THE PRESSURES OF RISING COSTS ON EMPLOYER PROVIDED HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION
AND THE WORKFORCE

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C O N T E N T S

THE PRESSURES OF RISING COSTS ON EMPLOYER PROVIDED HEALTH CARE

Thursday, March 10, 2011
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and the Workforce
Washington, DC

The committee met, pursuant to call, at 10:05 a.m., in room 2175, Rayburn House Office Building, Hon. Phil Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, Kline, DesJarlais, Hanna, Bucshon, Barletta, Roby, Heck, Kucinich, Kildee, Hinojosa, Tierney, and Wu.

Staff present: Katherine Bathgate, Press Assistant; Kirk Boyle, General Counsel; Casey Buboltz, Coalitions and Member Services Coordinator; Ed Gilroy, Director of Workforce Policy; Barrett Karr, Staff Director; Ryan Kearney, Legislative Assistant; Brian Newell, Press Secretary; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Ken Serafin, Workforce Policy Counsel; Linda Stevens, Chief Clerk/Assistant to the General Counsel; Alissa Strawcutter, Deputy Clerk; Aaron Albright, Minority Deputy Communications Director; Daniel Brown, Minority Staff Assistant; Jerrica Mathis, Minority Legislative Fellow; Megan O'Reilly, Minority General Counsel; Meredith Regine, Minority Labor Policy Associate; and Michele Varnhagen, Minority Chief Policy Advisor and Labor Policy Director.

Chairman ROE [presiding]. Good morning, everyone. I want to thank our witnesses for being with us today, and for sharing their thoughts and experience on this very important subject.

The steady rise in cost is a critical challenge facing our nation's health care system. For many patients, the price of health care is the determining factor when deciding whether to receive the care he or she needs. It also imposes a tremendous burden on taxpayers, as government health services become more and more expensive.

As a parent, a physician and elected official, hardly a day goes by when I am not reminded of this difficult reality. Yesterday was no exception. Employers, however, understand better than most the tough choices workers and their families face as health care costs go up year after year.

In 1974, the Employee Retirement and Income Security Act, commonly known as ERISA, became law. It provides the rules of the road for benefit plans offered by employers, including employer-pro-

vided health care. Employer-provided health care is now as common to employee compensation as wages, paid vacation and sick leave.

Roughly 170 million individuals receive health insurance through an employer-provided health care plan. It has become central to our nation's health care system. While not perfect, it has served employers and employees well for nearly 40 years. Any changes to the nation's health care system will affect the lives of millions of employers, workers and their families.

That is why the challenge of rising costs is a pressing national concern. An aging workforce, more advanced therapies, higher utilization, liability and fewer providers are just some of the factors contributing to the increases.

As policymakers, we have a responsibility to understand the underlying causes of these factors and to consider common-sense solutions that ultimately reduce expenses for workers and their families.

President Obama understood this responsibility when, as a candidate for the presidency, he outlined a plan he promised would reduce costs or the families and businesses. Without providing specific details for businesses, then-Senator Obama promised his health care plan would lower premiums by as much as $2,500 per family. As president, Mr. Obama claimed that under his plan, "if you like your current health care, you can keep it."

Unfortunately, now, we know these assertions to be untrue. Along the path to health care reform, the president and his Democratic allies are banning any effort to reduce costs, and instead focused on expanding access through the creation of a new government entitlement program; a program that will surely change how workers receive their health care, regardless of whether they like it or not.

This has left this issue of rising costs unresolved as the need for meaningful reform grows more urgent.

There are a number of provisions in the recent health care law that not only fail to address rising costs, but actually exacerbate the problems facing employers and their workers. For the first time in our nation's history, we have a mandate requiring certain employers provide government-approved insurance, or pay a fine.

However, providing government-approved health care will grow more and more expensive, as benefit plans begin to comply with a number of additional mandates and requirements controlled by Washington bureaucrats. Existing employer plans were supposed to be grandfathered from the new law's requirements. But we have since learned this will not be the case for up to 69 percent of the plans, including up to 80 percent of smaller plans.

We all want to see individuals with pre-existing conditions get the care they need and young adults receive extended help from their parents, if they so desire.

But a sea of government mandates will not lead to lower costs and better health care. A number of independent health care researchers have examined the issue and determined costs will continue to increase at a rapid pace, due in part to Obamacare.

That is why we are here today. We must examine these and other driving forces behind rising health care costs, their effects on

employers and workers, and begin to consider responsible solutions that address the needs of the nation.

I would now recognize my colleague and friend from Ohio, Mr. Kucinich, the senior Democratic member of the subcommittee here today, for his opening remarks.

[The statement of Dr. Roe follows:]

Prepared Statement of Hon. David P. Roe, Chairman, Subcommittee on Health, Employment, Labor and Pensions

Good morning everyone. I want to thank our witnesses for being with us today and for sharing their thoughts and experience on this important subject.

The steady rise in cost is a critical challenge facing our nation's health care system. For many patients, the price of health care is the determining factor when deciding whether to receive the care he or she needs. It also imposes a tremendous burden on taxpayers, as government health services become more and more expensive. As a parent, physician, and elected official, hardly a day goes by when I am not reminded of this difficult reality.

Employers, however, understand better than most the tough choices workers and their families face as health care costs go up year after year. In 1974, the Employee Retirement and Income Security Act, commonly referred to as ERISA, became law. It provides the rules of the road for benefit plans offered by employers, including employer-provided health care. Employer-provided health care is now as common to employee compensation as wages, paid vacation, and sick leave.

Roughly 170 million individuals receive health insurance through an employer-provided health care plan. It has become central to our nation's health care system. While not perfect, it has served employers and employees well for nearly forty years. Any changes to the nation's health care system will affect the lives of millions of employers, workers, and families.

That is why the challenge of rising costs is a pressing national concern. An aging workforce, more advanced therapies, higher utilization of services, and fewer providers are just some of the factors contributing to the increases. As policy makers, we have a responsibility to understand the underlying causes of these factors and to consider commonsense solutions that ultimately reduce expenses for workers and their families.

President Obama understood this responsibility when, as a candidate for the presidency, he outlined a plan he promised would "reduce costs for families and businesses." Without providing specific details for businesses, then-Senator Obama promised his health care plan would "lower premiums by as much as $2,500 per family." As President, Mr. Obama claimed that, under his plan, "if you like your current health care, you can keep it."

Unfortunately, we now know these assertions to be untrue. Along the path to health care reform, the president and his Democrat allies abandoned any effort to reduce costs and instead focused on expanding access through the creation of a new government entitlement program; a program that will surely change how workers receive their health care, regardless of whether they like it or not. This has left this issue of rising costs unresolved as the need for meaningful reform grows more urgent.

There are a number of provisions in the recent health care law that not only fail to address rising costs, but actually exacerbate the problems facing employers and their workers. For the first time in our nation's history, we have a mandate requiring certain employers provide government-approved insurance or pay a fine.

However, providing government-approved health care will grow more and more expensive as benefit plans begin to comply with a number of additional mandates and requirements controlled by Washington bureaucrats. Existing employer plans were supposed to be "grandfathered" from the new law's requirements, but we've since learned this will not be the case for up to 69 percent of plans, including up to 80 percent of smaller plans.

We all want to see individuals with pre-existing conditions get the care they need and young adults receive extended help from their parents if they so desire. But a sea of government mandates will not lead to lower costs and better health care. A number of independent health care researchers have examined the issue and determined costs will continue to increase at a rapid pace due in part to ObamaCare.

That is why we are here today. We must examine these and other driving forces behind rising health care costs, their affects on employers and workers, and begin to consider responsible solutions that address the needs of the nation.

I would like to now yield to Mr. Andrews, the ranking member, for his opening remarks.

Mr. KUCINICH. I want to thank my friend, Chairman Roe, for calling this hearing. I would also like to thank our distinguished panel of witnesses for appearing.

It has been nearly 1 year since the Affordable Care Act became law, and already, millions of Americans are realizing its benefits. The new health care law comes at a time when both employers and families are struggling to keep up with skyrocketing increases in their health care costs.

Over the last decade, family premiums more than doubled in the employer-based health insurance market. We know that without reform, the problem of rising health care costs will just get worse.

The Commonwealth Fund estimates that, absent health reform, the average family premium will nearly double again by 2020, to almost $24,000. These increases are unsustainable, and this country could not afford the status quo any longer. Higher health care costs means employers have less to reinvest in their business, and families have a harder time making ends meet.

While the Affordable Care Act is not a perfect law—and I know that, because I was involved principally in challenging it—it dramatically expands access to affordable, quality health care. It takes critical first steps in reining in the abuses of an insurance industry that so far has gone unchecked.

It will provide small employers with the same purchasing power as large employers and will give them tax credits to help them cover their workers.

It also extends flexibility to the states, should they want to pursue an alternative to the federal health law, as long as it provides at least the same protections and access to health care as is afforded under the ACA.

It is unconscionable that we have allowed the insurance industry in this country to pad its pockets at the expense of hard-working Americans by charging more but spending less on benefits. In 2010, the top five insurance companies—UnitedHealth, WellPoint, Aetna, Humana and Cigna—saw record profits, $11.7 billion.

While 43 states already had some kind of premium rate review process before the ACA, the law gives states the ability to enhance or create a rate review process to go after unjustified rate increases. It also ensures that these rate increases and the justification for them are publicly available.

The Affordable Care Act further protects against insurance company abuses by requiring them to spend more on benefits and less on profits and CEO pay. The law's medical loss ratio requirements require insurance companies spend 80 to 85 percent of premium dollars on medical care and health quality. This provision alone will provide up to $1.2 billion in rebates starting in 2012.

The law's benefits for employers are already being realized, even before the law is fully implemented. More than 5,000 employers are taking part in the law's retiree reinsurance program, which has reimbursed more than $535 million in health care benefits, benefiting more than 4.5 million Americans.

Four million small businesses are eligible for the small business tax credit, and many are seeing real savings this year. As a result, more are offering health care. The number of small employers with three to nine workers offering health insurance has risen from 46 to 59 percent.

After starting in 2014, small employers will be able to pull together to provide more health care choices to employees at lower cost.

Employers will also benefit from the law's Patient's Bill of Rights. A healthier workplace is a more profitable and more productive one.

If these new protections were taken away, it is clear that employers, especially small employers, will be worse off. Helen Darling, president of the National Business Group on Health, which includes almost 300 large employers, has said, "If the law gets repealed or gutted, we will have to start over, and we will be worse off."

The Congressional Budget Office states that repealing the law will slightly increase employer-sponsored premiums.

Ultimately, we need to remove the source of our health care problems: the health insurance companies. They are the reason that one out of every $3 spent on health care goes to something other than providing care.

I believe the demise of the for-profit health insurance industry is inevitable. Until then, Mr. Chairman, the American people who are trying to survive this recession need our help. And the Affordable Care Act provides Americans relief from the burden of health insurance companies.

I look forward to today's hearing. I yield back the balance of my time.

I just want to say, Mr. Chairman, we have votes going on in Government Oversight right around the corner. I may have to duck out for a moment here and there. But otherwise, I will be here with you.

Chairman ROE. I thank the gentleman for yielding.

Pursuant to committee rule 7c, all members will be permitted to submit written statements to be included in the permanent hearing record.

And without objection, the hearing record will remain open for 14 days to allow questions for the record. Statements and extraneous material referenced during the hearing will be submitted for the official hearing record.

It is my pleasure to introduce our panel.

I know, Mr. Miller, you are probably a wreck in the Washington traffic, but thank you for being here.

Mr. Thomas Miller is a resident fellow for the American Enterprise Institute, where he focuses on health care policy, with a particular emphasis on such issues as information, transparency, health insurance regulation and consumer-driven health care.

He was a member of the National Advisory Council for the Agency of Health Care Research and Quality from 2007 to 2009. Prior to his work at AEI, Mr. Miller was a senior health economist for the Joint Economic Committee, where he organized a series of hearings on promising reforms in private health markets. Mr. Mil-

ler holds a bachelor's degree in political science from New York University and a law degree from Duke University.

Mr. Brett Parker is vice chairman and chief financial officer for Bowlmor Lanes. Bowlmor Lanes, as it is known today, was started in 1997, and operates bowling alleys in six locations in four states including New York, Maryland and Florida, and California. Bowlmor Lanes has grown from 50 to more than 500 employees—and congratulations for that—in the last 10 years, with more than 100 hired within the last year alone.

Mr. Parker is testifying today on behalf of the U.S. Chamber of Commerce.

I will now yield to the gentleman from Oregon, Mr. Wu, to introduce Mr. Jim Houser.

Mr. WU. Thank you, Mr. Chairman.

Mr. Jim Houser is co-owner of Hawthorne Auto Clinic, a AAA-approved auto repair facility located in Portland, Oregon. Hawthorne Auto Clinic has been the recipient of a number of awards, including the Blue Seal of Excellence Award from the National Institute for Automotive Service Excellence; the Best Practices for Sustainability Award from the City of Portland; and the Small Business of the Year Award in both 1996 and 2007, from the Better Business Bureau.

Mr. Houser is testifying on behalf of the Main Street Alliance, a national network of state-based small business coalitions. I have had the pleasure of meeting with Main Street Alliance members at home and welcome Mr. Houser to Washington and this committee.

Thank you, Mr. Chairman.

Chairman ROE. Thank you, Mr. Wu.

And also, thank you, Mr. Houser, for being here.

Our final witness is Mr. Michael Brewer, the president of Lockton Benefit Group located in Kansas City, Missouri. Lockton Benefit Group provides national employee benefits consulting services to about 2,500 companies nationwide in a broad range of industries.

Lockton Benefit Group is part of Lockton Companies, LLC, which provides global risk management, insurance and employee benefit services. Lockton is the world's largest privately owned, independent insurance brokerage firm, and it has more than 3,800 associates worldwide.

Before we start the testimony, let me explain the light system. Basically, you have 5 minutes, the yellow light with the green light. The yellow light means you have a minute, and the red light means that probably I will start tapping to end your testimony.

So with that, Mr. Miller, would you begin?

STATEMENT OF TOM MILLER, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

Mr. MILLER. Thank you very much, Chairman Roe, Representative Kucinich, members of the subcommittee, for this opportunity to speak on the pressures of rising costs on employer-provided health care.

We should be more concerned about what is likely to unfold as we approach 2014 and the immediate years afterward than the

most recent ups and downs of the limited dosage effects of the Affordable Care Act's initial year of implementation.

It has not provided much short-term help, but it still threatens to do more harm later. Partly because the ACA actually has provided very little in tangible first-year benefits, it also has imposed only modest immediate costs and complications on most employers.

Although the health sector appears to exhibit a longstanding ability to grow faster than the rest of the economy, the substantial effects of a deep recession within the last 3 years certainly slowed the absolute dollar growth of health spending and some health care utilization, if not its relative share of a troubled economy.

We often forget that national health spending has grown at a slower rate in every year from 2000 to 2009. However, we can neither afford, nor should we expect, to rely on a prolonged recession or sluggish economy to keep slowing down that rate.

There remains a substantial list of theories and explanations for this persistent excess growth of health spending and health insurance costs, but the most predictable common element behind many of the more politically effective ones is that it is always someone else's fault.

The unpredictability of what will be enforced under the regulatory domain authorized under the ACA, and how its complex and often inconsistent provisions will be interpreted, leaves many employers frozen in uncertainty in their health benefits planning. Leading examples include the narrowed range of grandfathering protection for previous employer health plans and future definitions of details to be unveiled later for central benefits and state health benefits exchanges.

In isolation, a few of the initial burdens for employers are likely to determine decisively whether most of them continue to offer health insurance. But over time, they amount to a steady drip-by-drip, political form of water torture that can eventually reach critical mass and push a much larger share of employers to reconsider their continued involvement in offering health coverage.

The structure of future penalties for noncompliance with employer coverage mandates will send out additional economic disincentive signals that tell different categories of business owners to grow slower, hire fewer, pay less and restructure their firms.

More ominously, the tilted playing field beginning in 2014 for future tax subsidies for workers at the same income level, depending on whether they are inside employer health plans or purchasing outside coverage in any benefits exchanges that actually come into existence by then, appears far from politically sustainable.

If and when the highly flammable legislative firewalls constructed to separate these two health insurance domains begin to break down, the federal budgetary implications of an employer coverage meltdown alone would be explosively unaffordable. And the future of market-based forms of private insurance would be in even greater jeopardy.

We still have time to pull back before testing the temperature of the water for the lead group of health policy lemmings nearing the edge of this cliff.

A short list of changes in direction would include a much stronger focus on responsible choice in competition in health care mar-

kets; more neutral, limited and transparent taxpayer subsidies for health spending by most Americans, but more targeted special protection for the most vulnerable and highest-risk portions of the populations; real steps toward meaningful information transparency; and realignment of incentives to reward better health care choices and higher-value health care delivery.

The last round of purported health care reform overloaded the operational circuits of our political system, overfed its appetite for more private resources and offended longstanding cultural norms. Rebalancing the mix necessarily must begin with repeal of many core components of the ACA, but it cannot end short of equally difficult but necessary and more sustainable reforms enacted to replace them.

Thank you.

[The statement of Mr. Miller follows:]

Prepared Statement of Thomas P. Miller, J.D., Resident Fellow, American Enterprise Institute

Thank you Chairman Roe, Ranking member Andrews, and members of the Subcommittee for the opportunity to speak this morning on the pressures of rising costs on employer-provided health care.

I am speaking today as a health policy researcher, a resident fellow at the American Enterprise Institute and co-author of the forthcoming book, "Why ObamaCare Is Wrong for America (to be published later this month). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based think tanks.

The subject of this hearing is not a new one, although the economic and policy context in which we examine it has changed and will continue to do so in the years and decades ahead. The two most significant factors are the recent deep recession—from which both the overall economy and its health sector are slowly recovering—and the passage and early implementation of the Patient Protection and Affordable Care Act (referred to hereafter as "ACA")—from which they may not, without a substantial change in direction.

Roughly 170 million Americans received private health insurance through the workplace in 2009,[1] and the vast majority of those workers and their families, despite periodic complaints, value it very much. However, our largely employer-based system of private health coverage does not work well for everyone—most notably those workers who lose their jobs. Or who cannot find either new or initial work. Or who cannot afford their share of expensive and rising premiums. Or who need a better balance between lagging wages and rising health benefits costs. Or whose employer simply cannot afford to offer insurance. Millions of people need better options to get more stable and affordable health insurance.

As director of AEI's "Beyond 'Repeal and Replace:' Ideas for Real Health Reform" project, I would be happy to discuss in greater depth a number of better solutions to the continuing chronic conditions of high costs, inconsistent quality, gaps in access, and misaligned incentives throughout our health care economy. However, the primary focus of my testimony today is, first, to place employer health care cost challenges and assertions about them in perspective. I then will examine the likely effects of the ACA on the future "health" of employer-sponsored health insurance, and very briefly conclude with some suggested policy alternatives.

In brief, we should be more concerned about what is likely to unfold as we approach 2014 and the immediate years afterward than the most recent headlines of the limited-dosage effects of the ACA's initial year of implementation. It has not provided much short-term help, but still threatens to do more harm later. A number of blame-shifting assertions, statistical mirages, overstatements, and simplistic pet theories should not distract us from the more complex and daunting task of both

[1] As calculated under Current Population Survey methods by the Census Bureau last year. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 3009, Current Population Reports, P60-238 (Washington, D.C.: U.S. Government Printing Office, 2010), table C-1.

rethinking the path that the previous Congress took in the ACA and pursuing more robust and realistic routes to sustainable, higher-value health care.

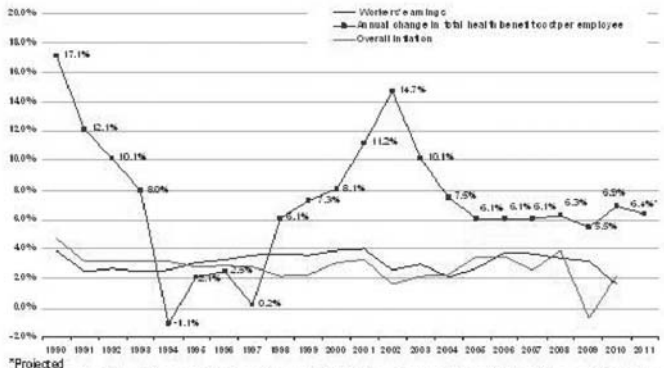
Putting Health Spending Trends in Perspective

Let's start with a reminder of the health spending context when the ACA was first proposed, debated, and enacted. From calendar year 2007 to 2008, overall national health spending (as measured by the "National Health Expenditure" accounts compiled annually by the Centers for Medicare and Medicaid Services) increased only 4.7 percent. That was the smallest percentage annual increase in the nearly 50 year history of that measure. And then national health spending rose only 4 percent more, in 2009.

As for the more narrow measure of the employer cost per employee of employer-sponsored health benefits, the most consistently accurate one over time—Mercer's National Survey of Employer-Sponsored Plans—indicates that those costs remained in a steady pattern of roughly 6 percent annual increases in the five years from 2005 through 2009, even though the underlying health care cost trend was running about 9 percent a year. However, those employer health benefits costs increased 6.9 percent in 2010. Even though the employers surveyed last year expected the health care costs they would face in 2011 to rise another 10 percent, they also planned to make changes in their health plan benefit designs and vendors in order to bring their actual employer benefits cost increases down to 6.4 percent (see Figure 1).

FIGURE 1

Total health benefit cost per employee rises 6.9% in 2010, the sharpest increase since 2004



*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2010.

The Mercer survey includes public and private employers with 10 or more employees. Another longstanding national employer health benefits survey by the Kaiser Family Foundation and the Health Research & Educational Trust (KFF/HRET) examines trends among nonfederal private and public employers with three or more employees. Its most recent annual survey found that average total premiums (both the employer and employee shares) for employer-sponsored coverage increased only 3 percent for single coverage and 5 percent for family coverage in 2010. This reflected a continuation of relatively modest premium growth in recent years.

For 2011, several other national employer health costs surveys have forecasted somewhat higher rates of increase. Last fall, Hewitt Associates predicted that large employers could expect 2011 health care cost increases of 8.8 percent, compared to annual growth rates of 6.9 percent in 2010 and 6.0 percent in 2009 and 2008. Also generally consistent with other forecasts of underlying health cost growth (as opposed to actual health premium cost increases), PricewaterhouseCoopers estimated last June that employers could expect medical costs to increase by 9 percent in 2011.

The above numbers and estimates tell several overlapping stories, with more than a few cautions and limitations. First, employers generally end up paying somewhat less for their health plan premiums than initial health care cost projections would suggest. Particularly in the case of larger employers, they do not accept passively the first set of premium prices quoted to them. They adjust their plan designs (e.g., greater cost sharing), insurance partners, and incentives to employees so that they can afford better the health benefits they ultimately finance either directly (in self-insured plans) or through purchases of fully insured coverage.

Second, it's more informative to focus on percentage increases and relative shares of both the employee compensation dollar and overall economic resources, rather than on nominal dollar amounts, in order to spot any changes in past trends. The persistence of real rates of increase in health spending relative to spending on other goods and services can be less obvious during periods of varying inflation rates.

Third, different employer benefits surveys often reflect somewhat different types of respondents (e.g., large versus small employers), time periods, and methodologies. No single survey tells the complete story, but the better ones all tell us important parts of it despite lesser inconsistencies. Aggregate national average numbers also can obscure substantial variation among different regions, types of purchasers, and insurance product markets. For example, large employers (500 or more employees) experienced a sharper cost increase in 2010 than smaller employers in the Mercer survey, even though they generally have greater advantages in bargaining leverage, risk pooling, benefits administration capacity, and regulatory flexibility. Much smaller employers—particularly in the below-50-employee "small group" market—consistently face higher insurance premium costs for any given level of benefits, but they purchase "less" and thereby bring down their actual premium expenses. Consumer-driven health plans with greater cost sharing continued to provide health benefits at lower costs, and increased their overall market share (but most notably among the largest employers).

Fourth, although the health sector of the economy appears to exhibit a long-standing ability to grow faster than annual GDP, wages, and non-health areas of government spending, the experience of recent years reveals the substantial effects of a deep recession in slowing the absolute dollar growth of health spending (and health care utilization), if not its relative share of a troubled economy. As a CMS team of health spending actuaries explained in a Health Affairs article, "Although health care spending has grown at a slower rate every year since 2002, the deceleration, or slowdown in the rate of growth, was more pronounced in 2008 and 2009 because of the severe economic recession. In contrast to prior recessions, when there was usually a lag before health care spending growth slowed, the recession that lasted from December 2007 to June 2009 had a more immediate impact on the health care sector."[2]

So the illusory "good news" of the last few years might be that the Obama administration can claim at least superficially that it already helped slow down somewhat the growth rate for health care spending, and related health insurance premiums. The "bad news" is we neither can afford, nor should we expect, to rely on a prolonged recession or sluggish economy to keep doing so.

