come out with just the standard premium rates, about \$17,000 for a family of four in Virginia or across the country. That's just the new family of four premiums, \$17,000. Is that sustainable?

Average family income in my counties is about \$65,000 for family. Family income 65, 17 health care. Is that sustainable? Deductibles are over 5,000 typically now for silver, bronze plans, right, not just high deductible. It is across the board. Is that sustainable?

And then my commentary is what I know is not sustainable. So currently we are 20 trillion in debt. And if you go out to CBO, the trendline is in 10 years we're going to add another 10 trillion. Likely, we'll be at 30 trillion in debt. When does the bond market call that in? Is that sustainable? I don't think it is.

The flip side of that is what's driving that debt? A lot of the pressure is coming from the mandatory spending programs. Medicare and Social Security are both insolvent in 15 years, roughly speaking. In 50 years, it's not clear whether our kids will have those programs at all.

And healthcare costs are, of course, probably the main driver of those programs, of Medicare, Social Security, Medicaid, veterans, *et cetera*. And I haven't heard enough analysis of that. This is a huge ethical issue and an ethical tradeoff of current generations versus the next generation. So everyone's talking about what we would all like right now, but the facts look to me, with Medicare and Social Security insolvent in 15 years and maybe nonexistent in 50 years when our kids retire, is anyone taking that into account?

And so what goes with that, the main graph out at CBO also shows in 10 years all Federal revenues will go only to mandatory spending programs, right? So all Federal revenues will only go to mandatory spending programs, Medicare, Social Security, Medicaid, Bush prescription drug plan, *et cetera*. Right? So that means

there's no money left for the military, education, transportation, everything we believe in across the aisle.

And the mirror image of that same statement, that there's no Federal revenues left, is the deficit in 10 years is expected to be \$1.2 trillion, which fully funds the discretionary budget, right? So we will be deficit financing the entire discretionary budget in 10 years.

So this is just CBO facts, most of it related to mandatories. And I just want to open it up to your comments. Why don't we just work down the -- Dr. Troy, why don't you lead off, just on the sustainability. And, sorry, I've left you probably with probably way too little time.

Mr. TROY. That's, fine, sir. I will be brief.

We have a chart that we've prepared. It's called "Hitting the Wall," and it talks about the period from 2025 to 2030 when we're going to have Medicaid spending hit over a trillion dollars. All of the baby boomers will have retired. The Medicaid trust fund, as you say, will be insolvent. And we are very concerned about all those trends going forward.

We are also concerned about recent public policy which puts more people onto government-sponsored healthcare programs and fewer on private programs. So we would like to see more reliance on this employer-sponsored care as a way to address these issues going forward. And I would like to submit that chart for the record.

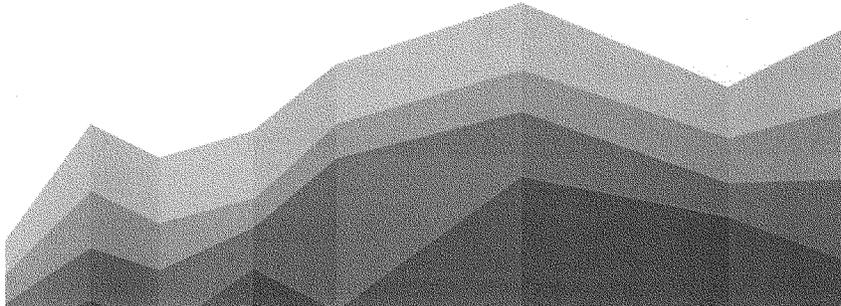
Mr. BRAT. Right. Thanks.

Chairwoman FOXX. Without objection.

[The information follows:]

Hitting the Wall: When Health Care Costs are No Longer Manageable

By Tevi D. Troy and D. Mark Wilson



American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

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"If something cannot go on forever, it will stop." Economist Herbert Stein, 1916 – 1999

Introduction

Relying on any system to continue requires that such a system is sustainable. If it is not, then, as the late economist Herb Stein has said, "it will stop." In stopping, however, such a system will impact those who rely on it and assume that it will continue. History is replete with examples of permanent seeming systems that eventually went away: The Roman and Ottoman empires, and the Soviet Union. This trend has moved into today's age with once seemingly permanent institutions folding—including the massive wave of major hospitals closures across the U.S.; the recent closing of colleges such as Sweet Briar College, a women's college established in 1901; and even U.S. military bases, forts, posts and sanctuaries around the world, including the fifteen bases that the Pentagon recently announced that will close between 2018 to 2021. Even the biggest and strongest institutions are subject to extinction.

When it comes to health care, 87% of Americans are dependent on one of two seemingly permanent systems: 33% of Americans rely on a variety of government programs, including Medicare, Medicaid, and the new Affordable Care Act exchanges. And 54% get the health care from employer sponsored health insurance, which today covers over 169 million Americans. Despite all of the tumult in U.S. health care over the past few years, employer sponsored health insurance (ESI) has remained a reliable constant. ESI provides health coverage to a majority of Americans, and a majority of them tell pollsters they are satisfied their current means of health care coverage.

That said, it is clear that changes are coming to both government programs and to ESI, and they are coming as a result of a variety of pressures facing American health care. These pressures have been long in building, but many of them are reaching a state where they will eventually force fundamental changes. The American health care system could potential handle or absorb any one challenging trend, but in combination they may be too much to bear. The concurrent strains in both ESI and government-run programs, which combined cover or subsidize the vast majority of Americans, could leave millions of Americans without any affordable health care options.

This paper will examine some of these pressures, and look at independent estimates of when each of them will be reaching a crisis point. According to these analyses, each system will be facing its own crisis in a narrow window of time, specifically the years between 2025 and 2030. The fear is that the convergence of these negative trends in a short window of time could lead employers and the federal government to make drastic changes to their health care delivery models, which in turn will lead to other changes in the health care system, as previously covered individuals scramble to find alternative ways to secure comparable benefit levels. Should all of these problematic trends converge in a short period of time, it is possible that the American health system will at that point be hitting the wall.



Elements of Hitting the Wall: 2025-2030

2025: Medicaid costs surpass \$1 trillion per year

2025: Worker to retiree ratio dips below 3:1

2025: 53 percent of private sector employees who are heads of families will face an average family premium and deductible that will consume 9.5 percent or more of the family's income

2025: Fewer than 20 percent of workers will receive health care through their employer, (Ezekiel Emanuel prediction)

2029: All of the baby boomers are 65 and older

2030: The Medicare HI trust fund is depleted

2031: Cadillac Tax hits Average value plan

Government Programs

A large component of the upcoming challenge we are facing is a demographic one. The various federal health care spending programs face enormous long-term unfunded liabilities. These liabilities will be coming due as the baby boomers continue to retire for the next decade and a half. There were about 76 million baby boomers born between 1946 and 1964, the peak baby boom years. These baby boomers are turning 65 at a rate of about 10,000 a day. By 2030, 18 percent of the population will be over 65, which is up from about 13 percent today.¹ All of these aging and retiring baby boomers will place additional pressure on our already overburdened health system, in a number of ways. First, the sheer number of people on Medicare will be a problem as the ratio of taxpayers per beneficiary shrinks. Second, the elderly tend to have higher health costs than the non-elderly, meaning that overall health spending will be going up as well.

The Congressional Budget Office (CBO) projects that spending per enrollee in federal health care programs will continue to increase at a faster pace than per capita GDP over the next 25 years. While the growth rate of spending per Medicare beneficiary is projected to remain very low over the next few years as many relatively healthy boomers retire and have lower medical care utilization, these costs are projected to increase gradually through 2039, as a large number of boomers hit their end of life costs in the next 10 to 20 years.² Come 2039, at the peak of the growth rate of Medicare spending, America's oldest baby boomers will be 94 years old. At that point, many of them will be relying on costly long term and end of life health care costs.

Another problem with the large number of pending retirees is the way in which we finance our entitlement programs. The federal government uses a “trust fund” fiction in which current tax dollars are used for federal spending programs, but are also assigned to cover future entitlement obligations. This system can work as long as contributors significantly outnumber recipients. But as baby boomer retirements shrink that taxpayer per beneficiary ratio, the trust funds start to run out, and soon.

The trust fund bankruptcies begin not with the retirement programs but with a disability program. The federal disability insurance program, which covers benefits for 11 million Americans, has been running an annual deficit of more than \$23 billion per year since 2010, and its trust fund will be exhausted in 2016.³ At that point disability benefits will have to be cut by 19 percent.⁴ The program currently has a \$1.2 trillion unfunded obligation that will eventually have to be made up by cutting benefits, raising taxes, or both.⁵

The retirement programs follow in the 2030s. In 2023, the Medicare program begins to regularly spend more than it takes in, and by 2030 the Medicare HI trust fund is depleted.⁶ At that point, the federal government faces a stark choice: reduce benefits by 15 percent, or raise taxes to cover the shortfall. Medicare currently has a \$28.5 trillion unfunded obligation.⁷

In 2022, the Social Security program begins to spend more than it takes in, and by 2034 the Old Age Survivor Insurance trust fund is depleted.⁸ At that point, the federal government faces an even starker choice: reduce Social Security benefits by 25 percent, or raise taxes to cover the shortfall.⁹ Social Security currently has a \$9.4 trillion unfunded obligation.¹⁰

The retirement programs are not the only programs in trouble. Medicaid and ACA subsidies are growing faster than the economy as well. Over the next ten years (2016 to 2025), ACA subsidies will cost \$895 billion.¹¹ Medicaid, which is covering the bulk of the newly insured under the ACA, will see its expenditures double over the next decade, rising from \$541 billion today to more than \$1 trillion annually by 2025.¹² Overall, federal health spending will come close to doubling as a share of GDP by 2039. In this period, all other federal spending, with the notable exception of interest on the debt, is expected to shrink.¹³

Unsustainable long term spending will have real implications for the country. Medicaid is a shared responsibility program. The federal government pays for a majority of the spending, but the states pick up a big share as well. As a result, over a quarter of all state spending goes to Medicaid, making it the largest single expenditure in state budgets on the aggregate. This means that Medicaid spending will be crowding out other state spending, on roads, public safety, and on education. One of the reasons that tuition at state schools is twice what it was in the 1980s is because of Medicaid spending. As Catherine Rampell wrote in *The New York Times*, tuition hikes result from the fact that “Struggling states have to prioritize other mandatory spending, like Medicaid.”¹⁴

Beyond the Medicaid problem, some states that have established ACA exchanges are experiencing higher than expected costs as well. The costs of the IT systems that run the exchanges, especially, are heavy cost burdens on states. In order to be self-sustaining, some states have turned to the federal government to take on these functions, while others are getting creative with dealing with these costs. For example, in her budget, Rhode Island Gov. Gina Raimondo recently proposed a new fee—3.8 percent for qualified health plans (QHPs) and 1 percent for Small Business Health Options Program (SHOP) plans—to help cover the exchange’s administrative costs. The state legislature is expected to vote on the proposal by July 1, 2015.¹⁵ New York State has found that it has insufficient funds for pay for the expected \$150

million annual costs of its state run exchange. As a result, Governor Andrew Cuomo proposed a \$69 million tax to pay for the costs of the exchange. Unsurprisingly, the New York State legislature was unhappy with the proposal, but the fact remains that the exchanges impose even higher costs on already strained state budgets.¹⁶

Employee Affordability

Government's financial challenges are only one aspect of the looming health care financing crisis. Individual Americans are finding that their costs are becoming less and less affordable, even for those in employer sponsored health care. The Affordable Care Act established an affordability metric for health insurance, and determined that premiums surpassing 9.5 percent of income should be considered "unaffordable." The problem with this determination is that it does not consider deductibles along with premiums. When deductibles are folded in, 37 percent of private sector employees who are heads of families will face the prospect of unaffordable health coverage by 2020. By the year 2025, a majority of private sector employees will fall into the unaffordable category, as 53 percent will surpass the 9.5 percent threshold in both premiums and deductibles.¹⁷ These figures notwithstanding, it should be remembered here that few Americans would consider spending 9.5 percent of their income on health care as something that they can afford.

Public opinion polls back up these estimates, demonstrating the level of uncertainty families face regarding the costs of health care. According to a New York Times/CBS poll, 46 percent of Americans find basic health care affordability to be a hardship for them and their family. Two years ago, this was at 36 percent.¹⁸ A Gallup poll corroborates the finding, as 41 percent of Americans report dissatisfaction with their current cost of health care.¹⁹ Although employees are generally more satisfied with the cost of their coverage, over 23 percent are dissatisfied with the premiums they pay, and 27 percent are dissatisfied with the deductibles they pay when receiving care.²⁰

Both the costs of and the worries about health are on the rise for Americans in employer sponsored plans. These plans, which have long been the backbone of our health system, are becoming less and less affordable to average Americans and their families. As the prospect of a majority of recipients finding employer sponsored health looms larger, the pressure will build to find some kind of alternative for these employees.

Unfortunately, public policy is pushing employer plans in the opposite direction, toward less generous plans. The ACA's Cadillac Tax was sold as a plan to hit only the highest value health plans, but it is increasingly hitting plans held by middle income earners. Already, 62 percent of employers are finding that the Cadillac Tax, or excise tax, is having an impact on their health care strategy, according to a recent TowersWatson survey.²¹ In addition, the Cadillac Tax will have a creeping impact, as it will be impacting more and more plans as time goes on. In 2031, even an average cost family health plan will likely cross the Cadillac Tax threshold. At that point, there will likely be few if any high value plans, as employers will reduce the value of their health care offerings to avoid being hit with the 40 percent penalty imposed by the Cadillac Tax. Furthermore, it is very much an open question whether at that point employer sponsored plans will be considered affordable at all.²²



Employer Plans

From the employer perspective, they are facing larger and larger costs for providing health care. While employers have to absorb some of these increased costs, the costs also get passed on to employees. According to a 2014 Kaiser Family Foundation and Health Research & Educational Trust study, the overall rate of inflation since 1999 was 43 percent. During the same period, workers earnings increased 54 percent, health care premiums rose 191 percent, workers contributions to premiums increased 212 percent. This premium increase does not even include co-pays and deductibles.²³

In addition to the rising cost of health overall, there is also the issue of costs imposed on employers by the ACA. According to an analysis of over 100 internal large employer estimates, the ACA is imposing additional costs of between \$4,800 and \$5,900 per employee over a 10 year period. Over that 10 year period, these marginal costs due to the ACA add up to somewhere between \$163 million and \$200 million per large employer, and between \$151 billion and \$186 billion for large employers as a whole.²⁴ There is a question of whether ESI is built to last in today's tumultuous health policy environment. A recent S&P Capital IQ analysis estimates that 90 percent of American employees who currently receive health insurance through their employers could be shifted to individual health insurance and government exchanges by 2020.²⁵ Even an architect of the law, Ezekiel Emanuel, has predicted a similar shift and has gone so far to say that by 2025, fewer than 20 percent of workers will receive health care through ESI.²⁶

Despite predictions that employer sponsored health insurance will no longer be the norm by the end of this decade, America's health care system as currently configured relies heavily on employers to pay for health care, and there would be significant disruptions were employers to bow out over such a short time period. Thus, many employers remain committed to continuing to provide health care to their employees, retirees, and dependents, albeit through different strategies and benefits models.

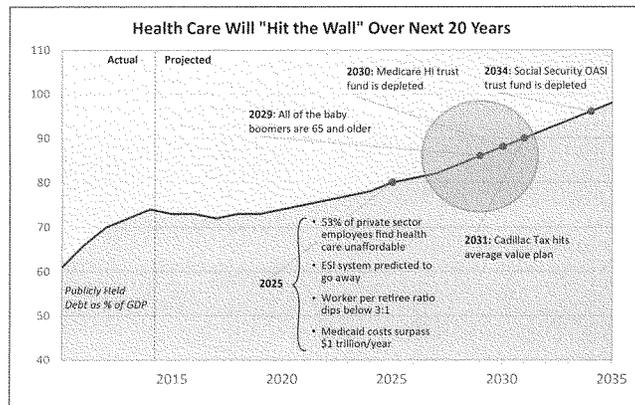
Employers are trying to cope with both higher overall health costs and newly imposed marginal costs, but despite their best efforts, employer health care costs per covered life are still rising at twice the rate of inflation. While Consumer Directed Health Plans, or CDHPs, have shown some effectiveness in reducing health costs, 82 percent of large U.S. employers have already made the shift to CDHPs, meaning that the limits of this cost control option are being reached.²⁷ Similarly, wellness programs, with which many employers have also experimented, do not appear to have the capacity to address long term health costs on their own. While many employers and employees alike have found them helpful, wellness programs in and of themselves cannot solve the problem. Some recent research has even questioned how much return these programs can provide. As *Health Affairs* summarized its view of latest research on wellness plans, "those changes are not large enough, and the relationship between health risks and spending too weak, to result in reduction of health care cost, let alone in return of investment."²⁸

As a result of this combination of cost pressures and the lack of effective tools to deal with them, U.S. employers are looking to change their relationship with their employees with respect to health care, and there is now evidence that employees themselves would be amenable to accepting such changes. According to a study by the Employee Benefit Research Institute (EBRI), only 40 percent of employees want to continue along the same health care path they are on today.²⁹ However, 40 percent want to be able to choose their health plan and are willing to provide additional resources, above what their employer pays, if necessary.³⁰ Another 20 percent

want a lump sum payment from employers to allow them to pick their health coverage on their own.³¹ What this means is that 60 percent of employees are looking for some new kind of way to get affordable health coverage.³² And U.S. employers are actively seeking ways to find those new options.

When Will American Health Care Hit the Wall?

