

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

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION

April 14, 2015

SERIAL 114-HL01

Printed for the use of the Committee on Ways and Means

COMMITTEE ON WAYS AND MEANS PAUL RYAN, Wisconsin, <i>Chairman</i>	
SAM JOHNSON, Texas KEVIN BRADY, Texas DEVIN NUNES, California PATRICK J. TIBERI, Ohio DAVID G. REICHERT, Washington CHARLES W. BOUSTANY, JR., Louisiana PETER J. ROSKEM, Illinois TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska LYNN JENKINS, Kansas ERIK PAULSEN, Minnesota KENNY MARCHANT, Texas DIANE BLACK, Tennessee TOM REED, New York TODD YOUNG, Indiana MIKE KELLY, Pennsylvania JIM RENACCI, Ohio PAT MEEHAN, Pennsylvania KRISTI NOEM, South Dakota GEORGE HOLDING, North Carolina JASON SMITH, Missouri	SANDER M. LEVIN, Michigan, CHARLES B. RANGEL, New York JIM MCDERMOTT, Washington JOHN LEWIS, Georgia RICHARD E. NEAL, Massachusetts XAVIER BECERRA, California LLOYD DOGGETT, Texas MIKE THOMPSON, California JOHN B. LARSON, Connecticut EARL BLUMENAUER, Oregon RON KIND, Wisconsin BILL PASCRELL, JR., New Jersey JOSEPH CROWLEY, New York DANNY DAVIS, Illinois LINDA SÁNCHEZ, California
JOYCE MYER, <i>Staff Director</i> JANICE MAYS, <i>Minority Chief Counsel and Staff Director</i>	

SUBCOMMITTEE ON HEALTH KEVIN BRADY, Texas, <i>Chairman</i>	
SAM JOHNSON, Texas DEVIN NUNES, California PETER J. ROSKAM, Illinois TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska LYNN JENKINS, Kansas KENNY MARCHANT, Texas DIANE BLACK, Tennessee	JIM MCDERMOTT, Washington MIKE THOMPSON, California RON KIND, Wisconsin EARL BLUMENAUER, Oregon BILL PASCRELL, JR., New Jersey DANNY DAVIS, Illinois

C O N T E N T S

[Advisory of April 14, 2015 announcing the hearing](#)

WITNESSES

Sabrina Corlette

Faculty, Georgetown University

Witness Statement [[PDF](#)]

Douglas Holtz-Eakin

President, American Action Forum

Witness Statement [[PDF](#)]

Scott Womack

President, Womack Restaurants

Witness Statement [[PDF](#)]

**THE INDIVIDUAL AND EMPLOYER MANDATES IN THE
PRESIDENT'S HEALTHCARE LAW**

Tuesday, April 14, 2015
House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C

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

Chairman Brady. The hearing is called to order.

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

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

Joining us today are three qualified witnesses: Doug Holtz-Eakin of the American Action Forum; Scott Womack of Womack Restaurants; and Sabrina Corlette, a senior research fellow, project director, and adjunct professor at Georgetown University.

Welcome, as well.

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

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

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

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

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

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

Even the President at one point was against this mandate, stating, quote, "A mandate means that in some fashion everyone will be forced to buy health insurance. But I believe the problem is not the folks trying to avoid getting health care; the problem is they can't afford it," unquote.

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

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

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

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

Chairman Brady. I now recognize the ranking member, Dr. McDermott, for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

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

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

Chairman Brady. Without objection.

[The information follows: [The Honorable Jim McDermott Submission](#)]

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

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

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

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

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

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

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

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

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

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

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

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

And I yield back my time.

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

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

Mr. Holtz-Eakin. Chairman Brady, Ranking Member McDermott, members of the committee, thank you for the chance to be here today.

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

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

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

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

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

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

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

Now, the trick is to get rid of both the mandate and the rating rules. And, in the table, we have two different ways of doing that. One way is to repeal the individual mandate along with the community -- the rating restrictions, so relax the age bans and allow the young, in particular, to have relatively low premiums. Or the alternative way to do it is to simply

allow people to buy the insurance they want outside the exchanges in nonqualified health plans, something that has been done temporarily by the administration.

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

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

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

Thank you

Chairman Brady. Thank you, Doctor, very much.