Other Statistical Mirages, Mis-Steps, and Pet Theories versus Longer-Term Trends

There remains a substantial over-supply of theories and explanations for the persistent "excess" growth of health spending and health insurance costs above the rate of annual growth in the rest of the U.S. economy. A number have some limited degree of plausibility, but either their overall impact, duration, or independent effects (or all of the above) tend to be over-stated at best. Recently on the hit list have been such explanations as:

- Excessive profits by * * * (chose a sector of the health economy you do not represent)
- Failure to receive more and better-reimbursed health services from * * * (choose a sector of the health economy you do represent)
- Cost shifting (by everyone else)
- Changes in the insured risk pool (too many healthy people either losing coverage or dropping out of the insurance market, too many sick people staying on employer coverage with enhanced COBRA tax subsidies)
- Insufficient health coverage and excessive out-of-pocket costs
- Almost everyone seemingly either has, or is about to suffer from, a chronic and costly health condition

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[2] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, "Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades," Health Affairs 30:1 (2011):14.

The full list, on both sides of the ideological as well as interest group divides, is of course much longer. It includes a wide assortment of "silver bullets" of health policy reform advocacy that never quite hit their elusive target. But the most predictable common element behind many of the more politically effective ones is that it's always "someone else's" fault! A broad consensus has existed for many decades that the small share of health care costs that we individually have to pay most directly are too high. But we appear to be nearing a newer frontier where the limits of what all those "someone else's" (particularly employers and taxpayers, and even U.S. Treasury creditors) are willing and able to pay are getting much closer in sight, as well.

One of the more pernicious misstatements of health care financing reality is the assertion that our mixed public/private system fails to pay enough of everyone else's health care bills; hence the need both for more insurance coverage and more comprehensive benefits. However, when one compares out-of-pocket (OOP) health spending to total national health expenditures, one finds that the OOP share in the U.S. continues to decline as part of a long-term trend—12.0 percent actual in 2009, 9.7 percent project for 2014, the first fully-installed year of the ACA's coverage mandates and enhanced taxpayer subsidies. Moreover, the U.S. OOP share of health spending, as of the last comparative figures available from the OECD in 2008 (12.1 percent) was below that of Germany, Canada, and the weighted average of all reporting members, respectively. Despite some apparent growth in the nominal dollar amount of potential cost sharing in certain segments of the private health insurance market, this first-party exposure to some of the costs of care has not yet translated into increases in the share of U.S. health spending that is paid out of pocket.[3]

Aside from occasional throwaway comments that aggregate health spending is too high and/or unaffordable, the default presumption in many elite health policy circles remains that the actual consumption of care should remain unburdened by the economics of paying more of its full price out of pocket—even at the margin. Early dollar deductibles are resisted as discouraging essential preventive care (as in * * * dropping by the doctor's office whenever the first unclear symptom appears, to see if one might be discovered, along with a billing code for it * * *). Partial cost sharing for larger medical expenses is seen as too punitive and overtaxing the limited abilities of patients to assess more complex tradeoffs. And leaving all the other mid-range types of health care cost decisions subject to cost sharing apparently either would single out the chronically ill too harshly and leave them prone to even greater health problems in the future, or it would jeopardize the underlying financial health of a health delivery system based on opaque cross-subsidies that detach prices from values. Before you know it, not a single dollar of health spending can be left at risk to the dangers of cost sharing.

The above represents only a slight exaggeration of the ambitions and presumptions of the ACA's coverage mandates, cost sharing limits, and expanded health spending subsidies through future health benefits exchanges, which are either imposed on employer-sponsored coverage or will directly affect its future. If left unchanged and fully implemented, they would push most Americans to believe they can and should spend even higher relative shares of other people's money. This in turn will aggravate the longstanding economic effects of distorted spending incentives and substantial dead-weight losses when re-routing greater shares of the economy through public financing mechanisms.[4]

Before examining both the likely short-term and long-term effects of the ACA on employer health care costs, overall health spending trends, and the larger economy, let's first remember some broader points about what really matters in improving the value of the health care we receive (i.e., delivering better health outcomes at lower costs).

• Although the ACA emphasizes expanded insurance coverage, redistribution and expansion of public subsidy payment streams, and scapegoating private insurers for a host of partly real but broadly exaggerated misdeeds, the overwhelming component of current health premium costs and their future rates of growth is comprised of * * * the underlying cost of health care as currently delivered in far from optimally effective or efficient ways. And it has failed to provide a clear, consistent, feasible, and sustainable route to address that problem.

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[3] For an earlier examination of this issue, see Thomas Miller and Rohit Parulkar, "Out of Pocket Theory for Health Spending Cutbacks Is 'Clueless,'" Health Affairs Blog, September 24, 2010, available at *http://healthaffairs.org/blog/2010/09/24/out-of-pocket-theory-for-health-spending-cutbacks-is-clueless*

[4] See, for example, Martin Feldstein, " How Big Should Government Be?" National Tax Journal 50:2 (1997): 197-213; and Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Policy Analysis no. 669, October 13, 2010.

• Producing better health outcomes and improved population health is driven much more by factors well beyond the supply and cost of medical care. Our long-standing political biases in health policy continue to neglect this crucial point. Despite a handful of fledging initiatives in less-noticed sections of the overall legislation, the ACA's overwhelming focus remained on politically controlling private health insurance more tightly, rearranging public subsidies for health care financing predominantly for political and re-distributional reasons, and then jerry-rigging the complex contraption to meet daunting political and budgetary scoring needs by whatever means necessary to ensure narrow passage last March.

• Although our health care system still manages to perform admirably in many respects despite the many public policy handicaps under which it continues to operate, its costs continue to exceed its value and this increasingly crowds other important private and public needs. We cannot afford to continue to neglect necessary spending and investment in a number of NON-healthcare sectors of our society.

• The employer-sponsored portion of private insurance will continue to provide a vital role in our health care arrangements. It remains much more creative, accountable, sensitive to workers' preferences, and value-conscious than the growing share of the health care marketplace dominated by politically-administered care and coverage. But the small employer portion of the health coverage market needs better tools and options. In an increasing number of cases, traditional small-group coverage is less and less financially viable. Nor is it a consistently satisfactory option for small business employees and their employers. The ACA failed to solve those problems, largely because it was pursuing a broader political agenda. Rethinking and restructuring a much different version of health benefits "exchange" options for some, but not all, of those people currently in the small employer, as well as individual, portion of the health insurance market, remains essential.

• Improved choice, competition, and value in health care arrangements still will have to be driven by more transparent, accountable, and decentralized private markets, rather than top-down political edicts. Real health care reform is not a public versus private either-or proposition, but we have overloaded the operational circuits of our political system and overfed its appetite for private resources. Rebalancing the mix necessarily must begin with repeal of many core components of the ACA, but it cannot end short of equally difficult but necessary reforms to replace them.

Assessing the ACA's Effects on Employers and Employees

In the very near term, the ACA has only done modest damage to employer-sponsored health coverage. Its main provisions were delayed for a number of years in a staggered "time-release" schedule of implementation due to political, economic, and administrative considerations. Employer coverage mandate penalties, crowd-out competition from highly-subsidized state health benefits exchanges and expanded Medicaid coverage, and more binding requirements for (plus actual definition of) essential health benefits, remain a number of years away ("apres 2013, le deluge"). So, because the ACA actually has provided very little in tangible first-year "benefits," it also has imposed only modest immediate costs and complications on most employers. Early projected estimates of the increased employer premium costs of initial mandates for offering group health insurance coverage to dependent "children" (up to age 26) of covered adults range in the one- to two-percent range. Premium cost increase estimates for the early prohibition on lifetime coverage limits, as well as the gradual phasing out of annual coverage limits, were equally modest. The less-noticed fact was that most employer group policies already had rather generous coverage limits, and hence they were largely unaffected by this "mandate." Of course, every two- to three-percent "average" increase in premium costs can be more problematic for profit-squeezed small employers already operating on the margin, let alone those who are at the high-cost end of those broad cost-estimate averages.

Several other claims of early deliverable benefits from the ACA remain overstated, if not even more questionable. The initial implementation of minimum medical loss ratio (MLR) mandates for fully-insured coverage that began this year will have a more disruptive coverage impact in the individual than in the small group market (80 percent of premiums must be paid out in medical benefits by insurers in both markets, under rather complex rules for calculating compliance with that threshold). However, the initial enforcement of the MLR rules threatens to squeeze out or reduce the valuable services of many insurance agents and brokers, and discourage private insurers' investments in useful ancillary services that do not meet more narrow ACA-enabled regulatory definitions of payments for "medical benefits"—rather than leave it up to small employers and their covered employees to determine whether they are worthwhile as part of an overall package of insurance benefits. Moreover, the exaggerated effort to paint insurers' "excessive" administrative costs as a key component of high and rising insurance premiums flies in the

face of the formers' relative share of those premium dollars as well as recent trends in their rate of growth. In general, administrative costs (including profits) for private insurers have been growing less rapidly than overall private premiums since 2003, as calculated by CMS in its annual National Health Expenditure account estimates (decreasing from 13.67 percent in 2003 to 11.15 percent in 2009).

Another "feel good" exercise of short-term political posturing under the ACA involves initial provisions for enhanced federal and state review of private insurers' premium rate filings. Although HHS does not have full power to deny proposed rate hikes, it has issued regulations enabling it to ask for more information to "justify" them, slow down requests for their approval by state regulators, and enhance the ability of the latter to block, reduce, or delay them further under state law. However, the long history of prior approval mechanisms for proposed insurance rate filings at the state level indicates that regulators may temporarily suppress rates but cannot keep them below the levels needed for insurers to pay claims and earn a reasonable economic rate of return on their capital.[5]

In a similar vein, the ACA claims to ensure that insurers in the employer group market eventually will be prohibited from denying coverage for employees with more costly pre-existing conditions (but not before 2014). Actually, earlier provisions of federal law under HIPAA (enacted in 1996) already provided similar protection in the group market for current and new employees with evidence of qualified continuous insurance coverage, apart from longstanding guaranteed renewability practices in most of the private insurance market in any event.

Early interpretation and enforcement of ACA's prohibition on lifetime insurance coverage limits for so-called "mini-med" health benefits plans reveals a different short-term "duck and cover" strategy by the current administration, when faced with bad publicity and substantial political pressure to reverse course in regulatory policy. Initially, a handful of high-profile or politically savvy companies offering such lower-cost, limited-benefits health plans to their lower-wage and/or shorter-tenured workers were granted short-term "waivers" from the new rules implementing the ACA's ban on lifetime benefits caps. But as public criticism of both the selective waivers and the jeopardy remaining for other providers of mini-med coverage increased, the trickle of waivers turned into a gusher of subsequent exemptions until almost all of that sub-market had received short-term relief by the end of last month (HHS recently reached the magic "1040" mark in the number of waivers granted).

The above rounds of early ACA implementation reveal the overly broad regulatory discretion granted to the HHS secretary in many hastily- and poorly-drafted sections of the law, as well as a short-term political strategy to push for tighter regulation unless and until it meets substantial resistance, at which point the administration's regulators may pull back temporarily. (One-year waivers and creative re-interpretations of ambiguous legislative language provide little assurance regarding later years). The more important objective is to avoid substantial political controversies on less essential ACA provisions that might threaten to undermine the implementation of much more important and far-reaching ones after the 2012 election cycle completes its course.

However, the unpredictability of what will be enforced and how it will be interpreted leaves many employers frozen in uncertainty in their health benefits planning, when not fearing the worst and finding their expectations met. The best illustration of the latter involves last year's expansive interpretation of the ACA's seemingly straightforward rules for grandfather protection from several of its new rules for employer health plans that were already in existence on the date of the law's enactment. By the time HHS had re-interpreted the conditions for such grandfathering far more narrowly, most employer plans concluded they were likely to lose it once they made even modest adjustments in their "grandfathered" plans. Even federal regulators acknowledged that by 2013, only about one in five small employers and one-third of large employers will remain grandfathered. The impact of the new grandfathering rules was less in terms of the additional obligations and costs to which employer plans would become subject (most of them have decided to live with those burdens as the price for making other necessary cost-reducing changes in the health plans). Rather it was the latest unforeseen construction of a new set of hoops (mostly restrictions on any significant changes in cost sharing and benefits structure) through which they would have to jump if they still wanted to "retain" the protection from a lesser set of regulatory hassles and burdens (primarily involving no cost sharing for coverage of "preventive" health benefits) that

[5] See Scott E. Harrington, "Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition," American Enterprise Institute, December 2010, available at *http://www.aei.org/paper/100163.*

the law had previously promised them on its face. Large employers generally shrug and make the economic and political tradeoffs as the price of doing business in a highly political and sometimes arbitrary regulatory environment. Smaller employers are more likely to be on the receiving end of new regulatory costs that they are proportionately less able to foresee, finesse, and finance.

Still ahead for the employer community are uncertainties in how the ACA's rules for such largely-uncharted definitions and details of "essential benefits" and "state benefits exchanges" will be written and then interpreted in practice. The reasonable fears in the employer community are that those benefits will be biased toward more generous and less affordable levels, and that the exchanges ultimately will be designed to capture a much greater share of current employer coverage, penalize them for it, and then trap those new "beneficiaries" in much more highly regulated and restrictive insurance plans that only look "private" initially but eventually gravitate toward more of an expansion of Medicaid-like public coverage over time.

Added on to this menu of bitter-tasting items are various new taxes that nibble away further at the affordability of employer coverage and the profitability of the enterprises that must finance it. Higher Medicare payroll taxes, including those imposed on a new category of "unearned" income, will hit not just the "rich" but a significant number of successful small business owners operating either as sole proprietors or in subchapter S corporate structures. New taxes on insurance premiums, medical devices, and on prescription drugs will add up as they are passed through to the end -ser consumers of health care in the form of higher insurance premiums and out-of-pocket care costs. A particularly obnoxious Form 1099 tax reporting requirement that would devastate many small businesses with new paperwork burdens remains widely unpopular but not yet fully repealed by the current Congress.

In isolation, few of the initial burdens under the ACA for employers are likely to determine decisively whether most employers continue to offer health insurance. But over time they amount to a steady drip-by-drip political form of water torture that can eventually reach critical mass and push a much larger share of employers to reconsider their involvement in offering health insurance coverage.

Former football coach Bill Parcells once said, "They want you to cook the dinner, at least they should let you shop for the groceries." The ACA sets in motion the temptations to impose stronger doses of a highly politicized and tightly regulated regime of health insurance in which employers are increasingly going to be asked first to pay for health insurance groceries selected by Washington regulators and then to cook and serve them according to recipes concocted by the previous Congress and at HHS.

The potential economic damage ahead posed by the ACA to employers is not limited just to the future cost of health benefits they will face or their decisions whether to offer or drop coverage. The structure of future penalties for failure to comply with the employer mandate to provide coverage, which begins in 2014, will send out additional economic disincentive signals that tell different categories of business owners that they may need in some cases either to grow slower, hire fewer workers (particularly lower-wage earners), pay them less, pay them more, restructure firms to be smaller or have a different payroll structure, outsource more operations, rely on more capital and less labor, or mix and match all of the above as the latest rules, ambiguous enforcement guidance, and the surrounding health policy terrain requires them to pay more attention to volatile health care politics and less to business operations. Some of the key economic disincentives include the need to stay below the 50-employee threshold for the upcoming employer coverage mandate penalties, to juggle the tradeoffs between higher average wages versus lower cost health benefits versus a larger employer share of health benefits premium payments—to limit penalties for employees declining "unaffordable" coverage, or to keep payrolls lower and smaller in pursuit of temporary and narrowly- defined small business tax credits for health coverage costs, Far too many employers will feel like they have left the difficult challenges of recent private health insurance markets, only to be trapped in a more complex maze where almost all the choices could go wrong but must be weighed again and again to determine which is the "least bad" one at the moment.

It is in this larger context that the "lure to leave" the many political and regulatory landmines of ACA-style employer coverage could reach a tipping point if and when we reach the years shortly after new subsidized health benefits exchanges have become established without crashing (no small feat!). Despite a host of uncertainties ahead, such exchange-based insurance coverage (as envisioned quite optimistically in the ACA) might seem like a great deal to many workers, particularly lower-wage employees whose premiums would be more heavily subsidized by taxpayers than under the current tax exclusion for employer-sponsored insurance.

As written in the law, however, these generous subsidies are officially limited to families earning between 100 percent and 400 percent of the federal poverty level, who do not receive qualified health insurance from their employers or from public programs such as Medicaid and Medicare. But many employers will face substantial economic incentives to reconsider continued offers of health coverage to their workers. A complex set of employer mandate penalties would loom large, with their amounts varying depending on the size of a firm and traded off against the net gains from eliminating direct health benefits costs, paying higher wages, and competing differently in labor markets.

The tilted playing field for tax subsidies for workers at the same income level inside employer health plans versus purchasing coverage in the exchanges appears far from politically sustainable, despite the temporary legislative "firewalls" constructed in the ACA to minimize such crossovers. If and when they begin to break down, two related effects would topple the superstructure of ACA's tenuous combination of more, but not unlimited, taxpayer financing of health care financing and reasonably predictable access to various types of (largely mandatory) "private" insurance coverage. As sketched out most notably by former CBO director Douglas Holtz-Eakin, the federal budgetary implications of this employer coverage meltdown alone would be explosively unaffordable. Whether market-based forms of private insurance would be sustainable under this vastly rearranged landscape also seems questionable, at best.

The massive uncertainties and confusion ahead under the ACA for employers and their workers are already mounting, after less than one year. Much grimmer reality could bite even before its full mandatory coverage and expanded subsidies roll out in full force in 2014. The sheer difficulty of understanding, anticipating, and maneuvering through the complex and shifting regulatory terrain of the ACA and ObamaCare will be difficult for any business firm. It will be particularly challenging for smaller firms still struggling to survive during challenging economic conditions. Many of the misguided economic signals sent by the ACA to the business community encourage slower, rather than faster, economic growth; economic paralysis amidst the search for clear and consistent regulatory analysis; and fewer opportunities for better-paying jobs.

We still have time to pull back before testing the temperature of the water for the lead group of health policy lemmings nearing the edge of the cliff. A short list of changes in direction would include a stronger focus on responsible choice and competition in health care markets; more neutral, limited, and transparent taxpayer subsidies for health care spending by most Americans (augmented to provide special enhanced protection for the most vulnerable low-income and high-risk portions of the population); real steps toward meaningful information transparency; and realignment of incentives to reward better health care choices and higher-value health care delivery.[6]

Thank you again for the opportunity to present this testimony. I look forward to your questions.

Chairman ROE. Thank you.

Mr. Parker?

STATEMENT OF BRETT PARKER, VICE CHAIRMAN AND CHIEF FINANACIAL OFFICER, BOWLMOR LANES, SPEAKING ON BEHALF OF THE U.S. CHAMBER OF COMMERCE

Mr. PARKER. Chairman Roe, Congressman Kucinich and distinguished members of the subcommittee, thank you for the opportunity to testify before you today, on the pressures businesses face from the rising costs of providing employees with health care benefits.

I am Brett Parker, vice chairman and chief financial officer of Bowlmor Lanes, which is headquartered in New York City. I am here to speak with you today on behalf of the U.S. Chamber of Commerce.

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[6] See, for example, James C. Capretta and Thomas P. Miller, "The Defined Contribution Route to Health Care Choice and Competition," American Enterprise Institute, December 2010, available at *http://www.aei.org/paper/100164.*

Bowlmor Lanes as we know it today was formed in 1997, in Greenwich Village. We purchased the original Bowlmor location and completely remodeled the internal operations by infusing a vision of upscale design elements and dramatic architecture into what had become a tired and dilapidated space.

The overhaul of Bowlmor Lanes saw the installation of video screens and lane-side food and drink service. We strove to make bowling a relevant activity to the city's residents and businesses again.

By 1999, Bowlmor Lanes became the highest grossing bowling alley in the United States. Today, it stands as one of the longest continuously running bowling alleys in the country.

Following the phenomenal success of Bowlmor in New York City, we knew that the Bowlmor concept could be introduced in other locations across the country. Today, we have a total of six locations in four states. And last year, we opened our new flagship location in Times Square that we are quite excited about.

Bowlmor has grown from 50 to over 500 employees in the last 10 years. We are creating jobs.

With the economic downturn, Bowlmor took a hit like most businesses in the United States. We did not cower from this challenge or simply hope that things would somehow play out favorably. We tightened our belts and continued to work hard and smart.

We are entrepreneurs. We believe in ourselves and our business, and we are willing to take risks and put our reputation and our money on the line.

I have found that many of the roadblocks that we face to doing those very things, expanding our business and generating new jobs, are erected by the government. Whether it is a threat posed by card check, the absurdity of the new 1099 reporting mandate, or the anxiety and complexity of the new health care law and its array of mandates, we feel like the federal government, time and time again, creates obstacles to success, and by doing so increases the likelihood of failure.

These forces combine to make future investments in growing our business less and less attractive.

Bowlmor Lanes currently employs 532 members of our team, with a workforce comprised of 258 full-time employees and 274 part-time employees. Under the new health care law, it seems probable that we will sustain a per capita cost increase on existing full-time employees of at least $2,000 per person. This poses a significant cash drain on the business.

For Bowlmor to develop a new location, we need to have $2 million in cash equity on hand. By depriving us of the cash we need to grow, through dollars paid to penalties and lost profits from facilities not developed, over the first 5 years the health care law will preclude us from opening five locations, creating over 500 jobs or investing $26 million in new infrastructure. The damage gets worse every year the employer mandate and the health care law are in effect.

When it comes to health insurance, we have been continually forced to weigh the difficult choice between increasing cost to the company and our employees with reducing coverage. Every year we pay more and get less.

To minimize the losses sustained due to this mandate, we will have to keep employees part-time and not allow them to work 30 hours a week. We are very unhappy about the effects this will have on our employees.

Unfortunately, even if Bowlmor found a way to offer coverage that meets the new law's standards, we would still be subject to $3,000 fines whenever a low-income employee gets a subsidy. This is a big incentive for us to stop offering any coverage at all.

If Bowlmor attempts to continue offering benefits, we can look forward to more expensive insurance thanks to the health care law.

Next, we have a host of new taxes to look forward to. Taxes that would make Bowlmor's health insurance more expensive, taxes on prescriptions, medical devices and insurance plans will be passed on to consumers, meaning Bowlmor and its employees.

First and foremost, Congress should repeal the job-destroying employer mandate. Senator Hatch introduced a bill to do that in the Senate that has 26 co-sponsors. But nobody in the House has introduced the companion legislation.

In conclusion, from the perspective of Bowlmor Lanes, the costs incurred with the new health care law will greatly hinder our ability to expand and develop new venues and create new jobs. I am hopeful that this body will make it a priority to repeal the most objectionable provisions, like the employer mandate.

Also, I hope you will look to real reforms that lower costs, such as tort reform. And throughout this process, I would ask that you continually be mindful of how your decisions directly, and oftentimes inadvertently, impact businesses in this nation.

We are the job creators. Please rebuild an environment that encourages, not suppresses, business growth, entrepreneurism, investment and job creation.

Thank you for this opportunity to testify, and I look forward to your questions.

[The statement of Mr. Parker follows:]

Prepared Statement of Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, on Behalf of the U.S. Chamber of Commerce

Chairman Roe, Ranking Member Andrews and distinguished members of the Subcommittee, thank you for the opportunity to testify before you today on the pressures businesses face from the rising costs of providing employees with health care benefits. I commend your efforts to further understand the impact the new health care law will have on the ability of businesses, including small ones like mine, to compete, grow and create jobs as well as our capacity to offer our employees health care benefits.

I am Brett Parker, Vice Chairman and Chief Financial Officer of Bowlmor Lanes, which is headquartered in New York City. I am here to speak with you today on behalf of the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

The Chamber did not support the status quo before passage of the health care law—in fact, we were parties to a number of collaborations aimed at building bipartisan reforms that would lower health care costs. We opposed the misnamed Patient Protection and Affordable Care Act (PPACA) because it failed to rein in costs, and instead increased them, while loading job creators with mandates, regulations, new taxes and burdens. Rather than solve the problems in the health care system,

PPACA ignores costs and instead redistributes money from producers in order to fund vast new entitlements and expand old ones—this was not an improvement over the status quo, it was a step backwards. Instead, the Chamber believes that we should replace PPACA, advance market-based reforms, and focus on lowering costs, increasing competition, and improving the health care delivery system.

Company Background

In 1938, the original Bowlmor Lanes opened its doors in the heart of Greenwich Village. During the golden age of bowling from the 1940s to 1960s, Bowlmor Lanes was at the forefront of the bowling revolution, hosting the prestigious Landgraf Tournament in 1942 and one of the first televised bowling tournaments in 1955. Through the 1970's and 1980's, Bowlmor Lanes was home to the top bowlers in the sport and became a regular hangout for village hipsters. But in the 1990's, as the popularity of bowling as a sport declined, so did the condition of the bowling alley.