These troubling trends, in our fiscal situation, in health care affordability, in employer sponsored care, appear to be reaching crisis point in roughly the same period, between 2025 and 2030 (see chart). It is no coincidence that the completion of the retirement of the baby boomers takes place in that same period: the worker to retiree ratio 3.99 now, dropping to 2.67 by 2030, will be exacerbating our fiscal woes.³³



Demographics, however, are not the sole source of the emerging problems. Public policies lie at the heart of many of our challenges: when it goes into effect in 2018, the excise tax will incentivize employers to reduce the value of health plans to stay under the tax's threshold; the ACA includes a host of marginal costs on employers that raise costs on employers and employees alike; relying on Medicaid to expand health coverage burdens overly strapped state budgets; and unrealistic entitlement program payouts threaten the fiscal viability of not only our entitlement programs, but of the U.S. as a whole.



Conclusion

Fortunately, while demographic realities are largely immutable, but public policies can be changed. The excise tax that will be impacting more and more health plans over time has not yet gone into effect. Perhaps it can be changed or eliminated before 2018, when it is scheduled to begin. Solving the excise tax will reduce, but not eliminate, some of the marginal costs that employers face, which could in turn limit the extent to which employers exit the system. As for our entitlement programs, the crisis may be staring us in the face, but it is still not too late to make real changes to future payment policies that could stave off a potential fiscal collapse.

Whatever happens in the years ahead, it is safe to assume that big changes are afoot. Government policies will likely change--but government is not the only place that such change can or will occur. Employers, fully understanding the marketplace power of the covered lives included in their respective plans, are already beginning to explore market-based remedies to the cost explosion. Both with respect to government policy and these market-based remedies the real question faced in this period is whether the changes will be planned out and thought through, or whether the changes will be reactive after disaster strikes.

To face these challenges, policymakers need to do two things. With respect to the public sector, there is still enough time to make changes now to shore up the public sector programs upon which an increasing number of Americans rely. To do this, policymakers need to stop making unrealistic promises and need to work to get outlays in line with available revenue. From the private sector perspective, policymakers should recognize that ESI is going to be changed and that public policy needs to support the ability of the private sector make the required changes. Wise policies would foster and encourage creative market-based remedies that will benefit employees, employers, the federal treasury and our entire economic system. Such a reformed ESI system can ensure that employers are still actively involved in providing health care to their employees and not turning that burden over to the public sector.



- ¹ Baby Boomers Retire, Pew Research Center, December 29, 2010 <http://www.pewresearch.org/daily-number/baby-boomers-retire/>
- ² CBO, July 2014, What are the Causes of Projected Growth in Spending for Social Security and Major Health Care Programs? <http://www.cbo.gov/publication/45543>
- ³ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, pg. 3.
- ⁴ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, Tables IV.A2 and IV.B2
- ⁵ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, Table IV.B5.
- ⁶ 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 28, 2014, Table III.B5 and pg. 7.
- ⁷ 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 28, 2014, Table V.F2.
- ⁸ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, Table IV.A1 and pg. 60.
- ⁹ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, pg. 60.
- ¹⁰ The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, July 28, 2014, Table IV.B5.
- ¹¹ Updated Budget Projections: 2015 to 2025, CBO, March 2015, https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-Updated_Budget_Projections.pdf#page=19
- ¹² National Health Expenditure Projections, extrapolated out to 2025.
- ¹³ CBO July 2014, Long-term Budget
- ¹⁴ Catherine Rampell, "Why Tuition Has Skyrocketed at State Schools," New York Times, March 2, 2012. http://economix.blogs.nytimes.com/2012/03/02/why-tuition-has-skyrocketed-at-state-schools/?_r=0
- ¹⁵ Inside Health Insurance Exchanges, Volume 5 Number 4, April 2015
- ¹⁶ Legislature Kills Cuomo's Proposed Tax on ObamaCare, New York Post, March 31, 2015, <http://nypost.com/2015/03/31/legislature-kills-cuomos-proposed-tax-on-obamacare/>
- ¹⁷ Institute estimates based on Census Bureau data and Kaiser Family Foundation data projected out to 2040.
- ¹⁸ How the High Cost of Medical Care is Affecting Americans, Elisabeth Rosenthal, The New York Times, December 18, 2014. <http://www.nytimes.com/interactive/2014/12/18/health/cost-of-health-care-poll.html>
- ¹⁹ Andrew Dugan, "As ACA Takes Effect, Majority OK With Personal Health Costs," Gallup, December 5, 2014.
- ²⁰ Adele Shartzter and Sharon K. Long, QuickTake: Nonelderly Workers with ESI Are Satisfied with Nonfinancial Aspects of Their Coverage but Less Satisfied with Financial Aspects, Urban Institute, Health Reform Monitoring Survey, September 4, 2014.
- ²¹ 2014 Health Care Changes Ahead Survey: Emerging Factors Influencing Employer-Sponsored Health Care Benefits, Towers Watson, September 2014. <http://www.towerswatson.com/en/Insights/IC-Types/Survey-Research-Results/2014/09/2014-health-care-changes-ahead-survey-report>
- ²² Tevi D. Troy and D. Mark Wilson, "The Impact of the Health Care Excise Tax on U.S. Employees and Employers," American Health Policy Institute, 2014. http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf
- ²³ The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2014 Annual Survey, <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>
- ²⁴ Tevi D. Troy and D. Mark Wilson, "The Cost of the Affordable Care Act to Large Employers," American Health Policy Institute, 2014. http://www.americanhealthpolicy.org/Content/documents/resources/2014_ACA_Cost_Study.pdf
- ²⁵ Neil Irwin, "Envisioning the End of Employer-Provided Health Plans," The New York Times, May 1, 2014. http://www.nytimes.com/2014/05/01/upshot/employer-sponsored-health-insurance-may-be-on-the-way-out.html?_r=0&abt=0002&abg=1
- ²⁶ Robb Mandelbaum, "Why Employers Will Stop Offering Health Insurance," The New York Times, March 26, 2014. http://boss.blogs.nytimes.com/2014/03/26/why-employers-will-stop-offering-health-insurance/?_r=0

²⁷ National Business Group on Health and Towers Watson, "19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care," 2014. Although 82 percent of employers offer a CDHP, just 32.6% of employees are enrolled in one, and just 30% of employers offer only a CDHP plan to their employees.

²⁸ Soeren Mattke, "When It Comes to The Value of Wellness, Ask About Fairness Not Just About Effectiveness," Health Affairs, March 18, 2015, <http://m.healthaffairs.org/blog/2015/03/18/when-it-comes-to-the-value-of-wellness-ask-about-fairness-not-just-about-effectiveness/>.

²⁹ Paul Fronstin and Ruth Helman, Views on Employment-Based Health Benefits: Findings from the 2014 Health and Voluntary Workplace Benefits Survey, Employee Benefit Research Institute, Notes Vol. 36, No.2, February 2015.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ Workers Per Retiree: 1950-2050, <http://www.econdataus.com/workers.html>

Mr. BRAT. Mr. Eddy, please.

Mr. EDDY. Yes. I think I would refer back to the concern about sustainability not only of the healthcare plan, but also of the tax base if this continues to damage small companies. A large part of the tax base, has to be remembered, comes from the small businesses. As our friend Adam Smith said, there's only three ways to create new wealth in any culture: agriculture, manufacturing, and resource extraction. And a lot of those companies that support those industries are small businesses now. So without change, I really am concerned about our sustainability even with the tax system. Thank you.

Mr. BRAT. Thank you for bringing in Adam Smith.

Thank you all very much.

Chairwoman FOXX. Thank you very much.

Mr. Grijalva, you are recognized for five minutes.

Mr. GRIJALVA. Thank you very much, Madam Chair.

I think it's important, kind of, to remind as we deal with ACA and have this discussion in this panel -- and thank you for being here -- and as we stumble or edge toward TrumpCare in the foreseeable future, it's important to remember that there were 60-plus votes for repeal in this House. And at the time it was a messaging vote. Now reality bites, that we have issues to deal with and how do we keep commitments that, perhaps, are contradictory to even some of the testimony that I read from the witnesses here today.

For example, President Trump said that he wanted health care for everyone, he mentioned that, and that he wanted it to be great, affordable care for everyone. The commitment not to touch Medicare and not to touch Social Security. Congressional leaders on the Republican side have talked about dealing with the popular parts of ObamaCare, no prohibition of preexisting conditions, no gender discrimination in terms of costs, preventive mandated examinations for wellness issues, no maximum caps, sons and daughters remain until they're 26.

And Mr. Troy, Mr. Eddy, those two are doable in your professional, learned experience, to do what the President said had to be done and to keep the essential programs that are popular with the public? That's why the public is demanding a replacement, just not merely a repeal. Are they doable at all?

Mr. TROY. Thank you for the question, sir.

First of all, I'd like to state that I am not a spokesperson for the Trump administration or the Obama administration.

Mr. GRIJALVA. Nobody is. That's not the point here.

Mr. TROY. And I was happy to reclaim my First Amendment rights when I left government 7 years ago.

But I would like to make the point that there are a number of serious plans that would reduce the overall cost of premiums on average according to CBO analysis, and I think that is the best way to go forward in order to incentivize people to purchase health care on their own without subsidies for some and an overall mandate. Thank you.

Mr. GRIJALVA. Yeah. Let me follow up, if I may.

Mr. Troy, part of what you also hear is that we have to eliminate the mandate, we have to eliminate the subsidy, we have to eliminate the medical device tax, high-end fees and taxes, and we have

to eliminate issues that are revenue generation that allow many of the important things, like Indian health care that's part of the *Affordable Care Act*, that would go out the window. Community health centers and the trust fund established for community health centers that are essential in rural America and in poor America for services, those would all go out the window.

So how can one wish that costs of premiums will go down, when in reality the balance of revenue and program offerings under ACA are intrinsically tied together? How do you eliminate all the revenue generation and still have a program?

Mr. TROY. So we do oppose elimination of many of the taxes, including the *Affordable Care Act*, the Cadillac tax in the *Affordable Care Act*. In terms of CBO projections being a wish, that is how public policy is made. We make projections based on what CBO assumes that the policies will do and that's how they're voted on. And I was pleased to see that this one particular CBO study showed that the costs would be reduced if a number of these programs in totum would be put together to lower the costs on individuals and their premiums.

Mr. GRIJALVA. I'm sorry, Mr. Eddy, but if you have any comment on either one of those points.

Mr. EDDY. Thank you, Congressman.

I really tell myself I should have no comment here, but what I would like to say is I think we've all learned a good bit about what works and what doesn't work in the last five years, six, seven years of ACA. You know, from my standpoint as a small-business owner, I would hope that there could be a balance created between this group, actually, to work towards what does work better. I have no answer for you on that, though. Thank you.

Mr. GRIJALVA. I appreciate it.

I yield back, Madam Chair.

Chairwoman FOXX. Thank you very much.

Mr. Bishop, you're recognized for five minutes.

Mr. BISHOP. Thank you, Madam Chairwoman, and thank you for the opportunity to be a part of this committee hearing today.

Thank you to all the panelists. A special thank you to Ms. Schlaack, a fellow Michigander. Also, I want you to know as a parent, husband, my heart goes out to you and your family. I do want you to know that your testimony here today makes a difference. And oftentimes people don't think that, but your being here today, your personal story makes a difference, and I want to thank you for that.

Higher premiums and uncovered out-of-pocket expenses for the most part are devastating families and entrepreneurs and everyday Americans of all backgrounds. The ACA has caused cancelled policies, rising costs, poor coverage, and lack of choices for families, business owners, and employees alike.

Many Americans simply can't afford health insurance. In fact, in 2015, 8 million Americans chose to pay the individual mandate tax penalty rather than to purchase insurance at all.

I hear from constituents every day and business owners. I have spent the last couple of years traveling the state. And just reflecting what I'm seeing in Michigan, plans in Michigan exchanges saw deductibles go up an average of \$492 in 2017. ObamaCare ex-

change rates will jump nearly 17 percent in Michigan regardless of what Congress does this year. Insurers are leading the exchanges, private practices are folding over, and our doctors are being forced into retirement because they cannot afford the cost to stay in practice to comply with all of the incredible regulation.

Nationally, those who currently have a plan under the exchange can expect an average premium increase of 73 percent, while individuals who are now just joining will see a 96 percent increase in premiums. The average cost to the new consumer in the individual market is expected to rise \$1,800 per year.

We often hear, as we absolutely did here today, the argument that if ObamaCare isn't implemented, costs would rise anyway. And I know, Dr. Troy, you've answered that question on more than one occasion. And just building on what Mr. Guthrie had asked you, as a healthcare policy expert, can you tell me -- obviously, prices would continue to increase. But would the cost of health care increase at the same rate under the previous system but for the implementation of ObamaCare?

Mr. TROY. So the healthcare inflation rate continues to be higher than the overall inflation rate. There has been some moderation in the healthcare inflation rate. So it's still higher than overall inflation in the last couple of years. CBO has looked at this and wondered what the effect of -- or the cause of this was. It looked at the ACA as one possibility, but it said that the biggest factor was the lingering effects on the recession in terms of moderating the healthcare inflation rate. Also, some of the premium hikes that we have seen in the last couple of years in the ACA exchanges suggest that new studies going forward might find even higher rates.

And then the other thing I would say is that employers have done a lot of work in recent years to try and bring the down costs. And we've seen some improvement in the costs in employer-sponsored care even as they face the additional effects of the ACA costs.

Mr. BISHOP. Okay. We could have a lot of this conversation for many days.

Doctor shortage. You just were asked -- you were just brought into that discussion as well, the fact that the current immigration plan may have an impact on that. But can you share with me the extent to which the result of rising costs on the current practitioners and the current costs with regulation compliance has an impact on the number of our doctors, especially those freestanding specialists who are leaving the practice of medicine?

Mr. TROY. I'm glad you raised that, because that study that I wrote back at Hudson Institute in 2013 did talk about the cost of the *Affordable Care Act* on our medical profession and suggested that we might have problems filling the number of doctors we need as a result of the costs imposed by the ACA, but also the lack of discretion imposed on doctors of the ACA. Doctors want to see that they actually have the ability to make decisions, and the more their decisions are constrained, the less likely they are to go into the profession.

Mr. BISHOP. What exactly is, what's the biggest regulation that doctors face that is causing the most consternation among the practitioners that's making them leave the practice almost overnight?

Mr. TROY. So I hear a lot of doctors complain to me about the electronic medical records and the way that it forces them to look at the screen instead of at the patient. And when you look at the patient, that's when you get to make better decisions about the patient's health. But I would, also, I know we're short on time, I would ask that entire paper that I wrote about the ACA's impact on doctors be submitted for the record. Thank you.

Mr. BISHOP. Thank you very much, Dr. Troy.

And I yield back.

Chairwoman FOXX. If the gentleman from Michigan would like, we can insert that study into the record.

Mr. BISHOP. I would. And I move to admit that to the record.

Chairwoman FOXX. Without objection.

[The information follows:]



Hudson Institute

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Tevi Troy

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Hudson Institute
1015 15th Street, NW
6th Floor
Washington, DC 20005
www.hudson.org

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How the Implementation of the Affordable Care Act Will Affect Doctors

By

Tevi Troy

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Introduction

Two years ago, President Barack Obama signed the Affordable Care Act (ACA), a law purportedly designed to increase access to health care and to “bend down” the health care cost curve. The last two years have seen a great debate over the impact and potential impact of that law, especially in the areas of coverage, affordability, and quality of care. Most of the discussion on this topic, though, remains in the speculative realm, as the law is not scheduled to be implemented until 2014, and certain aspects of the implementation will be ongoing until 2019. Furthermore, the law has been subjected to a series of political and legal challenges that have generated uncertainty about the law’s prospects within the health industry and at the state level, where much of the implementation is slated to take place.

Despite these uncertainties, the Department of Health and Human Services (HHS) has begun the long and arduous regulatory process involved in implementing any new law, and has already issued over 12,000 pages of regulations elaborating on the original 2,700-page law.¹ More pages are of course expected to follow, but the initial wave of implementing regulations has already given us an insight into how the new law will impact one of the most crucial actors in any health reform effort: doctors.

There are over 850,000 physicians in the United States, and they play a crucial role in the administration of health care as caregivers, patient counselors, administrators, and policymakers. There are eighteen physicians in the Congressional GOP Doctors Caucus alone. As research scientists, doctors are in the front lines of identifying diseases and potential cures. Moreover, they hold a special status in the minds of the public. According to a recent report in *National Journal*, even in this era of tremendous cynicism and distrust, the American people continue to place great faith in doctors, giving them high marks on ethical standards and trustworthiness.²

¹ Chris Jacobs, “Obamacare Creating Thousands of Jobs. For Bureaucrats.” Senate Joint Economic Committee, April 17, 2012.

² Margot Sanger-Katz, “Why Do We Trust Doctors?” *National Journal*, April 26, 2012, <http://www.nationaljournal.com/features/restoration-calls/why-do-we-trust-doctors--20120426>.

The attitude of the medical profession toward the ACA and the statements and actions of individual doctors as the law begins to be implemented will therefore bear great weight in the minds of the public.³

For this reason, it is worth examining how the health law will affect doctors and their participation in the system, paying special attention to the views and reactions of doctors themselves. A full summary of the new health law would take many more pages than available for this paper,⁴ but the broad strokes are as follows.

The Obama health law would:

- Cover 32 million additional Americans—16 million via Medicaid;
- Increase regulation of insurers, including coverage requirements for individuals and mandates on services;
- Create a mandate requiring individuals to purchase insurance; and
- Create new Health Insurance Exchanges in which individuals not covered by employer-sponsored insurance will purchase policies.

Funding for the \$800+ billion cost of the ACA will come mainly via new taxes and Medicare reductions. While this list gives a sense of what the law is trying to accomplish, it does not really convey the ways in which the law will actually operate, and particularly how the law would affect physicians. This is because the implementation process creates a great deal of discretion for appointed and career federal officials to determine the exact shape of the law's final requirements. The word "secretary" appears nearly 3,000 times in the 2,700 page bill, most frequently referring to regulatory implementation requirements that will have to be undertaken by the HHS Secretary (currently Kathleen Sebelius) and appointed or career staff. As former

³ Although the American Medical Association (AMA) publicly declared its support for the ACA, many individual doctors disagree, as this paper will demonstrate.

⁴ A full summary is available at <http://www.kff.org/healthreform/upload/8061.pdf>.

