THE HEALTH CARE LAW'S IMPACT ON JOBS, EMPLOYERS, AND THE ECONOMY

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JANUARY 26, 2011

Serial No. 112–03

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

70–870 WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

DAVE CAMP, Michigan, *Chairman*

WALLY HERGER, California
SAM JOHNSON, Texas
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
PATRICK J. TIBERI, Ohio
GEOFF DAVIS, Kentucky
DAVID G. REICHERT, Washington
CHARLES W. BOUSTANY, JR., Louisiana
DEAN HELLER, Nevada
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
AARON SCHOCK, Illinois
CHRIS LEE, New York
LYNN JENKINS, Kansas
ERIK PAULSEN, Minnesota
RICK BERG, North Dakota
DIANE BLACK, Tennessee

SANDER M. LEVIN, Michigan
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
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
SHELLEY BERKLEY, Nevada
JOSEPH CROWLEY, New York

JON TRAUB, *Staff Director*
JANICE MAYS, *Minority Staff Director*

CONTENTS

THE HEALTH CARE LAW'S IMPACT ON JOBS, EMPLOYERS, AND THE ECONOMY

WEDNESDAY, JANUARY 26, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The committee met, pursuant to notice, at 9:04 a.m., in Room 1100, Longworth House Office Building, the Honorable Dave Camp [chairman of the committee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Camp Announces Hearing on the Health Care Law's Impact on Jobs, Employers, and the Economy

Ways and Means Hearing to Examine the Impact of Taxes, Regulations, and Mandates Contained in the Health Care Law on Economic Growth and Job Creation

January 19, 2011

House Ways and Means Committee Chairman Dave Camp (R–MI) today announced that the Committee on Ways and Means will hold a hearing on the impact the "Patient Protection and Affordable Care Act" and "Health Care and Education Reconciliation Act of 2010" will have on the U.S. economy and employers' ability to hire new workers and retain existing employees. **The hearing will take place on Wednesday, January 26, 2011, in 1100 Longworth House Office Building, beginning at 9:00 A.M**.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of invited witnesses will follow.

BACKGROUND:

The Democrats' health care overhaul imposes more than one-half trillion dollars of tax increases and numerous pages of mandates and onerous regulations on employers. Employers of all sizes are expressing concern that the new mandates and regulations will deter them from hiring new employees, threaten their ability to retain existing workers, and harm their ability to increase wages for existing employees. The new health care law compounds the uncertainty employers and entrepreneurs are facing amid the most challenging economic climate since the Great Depression. Making matters worse, some insurance companies and employers have already increased their health care premiums, in part, to comply with the new health care law, exacerbating the drag on the U.S. economy from rising health care costs.

In announcing this hearing, Chairman Camp said, "**Employers have repeatedly expressed their concerns about the effects of the Democrats' health care law. This hearing provides us the opportunity to directly hear from employers about the higher taxes and new mandates that are in this law. This will also serve as a basis for how this Committee, and Congress, can best respond to the concerns of employers and workers and refocus its energy to develop common sense solutions that prioritize affordability, job creation, and economic growth**."

FOCUS OF THE HEARING:

The hearing will examine the economic and regulatory burdens imposed by the enactment and implementation of the "Patient Protection and Affordable Care Act" (P.L. 111–148) and the "Health Care and Education Reconciliation Act of 2010" (P.L. 111–152). It will explore the impact on jobs stemming from the new taxes and new federal regulatory requirements. It will also analyze the impact of the employer mandate on job creation.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, February 9, 2011**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at http://www.waysandmeans.house.gov/.

Chairman CAMP. The Committee will come to order. Good morning. Today's hearing is on the health care law's impact on jobs, employers, and the economy. We will have two panels today.

Our first panel will feature Austan Goolsbee, who is chairman of the Council of Economic Advisors.

I will begin by making an opening statement, and then I will yield to my friend and ranking member, Mr. Levin.

I want to start by reading the following quote. "I know one of the things that's come up is that the 1099 provision in the health care bill appears to be too burdensome for small businesses. It just involves too much paperwork, too much filing. It's probably counterproductive. It was designed to make sure that revenue was raised

to help pay for some of the other provisions. But if it ends up just being so much trouble that small businesses find it difficult to manage, that's something we should take a look at. So there are going to be examples where I think we can tweak, and make improvements."

That was President Obama on the day after the November elections. The President was saying the health care law appears to be too burdensome for small businesses, that it involves too much paperwork, too much filing. And last night, in his State of the Union Address, the President again referred to the 1099 provision, as we have come to call it, as a flaw.

But more importantly, the President asked us to identify and bring to him items that need to be fixed. And clearly, in a bill that's over 2,000 pages long, there is more than just the 1099 provision we need to address.

With unemployment rates stuck above 9 percent for the last 20 months, and with my home state's unemployment at nearly 12 percent, I have one simple question today. How is it that Congress passed a health care bill that is "counterproductive" to American employers? Especially at a time we need to be looking at solutions that encourage, not impede, job creation.

That's the focus of our hearing today, the health care law, and its impact on the economy, on employers, and their workers. If signed into law, the Democrat's health care law imposes more than a one-half-trillion dollars of tax increases and thousands of pages of mandates and onerous regulations on employers.

My friends on the other side of the dais have argued that we shouldn't be debating health care anymore, that we need to move on, and focus on jobs and the economy. What they need to recognize is that employers of all sizes are expressing concern that the new mandates and regulations will deter them from hiring new employees, threaten their ability to retain existing workers, and harm their ability to increase wages for existing employees.

The new health care law compounds the uncertainty employers and entrepreneurs are facing under the most challenging economic climate since the Great Depression. Making matters worse, many insurance companies and employers have already increased their health care premiums to comply with the new health care law, exacerbating the drag on the U.S. economy from rising health care costs.

That's the problem with the health care law that puts Washington, D.C., the Federal Government, at the center, instead of patients and doctors. And when you take a Washington-knows-best approach to legislation, you usually end up with a bill that only works for Washington, instead of working for the American people.

At the end of the day, the health care law fails to control costs, it fails to let Americans keep the insurance they have and like, despite the President's promise, it fails to protect jobs, it fails to ensure seniors have access to their doctors and hospitals, and fails to prevent tax increases from hitting middle-class families and the small businesses we need to move our anemic economy forward.

The hearing today is just the first of many with regard to the health care law. It's my intention to give the American people and employers, both large and small, the opportunity they did not have

when this law was being written, to testify in an open hearing about the impact this law will have on them.

We know what the experts have said. We all know that the nonpartisan Congressional Budget Office has estimated the health care law will increase premiums for millions of families by up to $2,100 on average by 2016. That's $3,200 more expensive than the Republican alternative I offered last congress.

We all know that the Obama Administration's own officials have predicted that as many as 7 out of 10 employers will have to change the coverage they offer to their employees because of the law.

We all know, from the joint committee on taxation, that there are well over $500 billion in new taxes, many of which will hit middle-class families and small businesses. That's what the experts have told us.

Today we will hear something different. We will also hear from real employers, and what they think about this law, and what they think the impact will be on their businesses and their employees. I look forward to hearing this testimony and getting more of this sort of insight in the future. After all, these are the very people who have to live with the decisions that are made here in Washington.

But before we do, I ask unanimous consent that all Members be allowed to submit an opening statement for the record.

Chairman CAMP. Hearing no objection, I now yield to the ranking member, Ranking Member Levin, for the purposes of an opening statement.

Mr. LEVIN. Thank you, Mr. Chairman. Dr. Goolsbee, I understand, will be here until 10:30. He will have a chance, Mr. Chairman, to respond to some of your criticisms that I don't think are valid.

But we want to hear from you, Dr. Goolsbee, so I will be brief.

Last night, the President said some very clear things about the health care issue. He said, "Instead of re-fighting the battles of the last two years, let's fix what needs fixing, and move forward." My concern about the hearing is that, indeed, we will be re-fighting the battles of the last two years.

For example, as to 1099, we introduced legislation in the last session. It passed here. It was opposed by the then minority because of the pay for. Ironically, much of what is in the bill was in the pay for is now the law of the land. We should have acted on 1099 last session.

In his speech, the President also said, "What I'm not willing to do is to go back to the days when insurance companies could deny someone coverage because of a pre-existing condition." He went on to point out that the law is now making prescription drugs cheaper for seniors, and giving uninsured students a chance to stay on their parents' coverage. So, I repeat, he then went on to say, "Instead of re-fighting the battles of the last two years, let's fix what needs fixing, and move forward."

I think that's exactly what we should do, and I would hope that would be the tone of the hearing today. I yield back.

Chairman CAMP. Well, thank you. Welcome to the Ways and Means Committee, Mr. Goolsbee. Under our rules you will have

five minutes. Your written statement will become part of the record. And so, welcome, and you may begin.

STATEMENT OF AUSTAN GOOLSBEE, PH.D., CHAIRMAN, COUNCIL OF ECONOMIC ADVISERS, WASHINGTON, D.C.

Mr. GOOLSBEE. Thank you, Mr. Chairman. And I would like to say good morning to Chairman Camp, Ranking Member Levin, and all the Members of the Committee. Thank you for inviting me to testify here today. And I know we were up late, and I saw several of you last night, and I appreciate your time.

The Affordable Care Act was designed to make sure that health insurance coverage is affordable for individuals, families, and businesses. And while millions of people are benefitting now, much of the impact of that act will begin when the major coverage provisions take effect in 2014.

The best evidence that we have gathered from outside experts suggests that, in addition to slowing the growth of Medicare spending and significantly reducing the deficit over the next 10 years and the 10 years after that, that the Affordable Care Act can be a significant benefit to the job market by easing the burden of health care costs on small businesses, and by reducing the growth rate of health care costs for all businesses.

Now, the impact of the Affordable Care Act on the labor market is an important topic. I applaud you for having this hearing. I believe there has been a significant amount of confusion on this issue, and I am happy to have this opportunity to try to clarify that.

I think the President laid out last night in a way that is most helpful, and you iterated in your opening statement, Mr. Chairman, that we should try to work together to improve—whatever is broken or problematic we should fix together. Anything that reduces costs is going to help jobs in this country.

Health care has, for years, been one of the most pressing cost issues facing the business world. Those costs have been rising dramatically, long before there ever was an Affordable Care Act, and the Affordable Care Act's intention is to try to address that.

I would highlight two basic mechanisms that I think the Affordable Care Act can have a—has had and will have a significant positive impact on the job market. The first mechanism is in the area of small business. Now, the role of entrepreneurs and small businesses in job creation and in the economy is well known. Equally well known is the fact that small businesses have, for years, consistently said that the cost of health care is one of their most significant problems.

Small businesses that want to provide insurance for their workers face much higher costs than large firms do for exactly the same plans. And in many states they also face the risk that a single sick employee, or even an employee's ill family member, will send their premiums through the roof for all of their employees.

The Affordable Care Act has begun to help make small business more competitive by making health insurance more accessible and more affordable. One of the first provisions to take effect is the small business health care tax credit that helps offset the costs of coverage. That applies to as many as four million small businesses that may be eligible right now for that small business tax credit.

In addition, the Affordable Care act can level the playing field for small businesses by giving these businesses and their workers access to the same kinds of stable premiums that larger businesses enjoy. The exchanges pool risk and reduce administrative costs for small businesses. New insurers will not be able to raise rates when some individual in the group becomes sick. And this will allow small firms to offer competitive health benefits. People can start their own company, or go work for a fast-growing small business without worrying to that they would have to give up access to secure affordable coverage. And that impact on job mobility is critically important.

The other mechanism that I would highlight are the many things that the act does to try to reduce costs overall, and reduce the health care cost inflation rate.

These include the immediate reduction in the implicit tax from the uninsured. Right now, the uninsured get health care in emergency departments or in other very high-cost ways. The estimates suggest that that is a hidden tax passed on to everyone else of up to $1,000 per worker. And by covering the uninsured, the Affordable Care Act will reduce that hidden tax directly.

Second, it makes innovations in the delivery systems in Medicare and Medicaid that, if we have successful innovations there that are adopted in the private sector, can reduce costs.

Chairman CAMP. If you could, just sum up very quickly.

Mr. GOOLSBEE. Sum up. Commitment to prevention and wellness, to patient-oriented outcomes, and to modernizing the health IT system. Those cost reductions and the small business credits can have a quite beneficial effect on the job market.

[The prepared statement of Austan Goolsbee, Ph.D.:]

This testimony is embargoed until January 26, 2011, at 9:00am

Chairman Austan Goolsbee
Council of Economic Advisers

Ways and Means Committee Hearing
January 26, 2011

Good morning Chairman Camp, Ranking Member Levin and members of the committee. Thank you for inviting me to testify today about the implications of the health reform law for the economy and jobs.

The Affordable Care Act was designed to make sure that health insurance coverage is affordable for individuals, families, and businesses. While millions of people are benefitting now, much of the impact of the Act will begin when the major coverage provisions take effect in 2014. But the best evidence from outside experts suggests that in addition to slowing the growth of Medicare spending and significantly reducing the deficit over the next twenty years, the Affordable Care Act can be a significant benefit to the job market by easing the burden of health care costs on small businesses and by reducing the growth rate of health care costs.

The impact of the Affordable Care Act on the labor market is an important topic for the nation and there has been a great deal of confusion over this issue, so I am very happy to have this opportunity to try to dispel some myths and answer your questions about the economics of health reform. I want to highlight two key mechanisms identified by health economists that could have significant positive impacts on the job market.

The first mechanism I want to highlight is the impact on small business. The role of entrepreneurs and small businesses in job creation is well known. And equally well known is the fact that small businesses have, for years, consistently said that the cost of health care is one of their most significant problems. Small businesses that want to provide insurance for their workers face much higher costs than large firms do for the same plan. In many states they also face the risk that a single sick employee or even an employee's ill family member will send their premiums through the roof.

The Affordable Care Act has already begun to help small business become more competitive by making health insurance more accessible and more affordable. One of the first provisions of the law to take effect is a Small Business Health Care Tax Credit that helps offset the cost of coverage for qualified small businesses. This credit covers up to 35 percent of a small business' premium costs; in 2014, this share rises to 50 percent. For qualified employers that were not already offering coverage, this will make it easier for them to do so. For those that were already providing coverage, this credit helps them with those costs, improving their bottom line and returning higher profits, higher wages for workers, and more jobs. As many as 4 million small businesses may now be eligible for the new Small Business Health Care Tax Credit.

In addition, the Affordable Care Act can level the playing field for small businesses by giving them and their workers access to the same stable premiums that large employers already enjoy. Exchanges pool risk and reduce administrative costs for small businesses; new insurers will not be able to raise rates when someone in the group becomes sick. This will allow small firms to offer competitive health benefits. People will be able to start their own company or go work for

a fast-growing small business without worrying that they would have to give up access to secure, affordable coverage.

Another aspect of the Affordable Care Act I want to highlight for its positive impact on job creation is its role in reducing the growth rate of health care costs and the impact that this reduction could have on employers. The evidence indicates that although almost all large firms already provide health insurance for their workers, health care costs have consistently been one of the fastest-growing components of employer compensation costs. And economic research indicates that these high costs have a direct negative impact on job growth at companies (Baicker and Chandra; Sood, et al).

The Affordable Care Act reduces the growth of health care costs for employers in several ways. The most immediate way is by reducing the indirect costs associated with caring for the millions of uninsured in the country that are passed through to insurance premiums. Today, the uninsured get their health care in emergency departments or in other high-cost ways and these costs are then passed on directly as a hidden tax on everyone else. Estimates put the cost of this hidden tax as high as $1,000 per worker per year. When fully implemented, the Affordable Care Act should significantly reduce this hidden tax on employers.

Second, the Affordable Care Act introduces a number of payment and care delivery innovations in Medicare and Medicaid that will reduce spending for those programs, according to the non-partisan Congressional Budget Office; if private payers adopt the successful innovations, savings could accrue to the private sector as well. Some innovations, such as "bundled payments" and

the Medicare Shared Savings Program, which will create Accountable Care Organizations, are intended to improve care coordination and efficiency. Others, such as initiatives to reduce hospital-acquired infections and preventable hospital readmissions, provide an incentive to improve patient safety and the quality of care while also reducing spending.

Third, the Act makes a significant commitment to prevention and wellness, including requiring new insurers to cover high-value preventive services with no out-of-pocket cost to consumers. Fourth, the Affordable Care Act invests in better information about what medical treatments work best, through the creation of a Patient-Centered Outcomes Research Institute. This information will enable patients and providers to work together to make informed decisions about which treatments are the most effective.

Fifth, the Affordable Care Act continues the modernization of our health information technology infrastructure that began under the Recovery Act. There is research to indicate that health IT adoption and connectivity will help achieve efficiencies and savings in health spending by enabling administrative simplification, process improvements, and business transformation. The recent research of health economist David Cutler and colleagues suggests that all of these factors taken together may reduce health care cost inflation sufficiently to generate hundreds of thousands of additional jobs per year.

In addition, the Affordable Care Act contains provisions intended both to expand the primary care workforce and to respond to growing concerns about current and projected shortages of direct care workers, such as nursing assistants and home health aides. Programs authorized by

the act will help prepare the health system to meet the demand for health care workers through training and support for doctors, nurses, nurse practitioners and physician assistants.

In summary, when implemented, the Affordable Care Act will help small businesses; and by slowing health care cost inflation, it can play an important role in boosting the job market. As the President has said, all of us should be open to ideas of how to reduce costs further and improve the system. But repealing the Act and going back to the old way of doing things would be a major step in the wrong direction for the economy and for our nation's health.

Chairman CAMP. All right. Thank you. And as I said, your full statement will be part of the record. And thank you for that.

Last night the President did say of the ongoing health care reform debate that, instead of re-fighting the battles of the last two years, let's fix what needs fixing and move forward. And he mentioned specifically the 1099 provision. What else does the President believe needs to be fixed in this new law?

Mr. GOOLSBEE. Well, I would say the 1099 provision, which was designed to reduce tax evasion, what put this burden on small business, was identified early as an important one.

You saw the President last night also say he was open to look at things. I know that there have been people that said we should have done more on medical malpractice reform, and the President said he was open to looking at that.

Now, I would highlight that the Affordable Care Act does create pilots that it funds in states to figure out—different states have experimented with ways to address medical malpractice reform, and it authorized examining and creating pilots to help us figure out what works in that area. But I would say that's an area that the President is open to ideas, and we would want to work with you on.

Chairman CAMP. So there is 1099 and medical liability reform. Those are two items. Are there any other items?

Mr. GOOLSBEE. I would say that the President is open to working with you if you identify other items. But the basic thrust of the Act, of trying to get costs down and trying to help small business to afford care, is fundamentally the right approach. And so I think that we want to stick with it.

Chairman CAMP. Well, in regard to holding costs down, which—I appreciate that sentiment and goal—both the CMS actuary and the Congressional Budget Office say the legislation that was enacted will likely increase, not decrease national health expenditures. And if they're right, isn't the health care law an economic failure that will increase health care spending and cost jobs? And I'm not asking if you agree with CMS or CBO, but I'm asking, if they're right, isn't this reform a failure?

Mr. GOOLSBEE. I don't view it as a failure. I think the key thing of the Affordable Care Act is trying to get the health care cost inflation rate down.

If more people are being covered and having their health improved and have the security to know that they cannot be denied coverage because of a pre-existing condition, the amount of total health spending is different than looking at what the prices are, and trying to control health care cost inflation. So, in my view, that wouldn't be the right way to evaluate it.

Chairman CAMP. But the expert non-partisan agencies that we rely on, like the Congressional Budget Office, like the actuaries at CMS, tell us that overall health spending is likely to go up under this legislation.

And if the stated claim that holding down health care costs is really a justification for this bill, and will help the economy and help businesses, particularly small businesses, and that isn't going to happen, how is this committee expected to evaluate this legislation, other than that it doesn't meet the stated goals, and that the reform that was purported was a failure?

Mr. GOOLSBEE. Well, I was trying to make the distinction—and I apologize if I didn't—between the amount of total spending and the, essentially, spending per person, or the cost of the same procedure.

So, the Congressional Budget Office and many health economists out in the country believe that the things that I have described in

my testimony are ways that we can, for any given business, reduce the health care cost inflation rate, and make them more competitive for small businesses, giving health care credits that they can use to help offer health care to their workers, where they do not now.

That is important. That will facilitate job creation. That is a different question than the one I think you're asking, Mr. Chairman, which is what will be the total spending on health care, overall, not on the prices, but on total spending. And total spending has been rising quite dramatically for many years. And I would observe that CMS's data suggested that health care spending overall rose at the slowest rate this past year that it has since they have been keeping records.

Chairman CAMP. Well, the Congressional Budget Office also indicated, as I said in my opening statement—I don't want to repeat that, though—but that health care premiums for millions of families will also go up by over $2,000 per family. And, obviously, in contrast to a reduction in premium, which occurred with the bill that I offered.

So, whether you—however you slice it, whether you look at the macro sense or you look at individual families, costs are going up. And as you said in your opening statement, getting costs under control in health care is a very important goal, and absolutely one we should look at.

Well, thank you very much. At this time I will yield to the ranking member. He has five minutes.

Mr. LEVIN. Thank you, Dr. Goolsbee. You are very polite. And I think proceeding that way is important.

But I think there needs to be driven home very clearly the distinction you make. Driving down costs does not mean necessarily that expenditures will not go up. We have now over 50 million people who have no insurance, whatsoever. And bringing most of the 50 million people so they have health care insurance and have health care may increase overall expenditures while we drive down the cost per patient. And there is nothing inconsistent.

And John Boehner's proposal has been analyzed. It would add only three million people to the insured. We are the only country, industrial country, on this globe that has anything like 50 million people who have no insurance whatsoever, the only nation like that.

So, you said it very discreetly, but I think it was clear. And I think we need to make those distinctions very clear, indeed.

Now, let me ask you about another argument that's made about the health care reform. And now that language has been somewhat moderated, I will use what's been said here, that it's a job-killing bill—reform. I don't think we should use that language, whatever language we use. Would you comment on that?

Mr. GOOLSBEE. Well, I would say, as a strictly factual matter, I think it's an inaccurate statement to say it's job-killing. I think the evidence suggests that the role of small business in job creation, and the role of reducing the health care cost inflation rate in job creation suggests that the two primary tenets of the Affordable Care Act may have even a significant positive impact on the job market.

You may have seen a health economist at Harvard, David Cutler, look at the best evidence we have of the projected impacts of these various inflation-reducing measures, and ask, "What would that mean for job creation or destruction," and found it would be job creating, in the nature of hundreds of thousands of jobs per year.

If you look at the evidence on employers, health care costs have been rising dramatically every year for many years. And that has been a tremendous burden on them, and has limited employment growth.

So, anything that we can do to reduce that inflation rate will have a positive impact. And I did not mean in any way to say to the chairman or to anyone else that we should close our minds and not be open to important ideas of how to improve this, or how to find other ways to get costs down. We should. The President has made that clear, and I would like to reiterate that, that we are open to sensible ways to improve care, to improve coverage, and to get costs down. I think to describe it as job-killing is not accurate, based on the evidence that we have.

Mr. LEVIN. Okay, just briefly in your testimony you refer to Patient-Centered Outcomes Research Institute as something that can help make treatments work better. And that means, I think, it will affect costs and try to get a hold of costs. Do you want to comment briefly on that? You have about 30 seconds.

Mr. GOOLSBEE. Well, I would say——

Mr. LEVIN. Some have said that Washington is going to dictate the care patients receive.

Mr. GOOLSBEE. It's not—that institute is not a dictation machine, it's not meant to do that. It is meant so that we can share information across the country of what do we find, what kind of treatments work.

The best analogy is my own. When I was a kid, it was routine to take everybody's tonsils out. I got my tonsils out, I was in the hospital three days. And of our own kids—I have three children—the studies indicated that that was not effective, except in certain circumstances. Now, our middle son had—I'm not a doctor, but—some kind of inflamed tonsils, had his tonsils removed. But our other two kids did not.

And that is a case where looking across the country, studies showed that it was more effective—that it was, in some sense, more dangerous to routinely just take all kids' tonsils out, and it's quite a significant expense to both families and to the health system that we were routinely doing that.

I would use that as kind of a personal example of what the intention of this would be, would be to share that information so doctors——

Chairman CAMP. All right, thank——

Mr. LEVIN. Thank you.

Chairman CAMP. Thank you very much. Mr. Herger is recognized.

Mr. HERGER. Thank you very much, Mr. Chairman. And, Mr. Goolsbee, I thank you for appearing before us, and your testimony.

But as I listen to you, there seems to be, in the Administration, a night and day difference between what I hear you saying on lowering of health care costs and what this Obamacare is doing for our

small business and creating jobs, and what I hear small businesses in my district telling me. And later this morning we will be hearing from some small business owners who do know firsthand what it takes to create jobs.

It's one thing to come up with academic arguments for why a particular policy will be good for job creation. It's another thing to have those results actually demonstrated in the real world. What we are going to hear from business owners in my district, and what I have heard from small businesses, is a very different story than the one you have presented. Their near-unanimous opinion is that this health care law is going to absolutely be devastating to their small businesses, and to creating jobs.

Let me share with you some of the feedback that I have received from business owners in my northern California rural district. Robert Boisey of Burney, California, writes, "I am a small businessman who is retired and collecting Social Security. I started my business in January of 2008, and it immediately took off. In 2009, I made more money than I ever have in my life, and I was ready to add 1 or 2 employees when they started talking about Obamacare. I have now decided not to expand, and to contain my business at a smaller size."