Bowlmor Lanes, as we know it today, was formed in 1997 under the leadership of our CEO, Tom Shannon, who secured financing, purchased the original Bowlmor location and completely remodeled the internal operations by infusing his vision of upscale design elements and dramatic architecture into what had become a tired and depilated space. The overhaul of Bowlmor Lanes saw the installation of video screens, glow in the dark lanes and lane side food and drink service. Simply put, we strove to make bowling a relevant activity to the city's residents and businesses again. And Bowlmor has achieved this goal and continues to grow and prosper. By 1999, Bowlmor Lanes became the highest-grossing bowling alley in the United States. Today, it stands as one of the longest contiguously running bowling alleys in the country.

Following the phenomenal success of Bowlmor Lanes in New York City, we knew that the Bowlmor concept could be introduced in other locations across the country. Today, we have a total of six locations in four states: two in New York, two in California, one in Florida and one in suburban Washington, DC, specifically Bethesda, Maryland. At each location, our objective is to blend a great American pastime with an upscale entertainment experience. And nowhere is this more exemplified than our newest venture—Bowlmor Lanes Times Square—where we invested $25 million, creating construction jobs in New York City and positions for the 179 individuals we directly employ there. With the doors to our new flagship location opened on November 23, 2010, Bowlmor Lanes has taken bowling to new heights—dividing 45 lanes of luxury bowling into 6 intimate themed lounges. Each lounge is themed to represent iconic places and time periods in New York City—Times Square, Chinatown, Central Park, Art Deco, Prohibition and Pop. Bowlmor Lanes Times Square also features The Stadium Grill, an upscale sports bar and restaurant that fuses innovative American cuisine with premier sports and entertainment viewing. We are proud of our new flagship, as well as our growing business—Bowlmor has grown from 50 to over 500 employees in the last ten years; we are creating jobs.

We are quite excited about our new venue in Times Square and proud of what it says not just about our company but the entrepreneurial resilience of visionary, hard-working, risk-taking men and women throughout our great nation. With the economic downturn, Bowlmor Lanes took a hit like most businesses in the United States. While I am guardedly optimistic that the worst is behind us, I will point out that we did not cower from this challenge or simply hope things would somehow play out favorably. We tightened our belts and continued to work hard and smart. We took concrete action, and perhaps most importantly, we moved proactively to fight our way out of this economic mess without looking for the government to guide the way. We are entrepreneurs—we believe in ourselves and our business and we are willing to take risks and put our reputation on the line. And we are confident that we can succeed, as we have in the past, in growing our business and creating jobs. I have unfortunately found that many of the roadblocks we face to doing those very things—expanding our business and generating new jobs—are erected by the government. Whether it is the threat posed by card check, the absurdity of the new 1099 reporting mandate or the anxiety, complexity, disorder, uncertainty and overall peril the new health care law and its array of mandates imposes, we feel like the Federal government time and again creates obstacles to success and, by doing so, increasing the likelihood of failure. These forces combine to make future investments in growing our business less and less attractive.

Health Care

Bowlmor Lanes currently employs 532 members on our team, with our workforce comprised of 258 full-time employees and 274 part-time employees. We have a healthy, profitable, viable business that grows by developing and opening new units which, of course, means more jobs. In considering whether to expand and open a

new Bowlmor Lanes operation, we have to very critically evaluate the costs of doing so, with particular scrutiny given to factors that increase our cost of doing business. For Bowlmor Lanes to develop a new location, we need to have $2-3 million in equity. Therefore, when the costs of implementing a new law or regulation threaten to reduce the cash flow from our existing locations, it stunts our growth. Having reviewed the new health care law, it seems probable that we will sustain a per capita cost increase on existing full time employees of at least $2,000 per employee. These fines quickly increase over time and confound Bowlmor's ability to invest, develop more locations, and create more jobs. As demonstrated by the chart below, the health care law may well incinerate more than $26 million that Bowlmor would have invested, as well as more than 500 jobs we could have created. The damage gets worse every year the employer mandate, and the health care law, are in effect. The bottom line is that our ability to expand, to open a new operation and create new jobs is very sensitive to costs increases that will make existing venues less profitable and future increases that will make all venues more expensive to operate.

BOWLMOR JOB LOSS RATE EXPECTED FROM PPACA

	Year					Aggregate impact
	1	2	3	4	5	
Lost Cash From Operations of New Units		$348,000	$991,800	$2,156,730	$4,237,466	$7,733,996
Lost Cash From Healthcare Penalties	$464,000	$510,400	$561,440	$617,584	$679,342	$2,832,766
Lost Units	0.2	0.4	0.8	1.4	2.5	5.3
Lost Jobs	23	43	78	139	246	528
Lost Investment	$1,160,000	$2,146,000	$3,883,100	$6,935,785	$12,292,020	$26,416,905

Currently, Bowlmor offers health insurance to exempt employees; Bowlmor pays one third of the premium and employees pay the remainder, with an option for an employee to buy more comprehensive coverage if he/she so chooses. When it comes to health insurance, we have been continually forced to weigh the difficult choice between increasing costs to the company and our employees, with reducing coverage. We have been forced to continually reduce coverage over time to ensure that our employees can afford the costs of insurance. Unfortunately, this was the only way that we could continue to offer coverage without running ourselves out of business or inducing our staff to opt out of coverage. Every year we pay more and get less, and under the new law it appears that this process could get even worse. And there has been so much market consolidation already, we have very few insurance companies to choose from.

Under the new health care law, the coverage Bowlmor offers will likely not be considered sufficient to avoid the employer mandate, which will penalize us to the tune of about $2,000 per full time employee. To minimize losses sustained due to this mandate, we will have to do whatever it takes to keep employees part-time, not allowing them to work 30 hours a week. We are very unhappy about the effects this will have on our employees—for example, an employee who currently works full-time in our kitchen will be shifted to part-time status with Bowlmor and he/she will likely have to find another part-time position at another restaurant or similar business. While Bowlmor would definitely rather not disrupt our full-time employees like this, we must do so to protect existing jobs. Unfortunately, even if Bowlmor found a way to offer coverage that meets the new law's standards, we would still be subject to fines—whenever our coverage fails to meet the affordability threshold for a low income employee and that employee gets a subsidy to purchase coverage in the new exchanges, Bowlmor would be fined $3,000 per head. This is a big incentive for us to stop offering any coverage at all. The structure of the penalties and mandates in the health care law seems to suggest that proponents want businesses to drop coverage and pay a fine, perhaps to funnel all Americans into government-run structures and eventually toward a nationalized health care system.

As the costs of the health care law and other burdensome mandates continue to pile up, Bowlmor will be forced to look for other ways to control costs and this may mean reducing our workforce. For example, Bowlmor Lanes currently provides in-person service at the lanes, but we are exploring the possibility of deploying touch screen kiosks that customers could use instead. We prefer to not have to go this route because the in-person service provides our clients with a personal experience and we would prefer to keep our staff employed; however, our hand is being forced by costly mandates and regulations. We must take action to protect the greatest number of existing jobs possible.

Another provision in the new law requires that companies with 200 full time employees automatically enroll workers in their health insurance plan. This would be a disaster for a company like Bowlmor, with a somewhat transient workforce, high turnover, and a large number of low wage employees. These employees do not want to purchase benefits, and automatically enrolling them would be contrary to both their financial interests and their wishes—not to mention an administrative nightmare. Even worse would be a requirement that employers automatically enroll employees in a plan with no value to them: if Bowlmor is pressured into participating in the CLASS Act Ponzi scheme, workers will be automatically enrolled in a program they not only have no interest in, but one that they will likely never realize any benefit from. Provisions like this make it blindingly obvious that people with any real-world business experience had very little input into the health care law.

If Bowlmor attempts to continue offering benefits, we can look forward to more expensive insurance thanks to the health care law. First the law will require a host of new benefits that we will have to pay for, including adding "adult children" up to age 26 as dependents, no cost-sharing allowed for some services, no annual or lifetime limits, etc. These might be nice to have, but when businesses are struggling to afford health insurance, these changes make insurance more expensive.

The law also makes affordable, high-deductible plans worse—a new cap on Flexible Spending Arrangements will reduce employee flexibility, and a new requirement prohibits employees from spending their own money in health accounts unless they have a prescription for things like aspirin, Allegra, and other over-the-counter drugs.

Next we have a host of new taxes to look forward to, taxes that would make Bowlmor's health insurance more expensive. Taxes on prescription drugs and medical devices will be passed on to consumers—meaning Bowlmor and our employees. Even more egregious, a new small business health insurance tax will hit companies like Bowlmor who purchase fully-insured health plans, while big businesses that self-insure will not pay the tax. I will not even discuss the looming so called "Cadillac" tax, which will be imposed in 2018. And let us not forget that the 1099 paperwork mandate is still out there, and unless the House and Senate can come to an agreement on how to offset the costs of repealing it, businesses like Bowlmor will be buried in useless tax filings.

While repealing the 1099 provision would be a good start, Bowlmor and businesses like ours will suffer if all Congress does in the next two years is repeal 1099s and talk about repealing the whole health care bill. If Congress really wants to help us grow the economy and create jobs, we ask that you do two things—take the health care bill apart piece-by-piece, and pass real health reforms that will actually lower our costs. First and foremost repeal the job-destroying employer mandate; Senator Hatch introduced a bill to do that in the Senate that has 26 co-sponsors, but nobody in the House has introduced companion legislation. Also, please go after the more than $500 billion in new taxes the health care bill created.

To actually help lower health insurance costs, Congress could consider a broad array of reforms, including medical liability reform, opening up health insurance markets to more competition, and allowing businesses to create new pooling mechanisms. Bowlmor's costs are directly increased because of cost-shifting from Medicare and Medicaid as well; so business has a big stake in helping you reform those entitlement programs. More transparency in the medical world would help drive greater efficiency and quality, so Congress should release the massive CMS claims database and allow that information to be used to report on the quality and efficiency of providers.

Conclusion

Congress knows that the national debt is now more than $14 trillion. You know the annual deficit will be $1.5 trillion if the President's budget proposal is enacted into law. And you know that our unfunded liabilities, promises that we have made under current law, for Medicare, Medicaid, and Social Security are more than $100 trillion. Congress knows that somehow our children and grandchildren are going to be forced to pay those costs, and still they created an entirely new health care entitlement that will add untold amounts to our promises going forward. Worse, it seems that small businesses are being forced to pay for this new spending through higher taxes, benefit mandates, and increased regulation. This is bound to reduce our value to society as investors and job creators, to shackle innovation, stifle economic growth, and create more fear and uncertainty about the future. If we did business the way the Congress that passed the health care bill did, we would already be out of business.

This hearing is aptly entitled "The Pressures of Rising Costs on Employer Provided Health Care." From the perspective of Bowlmor Lanes, the costs incurred with

the new health care law will greatly hinder our ability to expand and develop new venues and create new jobs. While the existing political reality makes a total repeal of the law impossible during this Congress, I am hopeful that this body will make it a priority to repeal the most objectionable provisions like the employer mandate, which impose burdens on businesses and hinder job creation and growth. Also, I hope you will look to real reforms to lower cost, like tort reform. And throughout this process I would ask that you be continually mindful of how your decisions directly and oftentimes inadvertently impact businesses in this nation. It is companies like Bowlmor Lanes and millions of others like us that serve as the engines of economic growth in the United States. We are the job creators; please, rebuild an environment that encourages, not suppresses, business growth, entrepreneurism, investment, and job creation.

Thank you for this opportunity to testify, and I look forward to your questions.

Chairman ROE. Thank you, Mr. Parker.

Mr. Houser?

STATEMENT OF JIM HOUSER, OWNER, HAWTHORNE AUTO, TESTIFYING ON BEHALF OF THE MAIN STREET ALLIANCE

Mr. HOUSER. Chairman Roe, Congressman Kucinich and members of the committee, thank you for the invitation to testify regarding trends in health insurance costs and their impact on small businesses.

My name is Jim Houser. I am an ASE certified master automotive technician and co-owner of Hawthorne Auto Clinic in Portland, Oregon.

I am also co-chair of the Main Street Alliance of Oregon, a small business group in my state. And I serve on the national steering committee of the Main Street Alliance, a network that creates opportunities for business owners to speak for ourselves on issues that impact our businesses.

When my wife, Liz Dally, and I opened Hawthorne Auto Clinic 28 years ago, we made the commitment to offer health insurance. It seemed like the right thing to do, and it made good business sense in a high-skill field where offering benefits to keep experienced technicians is important. But it has not been easy.

Small businesses are recognized as the engines of job growth. But a health care marketplace that stacks the deck against small businesses has put us at a consistent disadvantage.

Small business health care costs have grown a whopping 129 percent since 2000. We pay an average 18 percent more than large firms for the same coverage.

At my business, we pay 100 percent of the insurance costs for our nine full-time employees and their dependents. Our premiums have doubled over the last 8 years, reaching $100,000 last year, more than 20 percent of payroll.

This year, we witnessed a minor miracle. Our premiums went down 3 percent. It is the first time in my memory they have declined.

A provision of the Affordable Care Act has allowed my 22-year-old daughter, a recent college graduate, to return to our insurance plan. I am glad our family business can actually cover our family again.

We are also eligible for the new tax credits in the health law. My accountant says we should get back between $5,000 and $10,000 on our 2010 taxes. Combine that with the decrease in our premiums,

and we will save 8 to 10 percent of our insurance this year, due to the Affordable Care Act.

Now, I am well aware that health insurers are pursuing steep rate increases. I am also aware that insurance lobbyists are trying to pin these increases on the new law.

This claim just does not pass inspection. If insurers are jacking up their rates, again, it is in spite of the new health law, not because of it. If anything, insurers are seizing the moment to hit customers with one more off-the-charts increase while they still can get away with it before measures to rein in those increases take effect.

Even insurance executives admit the rate increases are not because of the new law. A senior vice president at Harvard Pilgrim in Massachusetts said, only one percentage point of this year's increases was attributable to the federal law. And that was mainly due to the requirement for free preventative services.

As my mechanics will tell you, customers who have us perform regular preventative maintenance rarely get towed in for unanticipated, expensive repairs. Similarly, it is much more cost-effective to spend $200 to get a patient's blood pressure under control than to spend $50,000 for the E.R. response to a stroke.

Preventative measures are an investment that pays off big in the long run.

Whatever the lobbyists say, the fact is the health law is giving small businesses tools to put the brakes on rising insurance rates; for example, the new premium tax credits. Four million small businesses like ours can qualify for a credit of up to 35 percent.

New customer protections allow young adults up to 26 to enroll on their parents' plan. Rate review resources give states new tools to protect small businesses from unreasonable rate increases. New medical loss ratio standards ensure small businesses get value for their premiums.

And the state insurance exchanges being designed offer greater transparency, more choices and, with as many as 970,000 people predicted to enroll in the exchange in Oregon, much more bargaining power.

Small businesses are moving forward on health care. Kaiser Family Foundation reports the percentage of employers with three to nine employees offering health coverage rose from 46 percent in 2009, to 59 percent in 2010.

Efforts to repeal or defund the health law will only hurt us. Even the possibility of repeal creates paralyzing uncertainties.

If the law is repealed, will I have to return my tax credit? What about next year? Will I be able to bank on the credit and use that money to invest in my business or not?

We cannot afford to go back to a system that stacks the deck against small business. We have got to move forward.

With proper implementation we can level the playing field, get control of insurance costs and allow small businesses to focus on what we do best—things like fixing cars, creating jobs and building local economies across America.

Thank you very much.

[The statement of Mr. Houser follows:]

Prepared Statement of Jim Houser, Hawthorne Auto Clinic and Main Street Alliance of Oregon

Chairman Roe, Ranking Member Andrews, and members of the committee, thank you for the invitation to testify regarding trends in health insurance costs and their impact on small businesses.

My name is Jim Houser. I am an ASE Certified Master Automotive Technician and co-owner of Hawthorne Auto Clinic in Portland, Oregon, a family business I founded with my wife, Liz Dally, 28 years ago. I am also co-chair of the Main Street Alliance of Oregon, a small business group in my state, and serve on the national steering committee of the Main Street Alliance, a national network that creates opportunities for business owners to speak for ourselves on issues that impact our businesses and our local economies.

When Liz and I opened Hawthorne Auto Clinic in 1983, we made the commitment to offer health insurance to our workers. It seemed like the right thing to do, and it made good business sense. Auto repair is a high-skill field where offering good benefits to keep experienced technicians is very important. We're also an aging profession. The makeup of our small group shows it, and with the current system of age rating where you're penalized for having older workers in your group, we have suffered relentless increases in our insurance costs year after year.

A Stacked Deck: Small Businesses at a Disadvantage in the Insurance Marketplace

Small businesses are recognized as the engines of the American economy. The country looks to the innovation and entrepreneurship of small businesses to create jobs and drive the economic recovery. But for decades, a health care marketplace that stacks the deck against small businesses has put us at a disadvantage.

The conditions small businesses have faced in the insurance marketplace of the last decade include:

- Small businesses' health care costs have grown 129 percent since 2000.
- We pay on average 18 percent more than large firms for the same level of coverage.
- Administrative costs can be two and a half times higher (sometimes even more) for small businesses compared to larger firms.
- High levels of market concentration, combined with a version of "competition" between insurers that is based on cherry-picking healthy enrollees rather than competing to offer the best services at the best rates, leave small businesses with few real options and nowhere to turn when double digit rate hikes strike again.
- Tens of millions of small business owners, our employees, and dependents forego health coverage altogether because the costs have been out of reach: of the 49 million Americans living without health care (up from 40 million in 2000), an outsized majority—about 60 percent—work for small businesses, according to the Employee Benefit Research Institute.

Cost Trends at Hawthorne Auto and Impact of the New Health Law

I know from my own experience that the pressure of rising insurance rates over the last decade, without health reform, has been severe and unrelenting. At my business, insurance costs for our nine full-time employees and covered dependents doubled from 2002 to 2010, reaching over $100,000 last year. That figure represented more than 20 percent of our payroll, adding greatly to our cost of doing business.

This year, we witnessed a minor miracle: our premiums went down 3 percent. It's the first time in my memory they've declined.

A provision of the Affordable Care Act has allowed my 22-year-old daughter, a recent college graduate, to rejoin our insurance plan. I'm not sure if that's why our premiums went down (because we're now sharing our health care risk over a larger, younger, and healthier pool of enrollees), but either way I'm glad our family business can actually cover our family again.

We're also eligible for the new small employer premium tax credits in the law, and my accountant says we should get back between $5,000 and $10,000 this year. Combine that with the premium decrease and we're going to save 8 to 10 percent on our health insurance this year due to the Affordable Care Act.

Broader Trends in Insurance Rates and Claims of Connection to the ACA

I'm aware that many health insurers are continuing to pursue steep rate increases—from Blue Shield of California's push for increases of up to 59 percent to Anthem in Maine's legal battle with the state. I'm also aware that some insurance lobbyists are trying to pin these increases on the new law.

This claim just doesn't pass inspection. If insurers are jacking up their rates—yet again—it's in spite of the new health law, not because of it. If anything, insurers

are seizing the moment to hit customers with one more off-the-charts increase while they can still get away with it, before measures to rein in those increases take effect.

Even insurance executives admit the rate increases aren't because of the new law. New York Times correspondent Robert Pear reported in an article on rising insurance rates that a senior vice president at Harvard Pilgrim in Massachusetts said only one percentage point of this year's increases was attributable to the federal law. And, according to this insurance company executive, that was mainly due to the requirement for free preventive services—a requirement that makes a lot of sense to me in the auto repair business.

As my mechanics will tell you, customers who have us perform regular preventive maintenance rarely get towed in for unanticipated, expensive repairs. Similarly, it's much more cost effective to spend $200 to get a patient's blood pressure under control than to spend $50,000 for the ER response to a stroke. Preventive measures—whether in auto repair or health care—are an investment that pays off big in the long run.

Health Law Gives Small Businesses New Tools to Put Brakes on Rising Insurance Costs

Whatever the lobbyists say, the fact is the health law is giving small businesses tools to put the brakes on rising insurance rates in a number of ways. The following are some examples:

Small Employer Health Premium Tax Credits

Business owners across our network from my Portland, Oregon to Portland, Maine are already benefiting from the new tax credits effective for tax year 2010. My accountant tells us we should expect to receive a credit of between $5,000 and $10,000 on our 2010 taxes. Other businesses that offer health coverage and pay half the cost can qualify for a credit of up to 35 percent now through 2013 and 50 percent in 2014. That's serious savings for a small business. It's like a time machine, turning the clock back on insurance rates. It's hard to think of a single other step that could cut a small business's insurance bill by 35 percent in one go.

Consumer Protections that Benefit Small Businesses

The Affordable Care Act puts in place important consumer protections in the small group and individual insurance markets where small business owners, our families, and our employees get health coverage. These protections include a ban on pre-existing condition exclusions, new limits on insurance caps, and the ability to keep adult children covered up to age 26 (this is the provision that has allowed us to re-enroll my daughter in our business's plan). These provisions will increase the quality of the coverage for small businesses and our employees. The under-26 provision will also help us spread risk across a broader age range to reduce our rates, as illustrated by the story of my business and my daughter.

Strengthening Premium Rate Review

After years of enduring double-digit rate increases with no recourse, I'm encouraged that Oregon and other states have new tools and new resources to review insurance rates and require insurers to provide justification for unreasonable rate increases. This is one of the most direct ways to protect small businesses and help us do our part to create jobs and grow the economy. Given the high level of market concentration in the health insurance industry and the absence of true competition (competition based on consumer value rather than competition based on cherry-picking risk pools), we need stronger rate review to protect small businesses from unreasonable rate increases.

Medical Loss Ratio Requirements and Value for Premiums

Running a small business, remembering the importance of providing real value to our customers becomes second nature. Somehow, it seems health insurance companies have lost sight of that basic tenet of good business. Minimum medical loss ratio requirements will restore a focus on ensuring value for our premium dollars. If insurers fail to meet this standard, insurance customers like us will receive cash rebates to make up the difference. It's high time we had a value guarantee like this in health insurance.

State Insurance Exchanges: Transparency, Choice, and Bargaining Power

The state insurance exchanges currently being designed will level the playing field for small businesses. By creating a mechanism whereby we can band together and shop for coverage in one large pool, the exchanges will give us greater transparency, more choices, expanded risk pooling, and more bargaining power. In Or-

egon, as many as 970,000 people are predicted to enroll in the exchange. I can't wait to join a group of almost a million people. For small businesses that currently have groups of 20 people, 10 people, or less, banding together in the exchange will represent an exponential leap in our bargaining power.

Cutting the "Hidden Tax"

Small businesses that have insurance now currently pay a "hidden tax" (estimated at over $1,000 per insured family and over $350 per insured individual in 2008) resulting from the cost-shifting of uncompensated care costs. By getting tens of millions more people insured and paying into the system up front, the new law should significantly reduce this cost-shifting and cut this hidden tax.

Conclusion: Small Businesses Moving Forward on Health Care

Small businesses are moving forward on health care:

• Nationally, the Kaiser Family Foundation reports the percentage of employers with 3 to 9 employees offering health coverage rose from 46 percent in 2009 to 59 percent in 2010—in part due to the ACA's tax credits.

• Information from states also indicates that small businesses are taking advantage of the opportunity to start (and continue) offering health coverage. For example:

• Blue Cross Blue Shield of Kansas City recently reported that after letting local businesses know about the new tax credit, they enrolled more than 9,000 new members covered by 400 new employers. The company reported a 58 percent increase in small businesses purchasing insurance since April 2010, the first month after the passage of the ACA.

• Blue Cross and Blue Shield of Nebraska reported a 34 percent increase in health insurance sales to small businesses for the new year.

• A spokeswoman for Blue Cross of Idaho reported a "huge increase" in the number of small employers requesting quotes, and a shift in employers keeping coverage for their workers.

Efforts to repeal or defund the health law will only hurt small businesses that are already benefiting or looking forward to the benefits of the new law. Even the possibility of repeal creates uncertainties that are harmful to business planning and job growth. For example, if the law is repealed, will I have to return my tax credit? What about next year—will I be able to bank on the credit and use that money to invest in my business, or not? And, will my family business be able to continue providing coverage to our family, including my 22-year-old college graduate daughter—or will she be bounced off our plan and left vulnerable to medical debt just as she's working to get on her feet and launch a career?

We can't afford to go back to a system that stacks the deck against small businesses. We've got to keep moving forward. With proper implementation of the health care law, we can level the playing field for small businesses, get meaningful control of insurance costs, and allow small businesses to focus on what we do best: things like fixing cars, creating jobs, and building local economies, in Oregon and across America.

Thank you.

Chairman ROE. Thank you, Mr. Houser.

Mr. Brewer?

STATEMENT OF J. MICHAEL BREWER, PRESIDENT, LOCKTON BENEFIT GROUP, LOCKTON COMPANIES, LLC

Mr. BREWER. Mr. Chairman, Ranking Member Kucinich and honored members of the committee, my name is Mike Brewer. I am the president of Lockton Benefit Group, the employee benefits consulting arm of Lockton Companies, LLC.