HHS Secretary Michael O. Leavitt said of the new law, “It puts more power than is prudent in the hands of one person, and it is not an answer to our national health-care crisis.”⁵

According to the Robert Wood Johnson Foundation initiative *Changes in Health Care Financing & Organization*, a representative list of “The Secretary shall...” requirements includes the requirements that the Secretary:

- Promulgate regulations defining the young adults who can now remain under their parents’ insurance policies;
- Develop standards for use by insurers in compiling and providing information for enrollees that accurately describe benefits and coverage;
- Develop reporting requirements, in consultation with quality experts, for use by insurers with respect to benefits and provider reimbursement structures that improve health outcomes, prevent readmissions, improve patient safety, and implement wellness and health promotion activities;
- Collect and make publicly available reports of insurers’ minimum loss ratios and adjust the ratios to avoid destabilization of the individual insurance market;
- Establish a process for an annual review of unreasonable increases in premiums for health insurance coverage; and
- Establish, in consultation with the states, a mechanism, including a website, through which individuals may identify affordable health insurance options within their state; and develop a standardized format for the presentation of coverage option information to individuals.⁶

Incredibly, the bill’s powers are not limited to the broad macroeconomic issues described above. They also regulate a wide range of medical areas in minute detail, extending their reach even to one of the most personal arenas: the dentist’s chair. Section 4102 of the ACA, for example, states: “The secretary shall develop oral healthcare components that shall include tooth-level surveillance.” As Secretary Leavitt describes it, the mandate for tooth-level surveillance would

⁵ Michael O. Leavitt, “Health reform’s central flaw: Too much power in one office,” *Washington Post*, February 18, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/17/AR2011021705824.html>.

⁶ “The Secretary Shall....” The Challenge of Implementing Health Reform’s Affordability Provisions,” *Changes in Health Care Financing & Organization*, April 2010, <http://www.hcfo.org/publications/%E2%80%9C-secretary-shall%E2%80%A6%E2%80%9D-challenge-implementing-health-reform%E2%80%99s-affordability-provisions>.

require “a clinical examination in which an examiner looks at each dental surface, on each tooth in the mouth.”⁷

The above sample is only a tiny percentage of all of the areas in which HHS has discretion under the new law. This discretion leads to additional uncertainty, beyond the political uncertainty about whether the law will indeed be implemented. There is already considerable evidence that doctors are nervous how the ACA will affect their incomes, their access to technologies, and their ability to practice medicine. According to a survey by the Doctors Company, sixty percent of physicians felt that the health care law will have a negative impact on overall patient care. Only twenty-two percent were optimistic in this regard. Furthermore, fifty-one percent felt that the law would have a negative impact on their relationships with their patients.⁸ In addition, a survey by the Physicians Foundation found that fifty-seven percent of young doctors are pessimistic about the future of health care, and thirty-four percent of them attribute their gloominess to the ACA.⁹ These troublesome numbers raise questions about how and whether doctors will participate in the new system.

Nature of Physician Concerns

Perception affects reality, and so if doctors feel that the Affordable Care Act will harm them and their ability to interact with patients, that will be problematic for the doctors, the patients who trust and rely on them, and the system as a whole. But reality shapes reality as well, and the more important question than that of physician concerns is that of the reality of what the ACA will do. Doctors want to know which areas of the bill are most likely to affect them and which aspects of

⁷ Michael O. Leavitt, “Health reform’s central flaw: Too much power in one office.”

⁸ “The Future of Health Care: A National Survey of Physicians,” Survey by The Doctors Company, February 29, 2012, http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/web_content/con_id_004676.pdf?utm_source=Newsletter&utm_medium=Email;utm_campaign=FHCP.

⁹ Anna Yukhananov, “Next generation of doctors sees gloomy future,” Reuters, April 11, 2012, <http://www.reuters.com/article/2012/04/11/us-usa-health-survey-idUSBRE83A0ZH20120411>.

their practices the new law will affect. The answers to these questions will determine whether the concerns demonstrated in opinion surveys will change as the law is implemented, or whether they will harden or even worsen in the months ahead. The answers to these questions, especially from analysts who share the physician perspective, will also provide insight into the next key issue: if doctor concerns are indeed justified, what will be their likely response to the implementation of the new health care law?

1. Reimbursement

Doctors, like most people, tend to be economically rational actors. There is of course a certain altruism involved in the decision to become a care-giving actor, but economic elements will always play a key role in the decision-making process. From the economic perspective, doctors' top concern raised by the Obama health care law is in the area of reimbursement rates. The reimbursement question usually centers on the Sustainable Growth Rate (SGR). The proposed cut in reimbursements would hit doctors hard, imposing initial cuts of over twenty percent.¹⁰

Without going into its long and complicated history, the SGR is an expected rate cut that the Centers for Medicare and Medicaid Services is by law supposed to impose on doctors in order to get Medicare spending under control. Because of the likelihood that doctors would balk if the SGR were to go into effect, Congress—which created the SGR in the first place—undoes the SGR every year so that doctors will not have to experience the cut. This annual legislative dance, known as the “doc fix,” gets more expensive and more difficult each year because the SGR is built into the budget baseline. Congress, in other words, counts on the SGR savings in its long-term budget prognostications while at the same time knowing that it will not realize those savings.

¹⁰ Robert Moffit, “Obamacare and its Impact on Doctors,” *Wall Street Journal*, June 19, 2010, <http://online.wsj.com/article/SB10001424052748704122904575315213525018390.html>. (Note: article originally appeared in *Physicians News Digest*).

This problem gets more difficult because the “doc fix” has to be paid for, which means that the savings must come from somewhere, and the Obama health law has reduced the number of options for finding additional budgetary savings. This means that the Obama health law has made fixing the SGR even more difficult than it has been in the past, something doctors recognize and do not appreciate.

Even President Obama’s top aides and advocates for his health care plan recognize that the reimbursement question is a serious issue for doctors. In a 2010 article for the *Annals of Internal Medicine* that touts the Obama health law and its impact on physicians, three administration architects of the plan, Nancy-Ann DeParle, Dr. Ezekiel Emanuel, and Dr. Robert Kocher, acknowledge the uphill battle the administration faces in selling its new law to the physician community: “The uncertainty surrounding the sustainable growth rate policy is a distraction and potentially a barrier for some physicians to embrace the Affordable Care Act.”¹¹

In addition to the “distraction” of the SGR, there is also the issue of the growing Medicaid rolls. While the Obama health law will cover an additional 32 million Americans, 16 million of those newly covered Americans will get their coverage through Medicaid, according to the Congressional Budget Office. Doctors are well aware that Medicaid reimbursement rates are lower than those they get from privately insured patients. In fact, according to Moffitt, “physicians in Medicaid are paid 56 percent of private payment.” This reduced reimbursement rate is the reason that Medicaid patients often have difficulty finding a doctor. Imposing these lower reimbursement rates on a growing number of patients will likely have the impact of exacerbating access issues in the future.¹²

¹¹ Robert Kocher, Ezekiel J. Emanuel, Nancy-Ann M. DeParle, “The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges,” *Annals of Internal Medicine*, August 23, 2010, <http://www.annals.org/content/early/2010/08/23/0003-4819-153-8-201010190-00274.1.full>.

¹² Moffitt, “Obamacare and its Impact on Doctors.”

2. Practice of Medicine

Beyond economic issues, physicians worry that the new law will interfere with their practice of medicine, and in a variety of ways. To begin with, there is a generalized concern about decision making being taken from doctors and having medical decisions made instead by government officials. Doctors worry about the imposition of “uniformity of practice,” the establishment of strict guidelines that fail to permit individual doctors to make decisions based on their in-person interactions with patients. As Dr. Saul Greenfield writes in the *Wall Street Journal*, “every physician must, at some point in the patient-care process, make decisions and take responsibility for them. And unless the doctor does so, the outcomes will be compromised.”¹³ While the fear of practicing medicine by committee is a long-standing concern among doctors, there are a number of provisions in the new health law that bring the prospect of committee-based medicine much closer to reality.

The main concern on this front has been the IPAB, or the Independent Payment Advisory Board. This fifteen-person board, selected by the President and confirmed by the Senate, will be charged with trying to control Medicare spending by making payment and practice decisions. This approach, which will make government decisions that are in almost all cases not then subject to Congressional oversight, has many doctors extremely nervous. As Drs. Jason Fodeman and David Gratzner describe it, “This unelected body will have the unprecedented ability to single-handedly change the allocation of health care resources should Medicare spending exceed medical inflation—which, for the record, it consistently does. IPAB’s recommendations, incidentally, are beyond congressional reach unless overturned by a supermajority of Congress.”¹⁴

¹³ Saul Greenfield, “In Defense of Physician Autonomy,” *Wall Street Journal*, September 7, 2010.

¹⁴ Dr. Jason Fodeman and Dr. David Gratzner, “Obamacare: One year later. Stripping patients and doctors of authority over care,” *The Washington Times*, March 22, 2011, <http://www.washingtontimes.com/news/2011/mar/22/obamacare-one-year-later-98975456/print/>.

A related worry is in the area of comparative effectiveness research (CER). President Obama famously described his view of CER's potential in July 2009 when he said: "If there's a blue pill and a red pill, and the blue pill is half the price of the red pill and works just as well, why not pay half price for the thing that's going to make you well?" A host of commentators have explained that this description vastly oversimplifies an enormously complex endeavor. Still, the Obama administration remains committed to pursuing CER and dedicated over \$1.1 billion to this type of research in the 2009 stimulus bill. The concern with CER is that it could lead to hard and fast rules dictating the practice of medicine, thereby limiting doctors' ability to practice as they see fit. A similar concept, that of Least Costly Alternative (LCA), could have a similar impact, although thus far the courts have limited the ability of the Centers for Medicare and Medicaid Services (CMS) to employ LCA. Still, MedPAC—the Medicare Payment Advisory Commission—often looks at LCA as a means for cost controls, and the new law's cost will increase the need for cost controls. Such a policy would not only affect physician choice, but also perhaps limit access to newer technologies. As noted, the courts have thus far blocked this approach, but the potential for its employment remains another consideration for physicians in making decisions about their future.

Another common concern stems from the ACA's creation of Accountable Care Organizations (ACOs). ACOs aim to depart from the strict fee-for-service model that does drive up costs, and try to use the concept of bundling payments as a way of getting costs under control. It is a concept that has had bipartisan support in the past, and is seen by many as a promising path forward. Unfortunately, HHS's first attempt at writing this rule was so restrictive that it put medical institutions at risk of losing money if they participated and failed to gain the anticipated savings. This and other restrictions scared off medical institutions, and, according to *Politico's* Lester Feder, "the 10 medical groups participating in a Medicare pilot program that paved the way for the ACO program declared that none would participate if the rule were not substantially modified."¹⁵

¹⁵ J. Lester Feder, "Health Reform Rule Spooks Providers," *Politico*, May 24, 2011, <http://dyn.politico.com/printstory.cfm?uuid=5BF19DDC-13F3-41A1-9AAD-B5C0E8E1CC16>.

After this poor uptake, the administration then rewrote the rule in a way that increased participation to some degree. Still, many physicians remain understandably skeptical about participation because of the way in which HHS initially approached the issue, as well as the still-imperfect nature of the revised version. As Sarah Kliff reports in the *Washington Post*, even with the new rule, willing participants “report little change in how they deliver care: The ones who felt confident enough to participate were already delivering integrated care and, with the start-up costs of administering the program, are not certain they’ll see significant savings.”¹⁶

ACOs and the IPAB have received most of the attention when it comes to new institutions that will impact the practice of medicine, but they are far from the only ones. According to a report by Senators Tom Coburn and John Barrasso, both physicians, the \$10 billion Center for Medicare and Medicaid Innovation is another source of worry for doctors. The report, which cites a Congressional Research Service memo to Coburn, demonstrates that the legislation authorizing the center gives the HHS Secretary and the CMS administrator enormous power not only to experiment with new payment and delivery systems, but also to impose the results of the experiments without external checks on those results.

Coburn and Barrasso note that CRS found “no references in [the law] to any external reviews or checks on the CMS” in evaluating the results of their experiments. Not only will patients lack judicial and administrative review if they object to the center’s demonstration projects, but doctors will as well. According to Coburn and Barrasso, “health care providers are also legally prohibited from contesting the Secretary of Health and Human Services’ (HHS) use of new payment models.” The Center for Medicare and Medicaid Innovation appears to be one more way in which the healthcare law will interfere with the practice of medicine.¹⁷

¹⁶ Sarah Kliff, “Why the Business of Health Care Will Never Be the Same,” *The Washington Post*, March 25, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-at-2-why-american-health-care-will-never-be-the-same/2012/03/22/gIQA7ssUVS_blog.html#pagebreak.

¹⁷ “Warning: Side Effects,” report by Senators Tom Coburn and John Barrasso, March 20, 2012, http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=98be1143-f556-469d-91af-4213946fcf2f.

Impact: How Doctors Will React

Interfering with the way that doctors practice can potentially have an even bigger impact than economic questions on doctor participation and satisfaction. If doctors cannot practice as they wish, it raises the question of whether they will practice. As Dr. Mark Siegel has noted, because of the anticipated changes in health care, “To stay in business under ObamaCare, doctors will have to adjust. Some will see fewer patients themselves and hire nurse practitioners to help carry the load; others will work part-time and supplement their income elsewhere. Many will join groups or become salaried employees of hospitals or clinics.” As problematic as these scenarios are, Siegel is most pessimistic about the fate of lone practitioners, whom he suggests “are going to become harder and harder to find, at least, ones who’ll take your insurance.” Many of them, he predicts, “will join the growing group of ‘boutique’ doctors who’ll only see patients who pay cash up front.” While the relatively small number of patients of those boutique doctors may be pleased with the service, large numbers of doctors opting out of insurance will only exacerbate the access challenge faced by everyone else.¹⁸

Another factor driving doctors to change their behavior is the increased complexity of practice under the new law. The ACA will introduce a much greater level of legal compliance responsibilities, increasing the difficulty and expense of maintaining a private practice. The drive to provide quality care for more patients, at less expense but with more paperwork, will make practice much more burdensome for all physicians, especially those in private practice. Decreased reimbursements for the same services will make private practices less financially viable. Not surprisingly, a recent survey of over 2,400 physicians found that nearly eighty percent believe the reform will “erode the viability of the private practice model,” with twenty-

¹⁸ Marc K. Siegel, “ObamaCare: Flight of the MDs,” *New York Post*, December 10, 2010, http://www.nypost.com/f/print/news/opinion/opedcolumnists/obamacare_flight_of_the_md_2zWYU1R9DYG4K6dJ8oi8gP.

eight percent reporting they believed the private practice model was “a dinosaur soon to go extinct.”¹⁹

Signs of this trend are already visible. Recent reports by the consulting firm Accenture found that doctors are increasingly backing away from individual practices and are joining larger groups, particularly hospitals, which have both more leverage with insurers as well as more staff to handle the increasing paperwork burdens. As a result, the percentage of doctors owning their own practices is dropping, and expected to continue dropping, from almost half in 2005, to forty-three percent in 2009, and to a projected one-third in 2013.²⁰ This is exactly the kind of trend Senator-physicians Tom Coburn and John Barrasso warned against in March 2010, predicting that the Obama health law, as a result of its complexity and attempted cost-savings, “could accelerate the trend of physicians leaving private practice to work in a centralized hospital setting.”²¹

Leaving private practices is one problem, but at least the doctors would still be practicing. A further concern is whether certain doctors would practice at all under the bureaucratic constraints and rejiggered economics of the new law, or if enough would continue to practice to meet the increased demands of the new health law, especially since we are already facing a looming physician shortage. As the Association of American Medical Colleges has noted, by 2020 we will already need an additional 91,500 more than we are currently projected to have—45,000 from primary care and 46,500 surgeons and specialists.²² While of course the AAMC has an

¹⁹ “Health Reform and the Decline of Physician Private Practice,” The Physicians Foundation, Oct. 2010, <http://www.physiciansfoundation.org/uploadedFiles/Health%20Reform%20and%20the%20Decline%20of%20Physician%20Private%20Practice.pdf>.

²⁰ “Physician Employment Trends Will Force Payers, Hospitals and Vendors to Revise Business Strategies, According to Accenture Survey,” Accenture study, June 13, 2011, http://newsroom.accenture.com/article_display.cfm?article_id=5220.

²¹ Tom Coburn and John Barrasso, “Grim Diagnosis,” October 26, 2010, 5, http://barrasso.senate.gov/public_files/FinalGrim.pdf.

²² Association of American Medical Colleges Fact Sheet: “Physician Shortages to Worsen Without Increases in Residency Training,” https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf.

interest in promoting the idea of physician shortages, their study shows the mentality of many in the medical field. Reports by the American Academy of Family Physicians (AAFP) came to similar conclusions, foreseeing a shortage of nearly 40,000 family physicians by 2020.²³ Other predictions are even more dire, with estimates of the shortage reaching 200,000 within the next eight years.²⁴

In addition to the question of practicing, there is the question of how doctors will practice. Will they create new pathways for cures, or will strict guidelines stifle their creativity? Another motivation for doctors, which can result in financial reward as well as the altruistic satisfaction of advancing medicine, is the ability to help in the innovation process. Doctors serve at the intersection of research and practice, and provide valuable feedback and guidance to life science companies about both products and needs. Doctors have also been known to invent a variety of products as well, from off-label uses to glidescopes and new vascular catheters. Unfortunately, the alphabet soup of governmental or quasi-governmental groups and approaches created by the Obama health law—including ACOs, IPAB, LCA, and CER—increases the concerns of government interference with innovation. These restrictive initiatives could not only affect the development of medical technology, they could also deprive doctors themselves of the freedom needed to create new products.

²³ Janice Lloyd, "Doctor Shortage Looms as Primary Care Loses Its Pull," *USA Today*, August 18, 2009, http://www.usatoday.com/news/health/2009-08-17-doctor-gp-shortage_N.htm.