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

STATEMENT OF SCOTT WOMACK, PRESIDENT, WOMACK RESTAURANTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you

Chairman Brady. Thank you, sir.

Ms. Corlette, you are recognized for 5 minutes.

**STATEMENT OF SABRINA CORLETTE, SENIOR RESEARCH FELLOW,
CENTER OF HEALTH INSURANCE REFORMS, GEORGETOWN
UNIVERSITY**

Ms. Corlette. Good morning. Thank you, Mr. Chairman, Ranking Member McDermott, members of the committee. My name is Sabrina Corlette, and I am a senior research fellow at Georgetown University's Center on Health Insurance Reforms. Thank you for the opportunity to testify here today and for the leadership of this subcommittee in conducting oversight of the Affordable Care Act.

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

On the eve of the law's passage, approximately 50 million Americans were uninsured and approximately 10 million got their health insurance through the individual market. And that market was an extremely inhospitable place, particularly for people in less than

perfect health, and that is about 129 million of us. Before the reforms in the ACA, in most States, applicants for health insurance could be denied a policy because of their health status or charged more in premiums because of their health or gender.

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

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

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

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

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

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

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

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

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

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

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

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

I look forward to your questions. Thank you

Chairman Brady. Thank you.

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

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

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

Dr. Holtz-Eakin, thanks for bringing some of these thoughtful alternatives to the table. You know, your numbers are so different from other models we have seen. Can

you expand a little on why these alternatives would work and why others place such a high priority on the coercive model?

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

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

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

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

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

Is that sort of the overall thought?

Mr. Holtz-Eakin. Yeah. That is the message.

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

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

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

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

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

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

Mr. Holtz-Eakin. Absolutely. Yes.

Chairman Brady. All right. Thank you.

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

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

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

Chairman Brady. Yeah.

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

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

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

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

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

I now recognize Dr. McDermott for his 5 minutes.

Mr. McDermott. Thank you, Mr. Chairman.

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

Mr. Holtz-Eakin. It is somewhere in that vicinity, yeah.

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

Is that a premise on which you are basing this?

Mr. Holtz-Eakin. No. Why do you --

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

Mr. Holtz-Eakin. They don't have health insurance.

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

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

Mr. Holtz-Eakin. Those costs are spread broadly through the system --

Mr. McDermott. So they are free-riders.

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

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

Mr. Holtz-Eakin. So the question is, what is the nature of these costs? Is this essential medical? They will essential medical here at a hospital; that is the law of the land. But

they won't be able to undertake any sort of discretionary health care unless they pay for it out of their pockets.

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

Mr. McDermott. But you are telling --

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

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

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

Mr. Holtz-Eakin. That is true. That is fine.

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

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

Mr. McDermott. It is estimated that it is about a \$1,000 a year on your healthcare premiums --

Mr. Holtz-Eakin. That is too high.

Mr. McDermott. -- going for uncompensated care.

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

Mr. McDermott. They are what?

Mr. Holtz-Eakin. Too large. A thousand dollars, no.

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

Mr. Holtz-Eakin. No, I do not.

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

Mr. Holtz-Eakin. Look, the vast majority of people are exempted. So, I mean, this individual mandate --

Mr. McDermott. Okay.

Mr. Holtz-Eakin. -- I mean, there are 20 million people, as an estimate, who have been exempted. So it is not much of a mandate, sir.

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

Mr. Holtz-Eakin. No.

Mr. McDermott. -- so they don't have any preventive care. So we want to wait until they have had --

Mr. Holtz-Eakin. No.

Mr. McDermott. -- the stroke. You don't do anything about their --

Mr. Holtz-Eakin. That is not what I am saying, sir.

Mr. McDermott. -- blood pressure before.

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

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

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

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

Mr. Holtz-Eakin. People have to buy products in America, yes. I mean --

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

Mr. Holtz-Eakin. No. I am not sure what you are saying.

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

Mr. Holtz-Eakin. Sure.

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

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

Chairman Brady. Thank you.

Mr. Johnson is recognized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you, sir. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Thompson, you are recognized.

Mr. Thompson. Thank you, Mr. Chairman.

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

Mr. Johnson. Thank you.

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

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

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

But my --

Mr. Holtz-Eakin. So --

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

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

Ms. Corlette. Yes, I think that is accurate. Not only that, sir, but roughly 98 percent of employers with 200 or more workers already provide health insurance. And I think that

number is about 94 percent for employers between 50 and 199 workers. So we are talking about a fairly small number of free-riders who are not currently providing health insurance who we --

Mr. Thompson. What?