Lockton Benefit Group provides employee benefits consulting services to 2,500 middle market clients nationwide. The vast majority of our clients employ between 500 and 2,000 employees. Our clients include private and governmental employers, and employers in a wide variety of trades and industries.

Our clients agree that improvements in the health insurance system are necessary and important. However, they are frustrated

that the health reform law imposes additional cost and other burdens upon them.

Our clients wish that Congress would work to make an employer's provision of health insurance easier and less costly, rather than more expensive and more burdensome.

Our actuaries have modeled for several hundred clients the impact of the health reform law on their group health insurance programs. To-date, we have aggregated the results from 136 of these modeling reports and broken out the results by industry segment. I would like to share some of those results with you today.

On average, the reform law's immediate benefit mandates add 2.5 percent to our clients' health insurance cost. The automatic enrollment requirement in 2014 adds 3.8 percent to our clients' health insurance spend, on average, even assuming that 75 percent of the automatically enrolled employees, who would not have otherwise enrolled in coverage, would opt back out of the coverage with the opportunity.

These increases may appear modest, but they are not. Many clients have health insurance expense trends of 10 percent or more annually. A 10 percent trend line becomes 12.5 percent in 2011, and 16.3 percent in 2014, just on account of the mandates that I have mentioned.

I would like to speak for a moment to the impact of employers' "play or pay" mandate, which also takes effect in 2014.

Across most industry segments, our clients will have significant financial incentive to terminate the group coverage once the insurance exchanges present employers with another subsidized health insurance option. That is because the vast majority of our clients currently spend far more on health insurance per employee than the penalty under the "play or pay" mandate. By 2014, this gap will become even wider.

On average, our analysis shows that by terminating group coverage our clients would save an amount equal to 44 percent of the projected health insurance cost in 2014.

In fairness, few clients have told us today, here in 2011, that they definitely intend to terminate group coverage in 2014. Similarly, few have said they intend to maintain their health insurance coverage. The vast majority tell us they are going to wait and see.

They tell us that what they do in 2014 depends upon their health insurance costs then and their perceived need to use the health plan to gain a competitive advantage for labor.

With regard to this latter point, many employers have told us, "We won't be the first to drop coverage, but we also won't be third."

The modeling results for our clients in the restaurant, retail and hospitality industry is a "damned if we do, and damned if we don't" scenario.

On average, to comply with the "play or pay" mandate and offer qualifying and affordable coverage to all full-time employees, the employer's health insurance costs increase 150 percent. Ironically, if the employer simply terminates its group plan, it still pays 56.6 percent more than it would to maintain the current plan offered today, because it then has to pay the $2,000 per year, non-deductible penalty for each of its full-time employees, even those employees to whom the employer has never offered coverage.

These clients and clients like them tell us they have but one option: to eliminate large numbers of full-time positions. By making full-time employees part-time, the employees are removed from the penalty equation.

Let me also note that health reform adds up to 19 additional disclosures and reports to the already daunting 27 disclosures and reports a mere health plan may already be required by federal law to make to its enrollees or to the federal government.

Our employer clients are not the bad guys. Our clients simply do not understand why, for making the effort to supply a valuable employee benefit to their employees, the federal government imposes so extensive an administrative and regulatory burden.

These obligations, because of their complexity and steep penalties for violation, give employers yet one more reason to simply surrender and exit the group insurance marketplace. This is, of course, a huge concern to us.

Again, Lockton greatly appreciates the opportunity before you today. We simply urge Congress that, in assessing the impact of this health reform legislation, you place yourselves not only in the shoes of those Americans who deserve and need access to affordable insurance, but also into the shoes of the American employers who supply valued health insurance coverage to 160 million of us.

[The statement of Mr. Brewer follows:]

Prepared Statement of J. Michael Brewer, President, Lockton Benefit Group, Lockton Companies, LLC

Mr. Chairman, Ranking Member Miller and honored members of the Committee, my name is Michael Brewer and I am the president of Lockton Benefit Group, the employee benefits consulting division of Lockton Companies, LLC. On behalf of Lockton I thank you for the opportunity to appear here today to share our views regarding the impact of the new health reform law on the group health plans sponsored by our clients.

Lockton is the largest privately held insurance brokerage and consulting firm in the world. Domestically, Lockton employs 2,300 employees in 24 offices nationwide who serve the insurance risk needs of approximately 9,000 employer clients from coast to coast. Lockton Benefit Group ("LBG ") provides employee benefits brokerage and consulting services to approximately 2,500 of those clients. Nearly all of those clients employ us to assist in the design and administration of their group health insurance programs.

The vast majority of LBG clients are "middle market" employers, employing between 500 and 2,000 employees, although we also have some small-group and "jumbo" clients. Our clients include private and governmental employers, and employers across many industry segments, including construction, health care, manufacturing, transportation, retail, professional services firms, and the hospitality/entertainment industry.

More than half of LBG's clients maintain self-insured group health plans. The others purchase group health insurance from licensed insurance companies.

Make Employer Based Coverage Less Expensive and Burdensome

Approximately 160 million Americans receive health insurance today through an employersponsored group health plan. Employees of our clients enjoy and appreciate this coverage.

Our clients tell us they have no quarrel with the notion that improvements in the health insurance system are necessary, to improve access to insurance and reduce the cost of health care and, concomitantly, the cost of health insurance. However, they are frustrated that in the effort to achieve these aims the health reform law adds additional expense to their health insurance costs and imposes additional administrative burdens upon them.

In short, our clients find that the health reform law makes what is already a costly and administratively burdensome endeavor—the sponsorship of a simple group health insurance plan—even more expensive and more hassle-prone. Our clients

wish that Congress would work to make an employer's provision of health insurance easier and less costly, rather than more expensive and more burdensome.

Modeling Results

We have modeled for several hundred clients the impact of the health reform law on their group health insurance programs, now and in 2014. As of the date we prepared these comments, our actuaries had aggregated the results from 136 of these modeling reports, and broke out the aggregated results by industry segment. I would like to share some of those results with you today. We will be pleased to supplement these remarks in the coming weeks and months as we continue to add additional modeling results to this aggregated analysis.

Effect of Immediate Benefit Mandates

On average, the health reform law's immediate benefit mandates (for example, the obligation to cover adult children to age 26, the elimination of lifetime dollar maximums, restrictions and ultimate elimination of annual dollar limits, etcetera) add 2.5% to our clients' health insurance costs.

Industries that currently supply more generous health insurance packages—that is, they already cover adult children to age 25, for example, and/or already apply high lifetime maximums, such as $5 million per lifetime—see the smallest increase (.5%).

Firms that supply more modest packages—such as coverage of children to age 22 and/or $1 million lifetime maximums—see the largest percentage increases (3.7%).

Standing alone, expressed as a percentage of total plan costs, these increases may not appear compelling. But the increases—particularly the larger increases—concern our clients, many of whom are already struggling with health insurance inflation well in excess of the rate of inflation generally. For example, an employer whose health insurance costs are trending at 10% without regard to the reform law finds its trend increased to 12.5% (an additional 2.5% increase, on average) on account of the reform law's mandates. If the employer has 2,000 employees and spends $16 million per year on health insurance, the additional cost of the mandates alone is $400,000.

Effect of Limited Waiting Periods (2014)

The health reform law prohibits waiting periods of more than 90 days, beginning in 2014. This mandate has little cost implication for most of our clients, because most do not currently maintain waiting periods in excess of 90 days.

For our clients that have waiting periods in excess of 90 days, the consequences can be more dramatic. For example, a construction firm client with a 6month waiting period for health coverage experiences a 3.9% cost increase, while another construction firm with a 12month waiting period experiences a 39.3% cost increase. Our transportation firm clients with 4month waiting periods experience a 6.4% increase.

Effect of Automatic Enrollment Requirement (2014)

The reform law also requires employers with more than 200 fulltime employees to automatically enroll in a health plan those employees who become eligible for coverage but who do not affirmatively enroll. These employees may, however, choose to affirmatively disenroll. The automatic enrollment feature adds 3.8% to our clients' health insurance costs on average, with our governmental clients seeing the smallest increase (1.4%) and our transportation industry clients seeing the largest increase (10%). For one client, a large hospital, our actuaries expect the automatic enrollment feature to add more than $1 million annually to the client's health insurance cost.[1]

Employer "Play or Pay" Mandate (2014)—Impact on Employers

Beginning in 2014, employers with at least 50 fulltime equivalent employees must offer their fulltime (30+ hours per week) employees "minimum essential coverage." That coverage must be "affordable" to the employee, that is, not cost him or her more than 9.5% of household income.

Where an employer fails to offer this coverage at an affordable cost and the employee instead obtains subsidized coverage in an Insurance Exchange, the employer is subject to a penalty. If the employer continues to offer coverage to some employ-

[1] In modeling the effect of the automatic enrollment provision, we assumed that 75% of employees who are eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will opt out of coverage. These modeling results do not reflect the impact of the automatic enrollment feature on our retail, restaurant, hotel and entertainment industry clients. The modeling results for these clients are described separately, later in this document.

ees, the penalty is a nondeductible assessment of $3,000 per year ($250 per month) for every fulltime employee who does not receive an offer of qualifying and affordable coverage, and who instead obtains subsidized coverage in an Insurance Exchange.

However, if the employer terminates its group plan and offers coverage to no employees, and at least one fulltime employee obtains subsidized coverage in an Insurance Exchange, the penalty is $2,000 per year times all the employer's fulltime employees.[2]

Across all industry segments in our book of business,[3] clients will have a significant financial incentive to terminate their group coverage once the Insurance Exchanges present employees with another subsidized health insurance option. The vast majority of our clients currently spend far more on health insurance, per employee, than the nondeductible penalty under the "play or pay" mandate. By 2014 this gap will be much larger still.

As a result, were they to terminate their group coverage they would, on average, save an amount equal to 44% of their projected 2014 health insurance costs. For clients whose health plans tend to be more expensive, savings are larger (84% for our governmental clients, 60% for our hospital clients).

Employer "Play or Pay" Mandate (2014)—Impact on Employees

We also modeled the impact of plan termination on clients' employees, were they forced to seek coverage in an Insurance Exchange. On average, to purchase Exchange-based coverage equivalent to the employer's health reform-qualifying coverage, our clients' employees would pay significantly more than they pay for the employer's coverage. This is because our clients typically subsidize a larger portion of employees' health insurance costs than the Exchanges will subsidize, and employees pay their portion of employer-based coverage with pretax dollars. Their portion of the cost of Exchange-based coverage will be paid with after-tax dollars.

On average, our clients' employees would pay between 101% and 155% more for Exchangebased coverage (101% assuming the employee is the sole wage earner in the household, 155% assuming there is household income in addition to the employee's salary, thus reducing the size of the subsidy the employee receives in the Exchange).

The more highly paid the employer's workforce, the more significant the expense borne by the employee in the Insurance Exchange (again, because higher household income means smaller subsidies, if any, in the Exchange). For example, employees of our professional service firm clients can expect to pay, for equivalent coverage in an Exchange, 113–148% more than they would pay for employer-based coverage.

This dichotomy has triggered within some employers a conflict between the financial officers, working to hold the line on expenses and increase profitability, and the human resource officers who, as necessary, work to fashion appropriate compensation and benefit structures for employees. Next to wages, health insurance costs are the most onerous component of labor expenses for the vast majority of our clients. By 2014, when the Insurance Exchanges open and present employees with another, largely subsidized option for health insurance coverage, the burden of group health insurance costs on an employer's balance sheet will create tremendous tension within many clients. What clients do then depends on several factors.

Thus far, few clients have told us they definitely intend to terminate group coverage in 2014, when Exchange-based coverage becomes available. Similarly, few clients have told us they definitely intend to maintain their group coverage. The majority of our clients tell us they will wait and see. What they will do in 2014 depends on their health insurance costs and budget in 2014, and their perceived need to use a health plan to gain a competitive advantage for labor.

With regard to this latter point, many clients have told us, "We won't be the first to drop coverage, but we won't wait to be third, either."

Our smaller clients will be the first to abandon group coverage. At a recent seminar presentation we made to approximately 200 employers ranging in size from 50 to 150 employees, half told us they intend to exit the group insurance marketplace in 2014.

To the extent the labor market continues to favor the employer in 2014, we expect some of our larger clients—particularly those employing relatively low paid, modestly-skilled hourly workers—to terminate their group health plans.

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[2] The first 30 such employees are not taken into account in an employer's penalty calculation.

[3] Except retail, hospitality and entertainment employers, whose modeling results are addressed separately.

Retail, Hospitality and Similar Clients Will Eliminate Full-Time Jobs

The modeling results for our clients in the restaurant, retail, hotel and entertainment (e.g., amusement park) industries are more sobering. Most of these clients do not offer group health coverage to all their fulltime employees because they cannot afford to do so. A restaurant chain, for example, will typically offer coverage to its corporate staff and restaurant managers. An amusement park will typically offer coverage to its year-round staff, but not to its extended seasonal workforce.

These employers are caught in a "damned if we do, damned if we don't" bind. On average, to comply with the "play or pay" mandate and offer qualifying and affordable coverage to all fulltime employees, the employer's health insurance costs increase 150%.

Maintaining the status quo—offering coverage to some employees, such as corporate staff, but not rank-and-file employees—can trigger excise tax penalties under the health reform law's nondiscrimination rule, and in any event would trigger $250 per month penalties for every fulltime employee not offered coverage and who instead obtains subsidies in an Exchange.

Ironically, if the employer simply terminates its group plan it still pays 56.6% more than it would pay to continue its plan. Although the employer saves a portion of its health insurance spend (it loses the tax deduction on those dollars, and the FICA/FUTA savings on employee pretax contributions), it pays a $2,000 per year, nondeductible penalty on each of its fulltime employees, even those employees on whose behalf the employer is not otherwise incurring a health plan expense.

These clients, and clients like them who employ a large number of fulltime, relatively low paid hourly workers who are not receiving an offer of robust health coverage today, tell us they have but one option: eliminate large numbers of fulltime positions. By making fulltime employees part-time, the employees are removed from the penalty equation.

Other Burdens

Federal law imposes other burdens and counterproductive barriers on group health plan sponsors, burdens that ratchet up the angst, anxiety and frustration of our clients, increase costs to their health plans, and give additional reasons for employers to escape the challenges of group health plan sponsorship the moment they think they can.

For example, under federal law alone, a simple group health plan must make up to 46 separate disclosures (to enrollees) and reports (to federal agencies). Nineteen of these disclosures and reports are required under the health reform law.

The disclosures often go to different individuals, at different times, via different means. Some are required annually. Some might be required even more frequently. There are requirements that some be provided in separate documents, or in specific fonts, or be "prominent," or provided in a "culturally and linguistically appropriate manner."

The myriad disclosure and reporting obligations add angst, cost and anxiety to the lives of our clients well in excess of the value that the vast majority of employees place in the bulk of the disclosures.[4]

We supply our clients with detailed "notice calendars," but employers are often compelled to pay third-party vendors to satisfy at least some of the obligations.

As they propose additional disclosure and reporting requirements, federal agencies estimate the relatively modest burden any single disclosure or report imposes on the employer. But there appears to be no effort to consider the cumulative burden—in time, money and effort—on the employer for supplying the currently required disclosures and reports.

Congress should endeavor to minimize the administrative burdens employers bear in order to supply group health coverage. Congress should: (1) legislatively streamline the disclosure and reporting obligations on employers, allowing them greater leeway to consolidate disclosures in single documents without existing special rules that require some notices to be more "prominent" than others; (2) synchronize due dates for various disclosures and reports, unless impracticable; (3) allow employers to consolidate multiple government reports in single filings to the extent practicable; and

(4) permit employers to post many of the required disclosures in the workplace or on their intranet pages rather than deliver by hand or by mail to employees, most of whom have demonstrated little or no interest in many of the disclosures.

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[4] Lockton employees have attended thousands of employee enrollment meetings, and it is not uncommon to find many of these disclosures simply littering the floor afterwards. Most employees are simply not interested. The burden on the employer, in terms of cost and effort, thus outstrips the value most employees place on many of these myriad disclosures.

Conclusion

Lockton greatly appreciates the opportunity to appear before you today. In assessing the impact of the health reform legislation, we urge you to place yourselves not only in the shoes of those Americans who need access to affordable insurance, but in the shoes of the employers who supply valued coverage to 160 million of us.

Employers are burdened and frustrated by aspects of the health reform law that add costs to their health plans, and will cause some of them to eliminate group coverage and fulltime jobs. They are perplexed by a federally-imposed reporting and disclosure scheme that has increased substantially under health reform and become far too cumbersome.

We welcome the opportunity to work with you to mitigate these burdens on the employer community.

Chairman ROE. Thank you, Mr. Brewer.

Since Mr. Kucinich may have to leave, I am going to allow—go ahead and start with your questioning, if you would.

Mr. KUCINICH. That is very generous of you, Mr. Chairman. I really appreciate it.

I would like to start with Mr. Houser. And I appreciate Mr. Brewer's remarks that we need to be sensitive to all of those businesses that are providing health insurance.

Now, Mr. Houser is here. And can you tell us how many employees you have?

Mr. HOUSER. We have nine full-time employees. We have two student interns, who work half-time and go to school half-time. And we have two part-time employees: a shop maintenance helper and a part-time office assistant.

Mr. KUCINICH. Do you offer family and individual coverage?

Mr. HOUSER. We provide complete, 100 percent coverage for full-time employees and their families. For the part-timers we offer proportional, and no one has taken us up on it.

Mr. KUCINICH. How much of the premium do you pay for your employees?

Mr. HOUSER. It was $100,000 last year, for the total.

Mr. KUCINICH. Now, so you are paying basically 100 percent.

Mr. HOUSER. Yes.

Mr. KUCINICH. Mr. Parker, in terms of your employees at your bowling company, do you pay 100 percent?

Mr. PARKER. No. We pay one-third.

Mr. KUCINICH. Okay.

Can you, Mr. Houser, respond to the statement that Mr. Miller makes in his testimony where he states that the Affordable Care Act provides very little in tangible first-year benefits and imposes modest immediate costs and complications on most employers?

Could you tell us about your experience with that?

Mr. HOUSER. Congressman, our experience has been several. One is, of course, the tax credit that we will be getting. But more than that, the new health insurance exchange is what appears to be going to provide the greatest benefit to our business.

The State of Oregon is currently very actively moving forward to not only cover about 970,000 more Oregonians, but also to change the—with that level of buying power—to change how health care is paid for to actually lower the cost of health care by changing from a fee-for-service, fee-for-procedure to a fee-for-outcome mode of how to pay for—to actually also bring down the cost of health care.

Mr. KUCINICH. Well, could you tell us any benefits that you have already realized from the—have there been any benefits that you realized——

Mr. HOUSER. The largest benefit is that our daughter, who is 22 years old and unemployed and out of college, is now back on our health care plan. And so, that is the biggest advantage that we have experienced so far.

I cannot say whether our decrease in premiums was a result of the Affordable Care Act or not. I do not know that.

Mr. KUCINICH. And do you think this law will raise your costs and complicate your ability to offer health care?

Mr. HOUSER. If the costs were to keep going up like they were before the Affordable Care Act was passed, then we would definitely have to re-evaluate our health care costs. I would have to——

Mr. KUCINICH. What about the role of the tax credits?

Mr. HOUSER. Well, the tax credits are going to have a huge advantage. Although our employees are toward the higher end; $50,000 is the limit. And so, we are not quite there on average, but we are pushing that.

But the tax credit does go up in, I believe it is 2014. So, that will certainly carry us quite a ways, and especially if we can get control of the health insurance rate increases.

Mr. KUCINICH. I have heard witnesses, the other witnesses say that they think that employers will increasingly stop offering health care to employees as a result of this law.

Do you think that is true? Do you think that more small employers are offering health insurance now? Do you have any experience in that outside your own? Have you talked to anybody? Can you——

Mr. HOUSER. I know that from reading the Kaiser Family Foundation report that actually, the number of small employers who are covering have increased from 2009, from 46 percent to 59 percent. So, actually, more small businesses are actually increasing their coverage.

Mr. KUCINICH. One final question. What power did you have to negotiate with your insurance company when you increasingly saw your health care costs increase during the last years?

Mr. HOUSER. I am sorry. I did not hear.

Mr. KUCINICH. What kind of negotiating power did you have with your insurance company prior to this?

Mr. HOUSER. None. All we can do is wait for our broker to bring us various—you know, what we are going to be paying.

Mr. KUCINICH. I thank you, thank the gentleman.

Thank you, Mr. Chairman.

Chairman ROE. I thank the gentleman for yielding.

Next is Dr. DesJarlais.

Mr. DESJARLAIS. Thank you all for being here. And I am also going to have to slip away.

So, Mr. Houser, you mentioned that your business will receive a credit of between $5,000 and $10,000 on your 2010 taxes, because of the small employer health premium tax credit.

Do you know who is paying for that credit?

Mr. HOUSER. My taxes, I assume.

Mr. DESJARLAIS. Any idea? Do you think your taxes are paying for that, for your employees?

Mr. HOUSER. If my taxes—I am sorry.

Mr. DESJARLAIS. Do you feel that your taxes are paying for that $5,000 to $10,000 tax credit? Yours personally?

Mr. HOUSER. My taxes and your taxes. And my health care premiums are also paying for people who work for companies who do not cover their employees.

Mr. DESJARLAIS. Okay. Do you have a plan in 2016 when that credit is no longer available?

Mr. HOUSER. I do not envision us ever dropping health care coverage for our employees.

Mr. DESJARLAIS. Okay. Thank you.

One thing, if I could yield just a few seconds to our chairman to explain the impact of Medicare's expense estimates and what they actually turned out to be over time?

Chairman ROE. What Dr. DesJarlais, I think, is talking about, when you look at the government estimates of how much a health care plan—the CBO estimated this would be budget-neutral.

Medicare was a plan they started in 1965 to cover our seniors. There was no CBO then, but the estimate in 25 years was this would be a $15 billion plan. In 1990, it was over $100 billion. So, they missed it seven times.

In Tennessee we saw where our Medicaid—we went through a managed care plan very similar to this in Tennessee in 1993, to try to control health care costs, because we had the things that you mentioned, rising costs, access and liability. And what happened was, in 10 years, in 10 budget years, our costs tripled in the state of Tennessee.

So, it is about, how do you hold the costs down?

I have sympathy. I have been a provider for all these years of health insurance. That is the major problem in America is the cost of the care. If it was all affordable, we could all have it.

I yield back.

Mr. DESJARLAIS. Okay, thank you for the history lesson. I know that you have those numbers well in mind.

Mr. Miller, we have heard supporters of the new law claim that Republicans have not provided concrete ideas or suggestions to change financial incentives in health care and expand access to affordable, quality coverage. However, your testimony suggests there are alternatives to Obamacare.

Can you elaborate on some of the alternative proposals to reform the health care system and design the lower costs of coverage and increase access?

Mr. MILLER. Let me put that in two tiers. I mean, I think that the actual, official congressional responses are still evolving. We have an earlier history of proposals in the House, and individual members in the Senate.

If you are asking for what I would advise the people I have spoken to along those lines, we need to do several things. We need to first, unfortunately, undo the damage. We lost 2 years on the clock, and we have gone in the wrong direction. So, we cannot over-extend our resources and, basically, overload the entire system with what has happened.

Some positive proposals, though. They have all limited effects in isolation. You have to combine them. The old toolkit includes ways to reduce regulatory costs.

Cross-state purchasing is one proposal in that regard. We certainly hear a lot about medical malpractice reform. It will make some contribution in that regard.

We ultimately need to step up to the plate in terms of rearranging the overall subsidy structure in health care financing. While putting more money into a different, more extensive version of high-risk pools, what is in the current law has failed in that regard. That would deal with what are the serious problems of people who have substantial spikes and continued problems in health care costs.

We then need to think about how we are going to rearrange our tax subsidies, not only for our private health insurance, but climb up to the plate on Medicare. We do need to make some cost changes in Medicare.

Unfortunately, most of the low-hanging fruit that was raided for Medicare spending reduction was then plowed right back into the system for the other type of entitlement in the private side.

Medicaid has been overloaded. We need to restructure that.

So, essentially, to be simple, we need more transparent measures of the value of health care being provided.

We talk a lot about insurance and financing. But until we change the cost of care, we have not changed that basic problem.

There are a lot of hypotheticals in the law, which someday, somehow might eventually happen. We need to get the private sector involved in actually making them come about.

You can change, realign the incentives, but we are going to have to solve this problem by having care delivered at a lower cost with better outcomes. We need to measure it, make that more transparent to consumers, and then empower everybody else in the marketplace as opposed to Washington to make those decisions.

Mr. DESJARLAIS. Thank you, Mr. Miller.

Mr. Chairman, I yield back.

Chairman ROE. I would thank the gentleman for yielding.

Mr. Kildee?

Mr. KILDEE. Thank you, Mr. Chairman.

Mr. Miller, a witness before the Senate Budget Committee stated that employees who have employer-sponsored health care do not have, as he put it, enough skin in the game—a round-about way of saying that workers need to pay more for health care, so they do not use it as much.