²⁴ Dennis Cauchon, "Medical Miscalculation Creates Doctor Shortage," *USA Today*, March 2, 2005, http://www.usatoday.com/news/health/2005-03-02-doctor-shortage_x.htm.

Conclusion

As the implementation of the Obama health law continues, the ways in which the Obama Department of Health and Human Services interprets the law will have far-reaching implications for the supply, practice structure, and flexibility of physicians for many years. As this paper shows, a significant number of physicians themselves are extremely concerned about these implications, and both perception and reality will shape how doctors practice medicine in the years to come. Many of these changes, while worrisome, are predictable, and government officials and health care administrators alike can make certain adjustments to prepare for the expected consequences. Many others, however, are less predictable, and it is unrealistic to expect officials to be able to react to them. The unknowables include the possibility that the supply of doctors cannot meet the demand, or that dedicated professionals may lose the incentive or flexibility to create new cures, or that talented individuals choose not to pursue medical training at all. If these outcomes occur, we may never know what the ultimate consequences might be, and who will be left waiting for the treatment or the cure that never comes.

About the Author:

Tevi Troy is a Senior Fellow at Hudson Institute, and a writer and consultant on health care and domestic policy, whose commentary has appeared in major media outlets including the *Washington Post*, *Wall Street Journal*, *Commentary*, *National Affairs*, *Politico*, *National Review*, and *The Weekly Standard*. He is also a frequent commentator on outlets such as CNN, Fox News, PBS' NewsHour, and the Bill Bennett Radio Show. Troy is the author of *Intellectuals and the American Presidency: Philosophers, Jesters, or Technicians* (Rowman & Littlefield).

In 2007, he was unanimously confirmed by the U.S. Senate as the Deputy Secretary of the U.S. Department of Health and Human Services. As Deputy Secretary, Troy was the chief operating officer of the largest civilian department in the federal government, with a budget of \$716 billion and over 67,000 employees. In that position, he oversaw all operations, including Medicare, Medicaid, public health, medical research, food and drug safety, welfare, child and family services, disease prevention, and mental health services. He served as the regulatory Policy Officer for HHS, overseeing the development and approval of all HHS regulations and significant guidance. In addition, he led a number of initiatives at HHS, including implementing the President's Management Agenda, combating bio-terrorism, and public health emergency preparedness. He also sponsored a series of key conferences on improving HHS' role with respect to innovation in the pharmaceutical, biomedical, and medical device industries. Troy has led U.S. government delegations to Asia, the Middle East, Europe, North America, and Africa.

Troy has held numerous other high-level positions, including Deputy Assistant and Acting Assistant to the President for Domestic Policy, Deputy Assistant Secretary for Policy at the Department of Labor, Policy Director for Senator John Ashcroft, and Domestic Policy Director for the House Policy Committee.

Troy has a B.S. in Industrial and Labor Relations from Cornell University and an M.A. and Ph.D. in American Civilization from the University of Texas at Austin.

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that promote
security,
prosperity,
and freedom*



Chairwoman FOXX. Ms. Adams, you're recognized for five minutes.

Ms. ADAMS. Thank you, Madam Chair, and thank you, Ranking Member Scott, for hosting today's hearing.

And thank you to all of the panelists.

Much of what has been discussed today includes the impact of ACA on the health and economic security of our country. Repealing it would take away vital health insurance, as we've heard, for nearly 30 million Americans, and with more than 129 million Americans with preexisting conditions would be denied coverage.

Madam Chair, I'd like to ask unanimous consent to enter into the record a letter from seven children's groups.

Chairwoman FOXX. Without objection.

[The information follows:]

January 3, 2017

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Paul Ryan
Speaker
U.S. House of Representatives
Washington, DC 20515

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

Dear Majority Leader McConnell, Speaker Ryan, Minority Leader Schumer, and
Minority Leader Pelosi,

As organizations dedicated to improving the health and well-being of children, adolescents, and pregnant women, we urge you to keep the unique needs of children in mind as you consider the future of the Affordable Care Act (ACA) and ensure that any changes do no harm to children. Thanks to Medicaid, the Children’s Health Insurance Program (CHIP) and the ACA, ninety-five percent of children in the United States have health coverage – an historic high.¹ Children must not lose ground: any health reforms must build on achievements already made to further improve coverage for children. We look forward to working with you to ensure no child is worse off as changes to our health care system are contemplated, and that we can work together to make even more progress for children.

As you consider the future of the ACA, we ask that you adhere to at least the two following principles:

Put children first and adopt a “do no harm to children” standard. Over the past 50 years, it has been clearly demonstrated that there are strong economic reasons to preserve and protect children’s health coverage. The return on investment is high. Children with health coverage are more likely to attend school, graduate from high school, go to college, and become healthier adults, with higher taxable earnings than uninsured children. Identifying and treating conditions early, before they become expensive long-term liabilities, is effective. As you consider *any* changes to the Affordable Care Act, we urge you to commit to the guiding principle that these changes must not leave children worse off. Consistent with the “do no harm to children” standard it is also essential that there be no structural changes to Medicaid that would negatively impact the comprehensive and affordable coverage the program provides to children.

Any repeal of the ACA must be accompanied by passage of a full, immediate replacement that meets the needs of children and their families. A repeal without a replacement will lead to large disruptions to the health insurance market and significantly higher burdens on families and communities. Children will be directly impacted by the

repeal of affordable coverage options. The Congressional Budget Office (CBO) estimates that in the absence of a replacement package, 22 million people will lose coverage by 2019. In fact, it is estimated that repealing the ACA without a full replacement would leave more people uninsured than before the ACA was passed.ⁱⁱ The American Academy of Actuaries also recently warned that delaying the effective date of repeal to give time to develop a replacement would not assure stability of the market and could result in “spiraling premiums, insurer withdrawals from the individual markets, and loss of coverage for millions of Americans.”

In addition to the four million children who would lose coverage as a result of repeal, millions more would be negatively impacted by their parents losing coverage. Research clearly shows that children are better off when their parents have health insurance coverage.ⁱⁱⁱ The disruption to the health insurance market overall and the loss of health care dollars will also impact jobs and divert important state and local resources that support other systems, such as education, that are critical to ensuring children are ready to drive our future economy.

The children’s advocacy community stands united in calling on Congress to prioritize the needs of children by protecting their coverage in *any* efforts to repeal the ACA or reform the health care system. Any attempt to repeal the ACA without immediately enacting a replacement that leaves no child worse off could jeopardize the health of our nation’s children. Under your leadership, Congress must reaffirm its commitment to ensuring a stable health care system for all Americans and build on the gains that have been won for children and families, without interruption, and without losing ground.

Sincerely,

American Academy of Pediatrics
Children’s Defense Fund
Children’s Dental Health Project
Children’s Hospital Association
Family Voices
First Focus
National Association of Pediatric Nurse Practitioners

ⁱ Alker, J. and Chester, A., Georgetown University Center for Children and Families, “Children’s Health Coverage Rate Now at Historic High of 95 Percent,” October 2016, available at <http://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf>

ⁱⁱ Blumberg, Linda J., Matthew Buettgens, and John Holahan, “Implications of Partial Repeal of the ACA through Reconciliation.” Urban Institute, December 2016. <http://www.urban.org/research/publication/implications-partial-repeal-aca-through-reconciliation>

⁶⁴ Center for Children and Families (2014). "Medicaid Expansion: Good for Parents and Children," Georgetown University Health Policy Institute. <http://ccf.georgetown.edu/wp-content/uploads/2013/12/Expanding-Coverage-for-Parents-Helps-Children-2013.pdf>

Ms. ADAMS. Thank you very much.

Ms. Schlaack, first of all, you've experienced a terrible tragedy. Again, I want to add my thought and sympathy to you and your family and commend you for having the strength to share your story.

You describe in detail the impact of ACA in terms of coverage both for your daughter and your son, and in your testimony you mention that having ACA allowed you to have coverage for your daughter without having to quickly go back to work simply to get the benefit of health insurance.

So it does sound like ACA allowed you to be flexible with deciding when to go back to work after your husband's death. Is that the case?

Ms. SCHLAACK. That's correct.

Ms. ADAMS. Okay. I also want to raise with you, you know, oftentimes with great personal tragedy comes the need to access mental health services. Under ACA, more individuals have access to such services. As someone who has experienced personal tragedy and currently working with those who have, how important is that mental health service, such as grief counseling, how important is that to be accessible and covered under health plans?

Ms. SCHLAACK. Thank you. Not only for myself to be able to effectively parent and continue on with my life, but also for my daughter.

It is statistically shown that children who suffer a loss of a parent or live with a parent with a serious illness often have difficulty processing that, and it then translates into school issues, behavioral issues beyond their young years, well into college, making not necessarily the best choices. And the fact that she and I are both able to continue with counseling, therapy for our own mental health has been invaluable because it is a very expensive service that we couldn't have afforded otherwise.

Ms. ADAMS. Okay. And so after actually working in this field, you believe it's important for other families to access it as well?

Ms. SCHLAACK. Very much so. I work with groups, peer groups, and many times that's not quite enough. A lot of times, especially children don't want to talk about things like this with their parents, with someone in their home, and they need a third party who they can express what they're feeling and help them work through the emotions that they often don't even understand.

Ms. ADAMS. Right. Okay. Thank you.

So you talked about your son -- or you mentioned it in your written testimony -- who was able to stay covered under an employer-sponsored plan after serving in the Peace Corps. What has it meant to him to have the coverage a young adult starting out in the world?

Ms. SCHLAACK. Well, as he was right out of -- he finished his bachelor's program, went straight to a master's program, as we were able to continue to cover him then, so he didn't have to work full time and go to school. And then in the interim, between graduating and starting the Peace Corps, which he did have full coverage from the government as a Peace Corps employee, but then once that service was up, he transitioned back into the U.S., his benefits stopped.

And until he was able to attain his own full-time employment, which thankfully he does have, I was able to keep him covered. So it was one less thing that he -- because, frankly, the medical care he could get in Mongolia where he was serving wasn't exactly stellar, and he was able to come back and have the coverage he had in the past and before he started out on his own as an independent adult.

Ms. ADAMS. Thank you. And as his mom, I know you have peace of mind.

Thank you very much. I yield back, Madam Chair.

Ms. SCHLAACK. Yes. Thank you.

Chairwoman FOXX. Mr. Byrne, you are recognized for five minutes.

Mr. BYRNE. Thank you, Madam Chairman.

Lady and gentlemen, thank you for being here today.

Most people expect to get their health insurance through their employer. Most people work for small businesses. So the topic we've been talking about today and the impact on small business is a big deal.

I represent southwest Alabama. We don't have too many big employers. Virtually everybody works for a small business. Between 2015 and 2016, for the urban county in my district, Mobile County, the increase for small businesses for their insurance premiums is 14 percent. That turns out to be about \$2,000 per employee in 1 year. For small businesses, that's a big hit.

And, Mr. Bollenbacher, I'm informed that you actually had a 156 percent increase and that you wrote President Obama about that. So I would like to ask you, sir, did you hear back from President Obama? Have you received any subsidy from the Federal Government to help you with that increase? And if you don't receive a subsidy and you get an increase of that magnitude, what do you, as a small-business owner, what do other small-business owners that you work with, what do you all do with that?

Mr. BOLLENBACHER. Yes. I don't think my microphone is working.

Chairwoman FOXX. Turn on your mike, please.

Mr. BOLLENBACHER. Yes. I did write a letter to President Obama.

Mr. BYRNE. Did you hear back?

Mr. BOLLENBACHER. I had somebody call me from the healthcare marketplace to the SHOP.

Mr. BYRNE. Did you hear back from the President that you wrote to?

Mr. BOLLENBACHER. No, I did not, but 156 percent increase is not feasible.

Mr. BYRNE. Did you get a subsidy to help you with it from ObamaCare?

Mr. BOLLENBACHER. No.

Mr. BYRNE. So how do small-business people deal with an increase with like that, if the President won't talk to him or write him back and won't give him a subsidy like he had given in other parts of the program?

Mr. BOLLENBACHER. What we were forced to do is look at options, and there were no good options. Basically, there was one plan that we ended up having to pick, which was a 78 percent in-

crease. I've had other companies, other clients I work with, have dropped their insurance altogether. They just cannot afford it. They've laid people off to get under the full-time employee equivalent.

Mr. BYRNE. And maybe, Dr. Troy, Mr. Eddy, make you all can answer this for me. As a result of this, have we seen a decline in the number of businesses and employees working for small businesses that have insurance? Have small businesses just said, "Look, we can't afford it"?

Mr. TROY. I'm not aware of statistics on that specifically, but I do know there are concerns among small businesses. And I've heard stories, including by some of your colleagues today, about limitation of hiring by small businesses as a result of the ACA.

Mr. BYRNE. How about you, Mr. Eddy?

Mr. EDDY. Again, I agree with Dr. Troy. I don't have any specific statistics, but I know how it affects us, and it curtails our hiring capabilities as well as our capital investments, which lead to additional hiring. So we plan, as long as we can afford, to cover our employees with as much coverage as we can. You know, with the high deductibles that we have today and the continuing uncertainty in the future costs, I'm not sure how long that will be able to be sustained. Thank you.

Mr. BYRNE. Mr. Bollenbacher, I'm sorry you didn't hear back from the President of the United States. You wrote him. You're a citizen of this country. You have a legitimate concern. And you had a right to get a response. He's not President anymore, so there's nothing we can do about that.

Madam Chairman, I really do worry about what's going to happen to all these employees in America that work for small businesses and want to get their health insurance, expect to get their health insurance through their employer, and their employers have just gotten to the point where they can't afford it.

And so the employers are left with one or two choices. Either they continue to pay the high cost of this, in which case they've got to figure out a way to recoup that somewhere else, and my fear there is there will be less hiring, fewer jobs; or we figure out a way to get some real relief to small businesses by getting this incredibly expensive burden off of them and let small businesses do what they've done through the history of this country, which is grow and prosper and hire and provide benefits and good wages to the people of America.

And I yield back.

Chairwoman FOXX. The gentleman yields back.

Ms. Shea-Porter, you're recognized for five minutes.

Ms. SHEA-PORTER. Thank you.

And, Ms. Schlaack, first, let me say I'm sorry for your loss, and I understand how challenging it is when there's somebody in your family, because I had a family member who had decided -- he was a registered nurse, and he decided that he wanted to do ministry with music. He's a gifted musician, and he wanted to go to nursing homes and work with Alzheimer's patients. And so he was able to do that with the *Affordable Care Act*. And then shortly thereafter, he was diagnosed with advanced prostate cancer. And the *Afford-*

able Care Act saved his life, because he had access to treatment. So while our outcome was certainly better, it was a terrifying time.

I am also concerned about small businesses, and so I urge my colleagues on the other side to work with us to help to reduce the costs and figure out more. The fact that we haven't been able to work together I think is a tragedy.

But since the *Affordable Care Act* began expanding access to health insurance in my home State of New Hampshire, 63,000 people who didn't have it before have gained that peace of mind that we have all been talking about and the financial security that coverage provides. Now, their coverage and many others is at risk.

Despite the fact that Republicans have had seven years to come up with a so-called replacement plan, the current plan looks like repeal and collapse. Insurers make decisions over the coming months about whether to offer plans for next year and you're still hearing the story, the dog ate my homework. The stakes cannot be higher.

If congressional Republicans go down this road, the Urban Institute estimates that 118,000 people in my State alone could lose coverage and 30 million nationwide. Just yesterday, the Economic Policy Institute released a report that repeal would cost 4,600 jobs in New Hampshire. This wouldn't just erase the gains that we've made, that would send us backward, and I don't believe anybody wants to go backwards here.

My constituents are deeply concerned, and rightfully so. I'd like to read some testimony from two of them. First is Jameson from Somersworth, New Hampshire, who shared this, and I quote: "The ACA gave me the opportunity to purchase affordable health care when I needed it most. It allowed me to get the medical service I needed without me going into more debt or standing up time after time after time just waiting in the emergency room. Although I'm not a profitable insurance policyholder, I surely am a grateful one. Repealing the ACA would be inhumane, irresponsible, and outright foolish."

And there's Jack from Rollinsford, New Hampshire, who said "Before the ACA, I was uninsured due to a preexisting genetic condition and high medical costs, struggling to afford even the most basic tests to keep myself healthy. Today, I have great affordable coverage and the help I need to live a long, productive life."

So my question to you, Dr. Troy is, today's hearing concerns the quote, unquote, "failed health law." What benchmarks would you allow Jameson and show Jameson and Jack to defend your allegation the healthcare law has failed in New Hampshire and around the country? The uninsured rate? Average medical debt? The number of plans that have comprehensive substance abuse treatment? The number of issuers offering coverage in our individual market? Because all of those have shown dramatic improvement.

You work with numbers. Are there any statistics you could show Jack and Jameson about access to coverage and care in New Hampshire that could possibly support the idea that this law has somehow failed to improve health care for my constituents?

Mr. TROY. Thank you very much for that question.

I believe and I've written that there are three basic metrics for judging whether the law is a success. Number one is coverage.

While you say that the law has increased the number of people covered, that is absolutely true, more people are covered subsequent to the ACA, but, A, not as many as the law said it would or CBO projected that it would cover. And we still do not have the level of universal coverage that I believe that we should strive for in this country.

Number two is costs. President Obama said that the law would reduce costs, bring down costs for individuals, bend the cost curve down. As Dr. Brat was saying earlier, our long-term costs are still quite high, and we've seen very high increases in the premiums at the exchanges in recent years.

And then the third, and I think really the key question that will determine whether the American people believe the law is a success, is President Obama's promise if you like your health care you can keep it. And we have seen disruptions in the individual markets that some people have not had the coverage they had previously as a result of the ACA.

And then there are questions that the costs we were talking about throughout this hearing imposed on employers. And if employers are changing the health care they're providing as a result of the costs of the ACA, then the answer to the question of that is no.