And then, from a Charles Watts of Chico, California, writes, "I have been a business owner builder/contractor for 35-plus years, and have survived 3 other recessions, this being the worst. What I don't understand is how our government figures that business owners can maintain work in an economy with a collapsed housing market, with no future in sight of recovery for years. Our company is hanging on by a thread. And if I have to provide health care for employees, I will have to close it down, no questions asked. I would have no other option."

And then a Mike Mullin in Cottonwood, California, writes, "As it stands right now, I can't afford to grow or hire new employees. Currently, the paperwork alone is a nightmare in labor costs. If Obamacare is not repealed, it will definitely increase labor costs, which is the most expensive part of running a business. Also, the 1099 deal definitely needs to go. If I have to cut a 1099 to every vendor I use, I won't have time to do my work."

Mr. Goolsbee, this is just a sample of what I and other members of this Committee are hearing from small business owners in the real world. I have double-digit unemployment in every one of the 10 counties in my district. We cannot afford this—to get this wrong. Can you explain why the Administration's claims are so out of touch with what we're hearing from people who are actually creating jobs?

Mr. GOOLSBEE. Well, Congressman, I respect that question, and I appreciate you bringing that evidence. I think the one thing I have noticed when I have talked to many small business people and large business people is some misunderstanding on the part of some business people of what's in the law, or what provisions would apply to them.

So, small businesses are—if you have 50 employees or fewer, you are not required to provide coverage to your employees. Second, small businesses, up to four million of them right now, would qualify for a very substantial tax credit to help cover their costs

that—they have never had such a credit before. And third, as we move to the exchanges, for the first time, small businesses will be able to get insurance coverage at a price that is comparable to the price that large businesses currently offer.

So, among very small businesses in the country, the majority do not offer any health care coverage now. And the surveys of the NFIB and other small business organizations have shown again and again—before there ever was an Affordable Coverage Act—that health care costs are one of the most pressing problems facing small business, that they had very hard times hiring employees to come work at their businesses, because the employees that were at large companies would say, "I would love to work at that start-up, but I can't get coverage if I move there, it will be too expensive."

Chairman CAMP. Thank you.

Mr. GOOLSBEE. So, I think——

Chairman CAMP. Your time has expired.

Mr. GOOLSBEE. I apologize, Mr. Chairman.

Chairman CAMP. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, you have said a lot of things that don't seem to be true in the real world. Maybe you better get out there and talk to people.

But, you know, that health care tax credit, for instance, very few small businesses that I talk to and their employees will benefit from the credit. In fact, CBO estimated that 88 percent of those who get health insurance from a small business work for a business that will not receive the credit. There are different credit amounts and eligibility requirements prior to 2014 than exist after the exchanges are operational. And after 2013, an employer can only claim the credit for 2 years. That's not giving them much.

One of the purposes of this hearing is to look at the impact of health reform law on jobs. I think we can all agree it is critical to pursue policies that create jobs, not eliminate them. And the health reform law places significant restrictions on physician ownership of hospitals. You've almost put it to a complete halt. And yet, my experience with physician-owned hospitals, they are far above in benefits to the patients of a regular hospital. They are precise, they know what they're doing.

Many projects, in planning, had to stop. And expansions were curtailed. Every one of those decisions had a negative impact on jobs in states like Texas. Industry experts tell me at least 30,000 jobs would have been created if this provision had not been enacted. Can you explain to me how the Administration could have supported a provision they knew would negatively impact well-paying health care jobs in many communities?

Mr. GOOLSBEE. Well, Congressman, I will need to look into this exact provision, and I will get back to you. I know that the primary goal of the various provisions in the act are how do we provide the best possible care at the lowest possible price, or with the lowest rate of inflation. If there are things about physician ownership of hospitals or any other subject that we can get together and work on, and find evidence that it could improve care and reduce costs, the President is open to look at any such ideas.

So, I will have to get back to you on this. I am not familiar with the details.

Mr. JOHNSON. Okay. Well, that's just one area of that bill that doesn't appear to be beneficial to the industry.

You know, we talked about 1099 reporting requirements, and I presume now you are in agreement that we need to get rid of that provision. Is that true?

Mr. GOOLSBEE. That is true.

Mr. JOHNSON. Okay. I'm hearing it from you and the President, I think.

Mr. GOOLSBEE. Yes.

Mr. JOHNSON. All right. Then let's do it. The health care, overhaul, provides health plans in existence on the date of the law's enactment, that they would not be required to meet all the requirements of the new law. And you all argued that it would allow individuals to keep the health insurance they have, and like. The statute did not define grandfathered plans, other than to ensure that all plans resulting for the length of the agreement—it's clear that many employer plans will not enjoy the grandfathered plan protections from the new law. Can you discuss that a little bit?

Mr. GOOLSBEE. Yes. What I would say is the—clearly, the intention and the overall impact of the Affordable Care Act is to—the President believes in the private system, and it is designed to try to preserve the option that if the employer is happy with the plan that they have, they can stick with the plan.

The intention of the grandfathering clause is to make it so that if there are things in the Act that would have some impact that the employer or patient doesn't want, they could just stick with what they have.

Now, you always have to choose the lines of what to draw—what counts as the same plan. Now, there is flexibility. You can—if you are getting the same insurance, but you want to change providers, that's still permissible, and you still keep the grandfathering. If you fundamentally change the nature of what health care you're getting, then the point of the grandfathering would not apply. And so that's why we put——

Mr. JOHNSON. Yes, but isn't that only for two years after you do that?

Mr. GOOLSBEE. It depends which, but on some of these there are phase-outs.

Mr. JOHNSON. All right. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. McDermott is recognized.

Mr. MCDERMOTT. Dr. Goolsbee, I fly across the country 35 times a year for 20 years, and I have been flying with United Airline attendants who have now gotten a little older. And I doubt there is a single flight I fly on where there isn't one flight attendant who is working simply to keep her benefits because her husband has a job that doesn't have benefits.

And when I read the attack on the job-killing aspects of this bill, I—they read the report from CBO and it sounds like they're saying we're going to kill jobs. But, in fact, that flight attendant would gladly give up her job at age 60 if she had health care for her family in some other mechanism.

Now, is that killing the job, or is that her choosing to leave the work force?

Mr. GOOLSBEE. To me, that sounds like a retirement. And the CBO report that you're citing, they did make clear that there would be a reduction of total jobs, but that most of those would be on what they call the labor supply side, of people not having to work as many years just to keep their medical benefits. So, to me, that would not be a job killing, that would be a retirement.

Mr. MCDERMOTT. So it really is political theater, hyperbole, to make it seem like this bill kills jobs.

Mr. GOOLSBEE. I'm just an economist——

Mr. MCDERMOTT. You're not going to——

Mr. GOOLSBEE. I'm not——

Mr. MCDERMOTT. Okay. Let me ask another question. You know, I—we're going to have another panel, and they've rounded up some people who say this doesn't help small business. And I'm sure that if you go through this country of 300 million people, you can find some small businessman or woman for whom it doesn't work.

But my—from reading your testimony, it sounds like more small businesses are buying insurance today. If I read the figures you had for United Health and for Kansas City's Blue Cross Blue Shield program, it sounds like people are actually getting in because of the small business tax credits.

Mr. GOOLSBEE. I think that's true. I would make three points. The first is if you don't have insurance, which, the smaller the employer you get, the greater the share that do not offer insurance now, because they would have to pay substantially more for exactly the same policy as large employers do, this—the small business health care credit gives them the opportunity to offer insurance for the first time, and you have seen substantial take-up.

Second, even if you already offer it, the small business tax credit reduces the cost to you in a way that has never existed before.

And third, we should not underestimate the importance of the exchanges that will be coming online, which will allow small businesses to get insurance at the kinds of prices and steady levels that large employers have had.

Those three things are critically important to small business. And for years, before there was an Affordable Care Act, they have been wanting to have, for some time, these types of credits and access to this type of insurance.

Mr. MCDERMOTT. And they have also talked about wanting to pool and—so that small businesses could join a pool——

Mr. GOOLSBEE. Yes.

Mr. MCDERMOTT [continuing]. And they could then buy, like Boeing or Weyerhaeuser, or one of the large company buys. So this really gives them the ability to get that kind of benefit, is what you're saying?

Mr. GOOLSBEE. Yes, that's a better way to say what I was saying, is it allows them to pool. That's what the exchanges are for, it allows them to pool and get prices as if they were a large employer.

Mr. MCDERMOTT. You may not have read the testimony of the people who are following after you, but I—can you think of any reason why a small business man or woman could not find a way for health care, if they're making money? Is there any reason why, be-

yond they don't want to do it? I mean is there some economic reason?

I don't understand, if you're making money in a business, how you can't put some of that money toward the health care of your workers. You would certainly care about your workers, I would guess.

Mr. GOOLSBEE. Well, look. It would be presumptuous of me to tell other folks. I don't know what the circumstances of different businesses are. I do know this, that if you take employers that are employing people without giving them health care coverage, the reason that there would be a mandate is to try to get away from the system we have now, which is people don't have coverage, still get sick, and they go down and they get medical care at the highest possible expense, and it doesn't become free just because it was in the emergency department. That's a cost that gets passed directly on to the employers who do cover their employees. And that cost is as high as $1,000 a worker.

So, I don't put any moral judgement of any kind. I know we've been through a very tough spot in the last few years, and everybody has been trying to get by, and we're trying to turn the corner to grow our way out of these problems. I think small business credits to help them afford to give coverage, as well as giving them the opportunity to buy at the kind of prices that larger businesses do, and doing everything we can to slow the growth rate of health care cost is important.

Chairman CAMP. All right, thank you. The time has expired.

Mr. MCDERMOTT. Thank you.

Chairman CAMP. Mr. Tiberi is recognized.

Mr. TIBERI. Thank you, Mr. Chairman. Dr. Goolsbee, the President repeatedly mentioned throughout the debate and afterwards that Americans making less than $200,000 or families earning less than $250,000 would not see their taxes increased, with respect to the Democrats' health care bill.

I would like you to tell me whether each of the following—in a yes or no answer—would suffice that were included in the health care law constitutes an increase in taxes for individuals or families making less than $200,000 or $250,000: a new tax on individuals who did not purchase government-approved health insurance.

Mr. GOOLSBEE. I don't think that's an accurate way to describe it, no.

Mr. TIBERI. Not a new tax?

Mr. GOOLSBEE. I don't think that's an accurate way.

Mr. TIBERI. A new ban on the use of flexible savings accounts, HSAs, HRAs on using pre-tax income to purchase over-the-counter drugs?

Mr. GOOLSBEE. I don't—that's not a tax increase of a normal form, and that's part of a broader reform effort, obviously.

Mr. TIBERI. An increase from 7.5 percent to 10 percent of income, the threshold after which individuals can deduct out-of-pocket medical expenses?

Mr. GOOLSBEE. [No response.]

Mr. TIBERI. Not a tax increase?

Mr. GOOLSBEE. I—as I'm saying, if you—I do not consider the Affordable Care Act, as a whole, to be a tax increase in people making less than $200,000.

Mr. TIBERI. I've got two more. Impose a new $2,500 cap on families' ability to use pre-tax dollars to fund an FSA.

Mr. GOOLSBEE. Could you——

Mr. TIBERI. A $2,500 cap——

Mr. GOOLSBEE. $2,500 cap——

Mr. TIBERI [continuing]. On——

Mr. GOOLSBEE. I don't consider that a tax increase.

Mr. TIBERI. A new 10 percent tax on indoor tanning services. [Laughter.]

Mr. GOOLSBEE. [No response.]

Mr. TIBERI. Not a tax increase?

Mr. GOOLSBEE. Well, that seems like a strictly voluntary thing that one could choose.

Mr. TIBERI. But not a tax increase?

Mr. GOOLSBEE. [No response.]

Mr. TIBERI. Here is the point, Dr. Goolsbee. We have, in this bill—and I'm quoting from the bill—a number of things that are going to—that's going to impact people, individuals, who make far less than $200,000.

I had a lady contact me in December who said she had just found out from her employer and her doctor that she could no longer manage her kids' health care costs with respect to prescription drugs, over-the-counter drugs, and now she was going to have to contact the doctor every time she wanted to deduct something from her flexible savings account, and had just found out in December, months after the health care bill was signed into law, that actually, her tax was going to increase, her income tax was going to increase, because her FSA was going to go from $5,000 to $2,500. And thus, her income was going to go up, with respect to her taxes, which means she was going to be paying more taxes.

So, two things were occurring in her mind that she had no idea with respect to the health care debate, that she was going to be paying more taxes, and her ability to mention her health care was going to be taken away from her, that she was not going to have to call her physician's office, which is going to make, ironically, the physician's office more involved, not less involved, and there is a cost to that, as well.

So, I know you chuckle about this, but the President was very, very firm in that nobody making less than $200,000, or families less than $250,000, would see income taxes go up, any taxes go up. And now we see a Department of Justice defense that this bill is constitutional because it's a tax, the individual mandate is a tax.

So, on one side, we say it's not a tax—or you say it's not a tax, the Administration. On the other side, you say it is a tax. So, which is it?

Mr. GOOLSBEE. Well, Congressman, first, let me apologize. I was only chuckling about the tanning salons. I wasn't meaning to make light of it.

As I say, we are open to work—if we look at the FSA rules, all I would say on FSA's is this was part of a broader package, that it's not picking out one thing in isolation and not taking into ac-

count other benefits. If you are paying for something with a pay for, but it's going to reduce health care cost inflation, or we're going to get additional coverage that you didn't have before, you do have to take it in totality before——

Mr. TIBERI. Here is my point, sir. I am just saying if you are telling the American people, and the President is telling the American people—if I am advising you, and you repeatedly say it's not a tax increase, and Mrs. Smith, who sees her FSA go from $5,000 to $2,500, and now she can't buy baby aspirin at the store and deduct it from her FSA, she looks at that as a tax increase.

So, there is a credibility issue. And again, we can chuckle about it, but this is a tax increase——

Mr. GOOLSBEE. I didn't chuckle about it, and I don't mean to——

Chairman CAMP. Just respond briefly, and then we will move on.

Mr. GOOLSBEE. Okay. My only brief response is if it changes the FSA rule, but simultaneously gives her a significant reduction in the cost of her health care, that should not be viewed as a tax increase on her, even though just looking at one component, you would say, "I had a disallowed expense on an FSA." But the point is taken in totality, it's not a tax increase.

Chairman CAMP. All right. Thank you. Mr. Davis is recognized.

Mr. DAVIS. Thank you, Mr. Chairman. I guess it all depends on what the meaning of "is" is. This is a big of a Back to the Future moment, when taking it in totality it's a huge tax increase.

I deal with constituents at all places in the economic spectrum, and they talk about a lack of purchasing power, they're seeing their dollars go down. And small business owners, in particular, contrary to the gentlemen that say this is not job-killing, I have met with hundreds of business owners over the last two years, and, really, since this bill implemented this year, business after business, our Chambers of Commerce members are telling us, and telling our office and me, they're not hiring people because they cannot afford to provide coverage, which leads me to a question.

Since we referred to the tanning tax as a strictly voluntary thing—I don't think the IRS agents would feel that way—but I want to ask you about the burdens of the Democratic health care law on small business.

For example, suppose you own a small business with 50 or more employees, and that business is not eligible for the small business tax credit, and can't afford to purchase health care for your employees. Contrary to the propaganda, rates have gone up significantly; they're going to continue to go up, because we didn't go after the cost drivers. The health care law requires you to provide health insurance or pay a fine.

Now, how would having to afford the cost of health insurance or paying the fine help your company grow and create jobs? Because when we get into this pricing issue here, there is, I think, a faulty assumption that businesses have unlimited supplies of money. The vast majority deal with vendors that have fixed costs on materials, as part of a supply chain.

And hence, on the outside, they often—and particularly if they're dealing with larger, established businesses, price ceilings that they

cannot exceed. So that margin skinnies down. The average manufacturing company that's considered successful in this company (sic) might make an eight percent profit margin at the end of the year. And we're watching health care just go up at an astronomical rate.

Here is my question. How would having to absorb the cost of health insurance or paying the fine help you grow jobs? Tell me that.

Mr. GOOLSBEE. Well——

Mr. DAVIS. That is a tax in your bill.

Mr. GOOLSBEE. Well, here is what I would say, Congressman, and I appreciate the evidence, and we are open to working and looking at the evidence.

If you take large employers, more than 95 percent of them offer health care. If you go to the five percent that do not and say, "Isn't it going to hurt those five percent, that they will be required to provide health care," I do think it is appropriate that we consider what is the cost that they are applying on to other employers when they aren't offering health care, and that's the hidden tax that already exists. The growth of health care costs has been astronomical year after year, before there ever was an Affordable Care Act. And the Affordable Care Act is trying to bring that more under control.

So, that there are—that the majority of small businesses in the country, some four million, would qualify for the credit is good for those businesses. To try to find an individual business who did not provide health care before, has over 50 employees, is not planning to use the great benefit of the exchange to get—so that they would have the opportunity to get significantly lower prices for their health care, to me feels a little bit of a selected example, when taken in totality——

Mr. DAVIS. Well, let's take this to a simple—the small companies, why couldn't they just pool together? Wouldn't that make sense? And—to be able to handle this issue, and to have the government stay out of it? Let the private market work.

Mr. GOOLSBEE. Well, they haven't——

Mr. DAVIS. I mean I ran a business for 12 years, and we ran into this time after time, where costs did go up. And the costs under this bill are going up dramatically. I know people who won't hire employees because they're going to go over the 50 threshold. Why should I hire somebody, if I'm going to be taxed? And you called just a minute ago, that——

Mr. GOOLSBEE. Well, as I say——

Mr. DAVIS [continuing]. Didn't tax——

Mr. GOOLSBEE [continuing]. You're selecting a group of employers that's at some specific sliver, and I am highlighting that there are millions of businesses just below that, which are the majority of small businesses in the country, who are getting a very significant tax credit——

Mr. DAVIS. Well, let me just point something out. You've asked us to take it in totality. And, just between Mr. Tiberi and I, we've probably pointed out 20 individual examples that, taken in totality, all point to significant increases in costs on business under this bill.

And I think we come back to the details. We're going to have to address the cost drivers. And we don't address the cost drivers, beginning here in Washington, with creating a huge new bureaucracy that places more overhead—if you ask any business owner about this bill, they will ask the question, "How can you create over 100 new agencies, commissions, and boards, massively increase the regulatory side of this, and somehow reduce costs, while raising taxes on businesses and cutting the direct access to benefits?"

Every doctor that I know calls this a denial of care bill, when they look at the economic aspects of this. And we are dealing with very different sets of definitions of terms, and we can't be fluid about that. I yield back——

Chairman CAMP. All right. His time has expired. Mr. Neal is recognized.

Mr. NEAL. Thank you, Mr. Chairman. Mr. Chairman, I would like permission to insert the CBO's preliminary analysis of the repeal of this health care legislation into the official record.

Chairman CAMP. Without objection.

[Information as follows: Mr. Neal]

Rep. Charlie Rangel

Statement for the Record

Wednesday, January 26, 2011

1099 Repeal

The House voted on July 30, 2010, on HR 5982, which would have repealed the expanded 1099 reporting requirements.

One of the revenue provisions in the health care reform law is an expanded reporting requirement that would have increased business to business information reporting (using form 1099). Repealing the provision in 2010 would result in revenue loss of $19.1 billion. The repeal in HR 5982 was fully paid for through the closing of a number of tax loopholes, including loopholes that incentivize companies to send U.S. jobs overseas.

Repealing the provision in 2011 would result in revenue loss of $21.9 billion.

Because HR 5982 was brought up under suspension of the rules, it needed support of two-thirds of Members to pass. Unfortunately, it was defeated by Republican opposition:

	Yeas	Nays	NV
Democratic	239	1	14
Republican	2	153	23

Mr. NEAL. Thank you. And, Mr. Goolsbee, if we were to repeal the health care bill, as some are proposing, that means eliminating $40 billion worth of tax credits. Doesn't that represent a tax increase?

Mr. GOOLSBEE. It would be very problematic, and it would be particularly problematic on small business. But it would be a major tax increase.

Mr. NEAL. All right. Let me take you to some of the facts here. One of the difficulties in the discussion of this legislation is that if our friends on the other side are asked by the local news media in their respective constituencies whether or not they favor banning pre-existing condition, they will say yes. If they are asked, "Is it not a good idea to keep your children on your health care plan up until they're 26," they will say, "Yes." If they are asked if it's

a good idea to cap out-of-pocket expenses, they will say, "Yes." Carrying insurance from one job to the other? They will say, "Yes."

The problem with that argument is, from an actuarial reality, or from risk analysis, how do you accomplish those outcomes if you don't require those who can afford insurance to buy it, and to help those who can afford it to get into the risk pool through the mandate?

I mean that—by the way, I wanted to say something for the record. This is very important. The mandate was the compromise in Massachusetts that was proposed by Governor Romney. That's how we got there. Senator Kennedy advocated for years, spent a career talking about health care. The difficulty is that, in attempting to do it, the compromise became the mandate.

Would you speak to that issue about actuarial reality, risk analysis, and what insurance companies might do to suggest that they could accomplish the former, as I've outlined it, to get us to the latter?

Mr. GOOLSBEE. Well, look. I do think the basic point of the matter is to get away from the economic problem of cream skimming and figuring out who is more likely to get sick and dropping them. And when you have circumstances like that, a lot of times markets can—the free market can fail when you have big differences of information like that.

That has plagued the health care system all along, and that is the point of the Affordable Care Act, is to try to get everybody into the system, so you can't either free-ride off your neighbor and, so on the other side, they can have some assurance that the probability of whatever illness is approximately the probability in the overall population, as opposed to everybody that knows they have the—some disease signing up only once they get sick. I think that's the basis.

Mr. NEAL. I would encourage all the members of this committee, and others, to visit an emergency room on a Friday or Saturday night. And if you can't do that, or you live in a rural area and it's more difficult, then I would encourage Members to be in touch with their local hospitals to find out what health care delivery is in the emergency room.

And for that man or woman who walks out of that emergency room thumbing their nose by suggesting that they beat the system, they didn't really beat the system. In fact, those costs are passed on to all of us. That's the whole idea of spreading risk, which I would have thought the other side would have paid a great deal of attention to, given their proclivity for the suggestion that we ought to allow the market to work.

Mr. GOOLSBEE. Look, I think that's the uncompensated care——

Mr. NEAL. Precisely.

Mr. GOOLSBEE [continuing]. Is a hidden tax on everybody, and it's a big one, $1,000 a worker by some estimates. And we cannot forget that that tax exists. It's very important. And we can get that cost down. And that is a big cost driver.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Nunes is recognized.

Mr. NUNES. Thank you, Mr. Chairman. Mr. Goolsbee, were you involved at all in the President's State of the Union address, in designing it or writing it or reviewing it, previewing it?

Mr. GOOLSBEE. Yes, a little bit.

Mr. NUNES. Okay, so you're familiar with the health care portions of the speech last night?

Mr. GOOLSBEE. Yes.

Mr. NUNES. Okay. So the new 1099 reporting requirements. Last night, to paraphrase, the President called it a "flaw," I think. At what point did he have the epiphany that it was a flaw?

Mr. GOOLSBEE. I don't know the answer to that, specifically, but the chairman quoted the President from a significant time ago. It wasn't at the State of the Union that he had it.

Mr. NUNES. Did the President or White House or anyone affiliated with the executive branch ever hear from any Members of Congress that this was a problem, 1099 problem, during the yearlong health care debate?

Mr. GOOLSBEE. I wasn't involved in the legislative discussion, but I think it's probably fair to say yes.

Mr. NUNES. Okay, thank you. What—so the President has now admitted that the policy he supported was flawed. He asked for other creative ideas. Where should this committee start? What creative ideas should we look at to identify possible additional flaws, other areas that we could reduce costs, improve the quality of health care, where should we start?

Mr. GOOLSBEE. Well, I do think that the previous congress people have identified, hearing from constituents and from business leaders themselves, if there are ways that we can reduce administrative costs, reduce regulatory or compliance burdens of the form.

Mr. NUNES. Any specific ideas? Is there anything like 1099 that we should strip out of the current health care law, or anything that we should put in?

Mr. GOOLSBEE. Well, I think 1099 is a good one, and the President outlined that we should look together at the medical malpractice issues that can lead to defensive medicine and those things. That strikes me as also a productive place to look.

Mr. NUNES. So medical malpractice we should look at. Any other areas——

Mr. GOOLSBEE. I mean——

Mr. NUNES [continuing]. You can think of?

Mr. GOOLSBEE. Those two, plus the general approach of talking to the small business community strike me as three important ones to begin with.

Mr. NUNES. I want to focus on the uninsured now, move to the uninsured. We have heard members of this Committee already this morning say that there is 50 million uninsured, I think was the number, and maybe there is more than that. Or possibly—at least people think there is more than that.

I was under the understanding when we passed this, two new entitlements adding to the two old entitlements of Medicare and Medicaid in the health care law, that this would be the Utopia for health care, and that everyone would now be covered. Is that happening?

Mr. GOOLSBEE. I would say we are dramatically increasing the number by tens of millions in who is covered. There obviously was the issue of undocumented immigrants who are not—were never intended to be getting covered under the——

Mr. NUNES. So how many new people have we covered since the law has been implemented that wouldn't have been covered under the old laws?