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

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

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

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

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

Ms. Corlette. I do not.

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

Ms. Corlette. I do. Yes. And, in fact --

Mr. Thompson. Why?

Ms. Corlette. -- 99 percent of employers report in national surveys that the Affordable Care Act is really not changing any of their decisions regarding employee benefits.

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

Ms. Corlette. We have not, sir.

Mr. Thompson. Thank you.

I have no further questions. Yield back.

Chairman Brady. Thank you.

Mr. Roskam, you are recognized for 5 minutes.

Mr. Roskam. Thanks, Mr. Chairman.

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

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

Mr. Womack. "Womack."

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

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

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

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

Okay. Pause on that. Enter your testimony.

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

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

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

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

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

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

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

Mr. Roskam. So you are arguing -- just in the interest of time --

Ms. Corlette. Uh-huh.

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

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

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

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

Mr. Roskam. I know, but --

Ms. Corlette. -- passage of the Affordable Care Act. Now, that may be --

Mr. Roskam. -- go back to him now.

Ms. Corlette. -- cold comfort to somebody like Mr. Womack, who every year gets a little bit of a percentage increase in his premiums. But what the Affordable Care Act promised --

Mr. Roskam. Right.

Ms. Corlette. -- to do --

Mr. Roskam. So my friend --

Ms. Corlette. -- was to --

Mr. Roskam. -- going back to my friend, just said 60 percent. Sixty percent. Come on.

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

Mr. Roskam. Okay.

Ms. Corlette. -- a lot of that growth --

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

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

Thank you for taking the time.

Chairman Brady. Thank you.

Mr. Pascrell, you are recognized for 5 minutes.

Mr. Pascrell. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chairman Brady. Without objection.

[The information follows: [The Honorable Bill Pascrell](#)]

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

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

Mr. Pascrell. If you have a couple of seconds?

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

Ms. Corlette. Certainly.

Chairman Brady. Time has expired.

Dr. Price, you are recognized.

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

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

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

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

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

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

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

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

Would you agree with that?

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

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

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

Chairman Brady. Without objection.

Mr. Price. -- on the employer mandate effects of ObamaCare.

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

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

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

From an anecdotal standpoint, I have a car dealership in my community; 168 full-time workers before the law, now 2. Now 2. 166 individuals were moved to part-time work. That is real stuff. That is real consequences for people out there.

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

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

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

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

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

Mr. Price. My understanding is --

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

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

And I yield back.

Chairman Brady. Thank you.

Mr. Davis, you are recognized.

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

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

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

Mr. Davis. Thank you.

Mr. Womack?

Mr. Womack. I would agree with that.

Ms. Corlette. I would also agree with that.

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

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

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

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

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

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

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

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

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

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

And, actually, I think it was Congressman Price, perhaps, or maybe it was Congressman Roskam who mentioned one of them, and that is around the area of consumer deductibles

or cost-sharing. While the ACA did take an important step forward in terms of limiting people's out-of-pocket costs so that there is a maximum in any year that somebody would to pay if they had a car accident or cancer or something like that, many people are finding the deductibles in the new health plans to be a significant barrier to accessing services.

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

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

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

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

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

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

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

Mr. Davis. But if we are going to reduce the cost of health care overall --

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

Mr. Davis. I yield back.

Chairman Brady. Thank you. Time has expired.

Mr. Buchanan, you are recognized.

Mr. Buchanan. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

Mr. Womack. \$19,000.

Mr. Buchanan. \$19,000 a year. That is insane. Who can afford to pay that? That is why this system is still broken today. It didn't work back 10 years ago, and it still doesn't work today.

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

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

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

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

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

Mr. Womack. Correct.

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

Mr. Womack. Correct.

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

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

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

With that, I yield back.

Chairman Brady. Thank you.

Mr. Smith, you are recognized.

Mr. Smith. Thank you, Mr. Chairman.

Thank you to our witnesses here today.

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

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

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

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

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

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

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

I will also say that the mandate --

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

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

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

Ms. Corlette. Right.

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

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

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

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

Mr. Smith. Uh-huh.

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

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

Chairman Brady. I apologize.

Ms. Corlette. That is all right.