Ms. SHEA-PORTER. Okay. Well, let me stop you there, because I'm running out of time. But first of all, the fact that the coverage isn't 100 percent but so much closer hardly seems a reason for you to complain. It seems to me you would want to say, well, that's wonderful, we've expanded coverage and let's do even better and get 100 percent.

And your second point, where the costs have not dropped, can you point out anything anywhere, starting from your sale of your home or whether you rent or whether you buy groceries, anywhere where the costs have dropped? We all know that the rate of increase has dropped. And you, yourself, introduced some of those numbers earlier in your testimony.

So I'm not sure what you're saying here. If you're saying that I didn't get everything I wished for, and that's how it sounds here, I didn't get everything I wished for yet, what would be the purpose of going backwards and taking away when you've acknowledged that the increase of people who are covered went much higher? What is wrong here?

Chairwoman FOXX. Ms. Shea-Porter, your time has expired. And we'll ask Mr. Troy to submit his answer for the record.

Mr. TROY. I will.

Ms. SHEA-PORTER. Thank you. And I yield back. And I would very much appreciate an answer to that. And thank you.

Chairwoman FOXX. Mr. Allen, you're recognized for five minutes.

Mr. ALLEN. Thank you, Madam Chair.

And, again, I appreciate the panel participating today. I, too, have learned a little bit about what you're dealing with.

Just 2-1/2 years ago I sat in your seat, Mr. Eddy, as a small business and dealing with not only the economy but the increase in benefit costs and stagnant wages, which is still a major problem. I think that probably, too, we should understand that really health insurance benefits came out of the business community. In fact, it

exploded during World War II when there were wage controls and the war board allowed the companies to extend benefits, health benefits and other benefits, to compete for employers. And, of course, now the government is heavily involved.

And we know that, again, costs are increasing. In fact, I have met with lots of groups that are involved in the markets. And, of course, the health insurers are getting a little bit -- well, they're getting a bad rap because they are blamed for the increase. But I know for a fact that most of them submitted certain reforms to the administration that would drive down costs and they were totally ignored.

And that brings me to my point here that I want to make today. And, again, I don't know if this is the first time you've testified here in Congress, but you obviously see the very partisan part of what -- in fact, I'm ashamed of it, really, of what happens here that we can't come together. We can send somebody to the moon, but we can't come together and do what's right for the American people, and that's sad.

But we're going to work on it. We're going to continue to work on it. Your testimony is very important to us, and we thank you for that.

With that, again, you've listened to us, and we've listened to you. Dr. Troy, I would like to start with you, and just we're getting to the end of this. Can you summarize in your mind where you see us going and what's best for the American people?

Mr. TROY. Thank you for that question, and I applaud your call for bipartisanship. Before the ACA, every piece of major social welfare legislation in this country had passed on a bipartisan manner, and that's one of the reasons that these laws were accepted and the American people moved on subsequently. When you have a law passed in a unipartisan manner, you have this situation where there's continued contentiousness about the law seven years later.

I would like to see some kind of bipartisan reform going forward so that it would be more lasting. I would like to see it along the lines of what we were talking about earlier in terms of building on the basic building blocks of American health care, which includes employer-sponsored care, which covers 177 million people, but also works to reduce the overall costs, thereby incentivizing people to purchase it on their own and not having to do it via mandate. Thank you.

Mr. ALLEN. Now, what's important about what you said there is incentivize. I learned that in the business world, that the best way to get the production from your workforce is to give them incentives to do these things rather than mandates.

Mr. Eddy, do you have any comments about how to solve this?

Mr. EDDY. I'd be in Congress if I had the ability to solve it.

Mr. ALLEN. Well, that's the reason I'm here. I'm not sure I'm getting anywhere.

Mr. EDDY. As I said, I depend on you all to work together to do this.

But along with the repeal of the taxes, I'd like to see us consider reducing some of the reporting requirements. The mandates generate a lot of reporting requirements, a lot of compliance issues.

Also, the greater flexible. I'd like to see the proposals and see options and flexibility improved.

Thank you.

Mr. ALLEN. Ms. Schlaack, my heart goes out to you for your loss.

Ms. SCHLAACK. Thank you.

Mr. ALLEN. What is your recommendation knowing that we're \$20 trillion in debt. And you've got a child. I have 12 grandchildren. How do we do this?

Ms. SCHLAACK. Again, fortunately, I'm on this side and not yours -- your side of this table, I'll put it.

But, I mean, to have a productive, efficient workforce you need healthy, happy employees, mentally and physically. And I know it's dollars and cents, but it comes down to loyal, healthy employees that you can count on to be at work and to maintain their job.

Mr. ALLEN. Let the record show that maybe was the most important thing that was said here today at this hearing.

Mr. Bollenbacher.

Mr. BOLLENBACHER. I believe for small businesses we need options. We need flexibility. We need more than one choice to provide for our employees.

Chairwoman FOXX. The gentleman's time has expired.

Mr. ALLEN. I yield back.

Chairwoman FOXX. Mr. DeSaulnier, you're recognized for five minutes.

Mr. DESAULNIER. Thank you, Madam Chair.

Let me start at the beginning, just agreeing to the comments by my friend from Georgia and by the chair. It would be wonderful if we could approach this more in a problem-solving perspective, acknowledging that we have philosophical differences as to how to accomplish that. And I say that from the perspective of being a small-business owner for over 35 years.

Mr. Bollenbacher, I hesitate to use this phrase, but I feel your pain. I owned restaurants in the bay area for a long time. And before the ACA, one of the problems I had was the cost, that it was going up. So for my employees, who I was able to pay 100 percent of their costs, I found situations before the ACA where I had a manager come to me in tears because she couldn't afford the copay. I contributed the copay.

So when we compare this and Dr. Troy, I would like to go back to the ranking member's comments and how we get to a perspective of more problem solving in a bipartisan fashion as you affirmed would be preferable.

But in addition to owning a small business, Ms. Schlaack, I also have great empathy for your perspective as a survivor, so far, of incurable blood cancer. I, fortunately, had insurance that I paid for, that has helped me pay for the very large costs for my treatment.

I will say, and I'd be curious about your experience, but perhaps just personally, as to the question about electronic records. There's somewhat of a joke about those of us who have gone through treatment, and I tease my oncologist that I see more of his back as he looks at my CAT scans and my blood. But he will say, but that's where the information is.

So understanding that there's a process to introducing technology and understanding that we should have done it faster when it

came to electronic records, there's still a long term and a short-term benefit for me. I'm an example of it.

And at some point, a wonderful book, "Rise of the Robots," where they talk about automatization. And for specialists in the medical field, I always ask when I go out to research facilities: How much is the oncologist in my case interpreting the results of my examinations and how much is a computer interpreting it and telling him or her what the diagnosis should be and what the treatment should be? And what I always get is over the course of time the computer is doing more and more of that work.

So to Dr. Troy, to follow on the ranking member's, if we're going to be rational about this, more than opinion, an opinion, even research that's based on a biased perspective, from my experience it would be better to look at where other similar examples have worked historically and where they work right now.

So in the industrialized world, one of the reasons I was so supportive of ACA and supportive of universal health care and Medicare for all, is that that's my perspective of who we compete with. And most of those countries that we compete with, their percentage of costs of health care is smaller than their GDP than the U.S. and their outcomes have historically been better -- Mongolia not included in this, by the way.

So the ranking member's question about if your theories are in play right now and practiced in a similar industrialized community, where is it? What can we learn from that? And why can we be so certain that your suggestions will work when they are applied to a very complex country?

And I'll just say, lastly, from my perspective having been very involved in the implementation in California when I was in the legislature, we had huge struggles. We continue to have huge struggles. We worked with the California NFIB. We delayed some of the requests in the mandates on small businesses. As a small-business person, I wanted to make sure that they didn't incur undue burden, as my friend from Alabama said.

So in the short time left, maybe you could just elucidate a little bit on your response from the ranking member. If you're going to be rational and evidence based and rely on as much empirical, non-biased research as possible from either perspective, it would suggest to me that we go to places that have implemented health care, dealt with this, and either from your perspective, being more market based or more driven closer to universal health care, where has it worked and where hasn't it?

Mr. TROY. Thank you very much for your question. I certainly try to avoid the word "certainty" when it comes to public policy, because I think it behooves us to have modesty in our approaches and not be completely certain about anything about the previous policies or going forward.

One of the reasons we spend more on health care is that we are, in many ways, a more generous country. We spend dollars until the last minute of life in ways, and some of these countries, some of our Western allies do limit treatments at the last hours of life in ways that we don't.

The results are certainly mixed. To some degree, we do have lower life expectancy, but part of that is unfortunately due to high-

er road deaths and higher gun deaths. So there are other factors at work.

I don't have the perfect plan in another country. I have seen some positive results from Singapore, which does have people have some kind of catastrophic plan and also combines it with some kind of has that can be transferred generation to generation, and that has showed some impact in moderating healthcare costs. But, again, Singapore is a small homogeneous country, and obviously, we are a very large heterogeneous one. So it is, obviously, a difficult public policy conundrum.

Mr. DESAULNIER. Thank you, Dr. Troy.

And thank you for indulging me, Madam Chair. I have some articles on the Treasury report issued on January 12 that I would like to submit for the record.

Chairwoman FOXX. Without objection.

[The information follows:]

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One in Five 2014 Marketplace Consumers was a Small Business Owner or Self-Employed

By: Adam Looney and Kathryn Martin
1/12/2017

Independent Workers Are Almost Three Times More Likely To Rely on Marketplace Coverage than Other Workers

Today, Treasury released a [report](#) with new data on sources of health insurance coverage for small business owners and self-employed workers. These data show that the Affordable Care Act (ACA's) Health Insurance Marketplaces are playing an especially crucial role in providing health coverage to entrepreneurs and other independent workers.

Prior to the Affordable Care Act, workers without employer-sponsored health insurance often lacked options for affordable coverage. Not only did high uninsured rates impede access to care and worsen financial security, but the risk of ending up without health insurance coverage prevented some individuals from striking out on their own. Experts considered "job lock," or individuals' need to stay in an employment situation to maintain health coverage, a [significant impediment](#) to entrepreneurship. To help address these challenges, the ACA's Marketplaces were designed to offer portable health insurance coverage to small business owners and other independent workers, a growing segment of the economy.

One in five 2014 Marketplace consumers was a small business owner or self-employed

New data included in today's Treasury Department report on alternative work arrangements show that small business owners and self-employed workers are taking advantage of the opportunity to purchase health coverage through the Marketplaces.[] In 2014, 1.4 million Marketplace consumers were self-employed, small business owners, or both, indicating that about one in five 2014 Marketplace consumers was a small business owner or self-employed. Indeed, among the 5.3 million workers who purchased Marketplace coverage for themselves (excluding their children or non-working spouses), about 28 percent were workers whose income was not primarily earned from wages paid by an employer.

In fact, small business owners and self-employed individuals were nearly three times as likely to purchase Marketplace coverage as other workers. Nearly 10 percent of small business owners and more than 10 percent of gig economy workers got coverage through the Marketplace in 2014. Among small business owners and other independent workers, those with annual incomes below \$65,000 were the most likely to rely on the Marketplace for health insurance. Middle- and lower-income Americans who buy coverage through the Marketplace are eligible

for tax credits to help keep coverage affordable. About 65 percent of small business owners and 69 percent of all self-employed or independent workers have incomes below \$65,000.

Between 2014 and 2015, the number of people who signed up for Marketplace coverage increased by around 50 percent. And enrollment increased further in 2016, and is poised to rise again in 2017. Marketplace coverage among independent workers has almost certainly risen as well. HHS is also partnering with outside companies that support freelance workers, entrepreneurs, and start-ups to reach more independent workers with information about Marketplace coverage and financial assistance.

Table 1: Marketplace Enrollment Rates for Self-Employed Workers and Small Business Owners, 2014

State	Self-Employed, Sole Proprietors*			Small Business Owners**		
	Number w/Marketplace coverage	Share with Marketplace Coverage	Share with Marketplace Coverage Among Workers with Any Health Coverage	Number w/Marketplace coverage	Share with Marketplace Coverage	Share with Marketplace Coverage Among Workers with Any Health Coverage
Alabama	14,400	7%	9%	9,790	7%	9%
Alaska	2,220	6%	8%	1,450	6%	8%
Arizona	16,080	5%	7%	11,110	6%	8%
Arkansas	6,030	5%	6%	4,500	6%	7%
California	276,900	12%	15%	204,180	14%	16%
Colorado	22,720	8%	9%	15,030	8%	10%
Connecticut	14,690	8%	9%	10,750	8%	9%
Delaware	2,160	6%	8%	1,560	8%	9%
District of Columbia	3,380	10%	11%	2,280	13%	14%
Florida	177,940	15%	20%	99,540	15%	19%
Georgia	54,330	10%	14%	35,580	10%	12%
Hawaii	2,240	3%	4%	1,820	4%	4%
Idaho	11,330	15%	19%	7,860	16%	21%
Illinois	33,700	5%	7%	20,500	6%	8%
Indiana	17,780	7%	9%	11,930	8%	10%
Iowa	4,260	3%	4%	2,840	3%	4%
Kansas	8,280	7%	8%	5,790	7%	8%
Kentucky	10,520	6%	7%	7,430	7%	8%
Louisiana	15,120	7%	9%	10,360	7%	8%
Maine	10,030	13%	16%	7,090	14%	17%
Maryland	12,110	4%	5%	8,530	4%	5%
Massachusetts	8,620	3%	3%	6,300	3%	3%
Michigan	37,590	8%	10%	24,050	10%	11%
Minnesota	7,230	3%	3%	4,930	3%	3%
Mississippi	8,470	6%	8%	5,160	6%	8%
Missouri	21,550	8%	10%	14,810	9%	12%
Montana	6,800	12%	16%	5,120	14%	19%
Nebraska	5,520	7%	8%	3,830	7%	9%
Nevada	6,730	5%	7%	5,110	6%	8%
New Hampshire	8,450	12%	14%	6,550	13%	16%
New Jersey	27,130	6%	8%	19,130	7%	8%
New Mexico	5,040	6%	7%	3,210	6%	8%
New York	69,660	6%	8%	50,400	9%	10%
North Carolina	54,960	11%	15%	34,650	12%	15%
North Dakota	1,560	5%	6%	1,730	6%	6%
Ohio	22,870	5%	5%	15,510	6%	6%
Oklahoma	11,290	6%	8%	7,560	7%	8%
Oregon	15,000	8%	9%	10,270	9%	10%
Pennsylvania	51,760	10%	11%	34,340	11%	12%
Rhode Island	4,900	10%	11%	3,530	12%	13%
South Carolina	26,180	7%	10%	11,220	8%	10%
South Dakota	1,970	5%	6%	1,340	5%	6%
Tennessee	25,350	7%	9%	16,960	8%	10%
Texas	114,390	8%	12%	78,080	8%	11%
Utah	9,540	9%	11%	6,710	10%	12%
Vermont	7,180	17%	19%	5,610	20%	22%
Virginia	33,340	9%	11%	20,990	9%	11%
Washington	30,060	10%	11%	21,120	11%	13%
West Virginia	2,700	4%	5%	1,650	5%	6%
Wisconsin	18,060	8%	9%	13,110	9%	11%
Wyoming	1,850	7%	9%	1,150	6%	8%
US Total	1,351,290	8%	11%	912,740	9%	11%

* Self-employed, sole proprietors are workers who earn at least 85 percent of their earnings from operating a sole proprietorship.

** Small business owner is defined using the criteria in Kimmel et al 2011 using a de minimis test (at least \$10,000 of business expenses or profits, or \$15,000 in combined business expenses and profits and a business activity test (having at least \$5,000 of business expenses).

Geographic patterns in small business owners' and independent workers' health coverage

Today's report includes detailed state-by-state data on Marketplace participation among entrepreneurs and independent workers. In all 50 states and D.C., thousands of small business owners and independent workers bought Marketplace coverage in 2014. Of note:

The ten states with the highest share of small business owners relying on the Marketplace for coverage were Vermont, Idaho, Florida, Montana, Maine, California, New Hampshire, Washington, D.C., Rhode Island, and North Carolina.

The 10 states with the largest number of small business owners with Marketplace coverage were California, Florida, Texas, New York, Georgia, North Carolina, Pennsylvania, Michigan, Washington, and Virginia.

Table 2: Marketplace Enrollment Rates for Self-Employed Workers and Small Business Owners, 2014

	Number w/Marketplace coverage	Share with Marketplace Coverage	Share with Marketplace Coverage Among Workers with Any Health Coverage	
Self-Employed, Sole Proprietors*				
<i>Income Group</i>				
< \$20,000	586,560	9%	12%	
\$20,000-\$40,000	413,650	16%	21%	
\$40,000-\$65,000	199,190	10%	12%	
\$65,000-\$110,000	97,960	5%	5%	
Above \$110,000	54,030	2%	2%	
All	1,351,390	8%	11%	
Small Business Owners**				
<i>Income Group</i>				
< \$20,000	355,680	12%	18%	
\$20,000-\$40,000	292,570	15%	19%	
\$40,000-\$65,000	147,810	10%	12%	
\$65,000-\$110,000	73,930	5%	5%	
Above \$110,000	42,750	2%	2%	
All	912,740	9%	11%	
Gig Economy Workers***				
<i>Income Group</i>				
< \$20,000	6,010	13%	18%	
\$20,000-\$40,000	4,130	14%	18%	
\$40,000-\$65,000	1,330	8%	9%	
\$65,000-\$110,000	460	4%	4%	
Above \$110,000	110	2%	2%	
All	12,040	11%	14%	
Compare: Employees	3,851,260	3%	1%	

* Self-employed, sole proprietors are workers who earn at least 85 percent of their earnings from operating a sole proprietorship.

** Small business owner is defined using the criteria in Knittel et al 2011 using a de minimis test (at least \$10,000 of business expenses or profits, or \$15,000 in combined business expenses and profits and a business activity test (having at least \$5,000 of business expenses).

*** "Gig economy workers" are those whose self-employment income derives in part or in whole from activities conducted through an online platform.