Mr. GOOLSBEE. Well, the full coverage provisions don't go into complete effect until 2014. But the estimates are in excess of $35 million.

Mr. NUNES. Why did it take so long to—why did we wait until 2014 to implement this, when we have this health care crisis and all these folks uninsured?

Mr. GOOLSBEE. I——

Mr. NUNES. I know you didn't write the law, but you look at the numbers.

Mr. GOOLSBEE. Yes, I look at the numbers. On any significant change of this nature, usually there is some transition period. Historically——

Mr. NUNES. Was it possible to hide the budget consequences of the health care provision?

Mr. GOOLSBEE. No.

Mr. NUNES. So we don't have a debt problem?

Mr. GOOLSBEE. We have a long-run fiscal problem facing the problem, for sure. But——

Mr. NUNES. Does health care have a part in that?

Mr. GOOLSBEE. In reducing it, yes.

Mr. NUNES. So this health care bill is going to reduce the——

Mr. GOOLSBEE. The deficit.

Mr. NUNES. The deficit?

Mr. GOOLSBEE. Yes. According to the non-partisan Congressional Budget Office, to repeal the health care act would increase the deficit by a quarter trillion dollars over the next 10 years.

Mr. NUNES. Wow. Thank you, Mr. Chairman.

Chairman CAMP. All right. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. Mr. Goolsbee, I've been taking some notes while you have been answering questions.

So, this Affordable Health Care Act, you say, was designed to reduce costs, yes?

Mr. GOOLSBEE. Yes.

Mr. REICHERT. Improve access, increased access for people?

Mr. GOOLSBEE. Yes.

Mr. REICHERT. Slow the growth rate of health care costs?

Mr. GOOLSBEE. That is its intention.

Mr. REICHERT. And reduce the deficit?

Mr. GOOLSBEE. Yes.

Mr. REICHERT. All of those things. I'm just an old retired cop, so I think—you know, I'm not a doctor. I've not been in the medical profession. So I'm just trying to understand this, like every other American across this country.

So, these were the goals. But I really—I want to go back to what Mr. Nunes and some others have pointed out. I'm really having a tough time understanding how a provision like the 1099 form gets included in a bill that's supposed to accomplish all these things, re-

ducing costs, et cetera. Because, if I'm not mistaken—do you know how the 1099 provision was inserted in the bill?

Mr. GOOLSBEE. I do not.

Mr. REICHERT. You don't know what Member of Congress, or who came up with the language? Or was it the Administration that suggested the——

Mr. GOOLSBEE. It wasn't an Administration proposal, but I wasn't involved in the——

Mr. REICHERT. So you have no idea? This is your project, right?

Mr. GOOLSBEE. I'm just—well, it's not my—I'm just an economist.

Mr. REICHERT. You're just a spokesperson?

Mr. GOOLSBEE. I'm not a spokesperson, I'm an economist.

Mr. REICHERT. So why are you here today?

Mr. GOOLSBEE. I am here to help evaluate the economics of the Act.

Mr. REICHERT. Well, let me just ask you. The 1099 form——

Mr. GOOLSBEE. Yes.

Mr. REICHERT [continuing]. We don't know how it got in there. But somehow it increases the cost of the bill by $19.2 billion. You have to hire 16,000 IRS agents. How can that just be overlooked? I think the American people have a credibility issue when you say that you're here to reduce costs, then all the sudden, miraculously, you discover that there is a $19.2 billion cost in there that shouldn't be there. How does that happen?

Mr. GOOLSBEE. Well, as I say, I wasn't involved when Congress——

Mr. REICHERT. But how does that happen?

Mr. GOOLSBEE [continuing]. Passed the legislation. But what I will say is, the people that supported it were trying—the goal, which has been a bipartisan goal, of reducing the amount of tax evasion, people who do not pay taxes on income that they should pay.

Mr. REICHERT. I know what——

Mr. GOOLSBEE. This was designed in a way——

Mr. REICHERT. Excuse me, excuse me——

Mr. GOOLSBEE [continuing]. That was excessively burdensome——

Mr. REICHERT. Excuse me. Okay. I know what the goal was. My question was, how did it get into the bill. And your whole premise is that this was to reduce costs. And $19.2 billion gets somehow inserted into the bill, and no one knows how.

Mr. GOOLSBEE. My understanding——

Mr. REICHERT. Did I hear you say just a little bit earlier, too, that you can keep your health care plan if you like it, or something like that, in one of your answers?

Mr. GOOLSBEE. That is the intention, yes. That's why the grandfathering clause exists.

Mr. REICHERT. Okay. I remember President Obama visited our retreat last year, and he was asked that question. And we have heard that time after time after time. "You can keep your health care plan, if you like it."

However, in his comments to us—and I will paraphrase his quote—he said, "Well, there may have been some language snuck

into the bill that runs contrary to that premise." How do you explain that? I mean you're telling me today that you can keep your health care plan if you like it, but the President says there is language in the bill that runs contrary to that premise.

Mr. GOOLSBEE. I apologize, Congressman. I'm not trying to be coy. I haven't heard the President say that. But I would like to look at that before I made any comment on it.

Mr. REICHERT. Yes. Well, it's in print.

Mr. GOOLSBEE. Okay. I will——

Mr. REICHERT. Can you see why the American people are confused about this bill, and whether or not it provides any benefits at all to them? Whether or not it does all those things that you laid out earlier, decreases cost, increases access, and is good for business and reduces the deficit?

I mean I just pointed out two things here that have quite a bit of controversy around it, and seems to be rather serious conflicts with the premises that you have laid out in this bill. Mr. Chairman, I yield back.

Chairman CAMP. Thank you. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman. Dr. Goolsbee, thank you for being here. My colleague, Mr. Neal, asked that the independent CBO analysis be read into the record. And I would like to just ask you on that issue—I'm glad he did that, it's an important fact that I believe we need to take into consideration—but that analysis says—and I think you pointed this out, that this—repeal of this bill would actually drive the deficit up by about $250 billion over the first 10 years, over a trillion in change over 20 years.

So, if that were to happen, and it had this upward push on the deficit, how would that impact business and investment in this country?

Mr. GOOLSBEE. Well, I believe that the—certainly addressing our longer-run debt issues is an area of bipartisan agreement, that we do need to do that, and that to not do it contributes uncertainty. And so I think repealing this and making that problem worse would likely add more uncertainty on that score.

Mr. THOMPSON. And a hit on the businesses that we're trying to—or hopeful will get going——

Mr. GOOLSBEE. Could be.

Mr. THOMPSON [continuing]. Get the economy up. Thank you. On the uncompensated care issue, I just want to point out I think everybody can find this out. I know that I did the run, and in my rural district in northern California last year the uncompensated care cost was $70 million. And the uncompensated care fairy doesn't deliver a check to the hospital when that happens. That's spread out, and the rest of us pay for that through higher taxes, higher insurance premiums, et cetera.

On the 1099 issue, I think it's important to point out that we took up the repeal of that bill last year in congress. And I think everybody on this side of the dais voted to repeal that. So this is not a newfound issue. This is something that we tried to fix in the last congress.

And I also want to point out that when this came up in the debate, I went out to every one of my counties and asked business

people, chambers of commerce, as to the impact of that. And there was concern that it was going to be problematic. A lot of folks said, however, that it's just a matter of time before the software catches up to it, and the problems resolve. But everybody, irrespective of their position on it, noted that it was trying to solve an almost $20 billion tax evasion problem.

So, as we repeal this, which we will do, we're going to need to figure out how to solve that problem.

And, Mr. Chairman, on the issue of the cost going up, I just want to read from a statement by Blue Cross—or by Blue Shield of California. And I think everybody knows that premiums have been going up in my home state. But the head of Blue Shield writes, "These rates reflect trends that were building long before health reform. Our individual market medical costs are rising rapidly, due to higher provider prices, increased utilization, and the fact that healthier people are dropping coverage during a bad economy. Health reform will help slow down this trend by expanding coverage, which will keep healthier people in the system, and, through quality and cost containment initiatives, such as the independent payment advisory board, Center for Medicare and Medicaid Innovation, Patient Centered Outcomes Research Institute, and other initiatives for prevention and coordinated health care."

And I would like to ask that the head of Blue Shield's statement specifically stating that health care reform has nothing to do with their increased price be read into the record.

Chairman CAMP. The statement will be——

Mr. THOMPSON. And I yield back the balance of my time.

Chairman CAMP [continuing]. In the record, without objection.

[The information follows: Mr. Thompson:]

Executive Office
P.O. Box 942701
Sacramento, CA 94229-2701
TTY for Speech and Hearing Impaired: (916) 795-3240
Phone: (916) 795-3825; Fax: (916) 795-3410

December 10, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

As the nation's largest non-federal purchaser of health care, the California Public Employees' Retirement System (CalPERS) has a keen interest in national health care reform. From the beginning, CalPERS supported the reform necessary to contain costs for employers and their employees while maintaining quality health care.

Many health care elements we have championed, such as guaranteed issue policies; eliminating co-pays for preventive services; bans on pre-existing conditions; stabilizing health premiums; supporting innovative delivery system reforms; and patient protection against medical bankruptcies are now major components of health care reform.

We believe that key elements of national health care reform represent a fundamental and positive shift in the way health care will be purchased and delivered in the United States. Together, they will dramatically shape the future of health care in our country and ultimately benefit everyone.

During our recent open enrollment period, CalPERS emphasized the benefits of many health care reform provisions—including extension of dependent coverage, elimination of lifetime limits, and the Early Retiree Reinsurance Program. We are writing to share some of our implementation successes.

1) Extension Of Dependent Coverage to Age 26

In recognition of young adults' need for health care coverage, CalPERS launched a massive communication effort to educate and inform employers and members of the extended dependent coverage benefit. We developed special enrollment teams, published communication materials, posted information on our website, and issued press releases highlighting this new health care reform provision.

Our efforts successfully resulted in more than 27,000 young adults being added to their parents' health plans effective January 1, 2011. Best of all, adding them to our program resulted in a 2011 health insurance premium increase of less than 1 percent. Families can now rest easier in these uncertain economic times knowing their dependents, regardless of marital status, can be covered up to age 26.

2) Removal of Lifetime Limits

Most CalPERS health insurance plans have never included lifetime limits on the dollar value of benefits. Further, we proactively monitored our members who were enrolled in the few health plans that did include lifetime limits, so we could work with them to change plans when they approached these limits.

As a result of health care reform, CalPERS has removed lifetime limits from all our plans that had included them, and now our members enjoy more health plan options and less financial risk.

3) Early Retiree Reinsurance Program (ERRP)

For years, CalPERS health plans have included wellness and disease management programs that promote prevention and manage chronic conditions. These programs, now required of ERRP participants, mitigate the on-going fiscal impact of caring for an older population. It's encouraging that these programs can reduce costs.

Notwithstanding this success, approximately 24 percent of our non-Medicare medical and pharmaceutical costs are associated with early retiree health liability. Recognizing this, the Affordable Care Act included much needed provisions for relief from these costs. CalPERS 2010 health premium rates reflected the lowest increase in 14 years.

In anticipation of the Department of Health and Human Services certifying our ERRP application, CalPERS proactively negotiated 2011 health plan contracts that reduced premium increases by more than 3 percent for our non-Medicare plans. We estimate ERRP will provide premium savings of approximately $200 million based on reimbursement related to more than 115,000 early retirees and their spouses, surviving spouses, and dependents.

We thank you for expeditiously implementing important health care reform provisions and we are committed to being a collaborative partner in ensuring the smooth and successful implementation in the months and years ahead.

If you have any questions regarding our program, please contact me at (916) 795-3818.

Sincerely,

ANNE STAUSBOLL
Chief Executive Officer

Chairman CAMP. Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman. To my friend from Massachusetts, I have spent countless hours in emergency rooms, and there is a hidden tax, as you suggest. But also, your solution in expanding Medicaid coverage is also a hidden tax. And it's basically an unsustainable situation. We can do better.

Mr. Goolsbee, my medical career spanned 1978 through 2003. And to put it in perspective for you, in medical school I saw the first drug to treat peptic ulcer disease, which radically changed not only the quality of care for folks, but the cost of care. And since then, of course, we have seen all kinds of developments in pharmaceuticals and medical devices that have given patients more than

just a hope and a prayer. I remember dealing with heart attack patients, giving them an aspirin and a first-generation beta block. And now—you know, in my career we did complex open heart surgery using all kinds of assist devices and things that have saved lives, improved the quality of life.

I can go on and on about all the problems of cost, coverage, quality, and so forth, but I'm going to focus on one particular issue. Last night the President talked about innovation, research and development, American competitiveness. And one area where we have stood out, as a country, is in our development of medical devices and pharmaceuticals. We are first and foremost in the world on this. And we stand to lose that competitiveness, partly as a result of what's being proposed here: the innovation tax, a 2.3 percent tax on medical devices.

Now, let me—why is this not only a danger for innovation? It's also a danger to job growth, and could potentially lead to significant job loss. Let me just point out a couple of statistics.

Sixty-two percent of the companies that develop these devices, that do the research and development, are very small businesses. Sixty-two percent have less than twenty employees. Only 2 percent have greater than 500 employees. These are small and mid-sized firms that really take on the responsibility of creating that innovation in research and development.

So, my question is, will this tax on innovation run contrary to the President's plan to expand research and development? Secondly, will it hurt job growth, along with innovation? And, thirdly, how do you reconcile this with, on one hand, the President wants to extend the R&D tax credit, and, on the other hand, wants to impose a new innovation tax? This is just very inconsistent.

So—and then, finally, as we look at tax reform and the big picture—and the President has talked about fundamental tax reform, cleaning it up, simplifying it—if you look at this bill, this law, it has added significant complexity to the Tax Code, way beyond where we were, just a year ago. And so, I would like you to address those three points.

Mr. GOOLSBEE. Okay, Congressman. Well, first, let me thank you for your service to the country, as a medical professional, as well as a doctor (sic). We need more people in the medical profession with a commitment like that.

I would say on the issue of medical devices the area of innovation, medical innovations particularly, are critically important, both for our health and for our industrial base. In this case, the medical devices fee is being offset to some considerable degree by the fact that there will be an expansion in the demand for those devices by the fact that we are having 35 million-plus new customers——

Mr. BOUSTANY. But, sir, that's debatable, because a lot of these patients are getting that care. It's just not being compensated for.

Mr. GOOLSBEE. In——

Mr. BOUSTANY. I can tell you I have operated on patients——

Mr. GOOLSBEE. I would like to see——

Mr. BOUSTANY [continuing]. Complex open heart surgery, and you never saw——

Mr. GOOLSBEE [continuing]. Including advanced devices?

Mr. BOUSTANY. Advanced devices, as well, yes.

Mr. GOOLSBEE. Look, this is an area—if there are areas that have a negative impact on innovation, we should examine those.

Now, it had been our data that we first came to the table with, the suggestion was that the increased demand for the medical devices would be, in some sense, far in excess of what impact the charge on the medical devices would be. But we are open to looking at——

Mr. BOUSTANY. You really need to look back at that assumption.

Mr. GOOLSBEE. On R&D tax credit and medical innovation, that's an area the President has put as much or more—dedicated as much or more resources to medical research as anyone ever has before.

Chairman CAMP. All right, thank you. Mr. Heller is recognized.

Mr. HELLER. Thank you, Mr. Chairman. I appreciate holding this hearing. I know it's a little backwards, to actually hold hearings after a bill passed, but at least we will have a hearing on the bill. So, thank you.

Last night—and thank you for being here, Dr. Goolsbee. Last night the President said, "If you have ideas about how to improve this law by making care better or more affordable, I'm eager to work with you." Do you believe he meant that, when he said it?

Mr. GOOLSBEE. Yes, I do.

Mr. HELLER. Well, he said the same thing in 2010, during his State of the Union. Do you believe he meant it when he said it then?

Mr. GOOLSBEE. Yes, I do.

Mr. HELLER. He said it in 2009. Do you believe he meant it when he said it then?

Mr. GOOLSBEE. Yes. And I hope that we will commence working together.

Mr. HELLER. Well, I've got a letter here July 23, 2009. I wrote the President, asking him specific questions about the health care bill because he wanted input. July 23, 2009. He didn't reply to the letter. Why didn't he reply to the letter?

Mr. GOOLSBEE. I don't know the answer to that. I apologize, Congressman.

Mr. HELLER. In September 8, 2009, because I'd received no reply from the first letter, I wrote him another letter. And I think it was pretty reasonable. And I'd like to quote some parts from it. It says, "I introduced the Step Towards Access and Reform, the STAR Act, in late July. While this legislation will not be a silver bullet solution to all the problems facing our health care system, my bill addresses medical liability reform, improves access to breast and lung cancer screenings, takes other important steps towards reform that I think most Americans would support."

I never received a response from this letter. Why didn't I receive a response from this letter?

Mr. GOOLSBEE. Congressman, I don't know the answer to that. But I will offer to read and respond to the letter, or find anyone that would. I mean the—if your ideas address medical liability reform, other forms of screening or preventative care, that sounds like exactly the kind of thing that we want to always be on the lookout for, good ideas.

Mr. HELLER. I guess my point is, would a reasonable person believe that the President had no interest in what the minority party at the time had to say on this piece of legislation?

Mr. GOOLSBEE. I don't think a reasonable person would believe that. But I can see that it would be frustrating if he did not reply to the letter you sent him.

Mr. HELLER. Would a reasonable person believe what he said last night, again?

Mr. GOOLSBEE. Yes, I think they would, and I think they did. And I am here to say that we are open to the ideas. And I would be both open and appreciate to see that or other letters.

Mr. HELLER. Do you think the President—he mentioned TORT reform. Do you think he is serious about TORT reform?

Mr. GOOLSBEE. Yes, he mentioned the medical malpractice reform in general. There is some significant pilot projects, and working through the states in the bill now, and the President is open to looking beyond that.

Mr. HELLER. Let me ask you a couple of other questions. Do you agree with the President and CBO's assessment that the health care bill signed into law last year will reduce unemployment?

Mr. GOOLSBEE. Yes. I believe that it has the potential to be a job creator because of these cost-saving measures that I outlined in my testimony.

Mr. HELLER. When?

Mr. GOOLSBEE. Over the next 10 years and over the next 20 years——

Mr. HELLER. Well, maybe in 2014——

Mr. GOOLSBEE [continuing]. The small business part would be——

Mr. HELLER. You keep throwing out 2014. Maybe in 2014 we will reduce unemployment through this bill?

Mr. GOOLSBEE. No, I think it's—the small business credits can have, and have had, an important impact right away, and there are other parts that come in in 2014.

Mr. HELLER. Okay. So you're saying that we should at least have seen some impact on unemployment with the passage of this bill last year?

Mr. GOOLSBEE. Over what it would otherwise be. That's the—that's not just my conclusion, that's the conclusion of many outside experts.

Mr. HELLER. Why is Nevada's unemployment level at 15 percent? And what impact does that have on the unemployment in Nevada?

Mr. GOOLSBEE. Well, I believe that the reason Nevada's unemployment rate is high, like the unemployment rate in the rest of the nation, is because we have gone through the worst financial crisis since the Great Depression that has had a devastating impact on the economy, and we are trying to work our way out of that.

Mr. HELLER. So you don't think——

Mr. GOOLSBEE. I think the Affordable Care Act is not the——

Mr. HELLER. Okay.

Mr. GOOLSBEE [continuing]. Cause of——

Mr. HELLER. So you don't think higher taxes, bigger government, and unreasonable regulations would have anything to do with the unemployment rate in Nevada?

Mr. GOOLSBEE. The taxes have actually been lower. The President cut taxes for 95 percent of workers, and has not raised taxes in that sense.

Mr. HELLER. Thank you, Mr. Chairman.

Chairman CAMP. All right, thank you. And because of our time limitations, the next questioner will be the last questioner for this panel. And Mr. Blumenauer is recognized for five minutes.

Mr. BLUMENAUER. Thank you very much, Mr. Chairman. Dr. Goolsbee, I would like to go back just where you left off a moment ago, because this litany of somehow higher taxes and more regulation—if I understand it correctly in your testimony, you pointed out that we have had a million private-sector jobs added in the course of the last year. Is that correct?

Mr. GOOLSBEE. Yes, 1.3 million, actually.

Mr. BLUMENAUER. And, if memory serves, that's more than the net job creation of the entire Bush White House years in eight years.

Mr. GOOLSBEE. I believe that is true.

Mr. BLUMENAUER. And in terms of taxation for the—over the course of the last year-and-a-half, isn't it true that taxes were actually lower than they were prior to the President taking office, because of the 40-some percent of the Recovery Act that was tax reduction?

Mr. GOOLSBEE. Yes, that's certainly true, and it's certainly true in the aggregate, as well, that the tax collections as a share of income are down.

Mr. BLUMENAUER. So, to somehow have the speculative bubble that burst in Nevada, which is probably worse than any state, perhaps with the exception of what happened in Florida and parts of Arizona, to try and blame that on the Administration's high taxes and health care, isn't that kind of turning the facts on their head?

Mr. GOOLSBEE. Well, I'm not——

Mr. BLUMENAUER. Don't mean to put words in your mouth, but——

Mr. GOOLSBEE. I've been to Nevada many times and enjoy it there. I'm not trying to get anybody mad at anybody else. I will say the President did not raise taxes; cut taxes, did everything he could to prevent a depression. And we avoided a depression.

And now we are to a phase, as the President outlined last night, that we need to grow and innovate and compete, and he is open to ideas from both sides of the aisle of how to improve the health care act, as well as other ways to innovate.

Mr. BLUMENAUER. Terrific. Could you comment for a moment on the trend line we were on, in terms of affordability of employer-provided health care, in terms—before we gave the tax credits that people—actually made it easier, and the health care plan actually gives an alternative to people if employers jettison them—under the reform act we have here, people have an alternative.

But what was the trend line we are on, if the health care act is repealed?

Mr. GOOLSBEE. I would say before the health care act, I would summarize the trend line as bad. And so, if we repeal it and go back to that, I think it would return to bad.

So, I guess what I would say is that the act is attempting to address a series of cost drivers. It's trying to help small business. There are things like the 1099 aspect of the bill. There are other things that may need improvement.

But I fail to see how the correct answer to some flaw is to get rid of tax credits for four million small businesses, to allow discrimination against pre-existing conditions, to reinstate the uncompensated care hidden tax on employers, a number of things in the bill that are really good, I don't see why we should get rid of those, rather than just fix the things that need to be fixed.

Mr. BLUMENAUER. And, of course, for the record, our committee passed, and the House approved, legislation to fix the 1099. So that's something that, last congress, we were on.

I want to just conclude on the notion of what impacts there are for small business. Currently, small business pays more—our committee has heard—pays more than large business. They are doing it without the—up until the Affordable Care Act—without the tax credits. How is small business going to be affected if some of my friends have their way, and somehow this bill is repealed?

Mr. GOOLSBEE. If you repeal the bill, I believe it would have a significantly detrimental impact on small business, that while you can try to find an individual small business that fits in some place and say, "That person would be harmed," we know, overall, four million small businesses qualify for a health care credit that they never had before and that they have wanted for decades.

And we know that to set up exchanges that allow the pooling of risk will allow small businesses to get health care coverage and insurance at prices that are significantly lower than they are now, because right now they have to pay significantly more than large businesses do, and it's a major competitive disadvantage.

Mr. BLUMENAUER. And you said this last year health care costs went up at a lower rate than ever before recorded.

Mr. GOOLSBEE. It was overall spending.

Chairman CAMP. All right, thank you.

Mr. BLUMENAUER. I'm sorry.

Chairman CAMP. All time has expired. I want to thank you, Mr. Goolsbee, for appearing before the Ways and Means Committee. I appreciate your testimony. And since all Members have not had a chance to question, I would ask you to allow Members to submit questions in writing, which will then become part of the written record of this hearing. Again, thank you for being here.

Mr. GOOLSBEE. Thank you, Mr. Chairman, for giving me that opportunity, and I would be happy to accept any questions, letters, or anything else from Members of the Committee.

Chairman CAMP. Thank you. Thank you very much. Panel one is concluded, and we will now move to panel two.

While our panel gets seated, I did want to introduce our panel to the Committee. We have three witnesses on panel two.

Mr. Douglas Holtz-Eakin is currently president of the American Action Forum, and is a commissioner on the congressionally-chartered financial crisis inquiry commission. During 2001 and 2002 he

was the chief economist of President's Council of Economic Advisers. He previously served as the sixth director of the non-partisan Congressional Budget Office.

Mr. Olivo is the president and co-owner of Perfect Printing, located in Moorestown, New Jersey. It was established in 1979. He has been president of the second-generation firm since 1988. It was originally established as a traditional retail copy center, and he has grown the business from 10 employees to 45 employees. He co-owns the company along with his wife, mother, and two brothers.

Mr. Scott Womack is a franchisee. And during his time as an IHOP franchisee has received numerous sales growth and performance awards, and was named Midwest franchisee of the year in 1993 and 2005, and regional franchisee of the year in 2008 of the northern region.

I want to welcome our witnesses to the Ways and Means Committee. I thank you very much for taking time out of what I know are busy schedules to be here, and help enlighten the committee on the health care law's impact on jobs, employers, and the economy.