In 2009, though, 60 percent of bankruptcies were caused by medical bills. Seventy-five percent of these bankruptcies were filed by workers who actually had health insurance.

Mr. Miller, you are on record supporting a road map offered by Congressman Paul Ryan. In that road map, Congressman Ryan proposes raising taxes on working families by eliminating the individual income tax exclusion for employer-sponsored health care.

Can you say that workers do not pay enough for health care when the bankruptcy figures indicate that even those who have assistance file for bankruptcy more than any other reason?

Mr. MILLER. What I can say is that 60 percent figure, and the conclusions that run from it, are erroneous. We have done work on that, primarily my colleague, Aparna Mathur, which, if you examine what that is based upon, there are a lot of reasons for bankruptcies.

They are not due to people paying too much for health care. Often these are done in a way that it says, as long as you had a medical bill along the way, it is then imputed that that somehow was what caused the bankruptcy.

We have serious economic problems in the country. I just think that is a miscalculation as to what is the cause and the effect in that regard.

On the larger issue as to whether workers are paying too much or too little, that is not the issue. The issue is whether or not they can see a way to find a better combination of health care that delivers improved health outcomes for them at a lower cost.

We have a structure which hides those price tags, hides the results, does not give the information that they need in that regard.

If you look at the measures as to how much workers are actually paying out-of-pocket for their health care, as opposed to what is rerouted through a very expensive, costly and inefficient insurance system, the vast proportion of that still flows through third party insurance.

There has been an increase in the amount of cost-sharing in some sectors of the marketplace through what are called consumer-driven health plans. They are probably about 20 percent of the market without necessarily having accounts. That has tended to slow down the overall increase in health care spending and in health insurance costs, and has been a positive.

The law is fundamentally aimed against it. It will not succeed in stopping that, because when we are about 5 years from now, we are not going to be able to pay for all this stuff we say is going to be covered by insurance, and we will end up resorting to that type of cost-sharing implicitly anyway.

Mr. KILDEE. Do you think we should repeal the exemption for the worker who gets part of his——

Mr. MILLER. We need to change it. It is somewhat of a distraction. We need to think about what assistance you provide to people through the tax system to help them buy health insurance.

But when we actually add it up, everyone is going to have to pay some money themselves. We cannot subsidize everyone's bill and think they all come out ahead.

It has tended to drive up the cost of care, the cost of insurance. And we pretend that it actually brings us ahead, and it sets us further back.

If you are not going to eliminate public assistance through the tax code, you are going to move it in a different direction.

The Ryan proposal that you partly described does not eliminate tax relief. It puts it in a different form in more of a defined contribution approach, which flows directly to individuals to decide how they are going to spend it on their health care and their health insurance, as opposed to routing it through third parties. If they want to stay in an employer plan, they will do that.

Mr. KILDEE. I thank you. And if you can get some of the figures that you said differ from these to us, I would appreciate that.

Mr. MILLER. Yes. We will be happy to provide you with a different analysis of—there are bankruptcy problems and economic problems.

But I know the studies. They have been around for a while. They get recycled. They take the wrong database. They do it in a different way.

But I would be happy to provide you with some information on that.

Mr. KILDEE. Thank you very much, Mr. Miller.

[The information follows:]

Question for the Record Submitted by Mr. Kildee

Mr. Miller, at the hearing I cited a figure that stated 60 percent of bankruptcies were caused by medical bills. You responded that the 60 percent figure is erroneous and that you have a different analysis to prove your claim. Can you provide this analysis to the Committee?

Response From Mr. Miller to Mr. Kildee's Question for the Record

At the March 10 hearing of the House Education and the Workforce subcommittee on Health, Employment, Labor, and Pensions regarding the overall topic of "Employer Health Costs," Rep. Kildee asked me a question following my oral testimony. It related partly to cost sharing by employees in employer-sponsored health insurance plans and also to a recent study claiming that 60 percent of bankruptcies were caused by medical bills, and that seventy-five percent of these bankruptcies were filed by workers who actually had health insurance. As I recall, I referenced some of the related research on that topic by my AEI colleague, Resident Scholar Aparna Mathur, which challenges the methodologies and findings in that study and other related ones. Essentially, she concludes that there are a number of significant causes of bankruptcies besides medical bills, and the "Himmelstein et al." line of studies fails to connect causes with effects. .

Now the Rep. Kildee has submitted a shorter, subsequent version of this question to Chairman Roe as a formal part of the hearing record and requested a written analysis of the 60-percent bankruptcy claim, I have attached one immediately below by Ms. Mathur, along with links to some of our other work in this field.

Problems with the Himmelstein et al. (2005 and 2009) Studies, and the Massachusetts Study

(1) Sample Selection Issues

A major shortcoming with both the Himmelstein et al. (2005 and 2009) studies is what economists dub the "sample selection issue". Himmelstein et al. (2005, 2009) conducted a survey of bankruptcy filers from public court records for the year 2001 and 2007. Based on a sample of 1000 debtors, they concluded that more than 50 percent of these had filed for bankruptcy due to a medical reason. By limiting the sample to those who had already filed for bankruptcy, the study overstated the incidence of medical debt. To account for causation, the study sample should have, at the very least, included a "control" group of medical debtors who did not file for bankruptcy. In other words, if the authors were trying to establish whether medical debts cause bankruptcy filings, the appropriate sample should have included households with and without medical debt, and households who filed or did not file for bankruptcy. In short, what the authors have established is some correlation, but not causation.

The sample also seems skewed towards debtors with high medical debt. The USTP report of bankruptcy filers, which included a much larger sample of 5203 filers, found that 90 percent of filers had medical debts less than $5000. The Himmelstein et al.(2009) study reports nearly 35 percent of filers with more than $5000 in medical debt. The authors make no attempt to reconcile or explain their findings or reveal the distribution of medical debts across filers in their sample.

(2) Regression Analysis

The study also should have allowed for the possibility that other household characteristics, such as the filer's work status, marital status, income, and other kinds

of debts could have influenced the filing. As explained earlier, this could be done through the use of appropriate regression techniques applied on a suitably large, random sample of filers and non-filers. Mainstream economics literature discussing the relationship between debts and bankruptcy amply outlines these standard considerations. The study does claim to have done multivariate analysis, but the analysis is done on an even more restricted sample than the original 1032 in 2007. The sample only includes people who reported having any medical bills. Therefore, it simply assumes that medical debts are important for bankruptcy filing, rather than testing for that hypothesis in the entire sample of bankruptcy filers.

(3) Definition of Medical Bankruptcy

The 2005 study used an overly broad definition of "medical filers," which included people with any sort of addiction or uncontrolled gambling problems.

The 2009 study removed these clauses but still came up with a 62 percent number; i.e., nearly 62 percent of bankruptcy filings are due to medical reasons. The reason for the high number is puzzling, though as mentioned earlier, it is partly driven by the fact that the authors ascribe any remotely medical factor as causing the bankruptcy filing, not just medical debts. The survey results shown in Table 2 (Page 3) of the study clearly state that only 29 percent of the respondents believed that their bankruptcy was actually caused by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than $5000 in medical bills, and the percent of people reporting any medical problems. This is clearly an overstatement of the problem. Since the respondents themselves do not believe that these other factors caused the bankruptcy filing, it is wrong to ascribe the additional bankruptcy filings to their medical costs. A related point is that the survey fails to provide information on other causes of the bankruptcy filing or how the respondents would rank different factors, as in the PSID. Therefore, it is unclear whether medical bills were the most important cause or just another cause.

This criticism was also raised by Dranove and Millenson in reference to the 2005 paper. Exhibit 2 of that paper identified people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, Dranove and Millenson conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, it cannot be stated with any degree of certainty whether medical spending was the most important cause of bankruptcy.

The latest study by Himmelstein et al. suffers from the same kinds of issues as the earlier studies. The new study focuses on the impact of the Massachusetts Health Reform on medical bankruptcies. The study relies on the change in the percentage of people reporting medical bankruptcies between 2007 and 2009. Unfortunately, the 2007 survey did not especially focus on Massachusetts, so the authors are forced to rely on simply the 44 respondents who were from that state in the earlier survey. It compares that to the new 2009 survey relying on 199 people. The paper finds that the percentage of medical bankruptcies actually declined by a significant 6.4 percentage points. However, in absolute terms, the number of medical bankruptcies increased from 7,504 to 10,093. The fact that the percentage of medical bankruptcies in the population declined suggests that the growth rate of medical bankruptcies was lower than the growth rate of bankruptcies in the total population. Therefore, it is not clear from this statistic alone, whether the health reform had a positive, negative or any impact on medical bankruptcies. A proper analysis would include a sufficiently large-scale survey both before and after the Reform, which would also account for other contemporaneous changes in economic conditions in Massachusetts. Moreover, as mentioned earlier, more rigorous regression techniques would be required to establish causality. Factors that may be important at the household level as well as at the state level need to be controlled for. Further, the definition of a medical bankruptcy used in the 2009 study is subject to the same criticism as in the earlier study. To summarize, the new study provides no conclusive proof one way or the other of the effect of the Massachusetts reform on medical bankruptcies.

In addition, please see the following related testimony and research:

"The Medical Bankruptcy Fairness Act" Aparna Mathur, Testimony before House Committee on the Judiciary, July 15, 2010.

http://www.aei.org/speech/100157

"Can Bankruptcy Reform Facilitate a Fresh Start?" Aparna Mathur, Testimony before Senate Subcommittee on Administrative Oversight and the Courts, October 20, 2009

http://www.aei.org/speech/100089

"Medical Debt: Is Our Healthcare System Bankrupting Americans?" Aparna Mathur. Testimony before House Committee on the Judiciary, July 28, 2009.

http://www.aei.org/speech/100071

"Maxing out on Debt Hysteria," Aparna Mathur and Tom Miller, The American, June 20, 2007

http://www.american.com/archive/2007/june-0607/maxing-out-on-debt-hysteria

"Medical Bills and Bankruptcy Filings," Aparna Mathur, AEI Working Paper 24680, July 19, 2006

http://www.aei.org/docLib/20060719—MedicalBillsAndBankruptcy.pdf

"The Healthcare Bankruptcy Myth," Diana Furchtgott-Roth, RealClearMarkets.com, July 30. 2009

http://www.realclearmarkets.com/articles/2009/07/30/the—medical—bankruptcy—myth—97335.html

"Medical Bankruptcy: Myth vs. Fact," David Dranove and Michael Millenson, Health Affairs 74 (2006).

Chairman ROE. Mrs. Roby?

Mrs. ROBY. Thank you, Mr. Chairman.

Thank you so much to the witnesses for taking the time to be here this morning.

So, in a very timely fashion, just yesterday, the Montgomery Chamber of Commerce from Montgomery, Alabama, was here in Washington, and I met with them. And the mayor of Montgomery was present.

And during this meeting I learned that the City of Montgomery—and I served on the city council there from 2003 until just recently—they are going to see an increase in their health care premiums by $4.6 million this year, due to Obamacare.

And I guess I can direct this to Mr. Brewer, because I saw in your testimony where you also work with governmental employers.

And then, Mr. Miller, if you will address it, as well.

But the president promised in 2008 that his health care reform efforts would lower health insurance premiums for families by as much as $2,500.

So, I am having a hard time understanding why, then, the City of Montgomery is not seeing a decrease in their premiums for the cost of their employees.

Mr. BREWER. I cannot speak to where that came from.

What I can speak to is the reality of what has happened with the benefit mandates that have been imposed upon employers like the City of Montgomery, Alabama, larger, self-funded groups. I am presuming they are self-funded, would be my guess.

But the immediate benefit mandates, as I indicated in my testimony, increase cost to employers like the City of Montgomery by about 2.5 percent this year. The auto-enrollment feature down the road will add incrementally more cost to it.

It certainly would have been great, had the Congress been able to deliver a bill that actually reduced the cost of health insurance coverage for the vast majority of employers in the United States.

It would have been a message that probably would have resonated better and been better received.

Regrettably, I think the bill falls short in a number of areas of addressing the actual root causes of the cost, increasing cost of health care. With all due respect to Mr. Kucinich, I do not believe that the insurance companies, in and of themselves, are the problem. I think there are plenty of other areas where there are opportunities for savings.

So, Mr. Miller?

Mr. MILLER. Yes, I would agree with that last comment by Mr. Brewer. Certainly, we all can do better, and it is also distributed in that regard.

The $2,500, let us be straightforward about it, was a campaign document. I know the scholars who put it together, and you put this on the back of the envelope, and you make pretend it will happen.

They have been backpedaling from that and rearranging what it is supposed to eventually do. A lot of it now is basically, well, you are going to get all this tax money from other people. And that is how you are saving your $2,500.

It has not brought down the essential cost of care. There are important things that need to be done in restructuring our health care delivery system, making everybody participating in it more accountable.

Hypothetically, there are a lot of grand plans, you know, national strategies, but we do not have anything deliverable in the first couple of years.

What this legislation essentially was about was about redistribution of money without fixing the problem, so the costs just move one place to another. Some people win, some people lose. If you happen to be one of the tiny handful of people who might qualify for a small business tax break, you are a winner.

It does not deal with the larger organic system, which is that all of the care costs too much compared to what is given. We have got to make some decisions in that regard and get that more transparent.

So, when you move past the politics of getting a law passed by any means, the question is: How do we drive forward and think about what is actually going to get to the causes of these costs?

Until care is delivered earlier, cheaper and better, and people are healthier and do other things outside of the health care system, which means they are presenting fewer things to the table, no matter how much we do to tweak the tiny amount of insurance that is administrative costs, which have been going down for the last 5 years as a percentage of the premium; until we actually change that underlying cost growth, which is what gets reflected in the premium—we can fight about whether insurers are evil or slightly bad—it does not make a difference.

And if we think we can route all this money through our tax system, there is no money left. We can just borrow some more and have it go back and forth.

We cannot continue subsidizing. We actually have to confront the fact that we have got to get better care at a lower price. When we

get to that stage, then we will have real reform. That is not what this bill was about.

Mrs. ROBY. And I appreciate your comments, both of you, on this issue.

But to go to the point that you just made, municipalities and local governments all over this country are required by law to balance their budgets.

Mr. MILLER. That is correct.

Mrs. ROBY. And so, when you see this kind of impact in a local municipality on their smaller budget, it can be quite devastating. They do not print money.

Mr. MILLER. And they have other problems with their employee health care——

Mrs. ROBY. That is right.

Mr. MILLER [continuing]. Their retirees, their pensions. We are seeing all this kind of collapse on it, because we could afford our way around all these mistakes for a long period of time.

And now, we have hit the margins where suddenly there is not someone else to pick up the tab. We are going to have to rework it.

Mrs. ROBY. Thank you. My time is up.

Thank you, Mr. Chairman.

Chairman ROE. Thank you for yielding.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Mr. Chairman.

My question is directed to Mr. Houser.

Mr. Houser, I want to thank you for your participation. You say in your written testimony that your insurance costs for your nine full-time employees and covered dependents doubled from 2002 through 2010, eating into more than 20 percent of your payroll. That is long before we started this health reform.

As a small business owner, I know the difficulty of providing quality and affordable coverage to employees, because I was president of a family business for 20 years and understand the choices you have to make. I experienced first-hand how, year after year, every dollar I spent on health insurance for my employees bought less and less.

Given that, number one, the Affordable Care Act places no requirement on small businesses with fewer than 50 full-time employees, and being that the Affordable Care Act provides incentives and tax breaks, as you pointed out in your remarks, for those small businesses that do offer coverage, it is important that the record show that President Obama did not promise that the premiums were going to drop $2,500 in 2011, when it starts and begins to ramp up.

He did say that the real bulk of the law will be implemented by 2014, and that at that time, we will have insured an additional 30 million people, thus being able to reduce the cost. And some of our other witnesses are trying to make this appear as though the president did not keep his word, or that he misled people.

But there is no question that, as people in my district find out the benefits of this health reform, that they are very happy. And they are hoping that we will tweak it, but certainly not repeal it.

I would like to ask you this question. Do you expect that tough choice I mentioned earlier to get tougher, or easier, going forward for your business and small businesses like yours that you talk to?

Mr. HOUSER. I am sorry. I did not understand.

Mr. HINOJOSA. Do you expect that, between now and 2014, that things are just going to be so tough that you would not be able to offer health insurance to your employees?

Mr. HOUSER. No, Congressman, not at all. I believe, especially based on the most recent trend with our premiums actually going down, and with the State of Oregon being very actively pursuing the exchange, which will, if the legislation goes through at the state level that is currently being proposed, will change the formula for how health care is paid for from the fee-for-procedure, fee-for-service to fee-for-outcomes.

Mr. HINOJOSA. So, you are optimistic that this is going to be——

Mr. HOUSER. It will go down.

Mr. HINOJOSA [continuing]. For small businesses.

Mr. HOUSER. And we will continue to have health care.

Mr. HINOJOSA. I would like to yield time to Congressman Dennis Kucinich.

Mr. KUCINICH. I want to thank my friend, Mr. Chairman.

I ask unanimous consent to enter into the record the American Journal of Medicine report on medical bankruptcies in the United States, 2007. It is a result of a national study.

[The information follows:]

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

Medical Bankruptcy in the United States, 2007: Results of a National Study

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ABSTRACT

BACKGROUND: Our 2001 study in 5 states found that medical problems contributed to at least 46.2% of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened.

METHODS: We surveyed a random national sample of 2314 bankruptcy filers in 2007, abstracted their court records, and interviewed 1032 of them. We designated bankruptcies as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

RESULTS: Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over $5000, or 10% of pretax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6%. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001.

CONCLUSIONS: Illness and medical bills contribute to a large and increasing share of US bankruptcies.

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KEYWORDS: Bankruptcy; Health care costs; Health economics

As recently as 1981, only 8% of families filing for bankruptcy did so in the aftermath of a serious medical problem.[1] By contrast, our 2001 study in 5 states found that illness or medical bills contributed to about half of bankruptcies.[2]

Since then, the number of un- and underinsured Americans has grown;[3] health costs have increased; and Congress tightened the bankruptcy laws.[4]

Here we report the first-ever national random-sample survey of bankruptcy filers.

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METHODS

We used 3 data sources: questionnaires mailed to debtors immediately after bankruptcy filing; court records; and telephone interviews with a sub-sample of debtors.

Sample Design

Between January 25 and April 11, 2007, we obtained from Automated Access to Court Electronic Records, a list of all 118,308 bankruptcy petitions filed in the US. We excluded filings in Guam and Puerto Rico, nonpersonal bankruptcies, and cases missing a name or address. Within 2 weeks of their filings, we mailed introductory letters to 5251 randomly selected debtors; 275 were returned as undeliverable. We then mailed self-administered questionnaires to the 4976 debtors with valid addresses; 2314 (46.5%) were completed and returned; 124 were returned incomplete (2.5%) and 83 (1.7%) declined to participate; 2455 (49.3% of those with valid addresses) did not respond.

We compared court records (described below) of respondents with a random sample of 99 nonrespondents. Nonre-

spondents resembled respondents in income, assets, debts, net worth, market value of homes, and history of prior bankruptcy.

Questionnaire

Introductory letters described the study and offered debtors the option of obtaining a Spanish-language version of the questionnaire. The questionnaire and $2 were mailed a few days later. Nonrespondents received replacement questionnaires, another $2, and were invited to respond via telephone or on-line. Subsequently, we offered nonrespondents $50 to complete the questionnaire.

The questionnaire asked about demographics, health insurance and gaps in coverage, occupation, employment, housing, and efforts to cope financially before filing. It also asked about specific reasons for filing for bankruptcy; the range of out-of-pocket medical expense (none, $1-$999, $1000-$5000, or >$5000); loss of work-related income; and borrowing to pay medical bills. Finally, it asked respondents if, for $50, they would be willing to complete a follow-up interview.

Court Records

We obtained the public bankruptcy court records of respondents and the sample of nonrespondents from the federal court's electronic filing system. Research assistants (mainly law students) abstracted each record.

The court records included the chapter of filing, income, assets, and debts outstanding at the time of filing. These records indicate the creditor to whom money is owed, but not why the debt was incurred.

Telephone Interviews

There were 2314 debtors who completed questionnaires, 2007 of whom were willing to be interviewed. By February 2008, research assistants had completed telephone interviews (in English or Spanish) with 1032 of them; 69 debtors no longer wished to be interviewed. We were unable to reach 906.

Interviewers collected additional detail about employment, finances, housing, borrowing to pay medical bills, and whether medical bills or income loss due to illness had contributed to their bankruptcy (questions we used to verify written questionnaire responses from the entire sample of 2314 debtors).

The 1032 telephone interviews identified 639 patients (debtors or dependents) whose health problems contributed to bankruptcy; details about medical expenses, health insurance, and diagnoses were obtained. Two physicians grouped diagnoses into 14 categories.

Telephone survey participants resembled other respondents on most financial and demographic characteristics. They were slightly older and better educated.

CLINICAL SIGNIFICANCE

- 62.1% of all bankruptcies have a medical cause.
- Most medical debtors were well educated and middle class; three quarters had health insurance.
- The share of bankruptcies attributable to medical problems rose by 50% between 2001 and 2007.

Data Analysis

We used data from the questionnaires and court records to analyze demographics, health insurance coverage at the time of filing, and gaps in coverage.

The questionnaires were the basis for our 2001-2007 time trend analysis. For this analysis, we replicated the most conservative definition employed in the 2001 study, which designated as "medically bankrupt" debtors citing illness or medical bills as a specific reason for bankruptcy; OR reporting uncovered medical bills >$1000 in the past 2 years; OR who lost at least 2 weeks of work-related income due to illness/injury; OR who mortgaged a home to pay medical bills. Debtors who gave no answers regarding reasons for their bankruptcy were excluded from analyses.

For all other analyses (ie, those not reporting time trends) we adopted a definition of medical bankruptcy that utilizes the more detailed 2007 data. We altered the 2001 criteria to include debtors who had been forced to quit work due to illness or injury. We also reconsidered the question of how large out-of-pocket medical expenses should be before those debts should be considered contributors to the family's bankruptcy. Although we needed to use the threshold of $1000 in out-of-pocket medical bills for consistency in the time trend analyses, we adopted a more conservative threshold—$5000 or 10% of household income—for all other analyses. Adopting these more conservative criteria reduced the estimate of the proportion of bankruptcies due to illness or medical bills by 7 percentage points.

To arrive at nationally representative estimates, we weighted the data to adjust for the slight underrepresentation of respondents who filed under Chapter 13 (bankruptcies with repayment plans). In calculating mean out-of-pocket medical expenses from our telephone interviews, we trimmed outliers at $100,000.

Chi-squared and 2-tailed t tests were used for univariate analyses. We used forward stepwise logistic regression analysis on the 2007 cohort to assess predictors of medical bankruptcy and predictors of home loss or foreclosure among homeowners. Finally, we performed logistic regression using the combined 2001 and 2007 cohorts to examine whether the odds of a bankruptcy being medical were higher in 2007 than in 2001, after controlling for demographics, income, and insurance status. SAS Version 9.1 (SAS Institute Inc., Cary, NC) was used for all analyses.

Table 1 Demographic Characteristics of 2314 Bankruptcy Filers and Comparison of Medical and Nonmedical Filers, 2007*

	All Bankruptcies	Medical Bankruptcies	Nonmedical Bankruptcies	*P* Value Medical vs Nonmedical Bankruptcies
Mean age	44.4 years	44.9 years	43.3 years	.01
Debtor or spouse/partner male	44.5%	44.9%	44.3%	NS
Married	43.9%	46.3%	40.1%	.02
Mean family size—debtors + dependents	2.71	2.79	2.63	.02
Attended college	61.9%	60.3%	65.8%	.02
Homeowner or lost home within 5 years	66.7%	66.4%	67.8%	NS
Current homeowner	52.3%	52.0%	53.2%	NS
Occupational prestige score >20	87.3%	86.1%	89.8%	.01
Mean (median) monthly household income at time of bankruptcy filing	$2676 ($2299)	$2586 ($2225)	$2851 ($2478)	.002
Debtor or spouse/partner currently employed	79.2%	75.5%	85.0%	.001
Debtor or spouse/partner active duty military or veteran	19.4%	20.1%	18.4%	NS
Market value of home (mean)	$147,776	$141,861	$159,145	.03
Mean net worth (assets—debts)	−$41,474	−$44,622	−$37,650	NS

*Bankruptcies meeting at least one of the following criteria: illness, injury or medical bills listed as specific reason for filing OR uncovered medical bills >$5000 or >10% of annual family income OR, lost ≥2 weeks of work-related income due to illness/injury, OR depleted home equity to pay medical bills.

Human subject committees at Harvard Law School and The Cambridge Health Alliance approved the project.

RESULTS

The demographic characteristics of our sample are shown in Table 1. Most debtors were middle aged, middle class (by occupational prestige),[5] and had gone to college. Their modest incomes reflect the financial setbacks common in the peri-bankruptcy period. Two thirds were homeowners.