Adam Looney is the Deputy Assistant Secretary for Tax Analysis at the U.S. Department of Treasury. Kathryn Martin is the Acting Assistant Secretary for Planning and Evaluation at the U.S Department of Health and Human Services.

[1] The Treasury report defines small business owners as Schedule C filers whose business activities (measured by expenses and gross receipts) exceed certain de minimis thresholds (a minimum of \$5,000 of business expenses and either \$15,000 of gross receipts or \$10,000 of business expenses). Self-employed workers are defined as individuals who earn at least 85 percent of their earnings from operating a sole proprietorship. "Gig economy workers" are those whose self-employment income derives in part or in whole from activities conducted through an online platform.

Posted in: Affordable Care Act

Chairwoman FOXX. Mr. Grothman, you are recognized for five minutes.

Mr. GROTHMAN. Okay. Mr. Bollenbacher, you are kind of what I think was going to happen until the ACA stepped in. You are somebody who, the way it is described, for a relatively small employee -- what, 11 employees over there? -- you are doing a great job of managing your costs.

I'd like to know what your costs per employee was or did you feel you had your costs per employee under control with a combination of HSAs and giving some money toward your employees?

Mr. BOLLENBACHER. Yes, I do. We were seeing increases, you know, 8 to 12 percent. The health savings accounts the employees really liked. They were able to save money to put away for those future unexpected claims. It was manageable for us to continue that.

Mr. GROTHMAN. And your costs were still going up 8 or 9 percent?

Mr. BOLLENBACHER. I'm sorry?

Mr. GROTHMAN. Your costs were still going up 8 or 9 percent? Or you felt you got your costs under control with a combination of HSAs and --

Mr. BOLLENBACHER. Yes, sir.

Mr. GROTHMAN. Okay. So you were happy to live with the 8 or 9 percent.

Mr. BOLLENBACHER. A lot better than 156 percent.

Mr. GROTHMAN. Okay. And is that after the ACA kicked in or before?

Mr. BOLLENBACHER. The 8 to 12 percent was before. We were seeing 156 percent last year.

Mr. GROTHMAN. Right. Okay.

I'll go to Mr. Eddy. There are a variety of problems that business has. And I don't know whether I caught how you're handling your healthcare costs. But could you give us in general the type of plan you were offering your employees before the ACA kicked in?

Mr. EDDY. It was a common plan with a thousand dollars for a single and a thousand-dollar deductible for the family plan. As I said, it was about \$13,500 per year for the family plan. I'm not sure how to describe the plan, but it was full coverage. We paid the entire amount of the plan for our employees.

Mr. GROTHMAN. Okay. Do you know, and I guess this is either for you or Mr. Bollenbacher, have you or other people involved in NFIB -- are you with NAM? Is that what you're involved with?

Mr. EDDY. Yes, I'm here with NAM.

Mr. GROTHMAN. Right. Stories of employees being conscious or other employers being conscious of both a desire to hold employees' hours below 30 hours or employees conscious of the cliffs in which they're going to lose their subsidies? Have you heard stories like that?

Mr. EDDY. Well, I've heard the stories, but we don't -- you can't experience that. That's not something that I think is pretty common.

Mr. GROTHMAN. Okay.

Mr. BOLLENBACHER. Yes, sir. I've been dealing with that almost on a daily basis where my self-employed clients, the farmers, the

pastors at churches, where they're right at that cutoff, and it's a cliff. And if they go over that cliff, they may pay \$7,000 or \$8,000 back, and it hurts them badly.

Mr. GROTHMAN. Bingo. I'm glad you're a CPA. Because that's what we want. At first I was thinking I was asking you as an employer. But I'm not asking you as an employer. I'm asking you as a CPA. So you see that your customers, the people you fill out tax returns for, are conscious of the fact that they cannot make more money. Or, in other words, they are maybe artificially holding down their compensation to make sure that they don't hit the cliff.

Mr. BOLLENBACHER. Absolutely. It's a big number for most of my clients.

Mr. GROTHMAN. Okay. And do you find employees sometimes conscious of that as well?

Mr. BOLLENBACHER. Not as much as the self-employed. But, yes, I have had individuals where they're an employee, they get a paycheck, maybe they sell some stock, and it puts them over the cliff, and all of sudden they owe \$2,000 or \$3,000 back that they weren't expecting.

Mr. GROTHMAN. Okay. Mr. Troy, you talked about the different taxes out there. I think you talked about the -- oh, the Cadillac tax and that sort of thing. And you advocate repealing them. But what would happen if we repealed them? Would that make ObamaCare that much more fiscally impossible?

Mr. TROY. I do believe that the Cadillac tax does not bring in nearly as much revenue as the CBO or the JCT, Joint Committee on Taxation, suggests it would. I think that the *Affordable Care Act* has a lot of spending itself. And so if the committee goes forward and the Congress goes forward with repealing it, along with the taxes, then it wouldn't make the ACA more fiscally responsible, but it would reduce both the costs and some of these revenues from taxes.

Mr. GROTHMAN. I guess the point I'm trying to make is if we repeal the taxes, the money is going to have to come from somewhere else, Right?

Mr. TROY. If you maintain the ACA as it is, but just minus taxes. But I don't think that's a working plan on the table.

Mr. GROTHMAN. Right. But that is what would happen. I mean, when people talk about continuing the ACA, if you continued the ACA and got rid of these harmful taxes, the money would have to be made up from somewhere else, correct?

Mr. TROY. As with any program, yes.

Mr. GROTHMAN. All right. Okay. Thank you for --

Chairwoman FOXX. Thank you. The gentleman's time has expired.

Mr. Courtney, you're recognized for five minutes.

Mr. COURTNEY. Thank you, Madam Chairman.

So at midnight last night this enrollment period for 2017 came to a close. This morning I checked in with the folks in Hartford about how the final numbers came in. The answer that came back is that we just about pretty much held steady in terms of last year's enrollment. It was a little bit of a dip, partly because they didn't use insurance agents to help with enrollment, which they're

going to reverse that for next year. That was a bad move they made. But nonetheless, I mean, it pretty much held steady.

And I make that point just because we've heard a lot of talk today and over the last few weeks about whether or not the law is in a death spiral. There was an interview recently that was reported with the American Academy of Actuaries, which I think we would all stipulate doesn't have a partisan bone in its body, about whether or not in fact there is a death spiral going on, and Cori Uccello, the organization's senior health fellow, answered, "I don't see any evidence of that happening right now. The problem with the argument," according to Uccello, "is that ObamaCare's enrollment is actually holding steady and not dropping off." And we know that from the national exchange as well. A death spiral is when people really start running towards the exits, and it just concentrates the sickest in the pool. And as Uccello points out, the age distribution for 2017 is pretty much holding steady.

In my district, which we've driven the uninsured rate down to 3.6 percent, I think it's almost the lowest of any member's district on this committee, and that's because of a grassroots effort with libraries, community health centers, hospitals, insurance agents up until last year, who really just flooded the zone in terms of trying to get people help and assistance that took place.

And I would just share this, because as a former employer I think the description of your problem is exactly the sore spot that we need to address, Mr. Bollenbacher. But, frankly, it is not a monolithic story that's out there.

Willimantic Waste, which is a trash hauler in my district, they have about 200 employees, I got a letter from the HR director who indicated to me, and I'll just read it quickly, "I was skeptical about the claims that the ACA would help level out the cost of our company-sponsored health plan. But the numbers have come in, and over the past three years we have seen a decrease or no increase in our premiums every year. 2015, minus 2 percent. 2016, minus 1 percent. 2017, zero percent."

And, again, I'm not saying that to diminish your comments. But the fact is it is really not monolithic that's out there. And what we ought to be doing is focusing on questions about whether to have a reinsurance mechanism, which was in the bill and unfortunately got stripped. It was part of the Republican Medicare Part D plan as a way of leveling off premiums through that. Very successful. We use it for flood insurance.

Again, and this is coming from Connecticut where we have a lot of insurance companies, that's the biggest weakness that they identify in terms of why the 2017 spike increased. But Standard and Poor's even then said it appears to be just a one-year phenomenon.

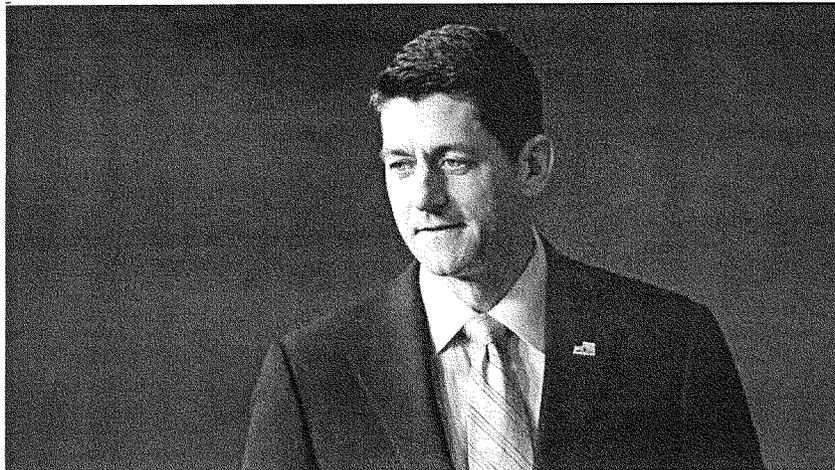
So, Madam Chairwoman, I would like to submit this story from the Academy of Actuaries, as well as Willimantic Waste paper for the record.

Chairwoman FOXX. Without objection.
[The information follows:]



Is healthcare law really going into a ‘death spiral’?

By Peter Sullivan - 01/24/17 06:00 AM EST [779](#)
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It's a central part of the GOP argument against ObamaCare: The Affordable Care Act is in a “death spiral” and on the verge of collapse, Speaker [Paul Ryan](#) (R-Wis.) and other Republicans argue.

Congress must act now to repeal and replace the law, the Speaker argues, because the system is already collapsing.

“You have to remember the law is in what the actuaries tell us [is] a death spiral,” Ryan said at a press conference this month. “So we’ve got to intervene to prevent this from getting worse.”

If the healthcare law is in a death spiral, it increases the need to repeal and replace it, since it suggests that health insurance markets will collapse without government action. That’s why it is a key argument for Republicans.

Yet non-partisan healthcare groups that have studied the law say that while it has some serious problems and faces challenges, they do not see it as collapsing into a death spiral.

The American Academy of Actuaries is a prime example.

The group, which represents the people who analyze data for insurance companies, says there is no evidence that ObamaCare is in a death spiral or that it is on the verge of collapse.

“I don’t really see evidence of that happening right now,” said Cori Uccello, the organization’s senior health fellow.

The idea is that rising premiums are making it more likely that healthy people will drop their coverage, despite the mandate for keeping insurance.

That will in turn cause a further spike in premiums, as insurers would be forced to cover a sicker group of enrollees.

Under the death spiral scenario, the healthcare system then falls victim to a vicious cycle in which more and more healthy people drop out, causing premiums to rise and rise until insurers pull out of the market entirely.

The problem with the argument, according to Uccello, is that ObamaCare’s enrollment is actually holding steady and not dropping off.

The latest administration figures show 8.8 million people have signed up for 2017 coverage, slightly higher than the 8.7 million at the same point last year.

“Enrollment seems to be holding fairly steady, as well as the age distribution,” Uccello said. “These things are not indicative of a premium spiral.”

Premiums did increase sharply, with an average rise of 25 percent for coverage in 2017.

But a report from analysts at Standard & Poor’s in December found that 2017 was a “one-time pricing correction” and premium increases for 2018 would be “well below” that amount.

“Obviously, 2016 is not a death spiral,” said Deep Banerjee, an S&P analyst and one of the authors of the report. “We don’t think 2017 will be a death spiral either.”

A majority of those on ObamaCare — 85 percent — receive subsidies to help pay for their premiums. As a result, those people don’t have to pay much if any of the rise in their premiums, though the cost for the federal government would go up.

“The way that current federal premium subsidies are set up, they largely would protect the market from heading into a death spiral for the subsidized population,” said Erica Coe, a partner in the healthcare practice at McKinsey & Company.

It’s not that the healthcare law doesn’t have problems.

In addition to rising premiums, Ryan and other Republicans have pointed out that several large insurers dropped out of ObamaCare markets last year because of financial losses.

The Kaiser Family Foundation finds that 32 percent of counties will have just one insurer offering ObamaCare coverage in 2017, compared to seven percent of counties in 2016.

But those problems are different from saying the law is collapsing in a death spiral.

Democrats argue that improvements could be made to fix issues like a lack of competition in some areas. They want a government-run “public option” to increase competition and more financial assistance to make insurance more affordable.

Ryan and other Republican leaders have pointed to the death spiral argument to justify their push to repeal the law.

When a cancer survivor who credited his life to ObamaCare asked Ryan at a CNN town hall this month why he wanted to repeal the law, Ryan responded in part by saying the status quo is unsustainable.

“The problem with ObamaCare: the actuaries call it a death spiral,” Ryan said in his response to the man. He also argued there are better ways to help people with pre-existing conditions, like high-risk pools.

He then added: “We have to step in and rescue people from the collapse of this law.”

Many insurers have indeed been losing money in the ObamaCare markets, and some have dropped out altogether, reducing choices for people. But the S&P report found that the situation is improving, not getting worse. More insurers will report profits in 2017, the report found, and another year or two of improvements will lead to more reaching their financial targets.

“It still isn’t a profitable line of business for most insurers, but what this indicates is that there is a way to make this work,” Banerjee said.

Some analysts think Republican repeal efforts actually could make things worse.

Uccello, for example, warned that repealing the mandate could actually bring about a death spiral, since the Congressional Budget Office has estimated that it could raise premiums by 20 percent.

She also noted that uncertainty around what Congress will do could hurt the market.

“Uncertainty is not something that bodes well,” she said. “Insurers need to know what’s going on.”

10/8/2016

Congressman Courtney,

Thank you for passing the ACA back in 2011. When it was first passed, business people were concerned about the law and how it would affect healthcare costs in our state. As a human resource manager for a local company with 285 employees, I was skeptical about the claims that the ACA would help level out the cost of our company sponsored health care plan. But the numbers have come in and over the past three years, we have seen a decrease or no increase in our premiums every year. 2014-15 : -2.0% 2015-16: -1.0% and 2016-17 : 0.0% . I believe the decreases were due in part to the competition in the health care marketplace that the ACA created.

Some people have told me that the ACA is not working because of this issue or that issue. I remind them that the ACA was the framework for the US healthcare system. New healthcare issues (deductibles, types of covered care, costs) can now be addressed within that framework that President Obama and you created. It will take time for those issues to rise to the surface but when they do, the issues will be addressed.

Thank you for your hard work on this piece of legislation.

John DeVivo
Willimantic Waste Paper
Willimantic CT

Mr. COURTNEY. Thank you.

And just to go back to -- I mean, one bipartisan ray of hope here is on the Cadillac tax. As many know, we teamed up last year on a bipartisan basis, pushed it back to 2020. A bunch of us did it back in 2010 and pushed it out to 2018. But nonetheless, I mean, there is, again, a strong feeling that this is a really totally inefficient way of trying to accomplish some type of goal, which is really just to shift costs to businesses and employees.

And I would just say, Dr. Troy, I mean, you point out that the CBO study, it really is not a traditional tax analysis. It's assuming an income windfall that will happen as employers don't incur as much costs in terms of paying higher premiums. I just wonder if you could comment in terms of really -- there really is no study that has ever really demonstrated that sort of backboard basket that they're describing, is it?

Mr. TROY. Thank you so much for that question, Mr. Courtney, and I would like to applaud you for your bipartisan efforts to eliminate the Cadillac tax. Thank you for that.

We have done a number of studies at the American Health Policy Institute about the deleterious impact of the tax, and we looked very carefully at this question of how much revenue it would supposedly raise. In doing so, we found that not only would it not bring in as much revenue as the CBO and the JCT projected, but also that to the extent that it is imposed and employers are trying to reduce costs in reaction to it, that the reduced costs are not necessarily going to employees as the CBO study projects or assumes. We talked to employers, and 71 percent said that it would not lead to increased wages. So I just think it's on unfounded assumptions.

Thank you for your leadership.

Mr. COURTNEY. Thank you. H.R. 173, and I think we could do it on the consent calendar if it was brought up tomorrow. Thank you.

I yield back, Madam Chairman.

Chairwoman FOXX. Thank you very much.

Mr. Thompson, you're recognized for five minutes.

Mr. THOMPSON. Madam Chair, thank you for this hearing.

As someone who arrived in Washington to serve in January of 2009 when this original -- and I won't say it was even a debate. I came here with 28 years of healthcare experience, nonprofit community healthcare experience. In my time off, I volunteered as an EMT, showing up at the homes of my neighbors at all times of the day and night -- or mostly the night when I was home -- to respond to healthcare needs.

And there was no debate in 2009. In fact, those of us who came here, and there was a lot, my good friend from Tennessee, Dr. Roe, came here as a physician, there was a lot of us with healthcare experience. A lot of friends across the aisle who had great experience. None of us were welcomed to the table. And we wound up with this very partisan legislation that was shoved down the throats of the American people.

So I appreciate this hearing. I think this is a part of a dialogue that we have had for some time with the American people, but also among ourselves. I respect that there are differences. But the fact that we are proceeding in a way with transparency to do better.

I happen to believe that our Nation's healthcare policy should be one that promotes the healing and the health of all Americans without hurting millions. And that's not what we have today.

And I also believe this debate should be conducted based on facts, not fear. So I really caution all my colleagues, and especially those across the aisle that I've heard just in the past few days, it's been about the fear, driving the fear. That doesn't help this process.

One of the things I heard was that we have no plans. And so I want to -- I'm going to be offering this, request unanimous consent for the record. But this is a submission for the record I have. This is a compilation of replacement plans or improvement plans or whatever you want to call it, plans for health care.