Each of you will have five minutes to give your testimony. There is a green light, and then there will be a yellow light, which gives you one minute to sum up, and then the red light is to conclude your testimony. And obviously, with all the people who want to have a chance to ask you questions, we're going to try to stick pretty closely to that schedule.

So, why don't I begin with Mr. Douglas Holtz-Eakin? Welcome to the Committee, and you have five minutes.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, D.C.

Mr. HOLTZ-EAKIN. Well, thank you, Mr. Chairman, Ranking Member Levin, and Members of the Committee. It's a great pleasure to be here today. I appreciate the opportunity to appear.

In my written testimony I sought to make four points that I will briefly summarize here. The first is that the mandates and assorted taxes in the Affordable Care Act are an impediment to jobs and growth in the United States, particularly at this moment, that on balance, the Affordable Care Act will raise the cost of insurance—this will crowd out scarce resources for hiring and for increasing pay, and directly hurt consumers—that the Affordable Care Act has strong incentives for employers to drop their employer-sponsored insurance. To the extent that they do so more than the CBO anticipates, we will not only have strong disruption in labor market contractual relationships, we will also have much large budgetary costs associated with the act than were anticipated.

And then, finally, even if that doesn't come to pass, the Affordable Care Act is, indeed, a budgetary danger at a very, very important moment in the U.S. fiscal history, and is a strong step in the wrong direction.

Let me begin by elaborating on the latter only briefly. I think my views on the Affordable Care Act's budgetary implications are, by now, well known. We are in a situation where the fiscal outlook is a direct threat to the U.S. prosperity and freedom, that to under-

take this act, which has a wide array of budgetary gimmicks, relies on unsustainable assumptions for cuts in Medicare that double-counts particular receipts, whether they be the class act premiums, receipts into the Medicare Health Insurance Fund under various taxes, or Social Security premiums, and to otherwise omit costs from the legislation itself, gives a very misleading picture of the budgetary impact, and that any fair reading of it is that it increases the deficit dramatically by as much as $500 billion over the first 10 years.

More generally, at the common sense level, we cannot set up too open-end entitlement programs that grow at eight percent a year as far as the eye can see, faster than the economy will grow, faster than revenues will grow, and not fix Medicare and Medicaid, and expect to improve the budget outlook. And this act did not.

Turning to the labor market implications, there are many mandates and taxes, and these will compete for resources for hiring, and they produce a bias against labor. If you look at the employer mandate, the best outcome for employers who have more than 50 employees is that it's a non-event. The best thing that could happen is nothing; the worst thing that could happen is they will be subject to penalties and fines, and lead to drops in coverage.

For those with fewer than 50 employees, this is a barrier to growth. Adding the 50th employee is a severe tax, and any small business is going to recognize this. There is in the act, as has been widely advertised this morning, a small business tax credit. It's important to recognize that it is temporary, so there is no permanent fix to this problem. It is very complicated. And even if someone winds their way into it, it has negative economic incentives for growth. If you add employees or pay better, you lose credits. It's a tax on your success, and should be perceived as such.

There are 700 billion other dollars worth of taxes in the act. There are taxes, for example, a surtax on payrolls labeled a Medicare payroll surtax of 9/10ths percent. There is a 3.8 percent investment—net investment tax. These have nothing to do with health care reform. These are pure taxes. They're exactly on the same group of small businesses and entrepreneurs that were at the focus of the recent discussion about the desirability of raising taxes in a recession. This bill replicates exactly the mistake that the previous congress avoided, and they will hurt jobs and growth in the United States.

There are hundreds of billions of dollars of fees, whether they be on pharmaceutical companies, medical device manufacturers, or the health insurers themselves. As I lay out in my testimony, these can only be perceived as taxes. They will only show up as higher premiums in insurance. And they have a dramatic impact, because they are not deductible. So they are, almost two-for-one, more expensive than they appear.

The upshot is that these $700 billion of taxes and fees will hurt the economy at a time when it can't afford it. The impact as well is to raise insurance premiums at a time when the economy can't afford it, and we have seen that on top of the additional benefits that the act mandates. If you have to cover more benefits, you have to raise premiums. There is no way around it. This is a bill that is going to raise premiums.

And since it doesn't control health care costs, there is no offset on the basic underlying problem. We have seen that from CBO and the CMS actuary.

The upshot is we are going to see continued pressure upward on health care cost, on insurance premiums. The taxes will contribute to that. And employers may drop coverage. And if you're a worker who has their coverage dropped, you've disrupted your labor market bargain. That's a bad thing for the labor market at a weak time. So, on top of the growth in jobs incentives, we have the disruption for those lucky enough to have a job.

So, I would be happy to answer your questions. I am pleased to be here today. But I think, on balance, it is a fair reading of this law that it is bad for jobs and growth at a time when we need both.

[The prepared statement of Douglas Holtz-Eakin, Ph.D. follows:]

This testimony is embargoed until January 26, 2011, at 9:00am

The Patient Protection and Affordable Care Act: Labor Market Incentives, Economic Growth and Budgetary Impacts

Douglas Holtz-Eakin, President
American Action Forum*

January 26, 2011

Introduction

Chairman Camp, Ranking Member Levin and members of the Committee, I am pleased to have the opportunity to appear today. In this testimony, I wish to make four major points:

- The mandates and tax provisions in the PPACA will have detrimental impacts on employment growth, wages, and economic growth;
- The impact of PPACA will be more expensive health insurance, putting employers in the position of either reduced wage rates, fewer employees, or dropping insurance coverage;
- The PPACA has strong incentives to drop health insurance coverage, and to the extent that employers pursue these incentives, taxpayers face tremendous upside risk to the cost of the PPACA; and
- Even without unexpectedly large numbers of employers dropping coverage, the PPACA will exacerbate an already-dangerous fiscal outlook.

Let me pursue each in additional detail.

Employer Mandate and Tax Impacts on Jobs and Growth

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more

---

* The opinions expressed herein are mine alone and do not represent the position of the American Action Forum. I am grateful to Cameron Smith, Michael Ramlet, and Matt Thoman for assistance.

modest and drawn out than recovery from a conventional recession.[1] Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

Unfortunately, key provisions of the PPACA are inconsistent with strong, pro-growth policies. In what follows, I focus on three in particular: mandate costs, administrative burdens, and tax increases.

Employer Mandate Costs

Among the key aspects of the PPACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The penalty is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of 1/12th of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer "play or pay" penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

From the perspective of economic performance, the most important point is that the *best* possible impact is that the firm is already offering insurance, no individual ends up receiving subsidies and triggering penalties, and thus costs are unaffected. In every other instance, health insurance will compete with hiring and growth for the scarce resources of those firms.

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of $2,000 per worker multiplied by *the entire workforce*, after subtracting the first 30 workers. In this case the fine would be $42,000 (21 (51-30) workers times $2,000). How many firms will choose not to expand?

Proponents of the PPACA like to point toward the fact that small businesses will receive aid in the form of a small businesses tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average wages are under $50,000.

---

[1] See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

Thus, the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitations on employees, limitations on earnings, and phase-outs has surprised the small business community. In particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.[2] Unfortunately, the net impact of the credit in offsetting the cost burden of the PPACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by the Congressional Budget Office. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."[3]

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under PPACA, is more likely 35 percent of all firms with less than 25 employees.[4]

---

[2] See, http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf

[3] See, http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

[4] See, http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099

In the same way that the mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 there by *reducing* the tax credit per worker from $2,100 to $1,596.[5] In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesson is clear in that the structure of the credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.[6]

The upshot is that the small business tax credit is a mixed economic blessing. Relatively few firms will qualify for the credit and be able to offset the costs of health insurance. For those that do qualify, receipt of the credit imposes a new regime of hidden effective marginal tax increase on improvements in scale and quality.

Administrative Costs

Perhaps the most expensive and intrusive new cost on small business is contained in Section 9006 of the PPACA. This adds a new information reporting requirement mandating that business will have to issue Forms 1099 for goods purchased after 2011, regardless of the corporate form of the vendor. Vendors of goods will have to furnish, and businesses will have to collect, Tax ID numbers for all aggregate purchases totaling over $600 annually. If a vendor fails to furnish a correct Tax ID, the businesses receiving the goods is required by law to impose back-up withholding at the rate of 28 percent of the purchase price. This means that

---

[5] This example assumes the employer contributes $6,000 toward insurance for each employer.

[6] See, http://www.ncpa.org/pdfs/ba703.pdf

businesses will now have to keep records of all purchases and keep them sorted by Tax ID.

This costly expansion of administrative requirements has nothing to do with the objectives of health care reform. Thus, it is best viewed as an initiative in tax administration. From this perspective its inclusion is puzzling as neither the National Taxpayer Advocate nor the Treasury Department recommended this 1099 legislation that extends information reports to vendors of goods. The Office of the Taxpayer Advocate is concerned that the new reporting burden, particularly as it falls on small businesses, may turn out to be disproportionate as compared with any resulting improvement in tax compliance.[7]

The health care reform's 1099 provision would apply to businesses of all sizes, charities and other tax-exempt organizations and government entities. Based on tax returns filed in 2009 for tax year 2008, more than 41 million organizations will now need to submit 1099 forms. This will be an administrative nightmare for businesses and non-profit organizations.

Moreover, it is not obvious that the Internal Revenue Service will be able to make productive use of this new volume of information reports. In general, the IRS' document matching system compares amounts shown on a taxpayer's tax return with amounts shown on third-party information reports like the form W2. Under this new provision, the amounts on the 1099 information reports will not match the tax returns.

Thus, from a tax administration perspective, it is exceedingly doubtful that the Section 9006 mandate comes close to making sense from a benefit-cost perspective. However, the greatest concern is the hidden impact of the 1099 provision on the operation of small businesses. For example, small businesses seeking to minimize recordkeeping burdens now have an incentive to use large vendors that can produce Tax ID reports for them. As a result, small business that lack that capacity to track customer purchases may lose customers, leaving the economy with more large national vendors and less local competition.

Tax Increases

The Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical that PPACA will not harm the pace of overall economic recovery.

---

[7] See http://www.irs.gov/newsroom/article/0,,id=225270,00.html

There are two taxes of particular interest contained in PPACA. Section 9015 increases the Medicare HI tax by 0.9 percentage points on wages in excess of $200,000 ($250,000 for couples filing jointly, $125,000 for married individuals filing separately), and also applies to self-employed earnings.

Sec. 1402 of HCERA imposes a 3.8 percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for joint returns, $125,000 for married filing separately, or $200,000 for any other case. Both taxes are effective for taxable years beginning after 2012.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars will finance the expansion of the new insurance subsidy entitlement program.

The second point to note is that these taxes apply to the labor and investment earnings of pass-thru entities taxed through the individual income tax. Thus, they are targeted at precisely the same group of individuals most likely to be business owners or entrepreneurs. The Joint Committee on Taxation projects that $1 trillion in business income will be reported on individual income tax returns in 2011. Notably, of that $1 trillion, roughly one-half, $470 billion, will be reported on returns that are likely to be the new surtaxes.[8]

This has the potential to impact employment. According to the Small Business Administration, there are almost 120 million private sector workers in the United States. Slightly more than half those workers, 60 million, work for small businesses. About two-thirds of the nation's small business workers are employed by small businesses with 20 to 500 employees. According to Gallup survey data conducted for the National Federation of Independent Business (NFIB), half of the small business owners in this group fall into the surtax brackets. This means there is a pool of more than 20 million workers in those firms directly targeted by the higher marginal tax rates. This is likely a conservative estimate as it ignores flow-through entities with one to 19 workers.

A final tax impact of the PPACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As noted in Brill and Holtz-Eakin (2010) the phase-outs in insurance subsidies contribute to high effective marginal tax rates.[9] The effect is to raise to as high as 41 percent the effective

---

[8] The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.

[9] Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal,* February 4, 2010. See also, Douglas Holtz-Eakin and Cameron Smith, "Labor

marginal tax rate on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

PPACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of the PPACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.[10] The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

In addition, the law's array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of pre-existing conditions for children, and the ability for children to stay on parents' policies, are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

As noted above, PPACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

The impact of fees on medical devices, insurers, and pharmaceutical companies is important and not well-understood. To understand better, consider the fee on health insurers. The fee amounts to a *de facto "health insurance premium* tax" that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to any U.S. health insurance provider, with the intent of raising nearly $90 billion over the next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and then rises thereafter. (See Table 1.)

Markets and Health Care Reform, 2010.
http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf

[10] See http://www1.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf or http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf.

Table 1
Aggregate Insurance Fees

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [11]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 2
Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0
$25 million to $50 million	50 percent
$50 million or more	100 percent

So far, seemingly so good, for families and small employers, as insurers have to pay this new "health insurance premium tax". Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. Firms don't really pay taxes; they attempt to shift them to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that

[11] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue serving policyholders effectively.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based

revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, greater is the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the new law has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible, but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly, the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the next 10 years, the upward pressure will be $134.6 billion.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability raise their scale of operations. In short, for insurers that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[12] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent. Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

The health insurance fee will likely quickly and nearly completely be incorporated into higher insurance premiums. The premium tax alone means that American families will pay as much as $135 billion more in insurance premiums over the next 10 years. Incorporating the impact of medical devices and pharmaceuticals raises the total impact.

The final channel by which PPACA affects insurance costs are the mandates regarding insurance benefit designs. Mandating greater benefits will unambiguously raise the costs of insurance. However, one widely-touted promise of the PPACA was that if the American people "like your health plan, you can keep it."

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.[13] A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by 2013.[14] Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

PPACA and Employer-Sponsored Insurance

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of the PPACA insisted that a key tenet of was to build on this system of employer-sponsored coverage.

---

[12] See http://biz.yahoo.com/p/522qpmd.html.

[13] "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act. Federal Register. Volume 75. Page 34571

[14] "2010 UBA Health Plan Survey." United Befit Advisors. October 2010.

Roughly one-half of the $900 billion of spending in the PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example, a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative, subsidized source of insurance for their workers, which can be accessed if they drop coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the PPACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – and another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – *and* save money.

As Table 3 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Do the economics of PPACA ever suggest that employer's could drop? Yes. The employer would receive $14, 176 in subsidies – *more than the value of the lost health insurance.* On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is room

for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminated employer-sponsored insurance.

The remaining rows of Table 3 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.[15]

Table 3

Health Care Reform and Employer-Sponsored Insurance in 2014

(Employer Health Plan = $11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	($128)	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

[15] Notice that what this really means is that an *existing* federal subsidy (via the tax code) trumps the new federal subsidy!

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.[16]

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 plus an additional, say, 38 million in 2014) – meaning the price tag would be $1.4 trillion.

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

PPACA and the Budget Outlook[17]

The United States faces a daunting budgetary outlook, with the Administration's budget displaying an unsustainable debt spiral emerging over the next decade. In this context, the fiscal consequences of the newly-enacted Patient Protection and Affordable Care Act are of extreme importance.

The Context: An Approaching Fiscal Train Wreck

The federal government's unsustainable long-run fiscal posture has been outlined in successive versions of the CBO's *Long-Term Budget Outlook*. In broad terms, over the next 30 years, the inexorable dynamics of current law will raise outlays, or committed federal expenditures, from about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[18] Any attempt to keep taxes

[16] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.
[17] This sections draws heavily on Holtz-Eakin and Ramlet "Health Care Reform Is Likely To Widen Federal Budget Deficits, Not Reduce Them," *Health Affairs*, 2010.
[18]Congressional Budget Office. The Long-Term Budget Outlook. Washington (DC): Congress of the United States; June 2009.

revenues at their post-war norm of 18 percent of GDP will generate an unmanageable federal debt spiral. In contrast, a strategy of ratcheting up taxes to the 30 to 40 percent of GDP needed to match the federal spending appetite would likely be self-defeating as it would undercut badly-needed economic growth.*

The policy problem is that spending rises above any reasonable level of taxation for the indefinite future. The diagnosis leads as well to the prescription for action. Over the long-term, the budget problem is primarily a spending problem and correcting it requires reductions in the growth of large mandatory spending programs and the appetite for federal outlays.

This depiction of the federal budgetary future has been unchanged for a decade or more. However, the most recent Administration budget shows that in part due to the financial crisis, recession and policy responses the problem has become dramatically worse and will arrive more quickly. The federal government ran a fiscal 2009 deficit of $1.4 trillion – the highest since World War II – as spending reached nearly 25 percent of GDP and receipts fell below 15 percent of GDP. In each case, the results are unlike those experienced during the last 50 years.

Going forward, there is no relief in sight. Over the next ten years, according to the CBO's analysis of the President's Budgetary Proposals for Fiscal Year 2011, the deficit will never fall below $700 billion dollars.[19] In 2020, the deficit will be 5.6 percent of GDP, roughly $1.3 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

The budget outlook is not the result of a shortfall of revenues. The CBO projects that over the next decade the economy will fully recover and revenues in 2020 will be 19.6 percent of GDP – over $300 billion more than the historic norm of 18 percent. Instead, the problem is spending. Federal outlays in 2020 are expected to be 25.2 percent of GDP – about $1.2 trillion higher than the 20 percent that has been business as usual in the postwar era.

As a result of the spending binge, in 2020 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.

The Budgetary Impact of the Patient Protection and Affordable Care Act
In light of the fiscal threat from growing spending, the budgetary impacts of the Act are central to any discussion of its merits. We begin by reviewing the CBO cost estimate that concludes the Act will serve to lower projected deficits over the next ten years and beyond. After our summary review, we proceed by analyzing the budgetary implications of altering certain assumptions.

---

[19] Congressional Budget Office. An Analysis of the President's Budgetary Proposals for Fiscal Year 2011. Washington (DC): Congress of the United States; 2010 March

The final score of PPACA with reconciliation amendments was released publicly on March 20, 2010.[20] The CBO and the Joint Committee on Taxation estimated the Act would lead to a net reduction in federal deficits of $143 billion over ten years with $124 billion in net reductions from health care reform and $19 billion derived from education provisions.[21]

Total subsidies in the Act exceed $1 trillion dollars over ten years and include insurance exchange tax credits for individuals, small employers tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program. To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly $500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition to the cost saving measures, the Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

To gain a rough feel of the longer-run impacts, consider extrapolating to the years 2020 to 2029 using CBO's estimated compounded annual growth rates. Under this crude approach, the PPACA is expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is important given the daunting fiscal outlook. But they raise an important question: is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the budget office is required to take at face value and not second-guess.

A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus. As shown in Table 4 a wholly different picture emerges: the PPACA would raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

The list of budgetary features embedded in the CBO score begins with the fact that the Act front-loads revenues and backloads spending. That is to say the taxes and fees it calls for began immediately in 2010, but its new subsides are largely deferred until 2014. This contributes to the illusion that the PPACA reduces the deficit. Note

---

[20]Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010. Washington (DC): Congress of the United States; 2010 March.

[21] To analyze the fiscal impact of health care reform, we have removed the education revenues from the government takeover of all federally financed student loans.

that if revenues were delayed to start in 2014, the Act's 2010-2019 net deficit impact would be $66 billion lower.

Additional budgetary provisions of interest fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and already reserved premiums. Table 4 summarizes the annual impact of each scenario and extrapolates the fiscal impact to 2029.

The first adjustment, labeled "Unachievable Savings", removes spending cuts that the Centers for Medicare and Medicaid Services (CMS) will ultimately be unable to implement. These are composed of cost reductions through Medicare market basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, and the Part D premium subsidy for high-income beneficiaries. While the specifics of each differ, these provisions share two features. First, the PPACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Accordingly, when the time comes to implement these savings (or those developed by the Independent Payment Advisory Board) CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible, as Congress is likely to continue to regularly override scheduled reductions. A vivid example is the Medicare Physician Payment Updates. Each year since 2002 the "sustainable growth rate" formula in current law has imposed cuts in payments to physicians under Medicare. And each year Congress has overridden these same cuts.

Table 4
(billions of dollars unless otherwise noted)

Adjustments	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
CBO Projected Subsidies	4	11	13	9	70	125	181	204	219	236	1072
CBO Projected Cost Savings	2	-2	-11	-18	-43	-51	-59	-75	-91	-109	-455
Unachievable Savings	0.1	1.4	4.9	10	20.1	25.7	32.3	41.7	52.1	64.8	253.5
Unscored Budget Effect	8	14.7	16.5	18	18.3	20.4	23.4	26.2	29.3	34.7	274.6
Subtotal	10.1	14.1	10.4	10	-4.6	-4.9	-3.3	-7.1	-9.6	-9.5	73.1
CBO Projected Tax Revenues	0	-8	-15	-43	-77	-90	-114	-123	-131	-141	-739
Uncollectable Revenue	0	-1	-2	-5	1	6	14	18	22.2	26.8	78
Premiums Reserved	0	0	5.4	8.8	10	11.3	11.1	9.1	7.6	7	70.2
Subtotal	0	-9	-11.6	-39.2	-66	-72.7	-88.9	-95.9	-101.2	-107.2	-590.8
Net Change in Projected Deficit	14.1	16.1	11.8	-20.2	-0.6	47.4	88.8	101	108.2	119.3	554.3
Percentage of GDP	*0.10*	*0.11*	*0.08*	*0.12*	*0.00*	*0.27*	*0.50*	*0.55*	*0.58*	*0.62*	*2.90*

Massachusetts and Tennessee provide recent examples where insurance coverage expansion has led to substantial cost increases, instead of savings. In 1994, Tennessee implemented a massive Medicaid expansion (eventually covering 500,000 additional residents). A decade later, the state abandoned the experiment after costs more than tripled from $2.5 billion in 1995 to $8 billion in 2004, consuming one-third of the state budget. When the experiment unraveled in 2005, 170,000 enrollees were dropped. More recently in April 2010, Tennessee announced that, due to cost overruns, the program would need to cut an additional 100,000 people from Medicaid rolls.[22]

In Massachusetts, the state's Special Commission on the Health Care Payment System has produced payment recommendations in the wake of passing an individual insurance mandate, but the commission has so far failed to bend the cost curve on medical inflation (growing 8 percent annually in Massachusetts).[23] The federally impaneled Independent Payment Advisory Board would likely follow a similar trajectory.

The second adjustment, "Unscored Budget Effects", highlights acknowledged costs that are not included in the CBO score. To operate the new health care programs over the first ten years, future Congresses will need to vote for $274.6 billion in additional spending. This spending includes the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage, explicitly authorized health care grant programs, and the Medicare Physician Payment Reform Act, which revises the sustainable growth rate for physician reimbursement.

Adjustment three, "Uncollectable Revenue", questions the political will of Congress and directly refers to the excise tax on high-premium, "Cadillac", health plans. This tax was supposed to start immediately in the Senate's version of PPACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax. Thus, the scenario shows the impact of not collecting the associated tax revenue of $78 billion over the next ten years.

The final adjustment, "Reserved Premiums", focuses on the CLASS Act premiums for long-term care insurance and the potential increase in Social Security receipts. In

---

[22] Wadhwani A. Tennessee removes about 100,000 people from Medicaid rolls. Kaiser Health News. 2010 Apr 8. Available from: http://www.kaiserhealthnews.org/Stories/2010/April/08/TennCare.aspx

[23] Kowalczyk L. Pay for care a new way, state is urged. The Boston Globe. 2009 July 19. Available from: http://www.boston.com/news/local/massachusetts/articles/2009/07/17/pay_for_care_a_new_way_state_is_urged/?page=2

principle, these receipts should be reserved to cover future payments and not be devoted to short-term deficit reduction. Specifically, the scenario shows the implications of reserving the $70 billion in CLASS Act premiums expected to be raised in the first ten years for the legislation's new long-term care insurance.

In addition to this accounting sleight of hand, the legislation uses $53 billion for deficit reduction from an anticipated increase in Social Security tax revenue. The CBO estimates that outlays for Social Security benefits would increase by only about $2 billion over the 2010-2019 period, and that the coverage provisions would have a negligible effect on the outlays for other federal programs.

What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance, produces a radically different bottom line. The Act generates additional deficits of $562 billion in the first ten years. And, as the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach $1.5 trillion.

Of course, this is not the only source of budgetary uncertainty. Proponents point toward the possibility that the Act will "bend the curve" more than anticipated, thereby reducing health care spending in federal programs and beyond. In this light, it is important to note that if federal subsidies do not grow at all between 2020 and 2029 – a herculean reduction in annual spending growth of 3.4 percentage points – it will reduce outlays by under $500 billion. That is, extraordinary success in bending the cost curve amounts to less than one-third of the downside budgetary risks embedded in the Act.

The future of the Patient Protection and Affordable Care Act is likely to be even more important than its passage. In light of the extraordinarily precarious state of federal fiscal affairs and the enormous downside risks presented by the Act, one can only hope that every future effort is devoted to reducing its budgetary footprint.

Conclusion

The PPACA will have a dramatic impact on the evolution of labor market incentives, economic growth, and the budget outlook over the near term. Unfortunately, at a time when job growth and controlling spending to restore fiscal balance are top policy priorities, not all of these impacts are beneficial. Thank you and I look forward to answering your questions.

Chairman CAMP. Thank you very much.

Mr. Womack, you are recognized for five minutes. And your written statement will be made a permanent part of the record.

STATEMENT OF SCOTT WOMACK, PRESIDENT, WOMACK RESTAURANTS, TERRE HAUTE, INDIANA

Mr. WOMACK. Thank you, Chairman Camp, Ranking Member Levin, members of the Ways and Means Committee. Thank you for this invitation to testify today. My name is Scott Womack, owner and president of Womack Restaurants, a 12-unit IHOP franchisee in Indiana and Ohio. I am pleased to be here today to testify on behalf of the U.S. Chamber of Commerce. I also come before you today on behalf of my company, my industry, and small businesses and entrepreneurs.