Compared with other debtors, medical debtors had slightly lower incomes, educational attainment, and occupational prestige scores; more were married and fewer were employed (reflecting more disability). Medical debtors were older and had larger families. Although similar proportions were homeowners, medical debtors' homes had 11% lower market value. The average net worth was similar (and negative) for medical and nonmedical debtors (−$44,622 vs −$37,650, $P > .05$).

Medical Causes of Bankruptcy

Illness or medical bills contributed to 62.1% of all bankruptcies in 2007 (Table 2).

Unaffordable medical bills and income shortfalls due to illness were common; 57.1% of the entire sample (92% of the medically bankrupt) had high medical bills, proportions that did not vary by insurance status; 5.7% of homeowners had mortgaged their homes to pay medical bills; 40.3% of the entire sample had lost income due to illness; 95% of the lost-income debtors also had high medical bills.

Data from the detailed telephone survey yielded confirmatory results. When asked about problems that contributed very much or somewhat to their bankruptcy, 41.8% of interviewees specifically identified a health problem, 54.9% cited medical or drug costs, and 37.8% blamed income loss due to illness. Overall, 68.8% cited at least one of these medical causes. An additional 6.8% had recently borrowed money to pay medical bills.

Insurance Status of Debtors and Dependents

Less than one quarter of debtors—whether medical or nonmedical—were uninsured when they filed for bankruptcy; an additional 7% had uninsured family members (Table 3). Medically bankrupted families, however, had more often experienced a lapse in coverage during the 2 years before filing (40.0% vs 34.1%, $P = .005$).

Table 2 Medical Causes of Bankruptcy, 2007*

	Percent of All Bankruptcies
Debtor said medical bills were reason for bankruptcy	29.0%
Medical bills >$5000 or >10% of annual family income	34.7%
Mortgaged home to pay medical bills	5.7%
Medical bill problems (any of above 3)	57.1%
Debtor or spouse lost ≥2 weeks of income due to illness or became completely disabled	38.2%
Debtor or spouse lost >2 weeks of income to care for ill family member	6.8%
Income loss due to illness (either of above 2)	40.3%
Debtor said medical problem of self or spouse was reason for bankruptcy	32.1%
Debtor said medical problem of other family member was reason for bankruptcy	10.8%
Any of above	62.1%

*Percentage based on recent homeowners rather than all debtors.

Table 3 Health Insurance Status of Debtor Households With and Without Medical Causes of Bankruptcy

	Medical Bankruptcy	Nonmedical Bankruptcy	*P* Value
Debtor or a dependent uninsured at time of bankruptcy filing	30.8%	30.7%	.93
Debtor or a dependent had a lapse in coverage during 2 years before bankruptcy filing	40.0%	34.1%	.005

In multivariate analysis, being uninsured at filing did not predict a medical cause of bankruptcy, while a gap in coverage did (odds ratio [OR] = 1.35, $P = .002$). Other predictors included: older age (OR = 1.016/year, $P = .0001$), married (OR = 1.59, $P = .0001$), female (OR = 1.34, $P = .002$), larger household (OR = 1.97/household member, $P = .01$), and lower income quartile (OR = 1.30, $P = .0001$).

Medical debtors' court records identified more debt owed directly to doctors and hospitals than did nonmedical debtors', a mean of $4988 vs $256, respectively ($P < .0001$). Medical debtors with coverage gaps owed providers a mean of $8338, vs $2740 ($P < .0001$) for medical debtors with continuous coverage. Nonmedical debtors had few medical debts, averaging under $300 regardless of insurance status. (Medical debts financed through credit cards or other borrowing, or owed to collection agencies are not included because they cannot be identified through court records.)

Patients Whose Illness Contributed to Bankruptcy

Telephone interviews identified 639 patients whose illness contributed to bankruptcy: the debtor or spouse in 77.9% of cases; a child in 14.6%; and a parent, sibling or other adult in 7.5%. At illness onset, 77.9% were insured: 60.3% had private insurance as their primary coverage; 10.2% had Medicare; 5.4% had Medicaid; and 2% had Veterans Affairs/military coverage. Few of the uninsured lacked coverage because of a preexisting condition (2.8%) or belief that coverage was unnecessary (0.3%); nearly all cited economic reasons.

By the time of bankruptcy, the proportion of patients with private coverage had fallen to 54.1%, while the percentage with Medicare and Medicaid had increased to 16.4% and 9.9%, respectively. The proportion whose employers contributed to coverage decreased from 43.2% to 36.6%.

Out-of-pocket medical costs averaged $17,943 for all medically bankrupt families: $26,971 for uninsured patients, $17,749 for those with private insurance at the outset, $14,633 for those with Medicaid, $12,021 for those with Medicare, and $6545 for those with Veterans Affairs/military coverage. For patients who initially had private coverage but lost it, the family's out-of-pocket expenses averaged $22,568.

Among common diagnoses, nonstroke neurologic illnesses such as multiple sclerosis were associated with the highest out-of-pocket expenditures (mean $34,167), followed by diabetes ($26,971), injuries ($25,096), stroke ($23,380), mental illnesses ($23,178), and heart disease ($21,955).

Hospital bills were the largest single out-of-pocket expense for 48.0% of patients, prescription drugs for 18.6%, doctors' bills for 15.1%, and premiums for 4.1%. The remainder cited expenses such as medical equipment and nursing homes. While hospital costs loomed largest for all diagnostic groups, for about one third of patients with pulmonary, cardiac, or psychiatric illnesses, prescription drugs were the largest expense.

Our telephone interviews indicated the severity of job problems caused by illness. In 37.9% of patients' families, someone had lost or quit a job because of the medical event; 24.4% had been fired, and 37.1% subsequently regained employment. In 19.9% of families suffering a job loss, the job loser was a caregiver.

Changes in Medical Bankruptcy, 2001 to 2007

In our 2007 study, 69.1% of the debtors met the legacy definition of medical bankruptcy employed in our 2001 study, a 22.9 percentage point absolute increase (49.6% relative increase) from 2001, when 46.2% met this definition ($P < .0001$). (Inflation, which might edge families over our $1000 medical debt threshold, did not account for this change. An analysis that used all criteria except the size of medical debts found a 48.7% relative increase. An analysis limited to the 5 states in our 2001 study yielded virtually identical findings.

In multivariate analysis, a medical cause of bankruptcy was more likely in 2007 than in 2001 (OR = 2.38, $P < .0001$) (Table 4).

DISCUSSION

In 2007, before the current economic downturn, an American family filed for bankruptcy in the aftermath of illness every 90 seconds; three quarters of them were insured.

Since 2001, the proportion of all bankruptcies attributable to medical problems has increased by 50%. Nearly two thirds of all bankruptcies are now linked to illness.

How did medical problems propel so many middle-class, insured Americans toward bankruptcy? For 92% of the medically bankrupt, high medical bills directly contributed to their bankruptcy. Many families with continuous coverage found themselves under-insured, responsible for thousands of dollars in out-of-pocket costs. Others had private coverage but lost it when they became too sick to work. Nationally, a quarter of firms cancel coverage immediately when an employee suffers a disabling illness; another quar-

Table 4 Multivariate Predictors of Medical Causes of Bankruptcy, 2001 and 2007 Combined

	Odds Ratio	95% Confidence Interval	*P* Value
Age	1.02	1.01–1.02	.0001
Married	1.32	1.13–1.55	.0006
Own home now or in past 5 years	1.10	0.93–1.30	NS
All family members insured at time of filing	1.23	1.03–1.46	.02
Gap in health insurance coverage for any family member within past 2 years	1.64	1.38–1.94	.0001
Income quartile	.99	.82–1.07	NS
Attended college	1.02	.87–1.18	NS
Year of bankruptcy filing, 2007 vs 2001	2.38	2.05–2.77	.0001

ter do so within a year.[6] Income loss due to illness also was common, but nearly always coupled with high medical bills.

The present study and our 2001 analysis provide the only data on large cohorts of bankruptcy filers derived from in-depth surveys. As with any survey, we depend on respondents' candor. However, we also had independent checks—from court records filed under penalty of perjury—on many responses. Because questionnaires and court records were available for our entire sample, we used them for most calculations. The lowest plausible estimate of the medical bankruptcy rate from these sources is 44.4%—the proportion who directly said that either illness or medical bills were a reason for bankruptcy. But many others gave reasons such as "aggressive collection efforts" or "lost income due to illness" and had large medical debts. Indeed, detailed telephone interview data available for 1032 debtors revealed an even higher rate of medical bankruptcy than our 62.1% estimate—at least 68.8% of all filers.

Our current methods address concerns expressed about our previous survey. We assembled a random, national sample and asked far more detailed questions. In addition, we adopted more stringent criteria for medical bankruptcy. Adopting an even more stringent threshold for medical debts (eg, eliminating those with medical debts below 10% of family income) would reduce our estimate by <1%.

Teasing causation from cross-sectional data is challenging. Multiple factors push families into bankruptcy. Yet, our data clearly establish that illness and medical bills play an important role in a large and growing proportion of bankruptcies.

Changes in the Law

Between our 2001 and 2007 surveys, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which instituted an income screen and procedural barriers that made filing more difficult and expensive. The number of filings spiked in mid-2005 in anticipation of the new law, then plummeted. Since then, filings have increased each quarter. They are likely to exceed one million households in 2008, representing about 2.7 million people.

BAPCPA's effects appear nonselective. Current filers differ from past ones mainly in having struggled longer with their debts.[7] New restrictions fall equally on medical and nonmedical bankruptcies, with no preferences for medical debts or sick debtors. It is implausible to ascribe the growing predominance of medical causes of bankruptcy to BAPCPA.

Conversely, there is ample evidence that the financial burden of illness is increasing. The number of under-insured increased from 15.6 million in 2003 to 25.2 million in 2007.[3] Of low- and middle-income households with credit card balances, 29% use credit card borrowing to pay off medical expenses over time.[8] Collection agencies contacted 37.2 million Americans about medical bills in 2003.[9] Between 2005 and 2007, the proportion of nonelderly adults reporting medical debts or problems paying medical bills rose from 34% to 41%.[10]

Adding to Other Studies

We have reviewed elsewhere the older studies on medical bankruptcy.[2,11] Most rely exclusively on court records where many medical debts are invisible, disguised as credit card debt or mortgages. In our cohort, most medical debtors had charged unaffordable medical care to credit cards.

Similarly, debts turned over to collection agencies by doctors or hospitals may be unrecognizable on court records. Moreover, income loss due to illness cannot be identified. In short, even though such studies find substantial rates of medical bankruptcy,[12,13] estimates based solely on court records understate medical bankruptcies.[9]

Population-based studies also are problematic because many debtors are unwilling to admit to filing. Thus, a study based on the Panel Survey of Income Dynamics could identify only 74 bankruptcies (0.4% of respondents), half the actual filing rate among the national population from which the sample was drawn.[13]

A few studies employed novel methods to analyze medical bankruptcy. One found a high bankruptcy filing rate in a cohort of patients with serious neurologic injuries.[14] A survey of cancer patients documented a 3% bankruptcy rate; 7% had taken a second mortgage to pay for treatments.[15] A questionnaire-based study found medical contributors to 61% of Utah bankruptcies; 58% of families seeking help at bankruptcy clinics in upstate New York reported outstanding medical debts.[16]

Medical impoverishment, although common in poor nations,[17,18] is almost unheard of in wealthy countries other than the US.[19] Most provide a stronger safety net of disability income support. All have some form of national health insurance.

The US health care financing system is broken, and not only for the poor and uninsured. Middle-class families fre-

quently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones.

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Chairman ROE. So ordered. Without objection.

Mr. KUCINICH. Thank you, Mr. Chairman.

This study, by the way, is done by a group of physicians from Harvard, and Ph.D.s from Harvard and Ohio University, who found that using a conservative definition, 62.1 percent of all bankruptcies in 2007 were medical.

Now, they have updated this report. I am also going to be submitting for the hearing record the 2010 copy of this report.

And also, I ask unanimous consent to submit for the record a report from the Commonwealth Fund entitled, "Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families," where it points out that an estimated 72 million American

families have bill problems or medical debts relating to medical bill problems or medical debt. And 49.5 are uninsured.

So, there is a problem with, if you have insurance, you are still stuck. So, I would like to submit this for the record.

[The information follows:]

THE COMMONWEALTH FUND

August 2008

Issue Brief

Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families

Michelle M. Doty, Sara R. Collins, Sheila D. Rustgi, and Jennifer L. Kriss

For more information about this study, please contact:

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ABSTRACT: Analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey finds the proportion of working-age Americans who struggled to pay medical bills and accumulated medical debt climbed from 34 percent to 41 percent, or 72 million people, between 2005 and 2007. In addition, 7 million adults age 65 and older had these problems, bringing the total to 79 million adults with medical debt or bill problems. All income groups reported an increase. Families with low or moderate incomes were particularly hard hit, as were adults who had gaps in health coverage or those underinsured. Because of medical bills or accumulated medical debt, an estimated 28 million adults reported they used up all their savings, 21 million incurred large credit card debt, and another 21 million were unable to pay for basic necessities. Sixty-one percent of those with medical debt or bill problems were insured at the time care was provided.

★ ★ ★ ★ ★

OVERVIEW

As health care costs continue to rise and adequate health insurance becomes increasingly unaffordable, many families across the United States are having problems paying for their medical care.[1] High out-of-pocket health spending and sluggish growth in real incomes are contributing to the rise of medical debt[2] and personal bankruptcies, forcing many families to make hard choices among life's necessities. All too often, health insurance and health care are sacrificed along the way.[3]

Drawing from the Commonwealth Fund 2005 and 2007 Biennial Health Insurance Surveys, this study estimates the prevalence and recent growth of medical bill problems and accrued medical debt among nonelderly U.S. adults (ages 19 to 64).[4] Our analysis finds that in 2007, 41 percent of this population—an estimated 72 million people—had problems with payment of medical bills, accrued debt, or both. This represents a significant increase since 2005.

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While families with low or moderate incomes were particularly hard hit, all income groups were affected. And while rates of medical bill problems and debt are highest among the uninsured, people with coverage hardly go unscathed. In fact, about 60 percent of adults who had coverage all year but were "underinsured"—that is, their out-of-pocket medical expenses or deductibles were high relative to their income[5]—reported medical bill problems, more than double the rate for those who had adequate coverage all year (26%).

Notably, adults age 65 or older were far less likely than working-age adults to report medical bill problems or debt (Table 1). Only 19 percent of seniors—half the rate for people under 65 (41%)—reported any medical bill problems or debt. Nearly all seniors have Medicare, which, combined with supplemental private coverage or Medicaid (for those with low income), provides substantial financial protection.

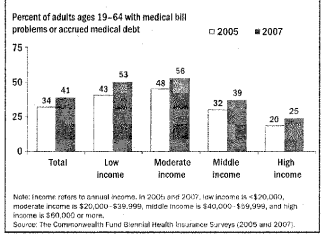
Overall, an estimated 79 million people over the age of 18, including 7 million elderly adults and 72 million adults ages 19 to 64, reported medical bill problems or accumulated medical debt. Given the link between being uninsured or underinsured and having financial problems related to medical bills, the remainder of this issue brief focuses on the 19-to-64 age group, the segment of the population that has been most affected by gaps in coverage and high levels of cost-sharing.

UNAFFORDABLE MEDICAL BILLS

Over the last two years, U.S. adults have become increasingly hard-pressed to pay their medical bills. The survey asked respondents whether they had experienced problems with medical bills over the past year, including if there were times when they had difficulty paying bills or were unable to pay them, whether they had been contacted by a collection agency concerning outstanding medical bills, or whether they had to change their lives significantly to pay their bills. The survey also asked respondents whether they were paying off medical debt over time. In 2007, more than two of five (41%) adults ages 19 to 64, or 72 million people, reported any one of those problems—up from 34 percent in 2005 (Figure 1, Table 2). This increase occurred across all income groups but was sharpest for families with low or moderate incomes: more than half of adults with incomes below $40,000 reported problems with their medical bills in 2007.

Over the two-year period, people experienced increases in all the types of bill payment problems that were examined. In 2007, 27 percent of adults said they had problems paying or were unable to pay their bills, up from 23 percent in 2005, and 18 percent said they had to change their way of life in order to pay their bills, up from 14 percent in 2005. In 2007, 16 percent also reported they had been contacted by a collection agency about bills that had not been paid, compared with 13 percent in 2005 (Figure 2).[6]

Figure 1. Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007



Note: Income refers to annual income. In 2005 and 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).

MEDICAL DEBT: A GROWING PROBLEM

Between 2005 and 2007, the share of adults who said that they were paying off medical bills over time rose significantly. Twenty-eight percent of adults, or 49 million people, said they were paying off medical debt in 2007, up from 21 percent, or 37 million, in 2005 (Figure 2). As a result, an estimated 12 million more working-age adults were grappling with medical debt in 2007 than in 2005.

Many individuals who are paying off their medical bills over time carry substantial debt loads.

Figure 2. Medical Bill Problems and Accrued Medical Debt, 2005–2007

Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).

One-quarter (24%) of adults who were paying off medical bills reported that they were carrying more than $4,000 in debt, and 12 percent had $8,000 or more (Figure 3). Adults who were uninsured for any time during the year had the highest debt loads: more than one-third (34%) of those who were uninsured at the time of the survey and one-quarter (24%) of those who were uninsured for a time in the past year reported debt of $4,000 or more, and 20 percent and 13 percent, respectively, had $8,000 or more in debt. In addition, many people are carrying debt incurred over multiple years: more than one-third (37%) of adults with medical debt had overdue bills from care received more than one year ago, and 8 percent were paying bills from both the previous year and earlier years.

Figure 3. Uninsured Adults Are More Likely to Be Paying Off Large Amounts of Medical Debt Over Time

Percent of adults ages 19–64 who are paying off medical bills over time

	Total	Insured all year	Uninsured Anytime in Past Year: Insured now, time uninsured in past year	Uninsured Anytime in Past Year: Uninsured now
How much are the medical bills that are being paid off over time?				
Less than $2,000	51%	57%	46%	38%
$2,000–$3,999	21	20	25	22
$4,000–$7,999	12	11	11	14
$8,000 or more	12	9	13	20
Was this for care received in past year or earlier?				
Past year	54	57	53	43
Earlier year	37	38	37	44
Both	8	7	9	12

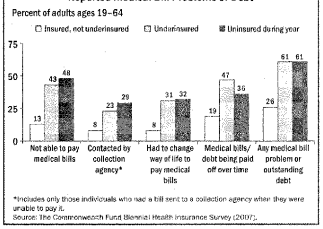
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2007).

THE UNINSURED AND UNDERINSURED ARE BURDENED MOST BY MEDICAL DEBT

Adults who were uninsured for any part of the year reported higher rates of medical bill problems and debt than those who were insured all year long. However, people who had coverage all year but were *underinsured*—meaning they were insured but reported high out-of-pocket medical expenses or deductibles relative to their income[7]—reported medical bill problems at similar rates to those who were uninsured for any part of the year (Figure 4). In 2007, three of five adults who were uninsured or underinsured reported medical bill problems or accrued medical debt—more than double the rate of those who had adequate insurance all year (26%).

Figure 4. Sixty Percent of Underinsured or Uninsured Adults Reported Medical Bill Problems or Debt

Percent of adults ages 19–64



*Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

CONSEQUENCES OF UNPAID MEDICAL BILLS AND DEBT

Confronted with medical bills and debt, many people are forced to make tradeoffs in their spending and saving priorities. The survey asked respondents whether they had to make certain adjustments or sacrifices in the past two years because of medical bills. A significant number of adults with medical debt and unpaid bills—an estimated 28 million—said they used up all their savings because of medical bills (Table 2). Meanwhile, an estimated 21 million adults incurred large credit card debt, and another 21 million were unable to pay for basic necessities like food, heat, or rent because of medical bills. Close to 8 million adults

reported that medical bills caused them to take out a mortgage against their home or take out a loan.

Such tradeoffs were especially common among adults who were uninsured for any time or were underinsured (Figure 5). Nearly half of working-age adults with bill problems or debt who had spent any time without coverage had used up all their savings to pay for medical bills, and two of five were unable to pay for food, heat, or rent. Underinsured adults made similar tradeoffs: 46 percent said they had used all their savings, 33 percent took on credit card debt, and 29 percent were unable to pay for basic necessities.

Figure 5. More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt

		Insured All Year		Uninsured Anytime During Year	
Percent of adults reporting:	Total	No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	28	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

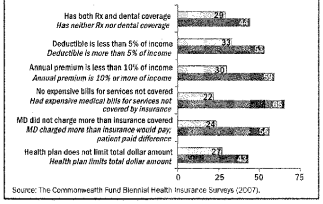
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2007).

INSURANCE DOES NOT GUARANTEE PROTECTION

The fact that American families can have health insurance year-round and still experience financial stress related to medical bills highlights the important role of insurance benefit design in ensuring financial protection. Gaps in benefits and substantial cost-sharing can undermine family finances in ways similar to having no insurance.[5] Indeed, the study finds an association between having medical bill problems or accrued debt and having a health insurance plan that lacks prescription drug or dental care coverage, or a plan that features high deductibles. Forty-four percent of working-age adults without prescription and dental coverage reported medical bill and debt problems, compared with 29 percent who had both of these benefits (Figure 6, Table 3). And more than half (53%) of adults who had deductibles that equaled or exceeded 5 percent of their income, compared with one-third (33%) of adults with lower deductibles, incurred medical bill burdens and debt.

Figure 6. Insured Adults with Less Comprehensive Coverage and Benefit Limits Are More Likely to Face Medical Bill and/or Debt Problems

Percent of continually insured adults ages 19–64 with bill and/or debt problems



Source: The Commonwealth Fund Biennial Health Insurance Surveys (2007).

Substantial cost-sharing relative to income can also erode family finances. Nearly six of 10 working-age adults (59%) whose insurance premiums consumed 10 percent or more of their household income reported medical bill problems or debt. These kinds of difficulties occurred half as often (30%) among adults who spent a lower percentage of their income on premiums.

Survey respondents who reported limitations in their health plan benefits experienced medical bill and debt problems at a rate double that experienced by those without such limitations. For example, two-thirds (65%) of continuously insured adults who had incurred expensive medical bills for services that their plan did not cover reported that they had problems paying these bill or had resulting debt; in contrast, 22 percent of adults who did not have uncovered services

experienced these same problems. Also, more than half (56%) of adults who indicated that their doctor charged more than what their insurance would pay for their care reported medical bill burdens and debt. Finally, 43 percent of continuously insured adults whose health plans limited the total amount they could spend incurred medical bill problems and unpaid debt, compared with 27 percent of adults who did not have total-dollar limits. Even after adjusting for other important factors (such as poverty status, health status, race/ethnicity, age, and gender), having insurance benefits that are less-than-comprehensive remains a significant predictor of medical bill problems and medical debt (data not shown).

A CHALLENGE TO POLICYMAKERS

During a period when average incomes barely budged in the U.S. and working families took on record amounts of household debt relative to income, gaps and inadequacies in the nation's health insurance system further strained family budgets.[9] In 2007, 72 million adults under age 65, or 41 percent of that population, reported a problem paying their medical bills or had accrued medical debt, up from 58 million, or 34 percent, in 2005. This increase occurred across all income groups, but families with low or moderate incomes were particularly hard hit: more than half of adults with incomes below $40,000 reported problems paying their medical bills or medical debt in 2007. An estimated 49 million adults said they were paying off medical bills over time, of whom 24 percent were carrying medical debt balances of $4,000 or more.

The financial consequences of medical bill burdens are often dire. Because of medical bills or accumulated medical debt, an estimated 28 million adults used up all their savings; 21 million incurred large credit card debt; 21 million were unable to pay for basic necessities like food, heat, or rent; and 8 million took out a mortgage against their home or took out another loan as a result of medical debt. Medical debt is affecting the lives of working Americans, and pushing more families to the edge of financial crisis.

The people most at risk are the uninsured, but even those who have insurance reported problems with medical bills and accrued debt. Sixty-one percent of those with medical bill problems or accumulated medical debt reported being insured at the time care was provided. For millions of U.S. families, the trend toward greater cost-sharing in employer-based health plans—particularly in the form of higher deductibles, which have more than doubled since 2000—has broadened their exposure to health care costs. Combined with sluggish income growth, this exposure to high out-of-pocket costs relative to income means many Americans are effectively underinsured. Twenty-five million adults under age 65 were underinsured in 2007, up from 16 million in 2003.[10] Three of five underinsured adults reported medical bill problems in the study, the same rate as adults who were without coverage during the year. In addition, people who identified limitations or coverage gaps in their health plans reported medical bill problems and accrued debt at higher rates than those whose plans did not have limits.

The findings of this study underscore the urgent need for policymakers to expand health insurance coverage to everyone in America. But the fact that millions of Americans are insured but have nonetheless fallen deeply into medical debt is a vivid reminder that the content, cost-sharing, and financial protection of health insurance must also be addressed in any health reform plan.