Just some of the titles on this first page: Patient Freedom Act, Obamacare Replacement Act, A Better Way: Our Vision for a Confident America. It's more of a vision. Patient Choice, Affordability, Responsibility and Empowerment Act. H.R. 5284, the World's Greatest Healthcare Plan Act. That was creative, I guess, in title. Empowering Patients First Act, which by the way, was a version of something that I had cosponsored back in 2009, before the *Affordable Care Act* came out of the back offices here in Washington, and that's been introduced in both the House and the Senate. And the American Health Care Reform Act, which actually the prime author of that is my good friend from Tennessee, Dr. Roe, that he referenced. That's page one of six.

So I request unanimous consent to present this, a list of detailed plans on how to reform the health sector for Members of Congress. Some of these are from Presidential candidates, some scholars and think tank community, and other top conservative thought leaders.

Chairwoman FOXX. Without objection.

[The information follows:]

Submission for the Record

House Committee on Education and the Workforce
“Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions.”
February 1, 2017

Submitted by: Glenn ‘GT’ Thompson, Member of Congress

Below is a list of detailed plans on how to reform the health sector from Members of Congress, presidential candidates, scholars in the think tank community, and other top conservative thought leaders.

Patient Freedom Act: Better Choices for Affordable Health Care

— **Sens. Bill Cassidy (R-LA) and Susan Collins (R-ME)**

Obamacare Replacement Act

— **Sen. Rand Paul (R-KY)**

A Better Way: Our Vision for a Confident America

— **Speaker Paul Ryan, the House of Representatives GOP**

Patient Choice, Affordability, Responsibility, and Empowerment Act

— **Sen. Richard Burr, Sen. Orrin Hatch, Rep. Fred Upton**

H.R. 5284 – World’s Greatest Healthcare Plan Act of 2016

— **Rep. Pete Sessions (R-TX), Sen. Bill Cassidy (R-LA)**

Empowering Patients First Act, H.R. 2300

— **Rep. Tom Price**

Empowering Patients First Act, H.R. 2300 (Companion to Rep. Price’s House bill)

— **Sen. John McCain, Sen. David Perdue**

The American Health Care Reform Act, H.R. 2653

— **Rep. Phil Roe, Republican Study Committee**

RSC Task Force Submission, H.R. 2653 Key Principles

— **Republican Study Committee**

Sen. Cassidy Maps a Plan to Overhaul Obamacare

— **Sen. Bill Cassidy**

The Anti-ObamaCare Recovery Plan

— **Sen. Ben Sasse**

2016 Presidential Candidates

Health Care: The Conservative Plan for 21st Century

— **Gov. Jeb Bush**

My Plan To Fix Health Care

— **Sen. Marco Rubio**

Prescription for Empowerment: We the People

— **Dr. Ben Carson**

A Conservative Approach to Better Health Care

— **Gov. John Kasich**

Healthcare Reform to Make America Great Again

— **Donald Trump**

Obamacare Is Failing. Here's What We Should Do

— **Carly Fiorina**

The Day One Patient Freedom Plan: My Plan to Repeal and Replace ObamaCare

— **Gov. Scott Walker**

The Freedom and Empowerment Plan

— **Gov. Bobby Jindal**

Analysis

First Look at the Republican Platform on Health Care

— **Joe Antos, American Enterprise Institute**

Untying the tax knots of the Bush Health Plan

— **Tom Miller, American Enterprise Institute**

On Health Care, Walker and Rubio Offer Obamacare Lite

— **Michael Cannon, Cato Institute**

Bernie Sanders' Single-Payer Health Care Plan Would Increase Federal Spending By At Least \$28 Trillion

— **Avik Roy, Manhattan Institute**

The “Blurred Lines” of Trump’s Health Plan (He Knows You Want It)

— **Thomas Miller, American Enterprise Institute**

Think Tank Community

Replacing ObamaCare with Consumer-Centered Health Reforms

— **Grace-Marie Turner, Conservative Reform Network**

Ideas for the New Administration: Four Urgent Health-Care Reforms

— **Paul Howard, Manhattan Institute**

The Fiscal Policy Context for a Conservative Reform Agenda

— **James C. Capretta, Conservative Reform Network**

Improving Health and Health Care: An Agenda for Reform

— **Antos, Capretta, Chen, et al., American Enterprise Institute**

[Here's How to Create a Better Health Policy Than Obamacare](#)

— **Sally Pipes, Pacific Research Institute**

[Transcending Obamacare](#)

— **Avik Roy, Manhattan Institute**

[Paving the Way to Full Repeal](#)

— **William Kristol and Jeffery H. Anderson, 2017 Project**

[Best of Both Worlds](#)

— **Bhattacharya, Chandra, et al., American Enterprise Institute**

[When Obamacare Fails](#)

— **Thomas Miller, American Enterprise Institute**

[How To Get A Health Care System That Answers To The Patient](#)

— **Grace-Marie Turner for The Heritage Foundation**

[Room to Grow, "Health-care reform to lower costs and improve access and quality"](#)

— **James C. Capretta, Young Guns Network, now Conservative Reform Network**

[Constructing an Alternative to Obamacare: Key Details for a Practical Replacement Program](#)

— **James C. Capretta, American Enterprise Institute**

[Memo for the Movement: Repeal and Replace](#)

— **Conservative Action Project**

[How to Replace ObamaCare](#)

— **James C. Capretta and Robert Moffit**

[Let States Exchange Obamacare For Something Better](#)

— **Doug Badger**

After Repeal of Obamacare: Moving to Patient-Centered, Market-Based Health Care

— **The Heritage Foundation**

The Critics Are Wrong About the Future of Free Market Health Care

— **Doug Holtz-Eakin and Avik Roy**

A Republican Alternative To ObamaCare

— **John C. Goodman, Goodman Institute**

Health Savings Accounts

— **John C. Goodman and Peter Ferrara, Duke Center for Health Policy & Inequalities Research**

Other

Tax Deductibility As A Regressive Federal Subsidy

— **Uwe Reinhardt, Health Affairs**

Are HSAs the Key to Making Obamacare Work?

— **Cyril Tuohy, Insurance News Net**

Companies Form New Alliance to Target Health-Care Costs

— **The Wall Street Journal (American Health Policy Institute)**

Why Section 1332 Could Solve the Obamacare Impasse

— **Stuart Butler, Brookings Institution**

Capping The Tax Exclusion Will Not Destroy Employer Health Insurance

— **Joe Antos**

Forget Insurance. These Delaware Docs Only Take Fees

— **The News Journal, Delaware Online**

Tithing for Healthcare

— **The Hill**

People could save a lot of money on health care—if only they knew how to use health savings accounts

— **Michael A. Fletcher, The Washington Post**

After King v. Burwell: Next Steps for the Affordable Care Act

— **Linda J. Blumberg and John Holahan, The Urban Institute**

Mr. THOMPSON. Thank you, Madam Chair. I really do appreciate that.

I have some questions. I have some concerns in terms of access. My observation is just because you have coverage doesn't mean you have access to health care. And I think that was the flaw of the *Affordable Care Act*. It focused on health insurance, not health. And I just look at premiums and -- I'm sorry, deductibles. I mean, we can look at it all differently. But the deductibles, which we really haven't talked about today.

It was reported to me about a constituent I have that was recently diagnosed with cancer, that because his deductibles are so high today, dramatically higher than what they were, grew faster than what they should have, he's made a conscious decision not to pursue care or treatment because when he looks at that annual deduction, at his age, he would really like to be able to pass something along to his children and grandchildren. That's an awful situation that we have put that individual in with these deductibles. And, again, you can have a card in your purse or your wallet that says you have coverage, but do you really have health?

So I like this debate we're having, and I look forward to it. And I've managed to use all of my time, but Dr. Troy, you mentioned innovation and flexibility in employer-sponsored benefits can help reduce the cost of health care for employees, retirees, and dependents. Can you give me just one example of that innovation?

Mr. TROY. Sure. So just one example, right now I have been working with a group of employers on something called the Health Transformation Alliance. This is a collection of over 30 employers who are working together, sharing data, looking at how to proceed based on actual facts and data -- we talked about that here in the panel -- in a way to improve the health of employees. And then they're going to go forward with a pharmaceutical initiative, a medical network initiative. And based on the data that they come together with, in order to get better results and better costs.

Mr. THOMPSON. Thank you, Chairwoman.

Chairwoman FOXX. The gentleman's time has expired.

And I recognize now, Mr. Mitchell, who's been very patient.

Mr. MITCHELL. Thank you, Madam Chair.

Actually the witnesses have been very patient, and we should commend you for your endurance if nothing else. Thank you for being here.

I am from Michigan. We have 15 counties that have one insurance carrier right now. Another 25 have only two. Eighty percent of the plans in Michigan are much narrower now in terms of providers than they were in 2007.

Dr. Troy, is there any mechanism within the ACA or any hope within ACA that situation will improve in Michigan, which is, in fact, a national phenomenon as well? Do you see anything coming out of ACA that could possibly fix that?

Mr. TROY. I don't see anything coming out of ACA that would fix that. I mean, ACA is kind of a static thing right now, and the conversation right now is not about putting something, a new mechanism into ACA that would lead to those improvements that you're seeking.

Mr. MITCHELL. I'm not sure we could identify a new mechanism which would cure that. But, yes, I don't see anything there either.

Before I joined this esteemed body, I was the CEO of a midsize company, not a small company, a little larger than yours. The impact, however, was similar in that year one, health insurance costs are going to go above 50 percent in year one, not quite 157 percent.

Question for the two employers in the group. How did you manage the cost increase within your price and your operating structure? How did you manage that cost? I doubt you were able to pass that on down the chain. How did you manage that?

Mr. EDDY. Again, the timing couldn't have been worse. As was stated, I've been with the company 21 years now, and I started as the new CEO, president and CEO, on January 1, 2009. I'd heard a lot about the potential for the *Affordable Care Act* coming. We saw our premiums, our deductibles, you know, the mandates, the costs. Again, I'm not sure how you manage without -- with uncertainty. I mean, you know, one of my sayings to my management group is, as we lose control, increase your options. Okay? And ACA took all of that away. So that really took one of my management philosophies away.

But when you're looking at annual increases in the mandates and the health care, the health insurance industry fees, you know, 3 percent per year of our premium costs increasing, 2.5 percent per year from the mandates changes. And these have continued. It's not a one-time increase. These are annual increases.

Mr. MITCHELL. Were you able to just pass those costs along, Mr. Eddy, to your consumers?

Mr. EDDY. We have not had the ability to increase our prices for the last five or six years because we haven't seen any GDP growth, so our company hasn't grown but maybe 2.5 to 3 percent on average. That's in revenues. Our profitability is down significantly. With the increase in the mandates and insurance and taxes and fees is one thing, but the others are the increases in premiums. It's taken away, as I said, I would like to have grown significantly more than we have. We have had the ability to increase our international markets, but we haven't been able to do that as fast as we would like to.

Mr. MITCHELL. Another question, Mr. Bollenbacher or Mr. Eddy. We talked a little bit briefly, a colleague talked about deductibles. We haven't talked about much of that here. I know I've seen the deductibles go wild for myself and the people close to me. What's been your experience in terms of deductible costs, the increases of the last several years?

Mr. BOLLENBACHER. The deductibles I'm seeing have increased from 5 to 8, up to 12,000 recently.

Mr. MITCHELL. In your opinion, I mean, you're close to your employees, does that adversely impact their willingness or ability to actually access care? I agree with my compatriots that health insurance doesn't mean you can access health care these days. What impact does it have on your employees?

Mr. BOLLENBACHER. It definitely does. It's a big hurt for them.

Mr. MITCHELL. Mr. Eddy, any feedback on that?

Mr. EDDY. Well, we're a little different. Again, we have a fully employer-funded HRA, the Health Reimbursement Accounts. So it's

a little different for our employees. We still cover 100 percent of the deductible.

Mr. MITCHELL. That's admirable and not commonplace, I don't think.

Mr. EDDY. Again, it's admirable, and it creates a lot of challenges, and we know it's not sustainable.

Mr. MITCHELL. Thank you.

And I'll yield back, Madam Chair. Thank you very much.

Chairwoman FOXX. Thank you very much.

Mr. Lewis, you're recognized for five minutes.

Mr. LEWIS. Thank you, Madam Chair. I'm so glad we're talking about employer-sponsored care today and the effects the ACA has. I do want to talk a little bit about the individual market that has been hit the hardest. If, in fact, you look at Minnesota, it's been hit the hardest. The State of Minnesota had to just do an emergency \$310 million subsidized premium plan. We'll call it that. So when we look at what repeal and replace might look like or repeal and repair or fix might look like, we know what the status quo looks like.

Before I came to Congress, I was a sole proprietor like many of your member businesses. I went through three insurers in 5 years. My premiums tripled to the point where we were paying \$2,200 a month for a \$10,000 deductible. A lot of folks here have said health insurance is not health care access, and that's certainly true. Has that been the experience of some of your members?

Mr. BOLLENBACHER. Yes, it has. And I would add that before the ACA most of my clients had insurance, if not all of them had insurance, and many of them have been dropped from their insurance and been forced to go in the marketplace.

Mr. LEWIS. Let's talk a little bit about the employer-sponsored market, because it hasn't just been the individual market. The 10 essential wellness benefits, the minimum amount of coverage that came down from the ACA so that you as business men and women had to buy this particular plan that the ACA dictated. Repealing some of those, Mr. Eddy, would that solve some of the problem, repealing some of those mandates?

Mr. EDDY. I believe that it would, Congressman, yes. Again, that is one of the options that we're looking to improve upon, having that as maybe another option that we can choose from.

Mr. LEWIS. You know, this committee and this Congress is dedicated to making certain no one slips through the cracks. We're going to have high-risk pools or some mechanism for people with preexisting conditions. But I want to get your take on portability and how that applies to people who have that very real problem of preexisting condition and can't get coverage.

When people get their insurance at work and they work 30 years or 25 years, and then they get a little older like me and a little sicker, and then they lose their job, they're thrown into that individual market, and now they're trying to buy insurance for the first time and telling the insurance industry, well, I'm going to have a lot of claims here, but I'm just starting my premiums. If we could unlock some of that tax advantage from the corporate side to the individual side, would it increase portability and solve some of that problem?

Dr. Troy, go ahead.

Mr. TROY. Yes, as I was saying in my testimony earlier, that some of the Republican plans call for something along the lines of association health plans, which would allow individuals to band together and purchase health care in a tax-preferred way in mechanisms other than just through their employer. That would include your civic organization, your religious organization, perhaps your union. And I think that would help unlock the job lock you're talking about and also provide possible additional portability.

Mr. LEWIS. Mr. Eddy.

Mr. EDDY. Obviously I think it's a good thing to be able to have portability supportive of the preexisting, you know, not having preexisting conditions. So, yeah, I think that would help tremendously.

Mr. LEWIS. And of course the best way for people to be able to afford health care is to have a good, robust, productive job. And to the degree that these sorts of regulations, including the ACA, have hindered the economy and hindered your ability and your members' ability to employ people, that has a real impact on health care access too, does it not?

Thank you all. I yield back my time.

Chairwoman FOXX. The gentleman yields back.

We were expecting Mr. Smucker, I believe. And there he is.

Mr. Smucker, you're recognized for five minutes.

Mr. SMUCKER. Thank you, Madam Chair.

I appreciate the testimonies from all of you. I can tell you businesses in my community, I've been out throughout the last year during a campaign talking to individuals and businesses, and then just recently during one of our weeks back in the district met with a few businesses, the *Affordable Care Act* and the impact on health insurance in their organizations and for their employees is top of the list in terms of their concerns about issues that will impact their ability to continue to do business as they have in the past.

They're very worried -- I'm thinking of one husband and wife who own a company, about 15 employees, who see their employees as a family, and then being able to help provide for their medical needs is an important part of sort of how they feel about their employees and the makeup of the company.

And so I'm glad that this is a top priority for us here, and I look forward to building a better healthcare system, working with everyone here to build a system that will work for everyone.

Dr. Troy, as you know, ERISA is the backbone of the employer-sponsored healthcare system that we're talking about. Since 1974, it has allowed multistate employers to offer uniform benefits to their employees across the Nation, reducing costs and allowing for innovation. ERISA's preemption of State laws is a key component in the law and one that you said needs to be strengthened. As we consider reforms to the healthcare system, how would you recommend the committee strengthen the ERISA preemption?

Mr. TROY. Thank you very much for that. A good question.

First of all, ERISA significantly reduces administrative costs by allowing multistate employers who self-insure to offer a uniform set of health benefits that are generally not subject to the 50 different State laws. So in terms of strengthening it going forward, we have been concerned about the increase in State fees and taxes on

self-insured health employer benefits in recent years. Some States have imposed fees on healthcare claims of self-insured employers, including Alaska, Kentucky, Maryland, Massachusetts, Rhode Island, Vermont.

So we're concerned about those kinds of taxes going forward, and we want to make sure that as we talk in the ACA repeal and reform effort about ways to use State flexibility, which I applaud, that we make sure that we still maintain the ability for employers to have better ERISA preemption.

Mr. SMUCKER. Thank you very much. I appreciate that.

And, again, I'm very much looking forward to working with my colleagues and this committee, with the chair, and with other Members of the assembly to rebuild an effective healthcare system where everyone can have access to the health care that they need at a price that they can afford and with the doctor that they choose.

Thank you.

Chairwoman FOXX. Do you yield back?

Mr. SMUCKER. I do.

Chairwoman FOXX. Thank you very much.

Well, even though I think I have the very best questions, I saved mine to the end so that if people want to be going other places, they can do that since I know I'm going to be here until the end. So I want to say again thank you to all of our witnesses for being here.

Mr. Bollenbacher, yours is a story we've heard over and over again. The healthcare coverage you had as a small business before ACA was working for your company and what your employees wanted. However, the ACA forced you out of that coverage -- several times, in fact, as you've described -- and added costs and burdens of lesser coverage.

Can you tell us what your employees liked about the previous coverage that you're not able to offer them today because of this failed law?