My first jobs were as a busboy and a cook. After college I joined the grocery industry. After five years I got fired, and found myself starting over. I was lucky to land a job at IHOP, as a manager. And soon, with a $15,000 loan from my parents, I bought my first IHOP franchise. After 10 years I began building IHOP restaurants. In 2006 I purchased a development agreement to expand into Ohio. Now, this would mean jobs in Ohio, not just in my restaurants, but also in construction, real estate, and also manufacturing. But thanks to this new law, those are not going to happen.

The restaurant industry serves an important role in our economy, employing 12.7 million people. I like to say it's an industry of first opportunities and second chances. First jobs, first careers, the first shot at small business ownership, and also second chances for people starting over, maybe from a forced career change or reentering society from incarceration, or a second job for those people digging out of a financial hole. Stories like mine are born every day in the restaurant industry.

The restaurant business is built on a small business model, with profit margins of five to seven percent. We're the most labor-intensive of any industry, ranking dead last in revenue per employee, at $58,000 per employee. This compares to retail at $170,000, banks at over $400,000, and other industries that actually bring in millions of dollars per employee in revenue.

Now, for restaurants, this new requirement to provide health coverage is not just a marginal cost increase. This is a huge new expense. And at $7,000 annually per employee, it is beyond our ability to pay. So, let me just be real clear about that.

Now, I estimate this to be 50 percent greater than my earnings. So please understand me. That is more than I can actually pay for the coverage. Our only alternative is to pay the penalties. Those penalties are not tax deductible. So that puts my company at risk, and many companies simply will not be able to pay those penalties, and will not survive.

Restaurants are already facing many challenges, including rising commodity, fuel and energy prices, rising state and local taxes, and higher unemployment taxes. Restaurants are unable to raise prices in this economy. We don't have a way to replace the lost income. Our only alternative is to cut costs. Cutting costs means cutting staff. It means reducing hours. It means pushing people into part-time status.

It also means that we will have to cut outside services, further hurting small businesses that serve my company. We will be forced to stop building restaurants and forfeit our investment. This future development would have amounted to about $22 million in construction and development spending, and 260 full-time jobs.

Another casualty of this is the restaurant equipment industry, which is a uniquely American industry. That industry has already been devastated by this recession.

Furthermore, our lenders require us to maintain certain levels of profitability. Our mortgages, leases, and franchise agreements are commonly 15 to 20 years long. They do not go away in 2014. Those are obligations we cannot walk away from.

Other parts of the law are also causing harm. I may not be able to continue to offer the coverage that I currently offer to my management staff, due to the compensation non-discrimination rules in the law.

Obviously, there are other examples of issues that have been raised today, issues with the HSA plans, taxes on investments, tax on the health insurance, and of course, the Cadillac tax, which will eventually hit everyone.

To that end, we are asking that Congress repeal this health care law. If that cannot be achieved, we urge you to address some of the major problems with the law. This bill is a ticking time bomb that will devastate our industry. A change of course now could end this uncertainty. Therefore, I am asking you to introduce and pass legislation that would repeal the employer mandate. The members of the U.S. Chamber of Commerce will work tirelessly to help you pass it.

I thank the members of this committee for the opportunity to testify today, and I look forward to working with you in the future to fix the problems created by this law, and implement real market-driven solutions. Thank you.

[The prepared statement of Scott Womack, follows:]

This testimony is embargoed until January 26, 2011, at 9:00am

Testimony
of the
U.S. Chamber
of Commerce

ON: **Health Care Law's Impact on Jobs, Employers, and the Economy**

TO: **House Ways and Means Committee**

FROM: **Scott Womack, President, Womack Restaurants**

DATE: **January 26, 2011**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

U.S. Chamber of Commerce, 1615 H St NW, Washington, DC 20062-2000

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – numbers more than 10,000 members. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 101 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. Currently, some 1,800 business people participate in this process.

Testimony on

Health Care Law's Impact on Jobs, Employers, and the Economy

THE HOUSE WAYS AND MEANS COMMITTEE

on behalf of the

U.S. CHAMBER OF COMMERCE (the "Chamber")

by

Scott Womack

President

Womack Restaurants

January 26, 2011

Chairman Camp, Ranking Member Levin, members of the Ways and Means Committee, thank you for the invitation to testify at this hearing. My name is Scott Womack, Owner and President of Womack Restaurants, a 12 unit IHOP Franchisee in Indiana and Ohio. I am pleased to be here today to testify on behalf of the U.S. Chamber of Commerce, the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region.

I also come before you today as a 25 year restaurant veteran to represent my company, my industry, and, especially, small businesses and entrepreneurs. My first jobs were as a busboy and cook. After college, I joined the grocery industry, but after 5 years, was fired, and found myself starting over. I was lucky to land a job with IHOP as a manager, and soon, with a $15,000 loan from my parents, I bought my first IHOP Franchise. After 10 years, I began building IHOP restaurants in Indiana, and in 2006 purchased a development agreement to expand our company into Ohio over the next 10 years. This would mean new jobs for Ohio – not just in my restaurants, but also in construction, real estate, and manufacturing. But, because of the new law, these new jobs will never be created. It looks like those new jobs have all been killed because of the health care law.

The restaurant business is built on a small business model, with profit margins commonly of 5% to 7%. We are the most labor intensive of any industry, ranking dead last in revenue per employee at $58,000 per employee.[i] Compare this figure to the next closest, Hotels, at $107,000 per employee, Retail at $170,000, Banks at $443,000, and other industries even more per employee. For most industries, the new law results in a marginal cost increase. For restaurants,

providing qualifying coverage to all full time employees is a huge new expense. At $7,000 per full time employee, this new expense is beyond our ability to pay. I estimate the cost to my company to be 50% greater than our company's earnings. Let me state this bluntly: this law will cost my company more money than we make. And our company is very profitable by industry standards.

The law is one-size-fits-all for employers, and restaurants don't fit. Though some restaurant companies offer coverage now, the cost is prohibitive for many employees, and many of their plans will not qualify in 2014. The only viable alternative is to pay the $2,000 per employee penalty, which is not tax deductible. A quick study of public restaurant companies shows that many did not earn enough in 2010 to pay the penalties and likely will not survive in the future. For my company, these penalties amount to 60% of our earnings, and again, our company is very profitable by industry standards.

Restaurants are already facing many challenges, including rising commodity prices, rising state and local taxes, higher unemployment taxes, rising energy prices and so on. The recent flood of regulations and looming uncertainty about what Washington D.C. will do next is only compounding these challenges. Restaurants are unable to raise prices in this economy. Our only alternative is to cut costs. This industry is not one with a lot of fat to cut, either. I believe it is the most competitive industry there is. For us, cutting costs means cutting staff and reducing hours worked, and putting more employees into part time status. The job-crushing effects of PPACA will flow downstream and hurt the many small businesses that serve our company.

Additionally, we will be forced to cease new restaurant development and may forfeit the development agreement we invested in. That agreement cost $360,000. This future development would amount to $22,000,000 in construction and development spending, and 260 full time restaurant jobs. I would like to also point out that the restaurant equipment industry is a uniquely American manufacturing industry. That industry has already been devastated by the recession.

Furthermore, our lenders, as required by regulators, require us to maintain certain levels of profitability via loan covenants. Our mortgages, leases, and franchise agreements are commonly 15 to 20 years long. We have major obligations that we cannot walk away from in 2014.

The restaurant industry serves an important role in our economy, employing 12.7 million people.[ii] It is a source 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, re-entering society after incarceration, or a second job for those digging out of a financial hole. Stories like mine are born every day.

On a related note, I have serious concerns that I will not be able to continue to offer the coverage I currently offer to my management and office staff, based on "non-discrimination" rules in the new health care law.

Also, the 1099 reporting requirement will be another unnecessary burden to our company. In an effort to make the health care law appear "paid for," a number of provisions were included that do nothing to improve health care, but make it harder to run a business. The 1099 paperwork mandate is a great example, but do not overlook new restrictions on FSAs and HSAs, taxes on things we buy, taxes on investments, new W-2 reporting requirements, a tax on small businesses' health insurance, and the new "Cadillac" tax that will eventually hit everyone unless health insurance magically stops getting more expensive.

To summarize, the goal of providing health insurance coverage is noble, but the restaurant industry can't afford the steep fines and mandates loaded upon us by the health care bill. Paying the penalties will be devastating for most.

The health care law does not include the kinds of solutions that would have made it easier and more affordable to offer health insurance. It did not include meaningful medical liability reform. It did not give me the option to shop for health insurance from companies in other states. It did not improve consumerism – in fact, it threatens HSAs, which my company just implemented. Making common sense, cost control a priority should have been first on the agenda.

To that end, Congress should repeal the health care law. If that cannot be achieved, I urge you to address some of the major problems with PPACA. This bill is a ticking time bomb that will devastate my industry unless significant changes are made.

Therefore I am asking you to introduce and pass legislation that would repeal PPACA's employer mandate. This must be just as urgent as developing the solutions called for in H. Res. 9. Members of the Committee, the U.S. Chamber of Commerce stands ready to help you pass it, and with the support of members like me and small businesses everywhere. In closing, I thank the members of this Committee for the opportunity to testify today, and look forward to working with you in the future not only to fix the problems created by the health care law, but to do the work PPACA failed to do, by implementing real, market-driven reforms that increase competition and make health insurance more affordable.

---

[i] CNN/Money's Fortune 500 Report, 2009
[ii] National Restaurant Association

Chairman CAMP. Thank you very much, Mr. Womack.

Mr. Olivo, you are also recognized for five minutes. And, likewise, your written statement will be part of the permanent record.

STATEMENT OF JOE OLIVO, OWNER/CEO, PERFECT PRINTING, MOORESTOWN, NEW JERSEY

Mr. OLIVO. Thank you, Chairman Camp, and thank you to the Committee for not just the opportunity, but the honor to provide my testimony today. My name is Joe Olivo, I am a small business owner. And I appreciate being able to relate to you the concerns that I have with the health care legislation, how it has already begun affecting my company, and some of the problems I see as the plan becomes fully implemented.

I am the president and co-owner of Perfect Printing in Moorestown, New Jersey. I own the company, along with my wife, my two brothers, and my mother. It was started in 1979, as a literal Mom and Pop copy center. I have run the business for the past 23 years. We have been very fortunate we have been able to grow it to a high of 54 employees prior to the economic downturn, and we currently have 45 employees.

An area which is of great concern to me that's been spoken about today is the 1099 compliance requirements. Simply put, I do not have the resources in place to implement this law, to—the resources that I will have to put in place, as far as software programs and calculating and managing receipts are just much more than I have the resources to do.

And I think it's important, when you think of the burdens that these—the legislation places on a small business, is thinking in the context of businesses like mine. In a good year, our profit is $.03 on every dollar we earn. Every time there is a new regulation that's put in place such as this, it typically comes out of that profit margin. It leaves me less resources in which I can grow my business, give my employee wage increases, and contribute to their benefits.

A key issue for any employer is how and when to grow the business. My company is currently on the cusp of the 50-employee mark, which—we were just there 2 years ago. And at that point I would be legally bound to offer my employees insurance, or face a penalty for not doing so. Besides being ridiculously complex, it's my understanding that even at the—once I go over the 50-employee mark, I can face penalties if one of my employees is eligible for the government-subsidized plan, even if I am providing insurance.

I'm still in the process of trying to compute the exact ramifications of this part of the law, but based on my current premium rates, the penalty is actually less expensive than the premium rates. So I find it ironic that the part of the law that is—mandates me to provide insurance to my employees is really an incentive not to provide insurance to them at all.

And this takes me to the issue of what we currently offer our employees. I am able to pay 100 percent of the premium cost for my individual employees. I pay 56 percent of the family portion. I am able to do this because we're able to use a high-deductible health savings account that we instituted six years ago. Now, this is important, because during the debate prior to the passage of this legislation we heard time and time again that my employees would be able to keep their existing coverage. Within 30 days of the law's passage, I received a notification from my insurer that my plan would no longer be offered.

So, my understanding is, because of the preventative care requirements and how it was treated under a high deductible plan, it was no longer in compliance with the law. So, after 20-plus years of myself voluntarily providing insurance for my employees, and paying most of it at my own cost, I am now told that this is no longer acceptable to the government.

Another area of concern to me is the tax credits that have been mentioned today that were promised to small business owners to help us pay for insurance. This point was made over and over, and even persuaded some in the small business community to support this plan, because they felt it would be a net positive for them.

I can say now that I have checked the tax credits for my company of 45 employees, and we are not eligible for a single dollar in tax credits. I have learned from fellow small business owners. I spoke to a woman that owns a bridal salon with three employees, and she had spoke to her accountant. She, too, is not eligible for a single dollar in tax credits. So, these are the issues that I know have already begun affecting my business.

But it's the unknown that causes me as much or greater concern. You have to understand. When I grow my business, when I take financing to buy a new press or increase the investment in my business, I put my personal assets on the line. I put my home on the line as collateral, my family's home on the line as collateral. When you have this much unknown, and unknown cost certainty in a law—and I challenge anyone on this committee to tell me what my health care cost will be two years from now—it creates much less of an incentive for me to take the necessary risk.

So, I will leave you with this, as I hand over the microphone. My story is personal, but it is by no means unique. There are hundreds of thousands, if not millions, of small business owners across this country facing the same issues. And how can we ask those businesses to help the economy prosper, yet put a drag on one of the main engines of economic growth?

Chairman CAMP. All right.

Mr. OLIVO. Thank you.

[The prepared statement of Joe Olivo follows:]

This testimony is embargoed until January 26, 2011, at 9:00am

U.S. HOUSE OF REPRESENTATIVES

TESTIMONY BEFORE THE COMMITTEE ON WAYS AND MEANS

HEARING ON THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" AND THE "HEALTH CARE AND EDUCATION RECONCILATION ACT OF 2010"

JOE OLIVO

PRESIDENT AND CO-OWNER OF PERFECT PRINTING

9AM

1100 LONGWORTH BUILDING

Good morning. I'd like to thank the committee for the opportunity and honor of allowing me to present my testimony today. My name is Joe Olivo and I own a small business. I appreciate the willingness to have an open discussion about some of the concerns that I, along with many of my fellow small business owners, face because of the new healthcare law. I would like to share with you my early experiences with the law, how it is already affecting my business and what additional consequences I expect to see as the regulations are fully put into place.

I am the president and co-owner of Perfect Printing. I own the company along with my wife, my mother and two brothers. My parents started the company as a literal "mom and pop" copy center in 1979 and I have been actively running the company for the past 23 years. We have been fortunate in that we were able to grow the company to a high of 54 employees prior to having to downsize during the recent economic downturn. We currently have 45 full-time and part-time employees.

One area I am certain will have a profound effect on my business is the new, expanded 1099 reporting requirement in this law. As you may know, the law now requires that I submit to the IRS a report of any transaction adding up to over $600 in business in a year. This is a huge requirement and I do not have any sort of system in place to account for it. Just to give you a couple of examples, I have drivers and sales people that fill up for gas. Based on a quick calculation, I estimate they have probably gotten over $600 in gas at 8 to10 filling stations. I will now have to track down who the gas station owners are, get the proper information and submit to them a form of how much we spent with each business entity. Another example is the salesperson or owner who frequently travels. Can you imagine trying to submit paperwork to the various airlines, hotels, rental car agencies and restaurants that you visit over the course of a year? I will most certainly have to purchase some sort of software program and waste my

resources calculating and collating receipts for purchases of thousands of items. I think it is very important to keep in mind the huge costs that additional regulatory burdens place on small businesses like mine. My business, like most small businesses operate with a very tight profit margin and with little extra money to spare on purchases that do not directly affect the profitability of the company. In a good year, our profit is 3 cents on every dollar earned. Many years it is less than that. When additional regulations, like those contained in the healthcare law, are instituted the cost to comply with this usually comes out of the profit portion. I do not have the luxury of simply creating new revenue or cutting additional expenses in order to afford the costs to comply. Besides the cost there is the issue of the availability of time. As a small business owner, I have to make decisions daily as to what issues can be attended to by the end of the day and which ones will have to be pushed off to the next day simply because I run out of time. My business can't afford the luxury of hiring an HR or accounting consultant, or a new employee to fill out all of the new government paperwork that is required by this law. Simply put, if this part of the legislation is not rescinded this will impair by ability to grow my business and the same would apply to the millions of other of small businesses in this country.

A key issue for any employer is how and when to grow their business. Our company is on the cusp of the 50 employee threshold, at which I would be legally bound to offer my employees insurance or pay a penalty if I do not. Besides being ridiculously complex, it is my understanding that, at the 50 employees or greater mark, I could possibly be penalized even if I do offer insurance to my employees and one or more of them decide to take a government-subsidized plan. I am still in the process of trying to compute the exact ramifications of this portion of the law. This being said, in the event I do hit that 50 employee threshold, based on my current premiums it may actually be less expensive for me to not provide any health insurance and just

pay the penalties. Ironically, the part of the law that mandates that I must now provide insurance is actually providing the perverse incentive for me not to provide any insurance at all. This would not only be more expensive to the federal government but it would mean that my employees would lose the administrative support that I offer them with their health insurance.

One of the main concerns I have with the law is how it will affect the current healthcare coverage that I already offer to my employees. We currently offer a plan where the company pays for 100 percent of our employees' insurance premium and pays 56 percent toward family coverage. We are also able to offer our employees additional plans that offer lower deductibles at a higher premium cost. Compared to a lot of our competitors we think this is quite substantial. We have only been able to do this by offering a high deductible plan with a health savings account. We began offering this plan six years ago and it has been a tremendous tool toward slowing the rate of the escalating healthcare premiums that we face, especially since we are located in New Jersey. New Jersey is a guaranteed access, community-rated state with heavily mandated policies. We have seen double-digit percentage increases to our annual premiums going back to 1993. I estimate our average premium increase for the past 17 years is around 20 percent each year. The high deductible plans have allowed us to continue to pay for our employees' premiums. With the savings to the company from offering these plans, we have been able to contribute to the employees' health savings accounts while encouraging the employees to do the same. I have seen how these plans encourage healthier lifestyle choices and make everyone more accountable and aware of how they spend their healthcare dollars. While I would not say high-deductible accounts are the sole answer to the crisis of rising healthcare costs, it has been a very effective tool for my company.

During the debate leading up to the passage of the legislation, I heard numerous times that my employees would be able to keep the same plan they currently have. Unfortunately, within less than 30 days of the law's passage, I received a letter from our insurance carrier notifying us that our plan would no longer be available at the end of the current term. The reason for this is that the preventative care portion of the plan did not meet the requirements of the new law. The promise that my employees would be able to keep their existing health insurance has proven to not be true. After 20 plus years of voluntarily providing coverage for my employees, much of it at my own cost, I am now finding out this coverage is no longer acceptable according to the government.

A final area of concern to me is the tax credits that were promised to small business in order to help them pay for health insurance. This point was made over and over during the debate and even persuaded some of my fellow small business owners to mute their criticism of the plan in the hopes that maybe the legislation would be a net benefit to their companies. The problem with the tax credit is that it depends on the government's definition of small. I checked the tax credits that I am eligible for and I come up with a big fat zero. Now at 45 employees there are certainly smaller businesses out there but I don't think anyone would consider us a big business. I have learned from fellow business owners with much smaller companies that the tax credit is so narrow and so limited that it would provide marginal assistance to a very low percentage of small businesses that are out there. For example, an 18-person business who pays, on average, $38,000, doesn't get anything either. Beyond this, the credit is temporary and, as I referenced earlier, the year over year increases in healthcare costs certainly aren't.

While those issues that I have mentioned are the known items that will affect my ability to grow my business, it is the uncertainty that causes concern as well. Questions such as:

What portions of the legislation are applicable to my company?

What are the exact ramifications if I go over 50 employees?

What taxes, fines and penalties will I be exposed to? How much will they be?

Will I need to hire outside consultants or new employees in order to see that I am in compliance with the new laws?

What is the definition of a part-time employee?

You should understand that when I make the decision to invest in my business and try to grow it further, I cannot afford to be wrong in my calculations. Like most small business owners, I put my home and a good deal of my personal savings on the line when I make these investments. When there is so much uncertainty regarding the costs that will be required of me to comply with these new laws, it makes me much more hesitant to invest and causes me to take much less risk in those investments that I do wish to proceed with.

My story is very personal but it is not unique. There are hundreds of thousands, possibly millions of small businesses owners that are facing these same issues. How can we make the economy prosper for all when we are stifling one of the main engines of growth? Thank you for the opportunity to testify today. I look forward to answering your questions.

Chairman CAMP. Thank you all for your testimony. We will now go to the questioning period. And as I indicated, we will pick up where we left off. And so, Mr. Roskam is recognized for five minutes.

Mr. ROSKAM. Thank you, Mr. Chairman. I just want the record to reflect that I respond promptly to emails and letters from Dean Heller, and even shoves in the elbow.

Mr. Holtz-Eakin, I'm sure you watched the speech last night that the President gave. And one of the things that struck me was his presentation of, really, a straw man argument, and that is the assertion—we even heard that asserted today from Mr. Goolsbee—that we don't want to go back to the days of, you know, folks being pressed out and not included on pre-existing conditions.

There is really nobody that's proposing that. House Republicans, Chairman Camp authored, I think, a very thoughtful piece of legislation that dealt with that through high-risk pools. Could you comment sort of generally on this whole notion of two different visions?

Dr. Boustany mentioned this in responding to Mr. Neal when he said, "Look, the underlying premise of this new law is to expand coverage by putting people on Medicaid." You alluded to this in your brief opening statement about entitlements outpacing the economy in general. Could you just give us a couple more thoughts on that?

Mr. HOLTZ-EAKIN. Well, certainly, thank you. And with all due respect to the President, I think it is a straw man argument. If you roll the clock back to the beginning of the debate over health care reform, there was a bipartisan agreement that it would be desirable to control the growth of health care spending in the United States, and to cover more Americans with affordable options. That's a bipartisan objective.

The difficulty is that this law doesn't control costs. And unless that is done, you will never be able to control insurance costs. And thus, even someone who has insurance will find it unaffordable.

The second thing I would say is that there are severe problems in using Medicaid as a source of coverage expansions. Having a piece of paper that says, "I'm a Medicare beneficiary" does you no good if you can't see a provider. And Medicaid beneficiaries are denied providers, you know, at much higher rates than Medicare or private insurers. About half of them can't find primary care physicians. So they end up in emergency rooms at twice the rate of even the uninsured. That's not a solution to a coverage problem.

The third thing I would say is there is a competing vision. The other vision is genuinely controlled health care costs. Give people control of their money, use those resources wisely, allow them to choose insurance that fits their family circumstances, their lifestyle, and make insurers compete, whether it be across state lines, or more vigorously within states, so that you get decent insurance options and underlying control of the costs. That's another route to the same two goals. But it's a shared goal, and it always has been.

Mr. ROSKAM. Thank you. Mr. Olivo, the previous witness, Mr. Goolsbee, said that there is a great deal of confusion about the health care law. And I was kind of thinking about that, and I was listening as he asserted that.

And, in one element, I would agree with that. There is confusion. There is a great deal of ambiguity, for example, about who gets exemptions from the Administration. There is about 200 businesses or unions or other groups that have been exempted. Apparently it's an exemption program that's only based on their initiative. In other words, you have to ask for it, it's not a blanket exemption. And it's not a permanent exemption, it's a one-time exemption. So there is a great deal of ambiguity and uncertainty, and you alluded to that.

But at another level, there is a real sense of clarity about the health care law. For example, you figured out that the cost pressures on you are making a dynamic such that it might make more economic sense to your bottom line not to offer coverage, and to have folks go into the pool. You figured out that you're knocking

on the door with 45 employees. Once you hit a 50-employee trigger, then your world changes on a whole host of things.

Could you reflect on how it is that the health care law, and that sense of clarity that I have articulated, how is that driving the business decisions for you and your family, as you're trying to move this company forward?

Mr. OLIVO. Thank you for your question. Yes. I mean the health care—the problem with the health care, the expenses have increased so much, especially against any other expense within my business. And you have to understand, like I had pointed out, is when we invested and put our personal assets up for collateral, I don't have the luxury of being wrong in my assumptions.

So, when there are these costs, and I feel that there is costs that are unknown in addition to that, I have no choice but to be reflexively—take much less risk—maybe not buy another press or hire that extra employee until it's absolutely—I absolutely have to have them. So it really forces me to be much more conservative in how I invest in the business.

Chairman CAMP. Thank you. Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman. Mr. Eakin, I wanted to ask you a question, because I get asked this a lot back home. And I think the ranking member had mentioned it.

How in the world can you add 32 to 52 million people, where you give either free or highly subsidized health care, and think, even though there is a third party out there that says that the deficit—we'll reduce the deficit, where are they coming up with this information, other than in Washington?

Mr. HOLTZ-EAKIN. Well, on the substance, I believe I've been very clear. I do not believe that this reduces health care costs. And if you add that many uninsured people to the pool, they will use more health care services. And all the evidence is health care costs will go up.