NOTES

1 S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families, Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008); C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive (June 10, 2008):w289–w309; C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?," *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302; S. Heffler, S. Smith, S. Keehan et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* Web Exclusive (Feb. 23, 2005):w5-74–w5-85.

2 H. T. Tu, *Rising Health Costs, Medical Debt, and Chronic Conditions*, Issue Brief No. 88 (Washington, D.C.: Center for Studying Health System Change, Sept. 2004); J. H. May and P. J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, Issue Brief No. 85 (Washington, D.C.: Center for Studying Health System Change, June 2004); D. U. Himmelstein, E. Warren, D. Thorne et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* Web Exclusive (Feb. 2, 2005):w5-63–w5-73; T. P. O'Toole, J. J. Arbelaez, R. S. Lawrence et al., "Medical Debt and Aggressive Debt Restitution Practices: Predatory Billing Among the Urban Poor," *Journal of General Internal Medicine*, July 2004 19(7):772–78; S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2004).

3 D. Dranove and M. L. Millenson, "Medical Bankruptcy: Myth Versus Fact," *Health Affairs* Web Exclusive (Feb. 28, 2006):w74–w83; Himmelstein et al., "Illness and Injury," 2005; O'Toole et al., "Medical Debt," 2004; M. B. Jacoby, testimony at U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, hearing, "A Review of Hospital Billing and Collection Practices," June 24, 2004.

4 This analysis is based on a 2005 Commonwealth Fund study that used data from the 2003 Commonwealth Fund Biennial Health Insurance Survey; see M. M. Doty, J. N. Edwards, and A. L. Holmgren, *Seeing Red: Americans Driven Into Debt by Medical Bills* (New York: The Commonwealth Fund, Aug. 2005). The ways in which the medical bill questions and debt were asked in 2003, however, differ from the 2005 and 2007 surveys and thus prevent comparison of two of the four questions as well as the composite statistic. In 2003, the survey asked only adults who reported a medical bill problem whether they were paying off debt over time. In 2005 and 2007, we asked the full sample whether they were paying off debt over time. In addition, in 2003, the survey did not distinguish between whether someone had been contacted by a collection agency because of a bill that had not been paid or because there was a billing error. In 2005 and 2007, the survey asks respondents to distinguish between those two reasons for the contact by a collection agency. The composite statistic in 2005 and 2007 includes only adults who were contacted by a collection agency because of a bill that had not been paid. In 2003, 71 million adults ages 19 to 64 and 6 million adults 65 and over reported a medical bill problem or accrued medical debt, for an estimated total of 77 million adults.

5 Schoen et al., "How Many Are Underinsured?" 2008. Underinsured adults are individuals who are insured all year but report at least one of three indicators of financial exposure relative to income: 1) out-of-pocket medical expenses equal 10 percent or more of income; 2) among low-income adults (below 200% of the federal poverty level), medical expenses amount to at least 5 percent of income; or 3) deductibles equal or exceed 5 percent of income.

6 All increases between 2005 and 2007 are statistically significant ($p<.001$), except for the percent reporting they had been contacted by a collection agency about unpaid bills ($p<.10$).

7 See note 5.

8 Schoen et al., "How Many Are Underinsured?" 2008.

9 The Federal Reserve Board, Household Debt Service and Financial Obligations Ratios; http://www.federalreserve.gov/releases/housedebt

10 Schoen et al., "How Many Are Underinsured?" 2008.

Table 1. Prevalence of Medical Bill and Medical Debt Problems Among Adults Age 19 and Older, by Insurance Status and Age

	Adults 19–64			Adults 65+
	Total (n=2616)	Uninsured Anytime (n=747)	Insured All Year (n=1869)	Total (n=840)
Total (millions)	177.0	49.5	127.5	36.1
Medical Bill Problems in Past Year				
Had problems paying or unable to pay medical bills	27%	48%	19%	11%
Contacted by collection agency for unpaid medical bills	16	29	11	6
Had to change way of life to pay bills	18	32	12	12
Any of the above bill problems	33	56	25	16
Medical debt or bills being paid off over time	28	36	24	10
Any bill problems or medical debt	41	61	33	19
Base: Any Medical Bills Being Paid Off Over Time				
How much are the medical bills that are being paid off over time?				
Less than $2,000	51	41	57	61
$2,000 to less than $4,000	21	24	20	11
$4,000 to less than $8,000	12	13	11	12
$8,000 to less than $10,000	2	2	2	2
$10,000 or more	10	16	7	3
Was this for care received in past year or earlier?				
Past year	54	47	57	54
Earlier year	37	41	35	35
Both	8	11	7	5
Base: Any Bill Problem or Medical Debt				
Percent reporting that the following happened in the past 2 years because of medical bills:				
Unable to pay for basic necessities (food, heat, or rent)	29	41	20	34
Used up all of savings	39	47	33	37
Took out a mortgage against your home or took out a loan	10	11	10	8
Took on credit card debt	30	29	30	22
Insurance status of person/s at time care was provided				
Insured at time care was provided	61	32	81	71
Uninsured at time care was provided	32	59	13	23
Other insurance combination	3	3	3	2

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Table 2. Estimated Number of Adults with Medical Bill Problems and Accrued Medical Debt, 2007

	Adults 19–64			Adults 65+
	Total (in millions)	Uninsured Anytime (in millions)	Insured All Year (in millions)	Total (in millions)
Total	177.0	49.5	127.5	36.1
Medical Bill Problems in Past Year				
Had problems paying or unable to pay medical bills	48.2	23.9	24.3	3.9
Contacted by collection agency for unpaid medical bills	27.7	14.2	13.5	2.2
Had to change way of life to pay bills	31.7	15.8	15.9	4.2
Any of the above bill problems	59.0	27.5	31.5	5.9
Medical debt or bills being paid off over time	48.9	18.0	30.9	3.6
Any bill problems or medical debt	72.1	30.0	42.1	7.0
Base: Any Bill Problem or Medical Debt				
Number reporting that the following happened in the past 2 years because of medical bills:				
Unable to pay for basic necessities (food, heat, or rent)	20.9	12.3	8.6	2.4
Used up all of savings	27.9	14.0	14.0	2.6
Took out a mortgage against your home or took out a loan	7.5	3.4	4.2	0.5
Took on credit card debt	21.3	8.7	12.6	1.6

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Table 3. Relationship Between Insurance Benefits and Medical Bill Problems and Debt Among Continuously Insured Adults Ages 19–64

Characteristics of Respondents	Total	Any Medical Bill Problem[a]	Any Medical Bill or Debt
Adults Insured All Year (in millions)	127.5	31.5	42.1
Percent insured all year	72%	25%	33%
Characteristics of Insurance Plan			
Has neither prescription nor dental coverage	27%	36%	44%
Has prescription and dental coverage	73	21	29
Deductible is 5 percent or more of household income	5[b]	43	53
Deductible is less than 5 percent of household income	71	25	33
Annual premium is 10 percent or more of household income	16	48	59
Annual premium is less than 10 percent of household income	84	21	30
Insurance Plan Difficulties and Limits			
Had expensive medical bills for services not covered by insurance	26	53	65
No expensive medical bills	73	15	22
Doctor charged more than insurance would pay; individual had to pay the difference	28	45	56
Doctor did not charge more than insurance would pay	71	17	24
Health plan limits the total dollar amount it will pay for medical care	38[c]	33	43
Health plan does not limit total dollar amount	41	19	27

Notes: [a] Problems paying or unable to pay medical bills, contacted by collection agency for inability to pay medical bills, or had to change way of life significantly in order to pay medical bills; [b] Values do not add to 100% because a number of respondents did not report income or a deductible amount; [c] Values do not add to 100% because 21 percent of respondents did not know whether their health plan limits the total dollar amount it will pay for medical care.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

STUDY METHODOLOGY

Data for this study were drawn from the Commonwealth Fund Biennial Health Insurance Survey (2007), a national telephone survey conducted June 6 through October 24, 2007, among a nationally representative sample of 3,501 adults age 19 and older living in the continental United States. The 25-minute telephone interviews were completed in both English and Spanish, according to the preference of the respondent. The survey achieved a 45 percent response rate (calculated according to the standards of the American Association for Public Opinion Research).

The survey sample was drawn using standard list-assisted random-digit-dialing methodology, which selected telephone numbers disproportionately from area-code/exchange combinations with higher-than-average density of low-income households. Using this stratified sampling design, this study obtained an oversample of low-income, African American, and Hispanic adults. To correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental U.S., the data are weighted by age, sex, race/ethnicity, education, household size, and geographic region, using the U.S. Census Bureau's 2006 Annual Social and Economic Supplement (ASEC). The margin of sampling error for the weighted data is +/– 2.2 percent.

We classified respondents by age and by whether they were insured all year or had any lapse in coverage during the year. There were 45 respondents who did not provide their age and were excluded from the analysis. This report includes 840 adults age 65 and older and 2,616 adults ages 19 to 64, of whom 747 were uninsured during the year and 1,869 were insured all year.

ABOUT THE AUTHORS

Michelle McEvoy Doty, Ph.D., director of survey research, directs survey development and analysis at The Commonwealth Fund and conducts research examining health care access and quality among vulnerable populations and the extent to which lack of health insurance contributes to barriers to health care and inequities in quality of care. She received her M.P.H. and Ph.D. in public health from the University of California, Los Angeles.

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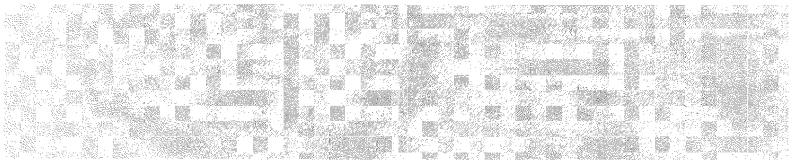
Editorial support was provided by Christopher Hollander.



Chairman ROE. Without objection, so ordered.

Mr. Barletta?

Mr. BARLETTA. Thank you, Mr. Chairman.

Mr. Parker, I am proud to say, Pennsylvania's 11th Congressional District is home to a number of initiatives designed to help spur small business growth and development; specifically, Wilkes University's Small Business Development Center.

As a former small business owner, I am well aware of the hurdles and challenges of both the start-up—which I did, I started a new business from scratch—and the growth challenges of small businesses.

I want to talk particularly about the employer mandate provision.

Would you say there is less of an incentive now? If you were a business that might have 47, 48 employees, would you believe that that is less of an incentive to expand and grow your business to over 50 employees?

Mr. PARKER. Absolutely. And more than that, even if you are already well above that number, the incentive now is to sort of batten down the hatches versus growing.

And I think, you know, people have been talking throughout this hearing about how, well, when we get to 2014, the impacts will be this, that or the other. I can tell you, it is not hypothetical. This is impacting our business right now.

You know, I run development for our business. Our growth is very much in fits and starts.

We have to develop a new location, so we have to make a big bet. We have to pick an area that we think can support it. We have to go in, invest several million dollars. And then, we create a big chunk of jobs, and we have a new business.

And each one of those is a big decision, and we have a lot of skin in the game, personally. And we are putting the well-being of everyone in the company on the line every time we do it.

And more deals that I have looked at over the last, you know, 6 months, I tend to say, it is marginal. We are going to pass. Just because, not only this bill and the impacts it has today, and knowing that it is only going to get worse, but, you know, what is next? And it is a huge disincentive to growth overall.

Mr. BARLETTA. And would you say that a business that might have 52 employees may actually—a business that might be struggling to stay in business and pay its bills—would you believe that they may lay a few employees off to get under the 50 employee mandate?

Mr. PARKER. Absolutely.

Mr. BARLETTA. Do you have any idea where they picked the number 50 from, and how we established 50 as a magic number?

Mr. PARKER. I have no idea.

Mr. BARLETTA. Mr. Brewer, same question. Would you believe that a business that might have 48 employees would be reluctant to hire a few more?

Mr. BREWER. Sure. We do not do business in that space. Our cases are typically significantly larger. But I cannot imagine the same logic would not apply.

We have got employers that we serve every day who are reluctant to add employees, because of the additional burden of sort of unforeseen health care mandates.

So, yes, I think it would be perfectly logical that somebody would be willing to do that.

Mr. BARLETTA. And would you believe, because of the Affordable Care Act, that in America there will be businesses who will lay off a few employees, if they are around 51, 52, 53 employees?

Mr. BREWER. I cannot tell you that I professionally believe that. On a personal level, that certainly makes sense.

Mr. BARLETTA. Especially if it is a business that is struggling?

Mr. BREWER. Yes.

Mr. BARLETTA. Mr. Houser, if your business had 48 employees, would you be reluctant to hire a few more, if it was going to put you over the 50 employee mandate, especially if you were a business that might be struggling today?

Mr. HOUSER. Congressman, I make decisions like that based on my workload. I would not turn down work because I did not have sufficient employees. I would make a decision about hiring more employees based on how much work I had to perform.

So, if I had 49 employees, and I had enough work for 52 employees, and that was going to make me more profitable, I would hire 52 employees. That would not make——

Mr. BARLETTA. But would you also maybe think about making the 49 work longer, so that you did not have to go over the 50 employee mandate?

Mr. HOUSER. I am talking about having enough work for 52 employees. That would be the driving factor in my decision, not whether or not I have to provide some—because I am already providing the health care. That is factored in.

Mr. BARLETTA. If you were a business——

Mr. HOUSER. So, I do not see it——

Mr. BARLETTA. I am talking about a business that might have 48, 49 employees that was not. And hiring one or two more employees would now throw you into a mandate, where you would be fined $2,000 per employee.

Mr. HOUSER. I do not——

Mr. BARLETTA. Why wouldn't you think of just making those employees work a little longer, rather than hiring another few more employees?

Mr. HOUSER. People make those kinds of decisions all the time, and I am not familiar with them.

Mr. BARLETTA. Mr. Miller, many small businesses have employees who work full-time hours. My business that I had was a line painting business. We painted lines on highways. In Pennsylvania, obviously, you cannot paint lines in January. It does not work that well.

Now, so, we would be considered seasonal. They might start working in April, and get laid off in October or November.

Now, would they be considered, under this act, would they be considered full-time employees, or part-time employees?

Mr. MILLER. Well, there is a calculation—and again, these, you know, the angels dancing on the head of a pin—where they can get, in effect, calculations of full-time equivalents by aggregating part-time, workers, so they can add up to full-time employees and get you above or below that 50 threshold.

And your description of this is exactly right. There is no one single factor that says we are going to shut down the business, or we are——

Chairman ROE. Mr. Miller?

Mr. MILLER. But these are all calculations. If you try to trap employers in a maze, and it looks like all the other doors are closed, they are going to find one to go through.

Chairman ROE. Mr. Miller?

Mr. MILLER. You will do calculations and say, does it pay for me to do something different? Do I restructure my firm? Do I suddenly

have two businesses, and you ship people out somewhere else? Do I pay you differently, because it turns out, when I pay you more, I lose money under other calculations?

Is it going to hit me when I grow too much? Can I do it in a different manner?

All these are not what businessmen should be doing, but they have to take into account the entire structure of costs imposed on them, and they will act the best they can. We are, though, overloading them, so that they are trying to do so many things that have nothing to do with running their own businesses, that it gets very complicated, just to run an effective business.

Chairman ROE. Mr. Miller, the time has expired.

Dr. Bucshon?

Mr. BUCSHON. Thank you, Mr. Chairman.

Just some background, I am a cardiovascular surgeon, so I have been in the health care industry for quite a long time.

Mr. Houser, a couple of questions for you. Have you testified before Congress before, or is the first time?

Mr. HOUSER. This is my first time, Congressman.

Mr. BUCSHON. Great.

Mr. HOUSER. Thank you very much for inviting me.

Mr. BUCSHON. Welcome.

Is it—under what you talked about—is it true or not true that your, the company that you run is currently exempt from the employer mandates in the new health care law?

Mr. HOUSER. That is correct. Under my understanding, that is correct.

Mr. BUCSHON. So do you know if your current health care plans that you are offering to your employees comply with the requirements of the Affordable Care Act? Do you have any idea whether they comply or not?

Mr. HOUSER. I have no idea. I could find out, but I do not know.

Mr. BUCSHON. Because under the Affordable Care Act, you really do not have to have your health plans comply at all, right, because your company is exempt.

Mr. HOUSER. As far as I know, that is correct.

Mr. BUCSHON. Okay. I mean, the basic premise of the discussion has been the cost of health care. And as you are probably aware, under congressional testimony January 26, chief actuary, Mr. Foster, from the Medicare services, stated that, promises the new health law would hold down costs were "false more than true."

And I applaud you for being a small business owner. It is tough. But in fairness, from your testimony, you are really exempt from the law and really do not have any risk under the law, other than the fact that you are hopeful the law will hold down health care cost. But we know the data shows that that is not true.

So, I just wanted to get your view on that, that—and again, with what Mr. Barletta said—if you were an employer that had 60 employees, 70 employees, and you were not exempt from the health care law, do you feel that you would try to put yourself in a position that you would not have to comply with not only providing health insurance, but the specific type that is required under the law, or else suffer penalties?

Mr. HOUSER. Congressman, there are over 4 million small businesses that fall in the category I am in, that will be able to, for example, get the tax credits for providing health care coverage for their employees.

Mr. BUCSHON. Excuse me. I do not want to interrupt, but those are going away in fairly short order. Those will be a temporary thing.

And then, again, I think you were asked the question earlier. Do you have a plan for your business, when the tax credits, not only do they go away, but who is paying for the tax credits? I mean, where does the money come from? It comes from the American taxpayer.

And as we know, with the testimony of Mr. Foster, as health care costs continue to rise under this health care bill, everyone is going to continue to struggle. Your premiums are going to continue to go up.

And if you do not have a plan for when you lose your short-term, small business credits, what are the other 4,000 businesses like yourself around the United States going to do when those go away?

Mr. HOUSER. Congressman, in part, my premium has gone down. And I do not see any reason why that might not continue, especially as more people join and are paying premiums, especially younger, healthier.

I have every reason to believe that health care premiums can go down, or stabilize. And especially as the State of Oregon makes improvements in health care delivery, I also believe premiums can go down.

So, I plan for the worst, I plan for the best. And you just sort of proceed on that basis.

Mr. BUCSHON. That opinion is in contrast to, again, the chief actuary, Mr. Foster, and most economists around the country that have looked at this health care bill, that your premiums will go down and the health care costs will go down.

Because, being in medicine, I think that it is very clear that the number one problem we have in America is the skyrocketing cost of health care. And I am concerned for businesses like yours, that when these tax credits go away, you are going to have trouble.

And also, you know, I do think, when you are discussing something which you are completely exempt from, that gives you a little bit different perspective on your testimony.

So, I am hopeful that we can get some real cost containment in place for businesses like yours going forward, because I am fearful that when these very small credits go away, you are going to be struggling.

And my time is up. Thank you.

Chairman ROE. I thank the gentleman for yielding.

I will finish the questioning by saying that not anybody on either side of the aisle did not think we needed to have a meaningful health care reform. This doctor sitting right here knew it better than anybody. And that is one of the reasons I ran and came to Congress.

So, the number one issue in America was: How do we control the cost of care? Because once we get the costs under control and it is more affordable, more people can buy it.

Number two, and the second problem we had in the American health care delivery system was, we had a group of people who did not have access to affordable insurance coverage in this country.

We had the working poor that did not apply for, did not qualify for Medicaid, that did not have a job that provided the insurance. That is the group we are talking about.

And thirdly, which did not even come up in this bill, which is a huge problem for Dr. Bucshon and myself, was liability reform. There is a huge cost for defensive medicine in this nation.

So, those were the three problems.

This bill did increase access to a program that has already failed, which is the Medicaid system, and it needs to be revamped. It did nothing to hold the costs down and did nothing for liability reform.

The other equation—I see some young, probably physicians, in the crowd out here, I am glad they came—is we have forgotten about that part of the program.

Let me explain to you what happens in these government programs. In TennCare, it paid the providers less than 60 cents on the dollar for providing the care. Medicare in our state pays about 90 percent of the cost of the care, leaving that cost shifted to the private sector.

That is one of the reasons that the cost of private health insurance has gone up so rapidly in this country, is the cost shifting.

Let me give you an example. When the implantable defibrillators first came out, a patient on TennCare—that is our Medicaid program in the state—had to have one. So, it was provided for him.

The hospital got paid $800 for the defibrillator. And at that time, the defibrillator cost $40,000. So, the hospital ate $39,200 of that.

And you, Mr. Houser, and Mr. Miller and myself, that provided health insurance coverage, that cost got shifted to you.

Let me just say a very simple thing. A 2,500-page bill got written. And you could do two-thirds of it with two paragraphs. One is simply, sign up the people who are currently eligible for Medicaid and SCHIP.

And number two, which I like, is leave your 26-year-old—you only had one child, I had three that did that—allow them to stay on. That covers over 20 million people.

And, then, lastly what you do, let people shop across state lines. It is the only insurance you cannot do that. Let them form association health plans and get bigger, like you are talking about. And have liability reform.

You do those simple things—not complicated—you can help force the costs down.

Here is a card. That is a health savings account card I have right here. I had to have some biopsies done. I had to have some anesthesia for it. I would recommend you get anesthesia, if you have the biopsies I had, too.

[Laughter.]

Anyway, I walk into the hospital and I have this card. It is called a health savings account. I do not ask the insurance company; I do not bother with them. I make a deal with the hospital. I said, how much will you give me this, if I pay you in a millisecond?

And guess what. I saved 35 percent. I was happy. The hospital was happy.

And that is what Mr. Miller was talking about, I think, is changing the way we pay for health insurance in this country.

So, Mr. Brewer, I have dealt with this issue as a former mayor and these costs that are being passed along. Let me ask you why I would not do this.

I had 350 employees in my practice. Right now, we put about $5,000 per person away. If I pay the fine and the penalty—we have 300 people who get health insurance through our practice—if I pay the $2,000, that is $600,000 I pay. If I pay the $5,000, that is $1.5 million.

If I dump my employees in the exchange, which I certainly do not want to do—we provided health insurance in our practice for over 42 years. And I won't be the first, but I won't be the third, either.

Why wouldn't I do that, to put that to my bottom line, and put that cost onto the government? Why wouldn't I do that?

Mr. BREWER. Do you want the CBO logic?

Chairman ROE. Yes.

Mr. BREWER. Because it is illogical. I do not see any reason why you would not do that.

You know, I think the way we have characterized this, there is going to be a conundrum as we present to our employer clients, the clients that we serve, there is going to be a dynamic tension between the CFO and H.R.

The CFO is going to look at that potential savings, and his eyes are going to get real wide. And he is going to say, why in the world wouldn't I do that?

H.R. is going to be fighting about, well, we need it for a competitive advantage. You know, the CBO refers to a tight labor market that does not exist, so I am not sure that one holds any water.

But over some period of time, if you have been in business—and you have—you know how this works. Over a period of time, the CFO is going to win that argument. The logic of survival will trump the logic of warm and cuddly H.R.

So, the answer to your question is, there isn't any reason why you would not do that, if you had any reasonable assurance that your employees were going to be adequately covered, or adequately managed, within the framework of the exchange.

Chairman ROE. And my time has expired.

Mr. Kucinich, any closing comments?

Mr. KUCINICH. Yes. You know, in listening to the testimony, it is very interesting. And in hearing your questions from my colleagues, I came up with this conundrum, and you have—and the challenges that small businesses face here.

You have Mr. Houser, who has being asked who pays for the small business tax cut he is receiving. But we know that he is paying 100 percent of his employees' health care, and he has been for 28 years.

And you have Mr. Parker's company. According to staff and documents that they are covering less than 100 of their 530 employees, and the rest will have little health care.

And who is paying for those other 400? Well, it is going to be the taxpayers, because what is happening is, you know, people go—they will get medical care somehow.

They will go to hospitals, they will go on Medicaid. As people who do not have any insurance, the hospitals end up being their emergency rooms. Taxpayers end up footing that bill in some way, shape or form.

After the exchanges are set up, Mr. Parker's employees will go to the exchanges, and which are government subsidized.

So, you know, we have to be sensitive to the sometimes conflicting and contradictory situations which businesses find themselves in, notwithstanding their position on the bill.

Thank you.

Chairman ROE. I thank the gentleman.

I thank all of the panelists for being here. It was an excellent discussion.

I will finish by this, by saying that I believe that businesses—and all of you all have been involved in business—are much better suited to decide what health insurance that they need to purchase for their business than the federal government.

What has happened is that the federal government will now decide which is adequate health insurance coverage. And let me give you just an example. They have a minimum benefit package that is going to be—and everyone will have to do it.

And Mr. Houser, what you may have purchased may not be the minimum. Your cost may go up, because you may not meet the standard that the government says you have to make. I think you should be able to make that decision.

There is a company in Tennessee—and I won't mention the name of it—that right now has a plan that they can afford—it is a large company—that they can afford and that they are happy with, their employees are happy with. But it will not meet this minimum standard that the government has laid out in this affordable health care plan.

It will cost them $40 million to comply with this. If they drop their employees into the exchange, it will save them $40 million. And Mr. Brewer clearly pointed out, that argument will go on, but eventually, the CFO will win out.