Mr. BOLLENBACHER. The plan we had before met their needs. It was affordable. They really liked the health savings account feature. Most of my employees are fairly young, fairly healthy, and they were able to put money away. As an employer, we put in up to \$3,000 per year to their accounts. Even when one lady had a baby, she had money in her has to help pay for that, so she had no money out of pocket.

Chairwoman FOXX. So it sounds as though what they liked is having control, more control over their healthcare dollars and their healthcare costs than is available to anyone under the ACA?

Mr. BOLLENBACHER. Yes, ma'am. That's correct.

Chairwoman FOXX. That's wonderful. Thank you.

Mr. Eddy, you mentioned in your testimony that one of the most challenging aspects of the ACA is the effect that it's had on your employee-employer relationship. Most employers fiercely protect that relationship and do not want to do anything to harm it. Can you talk about how the ACA forced this tension between you and your employees? Did your employees understand that it was the ACA and the Federal Government placing new requirements and

costs on the company that was forcing you to make difficult decisions?

Mr. EDDY. Of course I tried to educate our employees, but more specifically our United Steel Workers Union, that their best interests as always are our best interests and that we try to take care of them.

The tension obviously arose when we were trying to negotiate an increase -- or actually not an increase, but for the first time ever that they would have to copay a little bit. And with that, they know because I told them that it was ACA, but they look to us to take care of them. So from their standpoint, it was a company responsibility to take care of that.

We have had a situation where for years since I've been the CEO, I see every employee on the floor on their birthday, as well as many other days during the year, and they were impressed with that. But after the negotiations on our last contract and having to implement, and even with the staff rep agreeing to it, a little bit of copay, again, \$35 per pay, there were several folks that felt that we let them down. And explaining to them that the cost increases were not -- we couldn't sustain as a company, obviously the union agreed to it. But we also had to increase their pay rate over the life of the contract 4 years to help offset those costs. So it cost us, but, again, we were trying to incorporate more accountability for them.

Chairwoman FOXX. Thank you.

Dr. Troy, there were some comments made about other societies in the world these days who provide, quote, "free health care" to their citizens. And you mentioned Singapore being a rather homogenous society, much smaller than we are. We're often compared to Switzerland. I don't know the exact population of Switzerland, 7 million people or something; Canada, 35 million people. We have about 300 million people.

Is there any other similar culture to ours that provides free health care, quote, "free health care" to its citizens.

Mr. TROY. Look, we are a unique Nation. I am a proud believer in American exceptionalism, and I know that we are different. We have also tried to be more reliant on private sector health care and market. We are not completely there because it's a mixed system. So I think it is hard to compare our approach to different countries and say we should adopt, let's say, the British model or the Canada model. Even though we are close friends with those nations, we have different systems, and I don't think their systems would work if imported here.

Chairwoman FOXX. Thank you very much.

I would like to thank again our witnesses for taking the time to testify before the committee today. Other members have said to you thank you and that being here does make a difference, and I would like to say that to you also.

I would now like to recognize Ranking Member Scott for his closing remarks.

Mr. SCOTT. Thank you, Madam Chair, and thank you for having this hearing. It gives us an opportunity to flesh out many of the problems. This one witness said we all want less cost and more flexibility. We have a plan, the *Affordable Care Act*, where the costs

have gone up, but the studies have shown the costs have gone up at about one half the rate they've been going up before. People with preexisting conditions can get insurance at the standard rate. There are no lifetime or annual caps on coverage. Women aren't paying more than men. And instead of millions of people losing their insurance every year, 20 million more people have insurance than they did.

There are improvements we know we can make. We could insert a public option so in those States where the competition isn't what it should be, you would at least have an opportunity to buy the equivalent of a Medicare card. Or you can go to a single-payer plan, which would get the health care out of the employer costs. There are a lot of things we can do.

But we still have complaints about the present situation, but it's hard to debate when there is no credible alternative. One thing that is conspicuously omitted is, well, what could we do better? We have heard about the problems with small businesses. We didn't hear about the horror stories of small businesses if one of your employees happened to have diabetes or you had extremely high costs, you were unlikely to get affordable health care under the old days. Now you can get it at the standard rate.

But what is the alternative? We haven't heard that. We have seen some initiatives taken by this administration that have been counterproductive. We had an executive order right after the inauguration which essentially suggested a repeal of the *Affordable Care Act* without details, causing great concern and confusion in the insurance market. We have the executive order on immigration which, as many of the hospital associations have indicated, disrupts their ability to get students and professionals from other countries. We had the ads pulled at the last minute, making it more likely that the healthy, younger enrollees might not get the word and might not enroll. That just increases the costs for everybody.

So we have a lot of work to do. But until we have some credible alternatives, it's hard to have a coherent debate. I would just hope that we would agree that we're not going to do any repealing until we have a replace ready to go, and if that is the discussion, we have something to talk about. But if the idea is to repeal and inject total chaos in the insurance market, making it likely that nobody can buy insurance, we're not going to be very cooperative in that effort.

So, Madam Chair, thank you for having the hearing and allowing these issues to be voiced.

Chairwoman FOXX. Thank you, Mr. Scott.

I also am going to enter into the record some facts about our situation before the *Affordable Care Act* and during the *Affordable Care Act*, key facts on ObamaCare and health care. There have been so many numbers tossed about here. Your members, you've just said 20 million more people have gotten health insurance, but your Members have thrown around the number 30 million are going to lose their insurance. So it's a little difficult to keep track of all of these numbers that are being thrown around. But I do intend to put a fact sheet into the record today.

[The information follows:]

Key Facts on Obamacare
1/23/2017

- **25% average increase in premiums** this year for the millions of Americans trapped in Obamacare HealthCare.gov exchanges (Source: [HHS](#))
- **Nearly 1/3 of US counties have only 1 insurer** offering exchange plans (Source: [Kaiser Family Foundation](#))
- **4.7 million Americans** kicked off their health care plans by Obamacare (Source: [Associated Press](#))
- **\$1 trillion in new taxes**, mostly falling on families and job creators (Source: [Senate Budget and Finance Committees](#))
- **18 Failed Obamacare Co-Ops out of 23**, which were established as an alternative to the public option, have collapsed, costing taxpayers nearly \$1.9 billion and forcing patients to find new insurance. (Source: [House Energy and Commerce Committee](#))
- **\$53 billion in new regulations** requiring more than **176,800,000** hours of paperwork (Source: [American Action Forum](#))

Chairwoman FOXX. Forty-eight million Americans did not have health care before the *Affordable Care Act*. I happen to have the numbers on that, and I'll be entering that into the record. I think I just heard you say again that there are no credible alternatives, and yet Mr. Thompson just sat here five minutes ago and presented six pages of bills that have been presented as credible alternatives. So I think we have to constantly do fact-checking around here to give the real facts about what's happening.

Ms. Schlaack, I want to say, along with my colleagues, that we're sorry for your loss. But I was very intrigued in your comments that all of the examples you used about the great coverage that you got came under your employer-sponsored health care as a result of your husband's terrible illness and not as a result of the ACA, and yet it was implied that the coverage that you got came under the ACA. So we all want to share our concern and support for you in your loss. But I noted that in your written testimony, as well as in your spoken testimony.

So I do think that the hearing today has been helpful and I think has brought out a lot of good information about the negative impact of the ACA, particularly on working people in this country. That's where I think the real problem has been. And I would like to thank you all for coming again and tell you that we look forward to working with you on an alternative to this.

And with that I --

Mr. SCOTT. Madam Chair, may I make a brief comment, just very brief, because I think Ms. Schlaack's comment was she had employer-based coverage as well, but her husband died.

Ms. FOXX. Right.

Mr. SCOTT. She lost the employer, but had the marketplace as the safety net.

Chairwoman FOXX. Thank you very much for that clarification, Mr. Scott.

There being no further business, the committee stands adjourned.

[Additional submissions by Mrs. Foxx follow:]

Breaking Down the Uninsured

Uninsured ¹	45.7m
Non-Citizens ²	-9.5m
Eligible for Public Programs ³	-12m
Higher Income (+\$84,108/yr) ⁴	-7.3m
Only Temporarily Uninsured ⁵	-9.1m
American citizens, lower income, long-term uninsured	7.8m

Sources

¹ U.S. Census Bureau Current Population Survey

² Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007, Congressional Research Service

³ National Institute for Health Care Management Foundation analysis of data from the March 2007 Current Population Survey

⁴ National Institute for Health Care Management Foundation analysis of data from the March 2007 Current Population Survey

⁵ 1999 and 2002 National Survey of America's Families (nonelderly population)

[Additional submission by Mr. Scott follows:]

Press Release

Statement on President Trump's Executive Order on Immigration

Rick Pollack

President and CEO

American Hospital Association

A strong health care workforce is critical to ensuring patient access to high-quality care. However, we are concerned that, without modification, President Trump's executive order on immigration could adversely impact patient care, education and research.

We are hopeful that the Administration will find solutions to preserve patient access to medical and nursing expertise from across the globe, ensuring care is not disrupted.

Hospitals and the patients we serve often rely on international collaboration among clinicians to advance care, and an efficient visa program is essential to their success. We rely on a diverse workforce to deliver the care patients and families need. We will work with the Administration to come to a solution that patients can continue to rely on for their care.

About the AHA

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

[Questions submitted for the record and their responses follow:]

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April 28, 2017

Mr. Scott Bollenbacher, CPA
 Managing Partner
 Bollenbacher & Associates, LLC
 915 North Meridian Street
 PO Box 702
 Portland, IN 47371

Dear Mr. Bollenbacher:

Thank you, again, for testifying at the Committee on Education and the Workforce hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide written responses no later than May 12, 2017, for inclusion in the official hearing record. Responses should be sent to Callie Harman of the Committee staff, who can be contacted at (202) 225-7101.

We appreciate your continued contribution to the work of the Committee.

Sincerely,

Virginia Foxx
 Chairwoman

Enclosure

CC: The Honorable Robert C. "Bobby" Scott, Ranking Member, Committee on Education and the Workforce Committee

Rep. Barletta (PA)

1. Mr. Bollenbacher, you know as well as anyone that President Obama's health care law is a law that was built on false promises. Many Americans are now paying more for less.

As a former small business owner, I know that employers want to offer their workers competitive benefits. It's how you keep good employees. I've heard from a constituent – a farmer – who is also of this mindset. He values his employees and their hard work, and respects their contributions by paying for their healthcare premiums himself. This was, of course, before 2013. After passage of the legislation, the Obama Administration issued guidance preventing him from doing so directly. Instead, he must augment their salaries. As a result, they are subject to payroll tax on the supplement. He is effectively being punished for doing what is right for his employees.

This is a theme that has pervaded our government for the past eight years. Time and again, we have seen federal bureaucrats implement flawed policies that ignore the reality that small employers across the country are doing the right thing, and have been for years. Again, employers know: it's how you keep good employees.

Fortunately, the House and Senate passed the 21st Century Cures Act last year, which has since been signed into law. Included in the measure is a provision that allows small employers to offer a tax-preferred qualified health reimbursement arrangement, or HRA, to cover premiums. This is a good first step, but, we must work harder to make it easier and less costly for individuals like my constituent to provide the benefits that their employees deserve.

What other recommendations would you suggest as we work toward this goal?

Rep. Stefanik (NY)

1. Mr. Bollenbacher, like many of your employees who cross state lines from home to work and back, many of my constituents live in New York, work in Vermont and cross the state line each day. It's important to me that individuals have the flexibility to purchase the coverage that they need and want, whether in New York, Vermont, Indiana or even Ohio.

Has the lack of health plans that meet your employees' unique needs negatively affected the ability of your business to compete on the job market?

Can you elaborate on the difficulties you have faced trying to find a plan that covers your employees that live and work in two different states?



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CAROL SHEA-PORTER, NEW HAMPSHIRE
ADRIANO ESPALLAT, NEW YORK

April 28, 2017

Mr. Joseph Eddy
President & CEO
Eagle Manufacturing Company
2400 Charles Street
Wellsburg, WV 26070

Dear Mr. Eddy:

Thank you, again, for testifying at the Committee on Education and the Workforce hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions."

Please find enclosed an additional question submitted by a Committee member following the hearing. Please provide written responses no later than May 12, 2017, for inclusion in the official hearing record. Responses should be sent to Callie Harman of the Committee staff, who can be contacted at (202) 225-7101.

We appreciate your continued contribution to the work of the Committee.

Sincerely,

Virginia Foxx

Virginia Foxx
Chairwoman

Enclosure

CC: The Honorable Robert C. "Bobby" Scott, Ranking Member, Committee on Education and the Workforce

Rep. Stefanik (NY)

1. Mr. Eddy, in your testimony you mentioned how expensive and onerous the ACA has been for a small business owner like yourself. My family has owned a small wood products business for many years and always prided itself on providing a robust and generous benefits package to our employees until it was cancelled in 2013 because of the ACA and the business had to get a more expensive plan that covered less. Unfortunately, the ACA led us to cancel that coverage/that coverage was cancelled due to the ACA for the first time in our history.

Can you tell me how the ACA has affected your ability to provide coverage for your employees?

How has this law has affected your ability to attract and retain highly-skilled employees for your business?

[Responses to questions submitted for the record follow:]

 **Bollenbacher & Associates, LLC**
 Certified Public Accountants

SCOTT BOLLENBACHER ANSWER FOR REPRESENTATIVE BARLETTA'S QUESTION FOR THE RECORD:

Small employers did routinely utilize direct payment or reimbursement arrangements to help employees purchase individual market coverage. NFIB Research Foundation estimated 16 percent of small businesses utilized a reimbursement arrangement to help employees purchase health insurance on their own in 2015, which was after the prohibition date took effect. Many employers were unaware of the prohibition. In my experience, churches utilized these arrangements to assist with pastors' health insurance premiums. The arrangement worked well for both the pastors and the churches.

To improve these arrangements, I recommend lifting or removing the \$4,950 individual/\$10,000 family contribution caps because premiums are more expensive than these cap thresholds. Congress or the Administration could also allow for a limited Special Enrollment Period (SEP) for Health Reimbursement Arrangements (HRAs). A special SEP would be helpful because the 21st Century Cures Act was enacted (12/13/16) so close to the open enrollment deadline (01/31/17) that few small businesses knew about the restoration of the arrangements and eliminations of the penalties. Treasury and IRS did not issue any regulations or guidance before the open enrollment deadline.

SCOTT BOLLENBACHER ANSWER TO REPRESENTATIVE STEFANIK'S QUESTION FOR THE RECORD:

We treat our employees like family and do our best to work out for their needs, but finding a policy that is accepted on both sides of the border does add another variable that other firms may not need to consider. We must find a policy that is accepted by doctors and hospitals on both sides of the state line. This broader network requirement eliminates certain plans from consideration by our firm, but we shopped around to different insurance agents see whether multiple options existed.

After we lost our insurance in the fall of 2016, I contacted three agents to provide quotes. They all came back with the same policy and the only differences were their commissions. So, basically, we had only one choice. I feel it would be so much more beneficial to both employees and companies if they had more than once choice.



915 N. Meridian Street • P.O. Box 702 • Portland, IN 47371
 Phone: 260.726.4207 • Toll Free: 888.492.2445 • Fax: 260.726.4678 • www.balle-cpa.com



May 31, 2017

The Honorable Virginia Foxx, Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515-6100

RE: Response to Representative Elise Stefanik

Dear Chairwoman Foxx:

Thank you for the invitation to testify before your Committee on Education and the Workforce at the hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions." I am responding to additional questions as submitted by your Committee member Representative Elise Stefanik (NY), as follows:

Can you tell me how the ACA has affected your ability to provide coverage for your employees? And, how has this law affected your ability to attract and retain highly-skilled employees for your business? (Rep. Elise Stefanik)

At Eagle, we are proud of our long-standing tradition of covering 100% of medical costs for our employees, not because of government mandates or policies, but because it is the right thing to do for our employees and our community. Unfortunately, the past few years under the ACA have made this prior commitment financially impossible to continue at the present time. The ACA, with its taxes, fees and regulatory requirements, now costs our company an additional \$1,000 annually per employee. In addition, the ACA has significantly increased our annual healthcare costs from \$13,500 per employee in 2009 (before the ACA), to over \$26,500 per employee for 2017.

With nearly 200 employees, this additional cost and rate of increase is neither affordable nor sustainable, and adversely affects our company's financial status to a serious degree. In order to continue to cover our employees, for the first time in the company's history we were forced to seek concessions from our union and salaried employees for a co-payment of a small percentage of their healthcare costs (\$40/pay for union and \$75/pay for salaried personnel). As small an amount of co-pay as this appears, it still has acted to negatively impact the trust and partnership between the company and our employees.

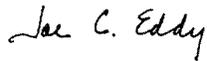
Like most other manufacturers, our number one business concern is the dramatic increase in healthcare costs, which clearly is a factor concerning decisions on hiring new workers, retirements, maintaining competitive pay rates, and expenditures for capital investments for new machinery and new product tooling. As a further result of these major cost increases, the ACA has limited our competitive carrier options, and has reduced our flexibility in plan designs. Overall, the ACA has been a costly, disruptive and distracting legislative program which severely hampers our company from accomplishing the things relating to our manufacturing industry.

Page 2

Because our company continues to have one of the best healthcare programs for employees in the area, we do not have much difficulty attracting and retaining highly-skilled employees. However, this comes at a great cost to the company, and as noted above, is no longer something that we can sustain even on a short-term basis. Therefore, as we are forced to increase co-pays, reduce quality of coverage, and limit our employee's healthcare options in the future, we expect that our ability to attract and retain quality employees will ultimately become much more of a business concern. Obviously, having a healthcare program that attracts potential highly-skilled employees will continue to create significant challenges.

I trust that the above perspective helps to address the specific issues raised by Representative Stefanik. Please thank her for her important and relevant follow-up questions. Again, I appreciate the opportunity to present the concerns of not only Eagle Manufacturing Company, but also manufacturers throughout our state and country with regard to the negative impact of the ACA.

All the best,



Joseph C. Eddy
President/Chief Executive Officer

[Whereupon, at 1:01 p.m., the committee was adjourned.]