With regard to the CBO's estimate of the budgetary impacts of the bill, my gripe is not with the CBO, which does its job under the rules that the Budget Act imposed. My gripe is with the drafters of the law, who used the Budget Act rules to make sure that CBO came up with exactly the answer they wanted, even though it was in defiance of economic common sense.

Mr. BUCHANAN. Yes, and I just want to say I was chairman of the Florida Chamber, and chairman of our little Chamber, and we had about 2,500 businesses, locally. This has been, by far, the biggest issue in the last 10, 20 years. This isn't something that's happened the last couple of years. Everybody is challenged. I get hundreds of stories, but everybody is challenged.

And that's why I don't understand, if people really get out and talk to businesses in their community or not. Being in business 30 years myself, and not a career politician, I can tell you this is drowning a lot of businesses.

I was in a business this week, one of the largest private employers in our region. His health care cost, he told me, went up a million-and-a-half dollars. Now, maybe he has 400 employees or 300 employees. If that's not job killing—that's his point to me; I know they don't like that term—but when your premiums are going up, the CBO, I think—no, the CEO roundtable mentioned that health

care costs for a family of 4 are about $10,000 in corporate America. They say in the next 10 years, with this health care bill being considered, it's going to go from $10,000 to $30,000.

I was at another small business—I wasn't there to talk to them about—they wanted to talk to me about private pharmacy. And he said, "By the way, Mr. Congressman," on the way going out, he said, "I want to show you this," and he brought out his bill. Just got his increase a couple of weeks ago. Another 23 percent increase. So, everybody is going up 23, 30 percent a year.

My experience is you get a bill and it's 28 percent, and you say, "Oh, my God, and you start working towards trying to get it down to 18. You cut some benefits, you have the employees pay a portion of it.

So, again, I don't see—and I think the ranking member mentioned our expenses are going to go up there—I don't see the offsets anywhere. I think this is a $1 trillion large entitlement going forward, and it does little or nothing for small businesses in the country.

And I think it is—however you want to look at it, personnel expense used to be 20 percent of the payroll, or whatever, benefits 20 percent of what you paid someone. Today there is a general feeling out there, "Do you want the salary, or do you want the benefits, but you can't have both." And that's what is driving, I think, a lot of things up here.

Let me mention—you had mentioned about being in the printing business, and I was in the printing business for a lot of years. How much has your cost gone up, say, in the last five years and then the last year, this year and then next year? Do you see a general trend, or a percentage increase over, let's say, 6, 10 years? Pick a number.

Mr. OLIVO. I would say the last 10 years the renewal for our existing policy has never been less than 12 percent, and has been as high as 49 percent. So every year we are faced with, as you described, the task of re-evaluating what type of new policy are we going to have to implement in order to provide coverage, to the point that we're still able to provide a plan that we pay 100 percent of the premium cost for our employees.

Mr. BUCHANAN. And then let me—Mr. Eakin, one other thing I touched on earlier today—I had to step out. But we have people that have talked to us about this medical tax. And I think one of our surgeons mentioned something about that. Many of them are telling me that they're going to pay more in tax than they will even make in profit, this 2.3 percent tax.

The fact of the matter is there is—the medical device industry has about 400,000 employees in the country, and another—indirectly, about 2.5 million people—2 million jobs that's being created. And they said if this tax goes into effect, it's going to really impede their ability to grow their companies. Do you have a thought on that?

Mr. HOLTZ-EAKIN. Well, as I laid out in the testimony, there are only a couple of possible outcomes. Number one, they eat the tax, but they don't have the financial resources to do it, so they will probably go out of business. Number two, they take it out of employee costs. That means lower wages, fewer jobs, bad for strug-

gling labor market. Or, number three, you pass it on to consumers in the form of higher prices. If medical devices are more expensive, insurance is going to be more expensive, and the problems of employers get multiplied.

And, as I mentioned, there is a perverse aspect of these taxes in the bill, which is that they're not deductible. So, to just break even, if you have $1 of tax, you have to have $1.54 in additional revenues. So you have to raise prices a lot, and that's a big pressure upward on premiums in this law.

Chairman CAMP. Thank you. The gentleman's time has expired. Mr. Pascrell is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman. I want to just respond first to Mr. Buchanan's remarks. What you have described is unsustainable, the exact situations which you have described.

Between 2007 and the passage of health reform, I had many small businesses—I have a small business advisory committee. And the increase in their health cost was between, on average, 28 to 40 percent a year. Health care reform, or as some on the other side would like to refer to it, Obamacare—and they say it with such love and charity—you can't sustain those numbers. I don't mean you, personally. We can't.

And those businesses, 60 percent of them, are no longer doing any business. They're done. The primary cause of those businesses closing their doors—the primary cause; there are other causes—is what they have paid in their premiums.

And I want to talk to you, Mr. Olivo, fellow Jersey guy. What's interesting, I read a little bit about what you said, because I came in a few minutes late. But I want you to think about this. Ninety-five percent of businesses are exempt from employer responsibility requirements. I just wanted to start with that.

Now, I think there is a possibility—I'm not saying this is guaranteed or for sure—that it sounds like your carrier might have pulled a fast one on you, and I will tell you why. When they raised your rates and lowered your benefits last year—by the way, that's not unfamiliar to any of us—and we were a good scapegoat. Obamacare was the perfect scapegoat before it even went into effect. "We'll blame this bill, which will become an act, on whatever we do this year." You saw what happened in California. It's a scapegoat. And we expect that. We're all big people, we understand what happens in a political debate.

You stated that your insurance carrier informed you that they would be—not be renewing your high-deductible coverage due to the preventative health benefits in the new law. Are you aware of the fact that the new preventative benefits don't apply to plans such as yours that are grandfathered? I would ask you—I ask that rhetorically. I just want you to think about that.

And are you aware that the new—the IRS rules, not the new IRS rules—permitted high-deductible plans to waive the deductible for preventative services, even before reform was enacted?

You know, I get a charge—I get a big charge—out of listening to folks tear this thing apart. Someone on the panel made this statement in a magazine that, "The elimination of denial of coverage for pre-existing conditions, and the elimination of the lifetime limit,

those things drive up costs. Premiums are going to go up in the short run if we don't take into consideration pre-conditions."

This is a battle. There is no question about it. We battle civilly here between what the insurance companies want out of this and what the patient really needs, so we can really drive down the cost.

We agree over the last 10 years premiums have skyrocketed. You and I both agree with that, two Jersey guys here. Families face bankruptcy due to medical bills. We agree.

Mr. OLIVO. Certainly.

Mr. PASCRELL. Okay. And competition decreased—I go through each state—in the insurance industry. In fact, you know, the average state, there are two or three people, companies, writing insurance. That's a good situation. Not for us, but for somebody else.

I haven't heard any response about those kinds of things. And why should you? You've got a script. Let's follow the script. The number of uninsured individuals grew that now, 1 in 5 young Americans under the age of 65 are uninsured. Those are the numbers from the Kaiser Foundation. These conditions are not ideal.

Nine months after health care reform, I am proud to say that change is already underway. And I would conclude my remarks that if health care reform is bad for business, why have over 120 businesses in my state, New Jersey, received grants to support groundbreaking biomedical research on pancreatic cancer, brain injury, Alzheimer's, and more? This money supports jobs.

Well, I have 150 employers in my state enrolled in the early retiree reinsurance program. Cities like Newark, Paterson, Clifton, all enrolled. And even big businesses, such as Johnson & Johnson, Mercedes Benz are enrolled in the program.

Chairman CAMP. The gentleman's time has expired.

Mr. PASCRELL. They see the benefits.

Chairman CAMP. Thank you for concluding.

Mr. PASCRELL. And I thank you, the panel, for telling us——

Chairman CAMP. Mr. Smith is recognized for five minutes.

Mr. PASCRELL [continuing]. What you did.

Mr. SMITH. Thank you, Mr. Chairman, and thank you to the panel for sharing your expertise and insight. Mr. Holtz-Eakin, if you could reflect a little bit on uncompensated care, is it conceivable that even Medicaid would fall into a category that a hospital would perceive to be uncompensated care?

Mr. HOLTZ-EAKIN. Yes, there are two large forms of cost-shifting in the insurance industry. One is from uncompensated care, the traditional someone walks into an emergency room uninsured, gets care, and has to be covered somewhere, and the second is the shifting from government programs, where Medicare pays about $.70 on the dollar, relative to private insurers, and Medicaid pays even less, roughly $.50 to $.55 on the dollar, depending on where you are. And those gaps have to be made up elsewhere, as well. So, those are shifted under private health care costs.

Mr. SMITH. And, I mean, is it your assertion as well that the health care bill does immensely grow the Medicaid rolls?

Mr. HOLTZ-EAKIN. Half of the coverage expansions come through Medicaid expansions. Sixteen million Americans will be put into a system that involves considerable cost shifting on to private insurance, and which, at present, they are twice as likely to

go to E/R's, instead of having that care on a regular setting, and where they can't find a—particularly a primary care provider at anywhere near the rates other people can.

Mr. SMITH. Would it be conceivable that any federally initiated medical liability reforms, that they might pre-empt some state medical liability laws?

Mr. HOLTZ-EAKIN. There is the option always for federal pre-emption. And so it would depend on how the law was written. But we do know that state-level experience has shown that a variety of different malpractice reforms have been effective at controlling some of the costs, and that if you had a strong federal pre-emption that applied universally, you would have a much bigger impact.

Mr. SMITH. I say that because I am a little bit nervous that Nebraska might lose its rather optimal scenario, given its medical liability——

Mr. HOLTZ-EAKIN. Draft carefully, sir.

Mr. SMITH. Duly noted. And I appreciate the business perspective shared here this morning, as well, certainly reflective of many of my constituents, some of whom have said they have held off hiring new employees, simply because of the unknowns contained in the health care bill.

So, with that, in the interest of time, I will yield back. Thank you.

Chairman CAMP. Thank you very much. Mr. Schock is recognized.

Mr. SCHOCK. Thank you, Mr. Chairman. I too will be brief. I have questions for the business owners.

You know, last year the President said his major focus in 2010 would be jobs. In 2011, last night in the State of the Union, he said his major focus will be jobs. So, as two employers, I'm kind of curious, specifically with regards to how the health care bill is going to affect jobs, particularly those opportunities for the young people in America who rely on part-time employment through their high school and college years to supplement their income to pay for education, which the President talked about last night being so important to America's competitiveness in getting long-term gainful employment for their futures.

Scott Womack, you mentioned that you have 800 employees. And I'm wondering if you have studied this bill—which it sounds like you have—the effect on what this will mean for your ability to hire part-time employees, considering the bill really, from what I'm hearing from my employers in my district, almost incentivizes doing away with part-time employment, and really consolidation of the number of employees you have.

Is that what you've found? Or how do you see, if this bill is implemented as it stands now, will affect the employment opportunities you can provide?

Mr. WOMACK. Well, thanks for the question. Actually, it incentivizes moving people from full-time status to part-time status. That part-time and hourly job market right now is absolutely saturated with people, people who are not working.

So, the reality is that we will be looking to get people under that 30-hour threshold, wherever we can. So I don't see it helping at all.

Mr. SCHOCK. And of the 45 employees who are full time that you offer health insurance to, how many of those 45 take your health insurance?

Mr. OLIVO. That would be my company. Currently, out of those 45, I believe it's approximately 30 take the coverage.

Mr. SCHOCK. And do you know the other 15, do they not take it because their spouse or someone else offers——

Mr. OLIVO. That is correct. No one in my company is uninsured.

Mr. SCHOCK. So it's not too bad that 30 out of your 45 seem to think your health care is a preference, and using the term in the bill, is "adequate" coverage.

Mr. OLIVO. Yes. Their biggest complaint would be—is the cost of the premiums on the family side. But, yes, the coverage is great. They feel it's very fair.

Mr. SCHOCK. Do you know if your health care coverage that you offer now is going to meet the minimum standard in the new law for adequate health care coverage?

Mr. OLIVO. The coverage that we offered in 2010 will not. We have already been notified of that, because of how preventative care is treated.

Mr. SCHOCK. And how much do your agents or your third-party administrators suggest—how much will your insurance premiums increase to meet the new standard?

Mr. OLIVO. We just got our premium increases in the other day. It's a 12 percent increase in premium, but also a significant increase in how emergency room visits are treated. It's much more costly to go to the emergency room, significantly more.

Mr. SCHOCK. And so, what will the cost per premium, on the average, be for you?

Mr. OLIVO. For an individual, the cost per premium in the coming year will be approximately $280 per month per individual.

Mr. SCHOCK. Have they looked at what the—when the bill is fully implemented in four years, what it will cost for you to be able to provide that minimum adequate health care coverage, as specified by the law?

Mr. OLIVO. I have no way of computing that at this point.

Mr. SCHOCK. Oh. I would ask your third-party administrator to do that, because I'm sure they're doing that.

So, thank you very much for your comments here today.

Chairman CAMP. Thank you. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman. I want to thank our panelists for their testimony here today.

Mr. Chairman, from my perspective, I think today's discussion is very healthy, and I would encourage you to hold more hearings in regards to the Affordable Care Act, because there is some belief out there that with the passage of the Affordable Care Act, that somehow the discussion ends, and it doesn't, that somehow the work ends, and it shouldn't. I think we will be judged, ultimately, in this congress and future congresses, by working hard to find out what's working in the health care system and what isn't, and making adjustments along the way.

So, getting testimony like this, and feedback in regards to the shortfalls which all of us are trying to accomplish, I think it's going to be helpful.

But there has been a lot of discussion in regards to job creation, and what the Affordable Care Act means in that regard. Now, let's just recall. We've had 11 consecutive months of private sector job growth in this economy, since the passage of the Affordable Care Act. We have had 1.1 million new private sector jobs that have been created. Over 207,000 of that is in the health care industry, alone.

And I don't know how many of you saw a recent Forbes article that was printed in the Forbes magazine, but a recent article in Forbes highlights how small business tax credits in the reform law are already helping small employers deliver health care coverage to their employees. According to Forbes—we'll just look at the facts, here—insurance companies are reporting a significant increase in small businesses offering health care benefits to their employees.

For example, United Health Group, the nation's largest health insurer, added 75,000 new customers working in businesses with fewer than 50 employees within the last year. Coventry Healthcare, a large provider of health insurance to small businesses, added 115,000 new workers in 2010, representing an 8 percent increase. Blue Cross Blue Shield of Kansas City, the largest health insurer in the Kansas City area, reports an astounding 58 percent increase in the number of small businesses purchasing coverage in their area since April of 2010.

Repeal of the Affordable Care Act, as my colleagues last week voted for, would entail the largest tax increase on small businesses in our nation's history—16,000 small businesses in western Wisconsin alone will see their taxes go up, who are today benefitting from these tax credits under the Affordable Care Act. Over four million small businesses nationwide are taking advantage of the tax credits, so they can better afford health care coverage for their employees.

And what's ironic—and, Mr. Olivo, I appreciate your testimony here today—but the health insurance exchange that we're setting up for small businesses and for family and individuals was based on the "shop act" that I, in a bipartisan fashion, had introduced in previous years that NFIB endorsed. The creation of an exchange, so small businesses finally have a chance to go and shop with complete transparency, so you know what the costs are and what the benefits would be, coupled with tax credits, which we did in the Affordable Care Act, is something that small businesses have been calling for for years. And it's part of this bill right now.

But I think, ultimately, we are going to be judged on whether this works or not, depending on whether we have the ability to bring costs down.

And here is another bipartisan idea that's in the bill. We have to change the way we pay for health care in this country. It's as simple as that. The current fee for service system under Medicare is all based on volume payments, regardless of results. This is crazy.

And right now we have an Institute of Medicine study, two-year study as part of the reform bill, that calls on them to change the fee-for-service system to a fee-for-value reimbursement system. They will present an actionable plan to the Administration, the IPAB Commission, to implement. And this is something that Newt

Gingrich has been talking about for years, that Dr. Frist is still talking about today. Tommy Thompson at HHS told me that if we do one thing with health care reform, change the way we pay for it, starting with Medicare. Because whatever we do in Medicare is going to drive the private health insurance market.

But it goes even beyond that. Health insurance companies from East Coast to West Coast have been calling for payment reform for years. Large providers, which are models of health care delivery systems, highly integrated, coordinated, patient-focused, from Innermountain to Mayo to Geisinger to Cleveland Clinic to Gundersen to Marshfield have been calling for this very thing that we finally have the tools in health care reform to accomplish. We start with accountable care organizations in the innovation center, telling providers, "We want you to be creative, we want you to innovate, we want you to deliver high-quality care at a better cost." This is where we need to drive the health care system.

But ultimately, if we stick with the fee-for-service system under Medicare, we will bankrupt our nation, because we will never be able to keep up with the cost, all based on volume payments, regardless of quality, regardless of outcome. And this is crazy. We finally have the ability now to do something about it, if we play it through. You don't change the way you pay for one-fifth of the U.S. economy overnight. It's not going to happen. It's going to have to be transitioned. And we instituted that in the reform bill, as well.

So, I would hope that we will have a chance to come together in a bipartisan fashion again, talk about the payment reform, which can really lead to cost reduction for everyone, so that health care is something that will be affordable to businesses large and small, and to individuals throughout this country.

Chairman CAMP. Thank you.

Mr. KIND. Thank you, Mr.——

Chairman CAMP. Thank you. Mr. Lee is recognized.

Mr. LEVIN. We have to vote, don't we?

Chairman CAMP. Yes.

Mr. LEE. Thank you, Mr. Chairman, and I want to thank our panelists for being here. I can't help but be a little skeptical, after hearing the President's State of the Union Address, as well as the first panelist, Mr. Goolsbee's testimony, when it comes to the reality of this health care bill that we're dealing with.

If you remember last night, the President talked about in his speech with the dysfunctionality of our government when he used the example of the Interior Department is in charge of salmon when it's in fresh water, but when it's in salt water it's the Commerce Department, and if it's smoked, God knows where.

Ironically—and I would ask this to Mr. Holtz-Eakin—isn't it true that this new health care bill will, in fact, create upwards of 160 new agencies, bureaus, and commissions? So, in effect, he is actually adding to the problem, rather than fixing it?

Mr. HOLTZ-EAKIN. The exact number has always been hard to figure out, but that's a safe guess.

Mr. LEE. I agree completely. The other point, too, as you brought up now, the issue of the 1099. It is very apparent, in my eyes, that this was more or less a cash grab. This was put into the bill—if you're a small business owner and you do not have an accurate tax

ID number, you're on the hook, and have to withhold 28 percent, as the small business owner.

Again, these are huge costs on someone who is trying to get by day in and day out. And I am learning from both Mr. Womack and Olivo, that, in your mind, this health care bill, is it more likely or less likely for you to go out and hire people at this point?

Mr. WOMACK. Well, without a doubt, it's created a tremendous amount of uncertainty. And it's frozen credit markets, as far as restaurants go. Those are just now starting to loosen up. But as we get closer to this, and the implications become more clear, credit markets are going to freeze up, it's going to be harder to borrow money to build new restaurants.

The other thing is that, as I stated earlier, the only way to pay for this in our business is to cut costs. And we are a lean, mean industry now. We don't have a lot of fat. And the things that we can control are payroll, and to minimize the impact of these penalties. So that means cutting jobs. It doesn't mean adding jobs.

Mr. LEE. We're getting to the tipping point where risk reward no longer makes sense for someone to go out, as a small business owner, and take his dream and go out and start a business.

The other—maybe I can bring this back to Mr. Holtz-Eakin, with regards to Medicaid, I have the luxury of living in New York State, which has, far and away, the highest Medicaid expenses. I think if you compare it next to equivalent states like Florida and Texas, where their economies are doing relatively better, the same number of citizens living in that state, but literally twice the Medicaid expenses.

With the passage of this bill, ultimately, is it going to increase or decrease the Medicaid costs that we're seeing in New York State?

Mr. HOLTZ-EAKIN. I think the states are at great risk. They are obligated to honor the expansions under the Affordable Care Act. They may get additional payments from the Federal Government for that, but they have to pay full freight on any current eligibles who now show up and take up benefits. And I think the real risk is that, in advertising the Affordable Care Act, we're going to draw out of the woodwork a lot of existing eligibles, and New York State will have to pick up their full share of their cost.

Mr. LEE. At a time where to start a small business in New York State, it is a huge obstacle. And, again, I—as someone who has run a small business, I just see this as a further death knell for the creative side of what made this country great.

And I would say the same thing deals with the medical device tax. When we are trying to—I come from manufacturing. When we're—the President spoke again, the contradiction of talking about in helping businesses thrive, we're going to go now and add a tax onto a business.

Again, Mr. Holtz-Eakin, in your view, is this going to help our manufacturers in the health-related device industry compete? Is it going to help or hurt them?

Mr. HOLTZ-EAKIN. This is an additional cost for our device manufacturers on the international market. It's going to hurt their competitiveness.

It's also one of many taxes that, if you just look at pure macro economics, the evidence is that discretionary tax increases—of exactly this type, things that have nothing to do with the business cycle, you just do it for other purposes—the evidence of Christie Romer, the former chairman of the Council of Economic Advisors, is that they are three times more detrimental to the economy than equivalent spending changes.

So, if you look at this act as a whole from that perspective, the tax increases' negative impacts far outweigh any possible benefits of the spending.

Mr. LEE. Thank you.

Mr. HERGER. [Presiding.] The gentleman's time has expired. The gentlelady from Tennessee, Ms. Black, will inquire for five minutes.

Mrs. BLACK. Thank you. Thank you again, panel, for being here. It looks like I'm the last one here, but the audience will still hear this question. And all of you can answer this question, but I think, Mr. Womack, you particularly talked about health care savings accounts.

And continuously, the Administration has claimed that the health care law is giving Americans more freedom in their health care choices. And, in reality, this law is really going to force many Americans to buy a product which is a government defined health care product. In addition to that, he, President Obama, also promised that the American people, if they liked their current health care insurance, they would be able to keep it.

But as we see in the law, it will limit the use of health care savings accounts. And being in the medical field for a number of years—40 years now—I think that one of the things that we have seen that has driven the cost of health care up is that we have taken the consumer out of the driver's seat, and they are not making choices.

And I was very excited about maybe expanding this product, because it would give an opportunity to put somebody back in the seat that wants to be in the seat, and it would also give more opportunities for different vehicles, rather than a set type of insurance that most employers do have and offer to their employees.

Mr. Womack, I think you're the one that mentioned about health care savings accounts, and all of you certainly can respond about where you feel that this might help companies, if they were given that choice, to use those as compared to being forced into a certain product or a certain type of care.

Mr. WOMACK. Thank you. And I am a Knoxvillian, believe it or not.

Mrs. BLACK. Oh, great.

Mr. WOMACK. Yes, nice to see you. We were faced with huge premium increases last year. And I can't remember the number, because we were bidding and we saw so many different numbers, but it was in the neighborhood of 30 percent. And so, we decided to go ahead and look at an HSA, and we did begin to offer an HSA as an option to our managers.

And I have my own HSA story. My wife had an MRI ordered recently by the hospital, at a cost of $1,100. And someone said, "You need to shop that around." And so we went out and into a diag-

nostic facility, literally just down the road, and got the same procedure for $350. Truthfully, I don't know that we would have even thought about that, had we not been using an HSA, where we were spending the money out of our account, ourselves.

So, it's that type of story that gets told over and over and over in HSAs. They're just a huge benefit. When you put the individual more in touch with their own spending, they will find ways to control it. And they get to keep that money in the account and roll it forward. And it's just—it's a beautiful plan that should not be impeded. We shouldn't do anything to hamper HSAs. Thanks for the question.

Mr. OLIVO. I would say, very quickly, I have a similar story. We put the health savings accounts in six years ago, and the first year the employees resisted it, did not like it. But, over time, they have grown to appreciate. Those that take care of themselves have seen their savings accounts grow.

And I, too, have seen instances where employees had exams or scanning type of tests to be done, and were able to go online and literally save a couple thousand dollars because they were able to research it themselves, and there was an incentive there to do so.

Mrs. BLACK. Yes, Mr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. Yes?

Mrs. BLACK. Do you have a comment?

Mr. HOLTZ-EAKIN. Oh. Well I don't have the business experience of these gentlemen. But certainly in the alternative reforms that were envisioned in the debate leading up to the Affordable Care Act, one version is to put consumers at the centerpiece of this one-fifth of the economy, in the same way that they have driven the other four-fifths, to be the largest, strongest, economy on the planet. And then, you know, require insurers and providers to compete in price and quality. And that's a very different vision than what we see in this law.

Mrs. BLACK. Thank you. I yield back my time.

Mr. HERGER. The gentlelady yields back. The gentleman from New York, Mr. Rangel, is recognized for five minutes.

Mr. RANGEL. Thank you, Mr. Chairman. And let me thank this panel for sharing with us the problems that you're having with this legislation, especially those of you who work every day in dealing with employees.

Tell me. Both of you, and certainly the Chamber, advocate repeal of the law that the President signed. Is that correct?

Mr. WOMACK. Yes, it is.

Mr. RANGEL. And you don't have a plan that you're recommending. Do you—strike that.

You think that we're better off without any changes in the law, than to enforce or to amend the existing law?

Mr. OLIVO. I could say from my vantage point, as a small business owner, that for—I look at it as action/reaction. For Congress—what Congress has passed, I'm seeing far more significant reactions to any positive that this will bring to my employees.