I believe that individuals should make those decisions, and businesses should make those decisions, not the government.

The other thing that I have a little problem with—matter of fact, a major problem—is with the cost estimates. It was a year ago the CBO—these are good people, they are honest, they plug in numbers that they get—told us that the budget deficit was going to be $1.2 trillion. It turns out it is going to be $1.65 trillion. So, in 1 year, they missed it by $400 billion.

And I am supposed to believe, looking at all the past history that I have with Medicare and with TennCare, and with Massachusetts, quite frankly, what their—the Massachusetts plan, which has the mandate, have the highest insurance premiums, rising faster than anybody else in the country.

So, when the government makes those decisions, and you do not make them as an individual or your family—and I have said this from day one. Health care decisions should be made by patients, their families and doctors. And it should not be decided by the federal government.

I have enjoyed this discussion immensely today. I thank each one of you for preparing. You did a great job.

And with this, without any further discussion, this meeting is adjourned.

[An additional submission of Dr. Roe follows:]

ASSOCIATED BUILDERS AND CONTRACTORS,
Arlington, VA, March 10, 2011.

Hon. PHIL ROE, *Chairman;* Hon. ROBERT ANDREWS, *Ranking Member,*
Subcommittee on Health, Employment, Labor Pensions, House Committee on Education and the Workforce, 2181 Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN ROE AND RANKING MEMBER ANDREWS: On behalf of Associated Builders and Contractors (ABC), a national association with 75 chapters representing more than 23,000 merit shop construction and construction-related firms with nearly two million employees, I am writing in regard to the subcommittee hearing on, "The Pressures of Rising Costs on Employer Provided Health Care."

Throughout the health care reform debate, ABC advocated for policies that would reduce the cost of health care for employers and their employees. ABC called on Congress to advance common-sense proposals that would address the skyrocketing costs of health insurance, especially for employer-sponsored plans, and the rapidly rising number of uninsured Americans.

Unfortunately, the massive and complex health care law, known as the "Patient Protection and Affordable Care Act" or PPACA, fails to address the core problem facing small businesses: the rising costs of health care. It is unfathomable that our elected leaders imposed new costly mandates and taxes on employers at a time of record high unemployment. Such actions demonstrate a fundamental failure of the federal government to understand the needs of small businesses. As a result, numerous provisions in the health care law will have a direct negative impact on ABC members, including:

- Higher insurance costs due to new mandated benefits
- New taxes on small business health insurance policies
- Prohibitions on HSAs, FSAs and HRAs that limit employer and employee flexibility
- An employer mandate that encourages job cuts
- New taxes, fees and mandates specifically targeted at the small business community

Additionally, ABC has expressed concerns about the regulatory burdens imposed by the massive health care law. The outcomes of many of the health care related federal rulemakings are currently unclear. This has created an environment of uncertainty in our industry that makes it difficult for firms to adequately plan for the future.

Providing quality health care benefits is a top priority for ABC and its member companies. ABC urges Congress to move forward with legislative proposals that will provide employers and their employees with health care solutions that are both practical and affordable.

ABC believes medical malpractice reform should be included in any true health care reform package. By enacting medical malpractice reform we will see a dramatic decrease in the cost of health insurance for the American public. ABC also strongly supports the inclusion of Small Business Health Plans (SBHPs) and expanding access to Health Savings Accounts (HSAs). Further, the unique nature of construction work demands that benefits be portable in order to reflect the reality of the industry workforce.

We appreciate your attention to this important matter and look forward to working with you on commonsense health care initiatives.

Sincerely,

CORINNE M. STEVENS, *Senior Director,*
Legislative Affairs.

[An additional submission of Mr. Kucinich follows:]

STATEMENT FOR THE RECORD

BEFORE HOUSE SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

ON

HEARING ON THE PRESSURES OF RISING COSTS ON EMPLOYER PROVIDED HEALTH CARE

MARCH 10, 2011

JOHN ARENSMEYER
FOUNDER & CEO
SMALL BUSINESS MAJORITY

This testimony is submitted in support of the small business perspective on the Patient Protection and Affordable Care Act and its impact on America's 28 million small businesses and the economy as a whole.

Small Business Majority is a nonprofit, nonpartisan small business advocacy organization founded and run by small business owners and focused on solving the biggest problems facing small businesses today. We represent the 28 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific opinion and economic research to understand and represent the interests of small businesses.

We are testifying in support of the Affordable Care Act, which will help reduce the cost of insurance and medical care while making coverage affordable, fair and accessible. Our research shows that reforming our broken healthcare system has been and still is one of small business owners' top concerns, and that the majority of small employers believe reform is needed to fix the U.S. economy. It also shows that small businesses support key provisions in the law, specifically ones that help them better afford insurance, such as tax credits and insurance exchanges, and those that contain costs. Controlling skyrocketing costs is essential to ensuring small businesses' ability to obtain high-quality, affordable healthcare for themselves, their families and their employees. Our research also shows that absent reform, these costs would continue to escalate, undermining small businesses' success and our economic recovery. The new law goes a long way toward fixing our broken system and stemming these spiraling costs, while helping to create jobs and stimulate the economy.

Our research, which is discussed in more detail below, shows the impact this legislation will have on small businesses and reveals that small businesses support many provisions in the law, especially those that benefit them immediately, such as the small business tax credits. In July 2010, Small Business Majority partnered with Families USA to determine

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the number of small businesses eligible for a tax credit on their 2010 tax returns, one of the key provisions of the Affordable Care Act.

- We found that more than 4 million small businesses would be eligible to receive a tax credit for the purchase of employee health insurance in 2010. [1]

We also recently commissioned a national survey of 619 small business owners to determine their views on the tax credits and insurance exchanges, another crucial provision of the Affordable Care Act for small businesses. The survey, which was released on Jan. 4, 2011, found that:

- Both the tax credits and the exchanges, once they take effect, make small business owners more likely to provide healthcare coverage to their employees;
- One-third of employers who don't offer insurance said they would be more likely to do so because of both the small business tax credits and the insurance exchanges;
- 31% of respondents who currently offer insurance said the tax credits and the exchanges will make them more likely to continue providing coverage. [2]

However, the poll also found that the vast majority of small business owners don't know the tax credits or exchanges exist to help them afford coverage.

As the debate around healthcare reform continues, it's important to understand the consequences a return to the status quo would have on small businesses and our fragile economy.

- Without reform, small businesses would pay nearly $2.4 trillion in healthcare costs by 2018, and $52.1 billion in small business profits and 178,000 small business jobs would be lost as a result of high premiums.[3] They would also lose $4 billion per year in healthcare tax credits and many small business protections, including a ban on denying coverage for preexisting conditions. This provision will provide much-needed help to many Americans, including the legions of self-employed individuals—many who currently can't get coverage because of this reason;
- Without reform, small businesses would be robbed of their ability to pool their buying power through state insurance exchanges, and the various cost controls the ACA puts in place would also be lost;
- A return to the status quo would mean an end to the tough enforcement measures in the law, which are saving billions in Medicare waste, fraud and abuse. This would result in higher taxes for employers and employees to fund Medicare, and higher taxes mean fewer jobs.

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[1] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July, 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.
[2] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php.
[3] Small Business Majority, The Economic Impact of Healthcare Reform on Small Businesses, July 2009, http://www.smallbusinessmajority.org/small-business-research/economic-research.php.

Small businesses create 70% of new jobs in our country. Spending less on health insurance will help them generate larger profits, which will help speed our journey down the road to economic recovery.

My testimony highlights the issues of greatest importance to small businesses in the Affordable Care Act. It explains what we have learned from our scientific research about both the opinions of small employers and the economic impact of reform on small businesses, including the consequences repealing the Act would have on them and the economy overall. The key issues are:

- Why healthcare costs are killing small businesses and sapping our economic vitality;
- What a return to the status quo would mean for small businesses and the economy;
- How the ACA is already helping small businesses afford insurance and provide their employees with coverage;
- Small businesses' No. 1 priority: Controlling the skyrocketing cost of health insurance and how the ACA tackles this problem;
- Why sharing the responsibility will strengthen our small businesses, their employees and the economy.

Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is their biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.[4]

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.[5] Small businesses, including the self-employed, need a level playing field to succeed and continue as the job generators for the U.S. economy.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a $13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. Small business owner Walt Rowen, owner of Susquehanna Glass Co. in Columbia, PA,

[4] Robert Wood Johnson Foundation, Study shows small business owners support health reform, 2008, http://www.rwjf.org/coverage/product.jsp?id=36558.
[5] J Gabel et al, Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down, *Health Affairs*, May/June 2006, http://content.healthaffairs.org/content/25/3/832.full.

was quoted a 160% premium increase from his carrier last year, forcing him to find a new plan. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of them feel they have a responsibility to do so. Small Business Majority conducted surveys of small business owners in 17 states between December 2008 and August 2009.[6] Our key findings included:

- An average of 67% of respondents said reforming healthcare was urgently needed to fix the U.S. economy;
- An average of 86% of small business owners who don't offer health coverage to their employees said they can't afford to provide it, and an average of 72% of those who do offer it said they are struggling to afford it.

It should be noted that respondents to these surveys included an average of 15% more Republicans (39%) than Democrats (24%), while 27% identified as independent.

The exorbitant cost of insurance means that many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, 54% of businesses with fewer than 10 employees don't offer insurance.[7]

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small business owners, employees or their dependents, according to Employee Benefit Research Institute estimates.[8] And nearly one-third of the uninsured—13 million people—are employees of firms with less than 100 workers.[9]

With staffs of 5, 10 or even 20 people, small businesses are tight-knit organizations. Owners know their employees well and depend on each employee for their businesses' success. They don't want to see their valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

The Affordable Care Act addresses all these issues and more. Without reform, we will impede our overall economic growth. Small businesses with fewer than 100 employees employ 42% of American workers.[10] Traditionally, small businesses lead the way out of

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[6] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, August 2009, http://www.smallbusinessmajority.org/small-business-research/opinion-research.php.
[7] Kaiser Family Foundation/HRET, Employer Health Benefits Annual Survey, 2008, http://ehbs.kff.org/2008.html.
[8] Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population, http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3975.
[9] Center for American Progress, What Will Happen to Small Business if Health Care Is Repealed, July 23, 2010, http://www.americanprogress.org/issues/2010/07/small_biz_reform.html.
[10] U.S. Bureau of Census, 2006 County Business Patterns

recessions. Continuing to address the healthcare crisis by implementing the Affordable Care Act is essential to our vitality as a nation. A repeal of this landmark legislation would send our primary job creators back into in a broken system that threatens their competitiveness, discourages entrepreneurism and jeopardizes our economic recovery.

What a Return to the Status Quo Would Mean for Small Businesses and the Economy

The shock of returning to the status quo would reverberate throughout the U.S. economy. The nonpartisan Congressional Budget Office (CBO) projects repealing the law would add $230 billion over the next 10 years to the federal budget deficit, and more than $1 trillion in the decade to follow. The national debt is already at its limit, and expanding the deficit would only cause additional lack of confidence in our nation's ability to recover from the recession.

When you examine what repeal would mean financially for America's 28 million small businesses, the picture is even bleaker. In June 2009, Small Business Majority commissioned noted economist and Massachusetts Institute of Technology professor Jonathan Gruber to apply his healthcare economics microsimulation model to the small business sector. He focused on businesses with 100 or fewer employees.[11] Our research showed that without reform:

- Small businesses would pay nearly $2.4 trillion over the next 10 years in healthcare costs for their workers;
- A staggering 178,000 small business jobs, $834 billion in small business wages, and $52.1 in profits would be lost due to these healthcare costs;
- Nearly 1.6 million small business workers would continue to suffer from "job lock," where they are locked in their jobs because they can't find a job with comparable benefits. This represents nearly one in 16 people currently insured by their employers.

In a recent article he wrote for the Center for American Progress, Gruber again addressed the issue of job lock.[12] He noted that "such a system significantly distorts our labor markets by forcing individuals to stay in jobs that offer health insurance rather than to move to newer and more productive positions where coverage is not available. Millions of U.S. workers are not moving to better jobs or starting new businesses because there is nowhere to turn for insurance coverage should they leave their jobs."

The Affordable Care Act remedies this problem and levels the playing field to support entrepreneurs willing to take a risk and start a new enterprise. Insurance reforms provided in the new law protect these entrepreneurs, and the insurance exchanges established by the law allow the self-employed and small businesses to pool together for lower premium rates.

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[11] Small Business Majority, The Economic Impact of Healthcare Reform on Small Businesses, July 2009, http://www.smallbusinessmajority.org/small-business-research/economic-research.php.
[12] J Gruber, Be Careful What You Wish For, Repeal of the Affordable Care Act Would Be Harmful to Society and Costly for Our Country, *American Progress*, Jan 2010, http://www.americanprogress.org/issues/2011/01/aca_repeal.html.

The Center for American Progress has also weighed in on what small businesses would lose if the Affordable Care Act were repealed. The percentage of small businesses offering coverage has decreased from 68% in 2000 to 59% in 2007; repeal would ensure that this downward spiral would continue. Since 40% of small employers spend more than 10% of their payroll on healthcare costs, repeal would cause those already providing insurance to do so at the expense of increased wages. This would result in less profits, business investment and job creation. Additionally, repeal would mean small businesses would continue to pay on average 18% more for health insurance than large firms. And they won't get the financial relief tax credits and insurance exchanges will provide.[13]

Healthcare reform will also reduce the "hidden tax" associated with health insurance. Repeal would keep this tax in place. The uninsured often delay treating their health problems until they become severe, and public and charity programs pick up a share. However, a portion remains unpaid. To cover the cost of this uncompensated care, health providers charge higher rates when the insured receive care, and these increases get shifted to consumers and small businesses in the form of higher premiums. This creates a "hidden health tax" that inflates the cost of premiums.[14]

Instead of helping us move forward, a repeal of the healthcare law would send us back to the status quo and ensure that small businesses will be unable to play their historical role as the country's primary job creators. In fact, Harvard professor David Cutler projects repeal would destroy 250,000 to 400,000 jobs annually over the next decade, increase medical spending by $125 billion by the end of this decade and add nearly $2,000 annually to family insurance premiums.[15] His summary of what repeal would do to the country is as dismal as it is succinct: "It would hurt family incomes, jobs, and economic growth."

The Affordable Care Act Is Already Helping Small Businesses Afford Insurance and Provide Their Employees with Coverage

Our research shows that small business owners are more likely to provide insurance to their employees because of the tax credits and exchanges provided through the new healthcare law. As I mentioned in my introduction, our most recent research includes a national survey of 619 small business owners that was conducted from November 17-22, 2010.[16] We wanted to gauge how entrepreneurs view two critical components of the Affordable Care Act: the small business tax credits—a provision allowing businesses with fewer than 25 employees that have average annual wages under $50,000 to get a tax credit of up to 35% of their health insurance costs beginning in tax year 2010—and health insurance exchanges—online marketplaces where small businesses and

[13] Center for American Progress, What Will Happen to Small Business if Health Care is Repealed, 2010, http://www.americanprogress.org/issues/2010/07/small_biz_reform.html.
[14] Kathleen Stoll and Kim Bailey, Hidden Health Tax: Americans Pay a Premium (Washington: Families USA, May 2009).
[15] D Cutler, Repealing Health Care is a Job Killer, Center for American Progress, 2010. http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html
[16] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php..

individuals can band together to purchase insurance starting in 2014. The survey's key findings include:

- One-third (33%) of employers who don't offer health insurance said they would be more likely to do so because of the small business tax credits;
- 31% of respondents—including 40% of businesses with 3-9 employees—who currently offer insurance said the tax credits will make them more likely to continue providing insurance;
- One-third (33%) of respondents who currently do not offer insurance said the exchange would make them more likely to do so;
- The same is true for those who already offer insurance, with 31% responding that the exchange would make them more likely to do so;
- However, most respondents are not familiar with the exchange or the tax credits; only 31% of respondents are familiar with the exchange and 43% are familiar with the tax credits.

We believe that once the public, and small business owners in particular, become more familiar with the new law, they will understand the financial benefits and cost savings it provides. In fact, a Kaiser Family Foundation study conducted in January 2010 found that although the public was divided overall about reform, they became more supportive when told about key provisions. After hearing that tax credits would be available to help small businesses provide coverage to employees, 73% said it made them more supportive, and 63% felt that way after learning that people could no longer be denied coverage because of preexisting conditions.[17]

The huge number of small businesses eligible for a credit on their 2010 tax returns shows how wide-ranging the benefits of the ACA are: Small Business Majority and Families USA's study on the number of small businesses eligible for a tax credit on their 2010 tax returns shows that more than 4 million small businesses are eligible.[18] That equates to 83.7% of all small businesses in the country. Perhaps even more encouraging is that more than 90% of small businesses in 11 states are eligible to receive the tax credits, with nearly 1.2 million small businesses nationally eligible to receive the maximum credit.

A recent RAND Health study also examined the impact of the Affordable Care Act on health insurance coverage for workers at small companies. It found that once the new law takes full effect, the percentage of employers that offer insurance will increase from 57% to 80% for firms with fewer than 50 employees, and from 90% to 98% for firms with 51 to 100 employees.[19] Additionally, a study released Jan. 24, 2011 by the Urban Institute (funded by the Robert Wood Johnson Foundation) also shows the positive benefits of the ACA on America's employers. The study debunks claims that the ACA would erode employer-sponsored coverage by providing incentives for employers to stop offering coverage, or that businesses would face increased costs as a result of reform. To

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[17] Kaiser Family Foundation, Americans Are Divided About Health Reform Proposals Overall, But the Public, Including Critics, Becomes More Supportive When Told About Key Provisions, Jan. 22, 2010, http://www.kff.org/kaiserpolls/kaiserpolls012210nr.cfm.

[18] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July, 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.

[19] RAND Corporation, "How Will the Affordable Care Act Affect Employee Health Coverage at Small Businesses?" 2010, http://www.rand.org/pubs/research_briefs/RB9557/index1.html.

the contrary, the study found that overall employer-sponsored coverage under the ACA would not differ significantly from what coverage would be without reform, but that in fact employer-sponsored insurance premiums will fall noticeably, by nearly 8%, and total spending on healthcare by small businesses will also decrease by nearly 9% because of healthcare exchanges and other provisions of the new law.[20]

Analysis after analysis shows that the new healthcare law holds significant promise toward empowering small businesses to provide their employees with health insurance, and to be able to do so without breaking the bank. Instead of repealing the small business health care tax credit, Congress should be examining how to expand it in order to provide more support to small business.

Small Businesses' No. 1 Priority: Controlling the Skyrocketing Cost of Health Insurance, and How the Affordable Care Act Tackles this Problem

Small business owners are deeply concerned about the exponentially rising cost of health insurance. As Harvard University economics professor David M. Cutler notes, while family health insurance premiums have increased 80% in the past decade after adjusting for inflation, median income has fallen by 5%.[21] When people have less disposable income to spend at local small businesses, small business owners feel the squeeze.

We know from our opinion surveys that small business owners want reform to lower these skyrocketing costs and believe it will be good for the economy overall.[22] The Affordable Care Act includes many provisions to contain costs. These measures will be felt throughout the entire healthcare system, lowering premium costs to small business owners and consumers alike. The Congressional Budget Office estimates the new law will lower federal deficits by more than $143 billion over the next 10 years, and by more than $1 trillion in the following decade. While there is still more that can be done to contain costs within the system, the new law is a great start. It moves our healthcare system toward greater financial stability and provides improved access to affordable, quality care for small business owners and their employees.

Along with small business tax credits and insurance exchanges, the ACA controls costs by reining in administrative costs for small businesses. As previously noted, small businesses pay 18% more on average than large businesses for comparable health policies. This is largely due to high administrative costs, which can be up to 30% of premiums. The law includes administrative simplification programs, helping to put the country on a path to lower-cost, standardized administrative transactions, processes and forms. Additionally, it establishes insurer efficiency standards that require 80% of premium dollars be spent on care, not administrative overhead and executive compensation, for small group and individual plans. For large groups plans, the standard will be 85%. All of these measures will lower the time doctors have to spend on paperwork.

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[20] Urban Institute, "Employer-Sponsored Insurance Under Health Reform: Reports of Its Demise Are Premature," Jan. 24, 2010, http://www.rwjf.org/coverage/product.jsp?id=71749&cid=XEM_749842.
[21] D Cutler, Repealing Health Care Is a Job Killer, Center for American Progress, 2010, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.
[22] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, 2009, http://smallbusinessmajority.org/small-business-research/opinion-research.php.

The ACA also includes numerous reforms in Medicare that will reward value of care, not the volume of care. It requires the Department of Health and Human Services (HHS) to adopt value-based purchasing and payment methods for Medicare reimbursements for both physicians and hospitals, and move away from the fee-for-service system that is so costly and inefficient. What's more, cost containment measures made to Medicare will have a ripple effect to other areas of the system, further reducing costs. Harvard professor David Cutler points out the steps the Affordable Care Act takes to cut these costs:

- Payment innovations including greater reimbursement for preventive care services and patient-centered primary care; bundled payments for hospital, physician, and other services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers;
- An Independent Payment Advisory Board with the authority to make recommendations that reduce cost growth and improve quality in both the Medicare program and the health system as a whole;
- A new Innovation Center within the Centers for Medicare and Medicaid Services, or CMS, charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program;
- Profiling medical care providers on the basis of cost and quality and making that data available to consumers and insurance plans, and providing relatively low-quality, high-cost providers with financial incentives to improve their care;
- Increased funding for comparative effectiveness research;
- Increased emphasis on wellness and prevention.[23]

Rather than focusing on repeal, lawmakers should focus on improving healthcare reform, especially when it comes to cost containment. While the new law is a good start toward fixing our system and strengthening our economy, we should be bolstering it even more by including additional cost containment provisions. This will bring health inflation down and help businesses create more jobs.

Sharing the Responsibility: Strengthening Our Small Businesses, Their Employees and the Economy

The Affordable Care Act requires that all residents purchase insurance—a requirement that, while not uniformly popular, is necessary in order for reform to be successful. It will ensure a broad distribution of health risks in the market and help bring down costs. While this requirement has spawned contentious debates, we found that many small businesses are willing to help share the responsibility of providing insurance if it means lower costs overall and better quality insurance. Opinion polling we conducted shows that:

[23] David Cutler, Repealing Health Care Is a Job Killer, Center For American Progress, Jan. 7, 2011, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.

- Small businesses are willing to share the responsibility for making health insurance affordable along with insurers, healthcare providers, individuals and government, according to an average of 66% of respondents. By state, those agreeing with the concept of shared responsibility ranged from 59% to 72%.[24]

We've also found that because so many small businesses are bombarded with misinformation, it has made it increasingly difficult for them to determine what the law actually requires of them. Most small business owners are surprised to learn that they won't be required to provide insurance. Businesses with fewer than 50 employees, which accounts for 96% of small businesses,[25] are exempt from all requirements in the law. Businesses with 51 employees or more will be required to provide insurance, however 96.5% of these businesses already cover their workers.[26]

The provision that all Americans purchase insurance was included in the law because businesses and the American people made it clear that they wanted to continue an employer-based health insurance system, not a government healthcare system, such as Medicare for all or Canadian-style healthcare insurance. Because 96% of employers with 51 or more employees are providing health insurance as well as paying federal taxes, it would not be fair to let 4% of employers have a free ride at the expense of the 96% of employers currently offering insurance, and at the same time have their employees covered by taxpayer funds to provide health insurance. Additionally, without the free-rider provision large employers would have an incentive to stop providing health insurance and let taxpayers provide coverage for their employees.

Small businesses today offer health benefits to attract and retain good employees and to be competitive with large businesses. This will continue under reform, except that now these small businesses will have the benefit of buying health insurance through the state insurance exchange—creating market leverage like that of big companies, while driving down and stabilizing costs for their employees.

Conclusion

Healthcare reform is not an ideological issue; it's an economic one. Small business owners know this, which is why they overwhelmingly support reforming our broken system and containing the skyrocketing cost of insurance.

Without healthcare reform, small businesses will once again be mired in a system that drains their coffers and stunts their growth—disabling them from playing their vitally important role as the nation's jobs creators. Harvard professor David Cutler is right when he concludes that repeal is "bad economic policy. The effort to repeal health reform will make our current problems worse."[27] We hope Congress will spend its time focusing

[24] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, August 2009, http://smallbusinessmajority.org/small-business-research/opinion-research.php.
[25] U.S. Small Business Administration, Office of Advocacy, based on data provided by the U.S. Census Bureau, Statistics of U.S. Businesses, 2006.
[26] Medical Expenditures Panel Survey, Insurance Component, Table I.A.2, 2008, available online at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2.pdf.
[27] D Cutler, Repealing Health Care is a Job Killer, Center for American Progress, 2010. http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html

on ways to make implementation of the Affordable Care Act as smooth as possible, and instead of trying to dismantle it, fix the parts that need improvement. Our small businesses and our economic recovery depend on it.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]

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