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

Ms. Corlette. I can submit it in writing.

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

Chairman Brady. Mr. Kind, you are recognized.

Mr. Kind. Thank you, Mr. Chairman.

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

And, Mr. Holtz-Eakin, let me start with you, because I think you were understating, I think, the significance as far as the individual-responsibility component of what this is at. Of course, there is the free-rider problem that we were trying to address. We were also trying to get at the guaranteed-issue problem, and that currently is a major problem in the healthcare system, but also the preexisting condition issue, as well, which would make it very difficult to make sure that people with preexisting conditions could get the coverage they need unless everyone is in. I mean, that is what makes Medicare so popular. Virtually every senior in Medicare has some form of preexisting condition, yet none of them are denied coverage.

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

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

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

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

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

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

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

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

But I am also getting tired, Mr. Chairman, of just having these hearings where you have one side that uses the Affordable Care Act as a convenient whipping post to score political points, the other side doing their best to defend it and highlight and accentuate the positive things that are happening. And I have to believe there is a lot of bipartisan overlap on issues that both parties can agree to, that we can work on together, some common ground.

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

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

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

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

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

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

Ms. Corlette, do you have --

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

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

Chairman Brady. Thank you.

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

Mr. Holtz-Eakin. No. The --

Chairman Brady. You were talking about how to get to continuous coverage --

Mr. Holtz-Eakin. We are talking about alternatives, yes.

Chairman Brady. Alternatives. Possibly bipartisan alternatives.

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

Chairman Brady. Got it. Thank you very much.

Mr. Marchant, you are recognized.

Mr. Marchant. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

Mr. Marchant. Okay. Thank you very much.

Chairman Brady. Thank you.

Ms. Jenkins, you are recognized.

Ms. Jenkins. Thank you, Mr. Chairman.

And thank all of you for your testimony.

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

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

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

Mr. Holtz-Eakin. Right.

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

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

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

And I know one fellow member asked about bipartisan solutions, and I am not particularly concerned about that. I want to know what the right thing to do is that focuses us on patient-centered coverage, to make it affordable, to get everyone covered,

that still maintains our freedoms and our liberties without the harmful effects to the pocketbooks for individuals, families, businesses, or the American economy.

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

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

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

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

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

Chairman Brady. Thank you.

Mr. Renacci, you are recognized.

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

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

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

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

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

This issue, in particular, led me to introduce a bipartisan bill, Simplifying Technical Aspects Regarding Seasonality Act, or the STARS Act, H.R. 863. This legislation would provide one clear definition of "seasonal employment" rather than multiple definitions applied to different aspects of the ACA's employer provisions. This is just one example of a flawed mandate approach taken by ObamaCare.

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

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

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

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

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

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

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

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

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

Mr. Renacci. Thank you.

Mr. Chairman, I yield back.

Chairman Brady. Thank you.

Mr. Young, you are recognized.

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

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

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

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

And just to give some sense of the hourly impact on wages, an employee going from 35 hours down to 29 hours is effectively receiving a 17 percent pay cut courtesy of this

healthcare law. An employee going from 39 hours down to 29 hours is losing an entire workweek's worth of wages.

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

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

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

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

Mr. Young. Yeah.

Mr. Womack. -- even if they had the healthcare coverage.

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

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

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

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

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

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

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

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

Mr. Young. More people.

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

Mr. Young. Thank you.

I yield back.

Chairman Brady. Thank you, Mr. Young.

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

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

Mr. Womack. Absolutely. Yeah.

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

Any words of advice as we wrap up the hearing?

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

And so I really think it is important to not stop here and to actually push forward to a much more efficient healthcare system that is really built from the ground up and allows a lot of choice on the ground.

Chairman Brady. Absolutely. Thank you.

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

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

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

Mrs. Black. Well, thank you.

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

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

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

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

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

Mr. Womack. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So thank you so much.

Thank you again, Mr. Chairman.

Chairman Brady. Thank you.

And Dr. McDermott would like to ask a follow up question.

Mr. McDermott. Thank you, Mr. Chairman.

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

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

Mr. Womack. Absolutely.

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

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

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

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

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

Mr. McDermott. Okay. Thank you.

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

Chairman Brady. Thank you.

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

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

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

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

Chairman Brady. With that, thank you for a good hearing.

The meeting is adjourned.

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

[Public Submissions For The Record](#)