Mr. RANGEL. I can understand that. But my question—and I don't have any experience at all in hiring employees—is that, as a business man—and I know you can't speak really on this issue, Mr. Womack, for the Chamber—but for yourself, with your businesses,

you would rather see the government just stay out of it, rather than to amend or try to correct the existing law. Is that your position?

Mr. WOMACK. Oh, I guess I've gotten used to the government being in the middle of things, and I don't say that sarcastically. We anticipate some sort of change——

Mr. RANGEL. Do you have—I'm concerned what happens if we just stop this, and—are all of your employees, one way or the other, covered by some type of health insurance?

Mr. WOMACK. I don't believe so. And——

Mr. RANGEL. So you do have employees that are uninsured that you would want to see insured, as anybody would, just—right?

Mr. WOMACK. Absolutely. But the problem is——

Mr. RANGEL. Do you have any idea as to how you would want to insure these people that are uninsured, other than what has been recommended and passed by the Congress?

Mr. WOMACK. No. And the reason is very simple. We're talking about more money than is available. We don't have the money.

Mr. RANGEL. And so—listen. The problem we're facing—there is sharp differences of opinion here. The National Business Group on Health indicates that they don't think they can get a better solution to the problem I mentioned during their lifetime, during our lifetime. If they get repeal, or gut it, we will have to start all over again, and we'll be worse off.

And so, I think, generally speaking, every nation truly believes that access to health care is important for the strength and security of the country, and that our workforces should be better educated and be exposed to preventative care and health care. You want that. You're just saying that you can't afford it.

Mr. WOMACK. Absolutely.

Mr. RANGEL. Well, our job is to say that, one way or the other, the government is going to make certain that it is affordable. We consider that as a national obligation and goal. All industrialized countries do it, not because of compassion, but even in the question of competition we do believe that an educated workforce and a healthy workforce is more productive.

I can understand how you cannot afford to do what basically you would like to do. But you just can't leave those people out there hanging that have no insurance at all. When we find out that personal lives and families are shattered, bankruptcies, not because of you, and not because of the employee that faces serious illness. So, if you wanted to help them—and I truly believe you do—it doesn't help the family to say, "Hey, my boss is great, he just can't afford to help me out in this crisis." No.

I believe, and a lot of people disagree, but I truly believe we have an obligation to at least give access to health care, one way or the other. And if you don't like this way, I really believe you have some type of an obligation as business people that have the experience that we don't have, generally speaking, not just to leave these people out there, hanging.

And to say that no insurance is better than what we have, I don't really think that's a legitimate—I don't think it's fair to us to say all the things we've done wrong, and not have any positive sugges-

tions that we can take care of those employees that you want to take care of.

Mr. WOMACK. Well, Mr. Rangel—and this is a dilemma that's been discussed for years. And so, you know, I don't take any offense to your comments. The problem——

Mr. HERGER. The gentleman's time has expired. If we could sum up very quickly.

Mr. WOMACK. Okay. The problem is that, in a nutshell, the only solution—if you ask the employers in our industry—and I will just speak for my industry—if you ask for employers from my industry to pick up that burden now, it's a crushing, complete disruption of our industry, and we can't turn on a dime.

Mr. HERGER. The gentleman's time has expired.

Mr. WOMACK. Thank you.

Mr. HERGER. I want to thank Mr. Holtz-Eakin for testifying. I understand you have a previous engagement you need to leave for.

Mr. HOLTZ-EAKIN. That's correct, Mr. Chairman.

Mr. HERGER. And if any of our members have any further questions for him, they could submit that in writing, and——

Mr. HOLTZ-EAKIN. I would be delighted, and apologize for having to excuse myself.

Mr. LEVIN. Mr. Chairman.

Mr. HERGER. Yes? The gentleman is recognized.

Mr. LEVIN. Before you go, Dr. Holtz-Eakin, I am going to send to you some inquiries about the forum. And I would like very much if you could respond.

Mr. HOLTZ-EAKIN. I would be happy.

Mr. LEVIN. You're a sister organization, as I understand it, of the American Action Network.

Mr. HOLTZ-EAKIN. That is correct.

Mr. LEVIN. Let me just finish. I want to tell him what I'm sending him. I was told he was going to be here until noon.

And so, as I said, I think your website and that of the network says you're sister organizations.

Mr. HOLTZ-EAKIN. Yes.

Mr. LEVIN. And we know the action of the network.

Mr. HERGER. If the gentleman could conclude——

Mr. LEVIN. I will conclude very quickly.

Mr. HERGER [continuing]. Dr. Holtz-Eakin has indicated that he will respond by letter, so——

Mr. LEVIN. I want to let him know in advance.

Mr. HERGER [continuing]. The gentleman from Michigan will have his inquiry answered. So——

Mr. LEVIN. Okay. So I just want you to know, so it doesn't take you by surprise. I am going to ask you if you will reveal the sources of the income of the forum. Will you do that?

Mr. HOLTZ-EAKIN. I will comply with the bylaws with the forum and with the U.S. tax laws. And I——

Mr. LEVIN. I

Mr. HOLTZ-EAKIN [continuing]. And I will get your questions, look at them, and do——

Mr. HERGER. The gentleman will respond——

Mr. LEVIN. Will you disclose——

Mr. HERGER. The gentleman's time has expired. The gentleman from Georgia——

Mr. LEVIN. Why don't you let him finish?

Mr. HERGER [continuing]. Mr. Price, will inquire for five minutes.

Mr. PRICE. Thank you, Mr. Chairman.

Mr. RANGEL. Wow.

Mr. PRICE. And I apologize for not being here earlier. And I am sorry that Mr. Holtz-Eakin has to leave, but I wanted to just make a comment about some of the taxes in the provision that are stifling the innovation.

The medical device tax, as we all know, when you tax something you get less of it. And the medical device tax, I believe, and many believe, that that increase in taxation there will significantly decrease innovation and affect remarkably high-paying jobs that have wonderful benefits to our society. And I think that that's a direction that we ought to look at. The estimates are that a 2.3 percent increase will be passed on to the consumers, either directly or indirectly, also.

So—but I appreciate Mr. Olivo, Mr. Womack being here, and I want to talk a little bit about the consequences. Maybe, Mr. Olivo, if you want to just talk about your business itself, this bill has all sorts of requirements and stipulations and mandates that every single business in this country, employer in this country, has to look at.

What have you—how much time have you spent in trying to make certain that you are going to be able to comply? What kind of costs have you expended to try to make certain that you will be able to comply? And what incentives are—is the bill providing you that might not be necessarily beneficial to your business, itself?

Mr. OLIVO. I have personally spent hours of time that I could better spend managing my business reading the health care bill. I haven't read it in its entirety, but interpreting it and using the resources I have with the business organizations like NFIB, in trying to interpret how it's going to affect me.

Your question was as far as exactly what the——

Mr. PRICE. And what have you determined? How is it going to affect you?

Mr. OLIVO. Just at every level. Just my concern about hiring a new employee, the cost that goes into hiring a new employee is not just his wage. The health care costs are such an integral component of what it costs me. And when that's unknown, and when there is all this legislation hanging out there, it really makes me more conservative and say, "Maybe I don't need that employee at this point in time."

Mr. PRICE. So the continued uncertainty, and the potential rules and regulations that will be passed on, leave you less able to expand your business or to hire new employees. Is that an accurate statement?

Mr. OLIVO. Without a doubt.

Mr. PRICE. Great. Mr. Womack, I know that my sense has always been that there are some perverse incentives within the bill itself that make it so that employers look at the situation and they say, "It's going to cost me more to provide health coverage for my

employees. Why should I do that? Shouldn't I just let them fall into the exchange?"

Are you hearing that from your members? And I wonder if you might expand on whether or not that is an accurate——

Mr. WOMACK. Oh, absolutely. And, of course, again, we can't afford the coverage. So we are absolutely going to have to look at the penalties. We have a real concern that our insurance companies that we've talked to are not going to allow us to continue to offer the coverage to our salaried staff, based on rules very similar to 401(k) rules regarding highly-compensated employees.

So, that means that, really, through a whole other avenue, we either offer insurance to everyone, or drop it. We have 50 families on health insurance now in our company, and it's an important part of what we offer as a benefit package.

Mr. PRICE. So the statement that we heard throughout this whole discussion, "If you like what you have you can keep it," may not necessarily be true in your business. Is that accurate?

Mr. WOMACK. Sure, absolutely.

Mr. PRICE. Would you expand, or do you have any thoughts on the incentives for other businesses, small businesses, to move individuals, their employees from the coverage that they currently have to the exchange?

Mr. WOMACK. Well, I measure that penalty, really, at $2,800, because $2,000 is not tax deductible. You have to account for the taxes you pay on the income to pay the penalty. So it's really more like $2,800. I cannot imagine that in the board rooms across the U.S., that people are looking at, you know, a $15,000 premium for an employee, or $2,800.

You know, very quickly you do the math, and you're going to opt to drop that coverage. And it may not be just that simple math, it may be some sort of an event where, you have an issue with an insurance company, or you have a 40 percent rate increase, and finally—enough is enough.

Mr. PRICE. In fact, aren't you almost, in the real world, obliged to drop that coverage, because your competitors will do so and then you're at a competitive disadvantage? Is that an accurate statement?

Mr. WOMACK. I would say that offering insurance is a significant benefit that helps make us more competitive. So we always want to offer the insurance, and we just can't afford it.

Mr. PRICE. Thank you.

Mr. HERGER. The gentleman's time has expired. The gentlelady from Kansas, Ms. Jenkins, is recognized for five minutes.

Ms. JENKINS. Thank you, Mr. Chairman. Thank you both for being here.

On a panel before you we had the chairman of the Council of Economic Advisors, Dr. Goolsbee, testify. And during his testimony, I noted that he said this. "The Affordable Care Act has already begun to help small business become more competitive by making health insurance more accessible and more affordable."

Mr. Olivo, you're a small-businessman. Could you give me an example of how the act has helped you—has already begun to help you become more competitive?

Mr. OLIVO. Unfortunately, I could not give you an example. All I can tell you is that our existing insurance, which the employees liked the coverage, is no longer available. And our insurance premiums have continued to rise in a double-digit percentage for the coming year.

Ms. JENKINS. Okay. If they haven't, in fact, already begun to, can you give me an example of how you will see them—how you expect them, in the future, to cause you to have a more competitive health insurance and an accessible and affordable plan?

Mr. OLIVO. I don't see how it's going to be—help us offer a plan that's more competitive. My concern with the exchange is that they're not true exchanges in the form of competition. They're still heavily mandated types of policies. So there is not real, true competition.

Living and residing and working in New Jersey, we have the—I believe it's the third highest insurance rates in the nation. We have had guaranteed access, a community-rated plan since 1993. And I can tell you from that point, when that law was instituted—I've been running the company since 1988—I have seen a direct correlation with our health care cost beginning to rise from when that guaranteed access was put into place.

So, I just don't see anything that's going to make the premiums less expensive.

Ms. JENKINS. Okay. Also in Dr. Goolsbee's testimony he said this. "The Affordable Care Act can be a significant benefit to the job market, by easing the burden of health care costs on small businesses."

So, once again, as a small-business man, I was hoping you could tell us approximately how many jobs that you will be able to create, thanks to the savings that you will incur.

Mr. OLIVO. And I can say, for my company specifically, at 45 employees, we are not eligible for any sort of tax credit which I believe he was referring to.

Ms. JENKINS. Okay, thank you. Mr. Womack, I was home in my district last week, and visited several major employers who have over 50 employees. And there was a consistent message that I was receiving this day, that they were frustrated with the regulations coming about, due to this bill.

And one in particular that they mentioned was that they were being required to provide lactation rooms if they employed more than 50 employees. And several of them were concerned, they had multiple locations, one location only had three men working at it—if they were required to provide a lactation room for those three men, because, overall, their employees had totaled more than 50.

I just wondered if you had any concerns about this particular regulation, or others within this bill.

Mr. WOMACK. Well, I do now. Thank you for informing me of that regulation. I wasn't aware of that. And, of course, no surprise. There are so many things buried in the law that, you know, we don't seem to be aware of. I don't know how to react to that one in particular.

But, this layering on of all these little things, I mean, they just go on and on. It creates a tremendous amount of uncertainty and,

you know, quite frankly, depression amongst the business community, just wondering how we're going to keep up with it all.

Ms. JENKINS. Is there any estimated cost for your business to meet all of these? I guess you probably can't—if you didn't even know about this one, you probably don't know about others to really adequately estimate——

Mr. WOMACK. You know, we're looking at that big bill, and we're not counting the small ones right now. The big bill is frightening enough.

Ms. JENKINS. Okay. If the Affordable Act isn't getting it done for you, the Republicans had an alternative bill, and we had TORT reform, expanded FSAs, HSAs, purchasing across state lines, access pools. What other ideas do you have for us?

Mr. HERGER. The gentlelady's time has expired.

Ms. JENKINS. Thank you, Mr. Chairman. I yield back.

Mr. HERGER. I recognize the ranking member, Mr. Levin, for five minutes.

Mr. LEVIN. Thank you very much. And we really appreciate your coming. I regret that Dr. Holtz-Eakin had to leave, and I am sending him a letter today. And since this was a public hearing, I will make that letter public. And I expect him to give us an expeditious response.

But again, I very much respect your different views. Everybody brings different experiences, and we need to tap into them. So, let me ask you, Mr. Womack, how many employees do you have?

Mr. WOMACK. Approximately 900.

Mr. LEVIN. And how many of them have insurance?

Mr. WOMACK. About 50.

Mr. LEVIN. And all of the 50, are they in a certain category or two of work?

Mr. WOMACK. They are either salaried management people or office staff.

Mr. LEVIN. So, none of your employees who aren't in management or in office staff have health insurance through their work?

Mr. WOMACK. That's correct.

Mr. LEVIN. You would be required to provide health insurance under this new law?

Mr. WOMACK. Correct, or pay the penalty.

Mr. LEVIN. Or pay the penalty. So your 800 or so are part of the 50 million who have no health insurance in this country?

Mr. WOMACK. That's correct.

Mr. LEVIN. Have you inquired into what the cost would be to insure them?

Mr. WOMACK. Yes, I have run those numbers many times.

Mr. LEVIN. And you find it too expensive?

Mr. WOMACK. It's much more than we earn.

Mr. LEVIN. And so, therefore, trying to get control of health care costs would be potentially helpful to you, in terms of having your employees covered?

Mr. WOMACK. Absolutely. The problem is the number has grown to a size where, even if you cut it in half, which is not going to happen, but even if you cut that number in half, it's beyond our ability to pay.

Mr. LEVIN. How many of them, do you know, are covered by some kind of a public program?
Mr. WOMACK. I have no idea.
Mr. LEVIN. You know what percentage are women?
Mr. WOMACK. Not off the top of my head, no, sir.
Mr. LEVIN. Just roughly?
Mr. WOMACK. I'm going to guess roughly half.
Mr. LEVIN. Do you know what happens when they get ill?
Mr. WOMACK. They go seek treatment, and you know, at a local provider, and they get treatment.
Mr. LEVIN. How do you know they get treatment?
Mr. WOMACK. Well, we hear the stories.
Mr. LEVIN. You don't have any systematic way of knowing?
Mr. WOMACK. No.
Mr. LEVIN. They go to emergency rooms?
Mr. WOMACK. Probably, or their local doctor.
Mr. LEVIN. And they go to a local doctor who doesn't charge them anything?
Mr. WOMACK. No, they go to a local doctor that does charge them something.
Mr. LEVIN. What's the average wage of your non-salaried, non-office employees?
Mr. WOMACK. It's approximately $9 an hour.
Mr. LEVIN. Okay. Mr. Olivo, you have a high-deductible plan?
Mr. OLIVO. That is correct.
Mr. LEVIN. What's the deductible?
Mr. OLIVO. Well, it varies. I mean—well, I—roughly, within $100 I would say. The current deductible for an individual is $1,500, and for a family it's $3,000.
Mr. LEVIN. So they pay the first $1,500——
Mr. OLIVO. The first——
Mr. LEVIN [continuing]. Or the first——
Mr. OLIVO. That's——
Mr. LEVIN. $3,000?
Mr. OLIVO. Correct.
Mr. LEVIN. I have no further questions.
Mr. HERGER. The gentleman yields back. I now recognize for five minutes the gentleman from Minnesota, Mr. Paulsen.
Mr. PAULSEN. Thank you, Mr. Chairman. And, first of all, let me just thank both of you for taking the time to come in here and share your small business background and experiences, and go through a pretty lengthy hearing.
I just want to touch on something, because I know Mr. Holtz-Eakin had to leave, but you know, last night the President said that we do need to be a nation of innovators and a nation of leaders. And during this speech he reminded us of what it takes to compete for jobs and for industries. And, as entrepreneurs, I'm sure you can appreciate that especially.
But he did say, and I agree, we need to out-innovate, out-educate, and out-build the rest of the world. We have to make America the best place on earth to do business. And there is one American industry I have to mention, because it's a Minnesota success story as well, and that's the engine of innovation and growth in the health care field. It's medical devices.

And we heard from some other Members earlier about that, and the medical technology industry. And that's an industry that employs about half-a-million individuals, and routinely revolutionizes patient care. And, unfortunately, the health care law does include a new $20 billion tax on this innovative industry.

I am going to call out one company in particular, because it's a larger company. Boston Scientific, which employs more than 5,000 individuals in my home state of Minnesota, has estimated that that tax is going to cost the company an additional $100 million a year, and up to 2,000 jobs. It's also going to cause a substantial cut-back in Boston Scientific's research and development budget, which is the origin of where all this innovation comes from that the President talked about in his speech last night.

And, you know, knowing that 62 percent of the medical technology industry is small businesses, small businesses like yourselves, for instance, you took an idea, you took the risk, you started it out, I'm just really worried that we're killing an industry that it's going to be very difficult to jump-start and bring back here. And we can't afford to lose it.

And so, just knowing we have to keep that innovation here, I had to make that comment, because Mr. Goolsbee had mentioned earlier that one of the benefits of that tax, as a part of the legislation, was going to basically allow about millions of patients now to access these device procedures that would not normally have had that market before. And I think the reality is that we look at it now in Massachusetts, which was the model upon which the legislation was built—there was no increase in device utilization at all, as was, I think, suggested.

But I want to follow up real quick with both of you, since you're small business people, and the health care savings account and the flexible savings account portion, and that's because, you know, we know the health care law instituted new caps on popular flexible spending accounts, FSAs, that individuals use for their health care expenses, and they also prohibited the use of FSAs and health care savings accounts for purchases of over-the-counter medications without a doctor's prescription.

And you mentioned a little earlier about, as an employer, what some of those results would be, or some of the detriments of the changes in the law would mean. And knowing that there are 10 million Americans that use FSAs, and 35 million Americans using FSAs—HSAs and FSAs—would you explain just—I mean, give the patient perspective. I mean your employees. As a small business that wants to have an additional option, I mean from a patient perspective, what does that—offer some ideas for your employees, rather than just the employer.

Mr. OLIVO. Well, as I had said before, we have had the health savings account, the high deductible plan, for six years. And I have witnessed how it has improved my employees' incentive to better manage not only their health, but how they choose to go about obtaining health care.

And as I had said before also, the first year was very rough, in the sense that it was an HMO—these people were raised on HMOs, and they did not like having to pay $150 initially to go to a doctor, when before it was $15 at the time. But over time, as they see their

health savings accounts start to build up, and they see, "If I take better care of myself, I could get off this medication and now I save money," it has certainly improved how they go about purchasing the health care.

Mr. PAULSEN. Mr. Womack, you want to comment, as well?

Mr. WOMACK. Well, I think that any time that you allow people to accumulate money in an account like an HSA for the purpose of spending on their expenses, it becomes a huge incentive for them to really manage all those little costs. And sometimes those little hidden costs can be significant. You know that when you have the money in your account and you get to keep it, you have a very big incentive to manage your costs.

Mr. PAULSEN. Well, and Mr. Chairman—and thank you for the testimony—I just want to comment. I have talked to numerous small businesses and their employees that feel like they have had the rug pulled out from under them now, as they have gone through this adjustment, to take care of their own health care. And they are going to have to make a huge adjustment now, as the law has been changed.

And I would rather see us move into the expansion of FSAs and HSAs, to allow more flexibility and control costs. So I yield back, Mr. Chairman.

Mr. HERGER. I thank the gentleman. At this point, everyone has—at least in the Committee—has gone through inquiring once. As long as we have other Members who would like to inquire who haven't inquired of this panel, we will leave that open. Mr.——

Mr. THOMPSON. I have not inquired of this panel. Neither has Mr.——

Mr. HERGER. Yes, I am aware. And the gentleman from California will be recognized after I inquire.

Mr. Olivo, you currently indicated you had 45 employees. And prior to the recession you had 54 employees. And I assume, like most businesses, that you would like to grow your business. But under the Democrats' health care law, if you have less than 50 employees, you are not subject to the employer mandate tax.

Will that have an impact on your decision to hire more workers?

Mr. OLIVO. Without a doubt, it will. And it will put me in the position that—not only questioning whether I should expand or slow down the rate at which I expand, and make me seriously consider, but it also puts me in the position that once I reach that 50 employee mark, and I either need to provide health care or pay a penalty, as I had mentioned previously, the penalty currently is less than my premiums. And, unfortunately, that is a scenario that I will have to look at.

Mr. HERGER. And I might mention I was talking to an employer in my own district, in Redding, California, who is in the same situation, that he had about 45 employees, and just knowing that made a difference of whether he was going to grow or not.

But you also mentioned in your testimony that you currently provide health benefits to your employees, and that you pay 100 percent of the premium for employees who choose high deductible plans. You also contribute to these employees' health savings accounts. Could you elaborate further on the benefits of pairing a high deductible plan with a health savings account?

And what would be the impact on you and your employees if this kind of coverage is no longer available under Obamacare?

Mr. OLIVO. Well, yes. That is something—with the savings that we have been able to gain with the reduced premiums from the health savings account, we have been able to contribute in certain years to our employees' accounts, which really helps them going towards paying that deductible. So there are some years, in effect, that not only are we picking up the cost of the premium, but we are picking up approximately two-thirds of the cost towards their deductible.

So, for all intents and purposes, their first $1,000 is covered under the plan. I would just say the health savings account has just been a huge benefit to us towards managing the escalating premium cost. I wouldn't sit here and say that it's the sole answer. But, without a doubt, if we did not have the ability to offer a health savings account for the past six years, I would not be able to pay anywhere close to 100 percent of my employees' premiums.

Mr. HERGER. I thank the gentleman. I now recognize the gentleman from California, Mr. Thompson, for five minutes to inquire.

Mr. THOMPSON. Thank you, Mr. Chairman. I just want to point out a $9 employee, under best case scenario, is making around $15,000 a year. And I don't care where you go for your health care on $15,000 a year, chances are you fall into that category of uncompensated care. So it's not being paid for out of pocket, it's not being provided for free. It's factored in to what's driving up the cost for your salaried employees, for everyone else who buys a policy, or everyone else who pays out of pocket.

Mr. Chairman, I would like to submit for the record a letter that I have that's—I just got a copy of it. It's from 275 economists from all over the country, including 3 Nobel Laureates, 4 Council of Economic Advisors, a former CBO chief, and 2 John Bates Clark prize winners. And the letter states that——

Mr. HERGER. Without objection, the letter will be admitted.

Mr. THOMPSON. Thank you.

[The information follows: Mr. Thompson, Economists Letter:]

January 26, 2011

Honorable Dave Camp, Chairman
Honorable Sander Levin, Ranking Member
U.S. House of Representatives
Committee on Ways and Means
Washington, DC 20515

Dear Chairman Camp and Representative Levin,

Congress this week is holding hearings on the economic impact of health care reform. We write to convey our strong conclusion that leaving in place the Patient Protection and Affordable Care Act of 2010 will significantly strengthen our nation's economy over the long haul and promote more rapid economic recovery in the immediate years ahead. Repealing the Affordable Care Act would cause needless economic harm and would set back efforts to create a more disciplined and more effective health care system.

Our conclusion is based on two economic principles. First, high medical spending harms our nation's workers, new job creation, and overall economic growth. Many studies demonstrate that employers respond to rising health insurance costs by reducing wages, hiring fewer workers, or some combination of the two. Lack of universal coverage impairs job mobility as well because many workers pass up opportunities for self-employment or positions working for small firms because they fear losing their health insurance or facing higher premiums.

Second, the Affordable Care Act contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending. These provisions include:

- *Payment innovations* such as greater reimbursement for patient-centered primary care; bundled payments for hospital care, physician care, and other medical services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers.
- *An Independent Payment Advisory Board* with authority to make recommendations to reduce cost growth and improve quality within both Medicare and the health system as a whole
- *A new Innovation Center within the Centers for Medicare and Medicaid Services* charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program
- *Measures to inform patients and payers about the quality of medical care providers,* which provide relatively low-quality, high-cost providers financial incentives to improve their care
- *Increased funding for comparative effectiveness research*

- *Increased emphasis on wellness and prevention*

Taken together, these provisions are likely to reduce employer spending on health insurance. Estimates suggest spending reductions ranging from tens of billions of dollars to hundreds of billions of dollars. Because repealing our nation's new health reform law would eliminate the above provisions, it would increase business spending on health insurance, and hence reduce employment.

One study concludes that repealing the Affordable Care Act would produce job reductions of 250,000 to 400,000 annually over the next decade. Worker mobility would be impaired as well, as people remain locked into less productive jobs just to get health insurance.

The budgetary impact of repeal also would be severe. The Congressional Budget Office concludes that repealing the Affordable Care Act would increase the cumulative federal deficit by $230 billion over the next decade, and would further increase the deficit in later years. Other studies suggest that the budgetary impact of repeal is even greater. State and local governments would face even more serious fiscal challenges if the Affordable Care Act were repealed, as they would lose substantial resources provided under the new law while facing the burdens of caring for 32 million more uninsured people. Repeal, in short, would thus make a difficult budget situation even worse.

Rather than undermining health reform, Congress needs to make the Affordable Care Act as successful as it can be. This would be as good for our economy as it would be for the health of our citizens.

Sincerely,

Henry J. Aaron
Senior Fellow
The Brookings Institution

Jean Marie Abraham
Assistant Professor
University of Minnesota School of Public Health

Randy Albelda
Professor of Economics
University of Massachusetts, Boston

Sylvia A. Allegretto
Economist
University of California, Berkeley

Stuart Altman
Sol C. Chaikin Professor of National Health Policy
Brandeis University

Elizabeth Oltmans Anant
Assistant Professor of Public Policy and Economics
Duke University

Rania Antonopoulos
Director, Gender Equality and the Economy Program
Levy Economics Institute

Kenneth J. Arrow
Professor of Economics Emeritus
Stanford University

Michael Ash
Associate Professor of Economics and Public Policy
University of Massachusetts, Amherst

David Autor
Professor and Associate Head, Department of Economics
Massachusetts Institute of Technology

Susan L. Averett
Charles A. Dana Professor of Economics
Lafayette College

Christopher Avery
Roy E. Larsen Professor of Public Policy
Harvard University Kennedy School of Government

Rojhat B. Avsar
Assistant Professor of Economics
Columbia College

M.V. Lee Badgett
Professor of Economics
University of Massachusetts, Amherst

El-hadj Bah
Lecturer
University of Auckland

Ron Baiman
Director of Budget and Policy Analysis
Center for Tax and Budget Accountability

Asatar Bair
Professor of Economics
City College of San Francisco

Dean Baker
Co-Director
Center for Economic and Policy Research

Radhika Balakrishnan
Professor, Women's and Gender Studies
Rutgers, The State University of New Jersey

Nesecan Balkan
Department of Economics
Hamilton College

Erol Balkan
Professor of Economics
Hamilton College

Steve Balkin
Professor of Economics
Roosevelt University

Nina Banks
Associate Professor of Economics
Bucknell University

William Barclay
Adjunct Professor
University of Illinois at Chicago

Drucilla K. Barker
Professor and Director, Women's and Gender Studies
University of South Carolina

David Barkin
Profesor de Economia
Universidad Autonoma Metropolitana-Xochimilco

Anirban Basu
Associate Professor, Department of Health Services
University of Washington

Francis M. Bator
Lucius N. Littauer Professor of Political Economy Emeritus
Harvard University Kennedy School of Government

Charles M. Becker
Associate Chair and Research Professor, Department of Economics
Duke University

Marc F. Bellemare
Assistant Professor
Duke University

Gunseli Berik
Professor of Economics
University of Utah

Carole Biewener
Professor of Economics
Simmons College

Cyrus Bina
Distinguished Research Professor of Economics
University of Minnesota

Christine E. Bishop
Atran Professor of Labor Economics
Brandeis University

Josh Bivens
Economist
Economic Policy Institute

Heather Boushey
Senior Economist
Center for American Progress

Roger Even Bove
Department of Economics & Finance (retired)
West Chester University

James K. Boyce
Professor of Economics
University of Massachusetts, Amherst

Elissa Braunstein
Associate Professor
Colorado State University

Clair Brown
Professor of Economics
University of California, Berkeley

Thomas Buchmueller
Waldo O. Hildebrand Professor of Risk Management and Insurance
Ross School of Business, University of Michigan

Colin Cameron
Professor of Economics
University of California, Davis

Jim Campen
Professor of Emeritus, Economics
University of Massachusetts, Boston

Kathleen Carey
Associate Professor
Boston University School of Public Health

Ann M. Carlos
Professor, Department of Economics
University of Colorado

Frank Chaloupka
Distiguished Professor of Economics and Director, Health Policy Center
University of Illinois at Chicago

Richard Chapman
Professor of Economics
Westminster College

John Dennis Chasse
Professor Emeritus
State University of New York, Brockport

Howard Chernick
Professor of Economics
Hunter College and the Graduate Center, City University of New York

Raj Chetty
Professor of Economics
Harvard University

Kimberly Christensen
Joanne Woodward Chair of Public Policy
Sarah Lawarence College

Betsy Jane Clary
Professor of Economics
College of Charleston

Paul D. Cleary
Dean of Public Health
Yale School of Public Health

Jonathan Conning
Associate Professor of Economics
Hunter College and the Graduate Center, City University of New York

Karen Smith Conway
Professor of Economics
University of New Hampshire

Philip J. Cook
ITT/Sanford Professor of Public Policy
Duke University

Paul Cooney
Associate Professor
Federal University of Para, Brazil

Richard R. Cornwall
Professor of Economics, Emeritus
Middlebury College

J. Kevin Crocker
Undergraduate Program Director
University of Massachusetts, Amherst

David Cutler
Otto Eckstein Professor of Applied Economics
Harvard University

Rada K. Dagher
Assistant Professor
University of Maryland

Anita Dancs
Assistant Professor, Department of Economics
Western New England College

Charles Davis
Professor, Labor Studies
Indiana University

Susan M. Davis
Associate Professor, Department of Economics and Finance
Buffalo State College

Partha Deb
Professor of Economics
Hunter College and the Graduate Center, City University of New York

Gregory E. DeFreitas
Professor of Economics
Hofstra University

Brad DeLong
Professor of Economics
University of California, Berkeley

Timothy M. Diette
Assistant Professor of Economics
Washington and Lee University

Marisa Elena Domino
Associate Professor of Health Economics
The University of North Carolina

David E. Dowall
Professor
University of California, Berkeley

Arindraijit Dube
Assistant Professor, Department of Economics
University of Massachusetts, Amherst

Niev Duffy
President
Eastern Economic Research

Mark Duggan
Professor of Economics
University of Maryland

Randall P. Ellis
Professor of Economics
Boston University

Elizabeth Elmore
Professor of Economics
Richard Stockton College of New Jersey

Christopher L. Erickson
Professor
UCLA Anderson School of Management

Jose Escarce
Professor of Medicine
David Geffen School of Medicine at UCLA

Loretta Fairchild
Professor of Economics
Nebraska Wesleyan University

Sasan Fayazmanesh
Professor Emeritus of Economics
California State University, Fresno

Steven Fazzari
Professor of Economics
Washington University

Judy Feder
Professor of Public Policy
Georgetown University

Susan Feiner
Professor of Economics
University of Southern Maine

Deborah M. Figart
Professor of Education and Economics

Richard Stockton College of New Jersey

Kade Finhoff
Assistant Professor of Economics
University of Massachusetts, Boston

Jason Fletcher
Assistant Professor of Public Health
Yale University

Nancy Folbre
Professor of Economics
University of Massachusetts, Amherst

Austin Frakt
Assistant Professor of Health Policy and Management
Boston University School of Public Health

Jeffrey Frankel
Harpel Professor of Capital Formation and Growth
Harvard University

Gerald Friedman
Professor of Economics
University of Massachusetts, Amherst

Bianca Frogner
Assistant Professor
The George Washington University

Bill Ganley
Professor of Economics and Finance
Buffalo State College

Lorenzo Garbo
Professor of Economics
University of Redlands

Irwin Garfinkel
Mitchell I. Ginsberg Professor of Contemporary Urban Problems
Columbia University School of Social Work

Paul J Gertler
Li Ka Shing Professor of Health Policy and Management

University of California, Berkeley

Mwangi wa Githinji
Assistant Professor of Economics
University of Massachusetts, Amherst

Devra L. Golbe
Professor of Economics
Hunter College and the Graduate Center, City University of New York

Heather Taffet Gold
Associate Professor of Public Health
Weill Cornell Medical College

Claudia Goldin
Henry Lee Professor of Economics
Harvard University

Don Goldstein
Professor of Economics
Allegheny College

Jose A. Gomez-Ibanez
Derek C. Bok Professor of Urban Planning and Public Policy
Harvard University Kennedy School of Government

Joshua Goodman
Assistant Professor of Public Policy
Harvard University Kennedy School of Government

Neva Goodwin
Co-Director, Global Environment and Environment Institute
Tufts University

Elise Gould
Economist
Economic Policy Institute

Ulla Grapard
Associate Professor of Economics and Women's Studies
Colgate University

Daphne Greenwood
Professor of Economics and Director, Colorado Center for Policy Studies

University of Colorado, Colorado Springs

Tai Gross
Assistant Professor, Department of Health Policy and Management
Mailman School of Public Health, Columbia University

Michael Grossman
Distinguished Professor of Economics
City University of New York Graduate Center

Jonathan Gruber
Professor of Economics
Massachusetts Institute of Technology

Kwabena Gyimah-Brempong
Professor and Chair, Department of Economics
University of Souh Florida

Jack Hadley
Professor and Senior Health Services Researcher
George Mason University

Paul Hancock
Professor of Economics
Green Mountain College

Jeffrey S. Harman
University of Florida Research Foundation Professor
University of Florida

Oliver Hart
Professor of Economics
Harvard University

John T. Havey
Professor of Economics
Texas Christian University

Gillian Hewitson
Department of Political Economy
University of Sydney

Vivian Ho
Baker Institute Chair of Health Economics and Professor

Rice University

Joan Hoffman
Professor and Chair, Department of Economics
John Jay College of Criminal Justice, City University of New York

Ann M. Holmes
Associate Professor
Indiana University-Purdue University Indianapolis

Barbara Hopkins
Associate Professor of Economics
Wright State University

Jill R. Horwitz
Professor of Law, Co-Director, Program on Law and Economics
University of Michigan Law School

Candace Howes
Professor of Economics
Connecticut College

Hilary Hoynes
Professor of Economics
University of California, Davis

Dorene Isenberg
Professor and Chair, Department of Economics
University of Redlands

Ken Jacobs
Chair, Labor Center
University of California, Berkeley

Joyce P. Jacobsen
Andrews Professor of Economics
Wesleyan University

Sanford M. Jacoby
Professor of Management and Public Policy
University of California, Los Angeles

Habib Jam
Associate Professor of Economics

Rowan University

Russell A. Janis
Senior Lecturer in Economics
University of Massachusetts, Amherst

Arjun Jayadev
Assistant Professor of Economics
University of Massachusetts, Boston

Neil Jordan
Assistant Professor and Director, Health Economics Center
Feinberg School of Medicine, Northwestern University

Ted Joyce
Professor of Economics and Finance
Baruch College, City University of New York

Geoffrey Joyce
Director of Health Policy, Schaeffer Center for Health Policy & Economics
University of Southern California

Kyoungrae Jung
Assistant Professor, Health Policy and Administration
Pennsylvania State University

Daniel Kahneman
Professor of Public Affairs, Emeritus
Princeton University

Rajani Kanth
Professor of Economics (Visiting)
Loras College & Washington College

Ethan Kaplan
Visiting Professor of Economics
Columbia University

Lawrence Katz
Allison Professor of Economics
Harvard University

Donald Katzner
Professor of Economics

University of Massachusetts, Amherst

Paula M. Kazi
Assistant Professor
Bucknell University

Valerie K. Kepner
Assistant Professor of Economics
King's College

Farida Khan
Professor of Economics
University of Wisconsin-Parkside

Marlene Kim
Associate Professor, Department of Economics
University of Massachusetts, Boston

Steven J. Klees
Professor of Education and Economic Development
University of Maryland

Andrew I. Kohen
Professor Emeritus of Economics
James Madison University

Brent Kramer
City University of New York

Brent Kreider
Professor of Economics
Iowa State University

Jill Kriesky
Economist
West Virginia Center on Budget and Policy

Karl Kronebusch
Associate Professor
City University of New York

Alan Krueger
Professor of Economics
Princeton University

David Laibman
Professor (retired), Deparment of Economics
City University of New York

Melaku Lakew
Professor of Economics
Richard Stockton College of New Jersey

Thomas Lambert
Economics Lecturer
Indiana University Southeast

Robert Lawrence
Albert L. Williams Professor of Trade and Investment
Harvard University, Kennedy School of Government

Arleen A. Leibowitz
Professor, School of Public Affairs
University of California, Los Angeles

David I. Levine
Trefethen Professor of Business Administration, Haas School of Business
University of California, Berkeley

Frank Levy
Rose Professor of Urban Economics
Massachusetts Institute of Technology

Peter M. Lichtenstein
Emeritus Professor of Economics
Boise State University

Jeffrey B. Liebman
Malcolm Wiener Professor of Public Policy
Harvard University, Kennedy School of Government

Peter H. Lindert
Distinguished Research Professor of Economics
University of California, Davis

Victor D. Lippit
Professor of Economics
University of California, Riverside

Linda Loubert

Assistant Professor, Economics Department
Morgan State University

Harold S. Luft
University of California, San Francisco

Catherine Lynde
Associate Professor, Economics
University of Massachusetts, Amherst

Sean P. MacDonald
Assistant Professor of Economics
City University of New York

Diane J. Macunovich
Department of Economics
University of Redlands

Mark Maier
Professor of Economics
Glendale College

Ann Markusen
Professor
Humphrey School of Public Affairs, University of Minnesota

Eric S. Maskin
A.O. Hirschman Professor of Social Science
Institute for Advanced Study

Thomas Masterson
Research Scholar
Levy Economics Institute of Bard College

Julie Matthaei
Professor of economics
Wellesley College

Peter Hans Matthews
James Jermain Professor of Political Economy, Department of Economics
Middlebury College

Kathleen McAfee
Associate Professor, Political Economy and International Relations

San Francisco State University

Elaine McCrate
Associate Professor, Economic and Women's and Gender Studies
University of Vermont

Thomas G. McGuire
Professor of Health Economics
Harvard Medical School

Ellen Meara
Associate Professor
Darmouth Institute for Health Policy and Clinical Practice

Michael Meeropol
Visiting Professor Economics
John Jay College of Criminal Justice, City University of New York

Martin Melkonian
Adjunct Associate Professor, Economics
Hofstra University

David Meltzer
Associate Professor, Department of Medicine and Associated Faculty Member, Department of Economics
University of Chicago

Peter B. Meyer
Professor Emeritus of Urban Policy and Economics
University of Louisville

Marcelo Milan
Assistant Professor of Economics
University of Wisconsin-Parkside

Lawrence Mishel
President
Economic Policy Institute

Alan C. Monheit
Professor of Health Economics, School of Public Health
University of Medicine and Dentistry of New Jersey

Taryn Morrissey

Assistant Professor of Public Administration and Policy
American University

Karoline Mortensen
Assistant Professor of Health Services Administration
University of Maryland

Tracy Mott
Associate Professor and Department Chair, Department of Economics
University of Denver

Alicia H. Munnell
Peter F. Drucker Professor
Carroll School of Management, Boston College

Richard J. Murnane
Professor
Harvard University

Jason Burke Murphy
Department of Philosophy
Elms College

Ellen Mutari
Professor of Economics
Richard Stockton College of New Jersey

Reynold F. Nesiba
Associate Professor of Economics
Augustana College

David Neumark
Professor of Economics and Director of Graduate Studies
University of California, Irvine

Len M. Nichols
Director of the Center for Health Policy Research and Ethnics, Professor of Health Policy
George Mason University

Laurie Nisonoff
Professor of Economics
Hampshire College

Brendan O'Flaherty
Professor of Economics

Columbia University

Albert A. Okunade
Professor of Health Economics
University of Memphis

Oladele Omosegbon
Professor of Economics
Indiana Wesleyan University

Shaianne T. Osterreich
Associate Professor, Economics
Ithaca College

Zhaochang Peng
Department of Economics
Rollins College

George Perry
Senior Fellow
The Brookings Institution

Mark A. Peterson
Professor of Public Policy and Political Science
UCLA School of Public Affairs

Karl Petrick
Assistant Professor of Economics
Western New England College

Kathryn A. Phillips
Professor of Health Economics and Health Services Research
University of California, San Francisco

Steven D. Pizer
Associate Professor
Boston University School of Public Health

Harold Pollack
Helen Ross Professor of Social Service Administration
University of Chicago

Daniel Polsky
Professor of Medicine

University of Pennsylvania

Paddy Quick
Professor of Economics
St. Francis College

Matthew Rabin
Professor of Economics
University of California, Berkeley

Sarah Reber
Assistant Professor of Public Policy
University of California, Los Angeles

Jim Rebitzer
Professor of Management, Economics and Public Policy
Boston University School of Management

Michael Reich
Professor of Economics
University of California, Berkeley

Uwe Reinhardt
James Madison Professor of Political Economy
Princeton University

Dahlia Remler
Professor, School of Public Affairs, Baruch College
City University of New York

Alice M. Rivlin
Senior Fellow
The Brookings Institution

Charles P. Rock
Professor of Economics
Rollins College

Christina D. Romer
Class of 1957 Professor of Economics
University of California, Berkeley

Samuel Rosenberg
Acting Vice Provost for Faculty and Academic Administration

Roosevelt University

Meredith Rosenthal
Associate Professor of Health Economics
Harvard University School of Public Health

Roy J. Rotheim
Professor of Economics
Skidmore College

Anne Beeson Royalty
Associate Professor of Economics
Indiana University Purdue University Indianapolis

Cristopher J. Ruhm
Professor of Public Policy and Economics
University of Virginia

Emmanuel Saez
Professor of Economics
University of California, Berkeley

Harwood D. Schaffer
Research Assistant Professor
University of Tennessee

John Schmitt
Senior Economist
Center for Economic and Policy Research

Charles L. Schultze
Senior Fellow Emeritus
The Brookings Institution

Eric A. Schutz
Professor, Economics
Rollins College

Joseph M. Schwartz
Professor of Political Science
Temple University

Charles R. Sebuharara
Visiting Assistant Professor of Finance

Pamplin College of Business, Virginia Tech

Eric Seiber
Assistant Professor of Health Services Management and Policy
The Ohio State University

Janet Seiz
Associate Professor of Economics
Grinnell College

Bisakha Sen
Associate Professor, Department of Healthcare Organization and Policy
University of Alabama, Birmingham

Mark Setterfield
Professor of Economics
Trinity College

Anwar Shaikh
Professor of Economics
New School for Social Research

Nina Shapiro
Professor of Economics
Saint Peter's College

Judith Shinogle
Senior Research Scientist
Maryland Institute for Policy Analysis

Peter Skott
Professor of Economics
University of Massachusetts, Amherst

Timothy Smeeding
Arts and Sciences Distinguished Professor for Public Affairs
University of Wisconsin-Madison

Eugene Smolensky
Professor of the Graduate School
University of California, Berkeley

Bryan Snyder
Department of Economics
Bentley University

Eswaran Somanathan
Visiting Professor
Princeton University

Paula H. Song
Assistant Professor, Health Services Management & Policy
The Ohio State University

Neeraj Sood
Associate Professor
Schaeffer Center for Health Policy and Economics, University of Southern California

Janet Spitz
Associate Professor of Business
College of Saint Rose

James Ronald Stanfield
Emeritus Professor of Economics
Colorado State University

Sally C. Stearns
Professor of Health Economics
University of North Carolina at Chapel Hill

Bruce Stuart
Professor
University of Maryland School of Pharmacy

Paul Swanson
Professor of Economics
William Paterson Univeristy

Katherine Swartz
Professor of Health Economics and Policy
Harvard University School of Public Health

Donald H. Taylor, Jr.
Associate Professor of Public Policy
Duke University

Chris Tilly
Professor and Director of the Institute for Research and Employment
University of California, Los Angeles

Mariano Torras
Professor of Economics
Adelphi University

Pravin K. Trivedi
J.H. Rudy Professor of Economics
Indiana University - Bloomington

Jennifer Troyer
Associate Professor of Economics
University of North Carolina at Charlotte

Robert Otto Valdez
Robert Wood Johnson Foundation Professor,
Family & Community Medicine and Economics
University of New Mexico

Paul N. Van de Water
Senior Fellow
Center on Budget and Policy Priorities

Courtney Harold Van Houtven
Associate Professor
Duke University

Lane Vanderslice
Editor, Hunger Notes
worldhunger.org

Elizabeth Richardson Vigdor
Research Scholar
Duke University

Anca Voicu
Assistant Professor of Economics
Rollins College

Mark E. Votruba
Associate Professor of Economics and Medicine
Case Western Reserve University

Geetha Waehrer
Research Scientist
Pacific Institute for Research and Evaluation

Jane Waldfogel
Professor of Social Work and Public Affairs
Columbia University

Kenneth E. Warner
Avedis Donebedian Distinguished University Professor of Public Health
University of Michigan

David Warner
Wilbur Cohen Professor of Public Affairs
LBJ School of Public Affairs, University of Texas at Austin

Mark Weisbrot
Co-Director
Center for Economic and Policy Research

Thomas E. Weisskopf
Professor Emeritus of Economics
University of Michigan

Charles K. Wilber
Emeritus Professor of Economics
University of Notre Dame

Michael Wilson
Instructor
Harvard Medical School

Cecilia Ann Winters
Associate Professor of Economics
Manhattanville College

Jon D. Wisman
Professor of Economics
American University

Barbara Wolfe
Professor, Economics and Political Science
University of Wisconsin-Madison

Justin Wolfers
Associate Professor of Business and Public Policy
The Wharton School, University of Pennsylvania

Robert S. Woodward
Professor of Health Economics
University of New Hampshire

Vivian Wu
Assistant Professor
University of Southern California

David Zalewski
Professor of Finance
Providence College

Joshua Graff Zivin
Associate Professor of Economics
University of California, San Diego

Mr. THOMPSON. The letter states—I just want it for the folks to know—it says that, "We write to convey our strong conclusion that leaving in place the Patient Protection and Affordable Care Act of 2010 will significantly strengthen our nation's economy over the long haul, and promote more rapid economic recovery in the immediate years ahead.

Also, Mr. Chairman, I would like to point out a letter that the Secretary of Health received from an entity that you're very familiar with, and I believe actually get some benefits from this, the CalPERS organization in our home state of California, which is the nation's largest non-Federal Government purchaser of health care. And in the letter they say that they believe that "key elements of the national health care reform represent a fundamental and positive shift in the way health care will be purchased and delivered in the United States. Together, they will dramatically shape the future of health care in our country, and ultimately benefit everyone."

They say that, more specifically, that the provisions regarding retired folks—in 2011, that they will save approximately $200 million, based on the reimbursement rate to more than 115,000 early retirees, their spouses, and their surviving spouses and their dependents.

They have also submitted written testimony, as well, in which they discuss that this year they will spend $6.7 billion on health care benefits for 1.3 million active and retired state and local government employees and their families.

They further testify that the overall structure of the law, which focuses on constraining the skyrocketing cost of health care in our country, while providing quality and ensuring health coverage for tens of millions of uninsured, some of those, those $9-an-hour employees who can't buy health care, who fall into the uncompensated health care cost that the rest of us all pay for, is the right policy prescriptions for this group, the largest non-Federal Government purchaser of health care in the country, its members, and our country at large.

I would also ask unanimous consent to submit a copy of this letter for the record, Mr. Chairman.

Mr. HERGER. Without objection.

Mr. THOMPSON. Thank you. And I yield back the balance of my time.

Mr. HERGER. The gentleman yields back. The gentleman from Ohio, Mr. Tiberi, is recognized for five minutes.

Mr. TIBERI. Thank you, Mr. Chairman. And thank you both for taking time away from your families and your businesses to come here and provide us with perspective from where you sit.

And your testimony, your verbal testimony earlier, reminded me of some discussions I had with local constituents, both small businesses and restaurant owners and retailers. In fact, a restaurant owner operator said to me, perplexed, "Where did 30 hours come from? In federal law, full-time is always 40 hours, and suddenly it's 30 hours."

Mr. Womack, you have 900 employees. I hope that you will reconsider and come to Ohio, if we can change this piece of legislation. I'm from central Ohio. My first job was at McDonald's, so I understand a perspective of the restaurant business. When I was working at McDonald's, a number of the people that I worked with were under the age of 21, were on their parents' policy. I was, as a 16-year-old. And a number of the adults were women who had coverage through their spouse.

So, my question to you is—and I have two—is how many employees now do you have that will be impacted by this new regulatory framework of 30 hours as full-time? If you could, answer that.

And how many—and I'm sure it's a guess at this point, since you don't have the figures in front of you—employees do you have are teenagers at your restaurant, or college-aged students, who have coverage through their parents, or maybe a spouse who has coverage through another spouse?

Mr. WOMACK. I think my best guess—and this is purely a guess, as we've not run the numbers—but my best guess is about 20, 25 percent of our staff are under the age of 20 or 21, and a substantial number of our employees are people who are second earners, bringing a second income into the family. And we know, just anecdotally, especially a lot of our service staff, they're the second earner, and their spouse has coverage elsewhere.

Mr. TIBERI. So—and correct me if I'm wrong—so you have a number of people who are already covered, whether they be teenagers working their first job, or a spouse with insurance, and there is a second earner. These costs, additional cost onto your business, will create a situation where at some point in time you're going to have to choose whether or not a person gets a raise, whether or not they get other benefits, or whether or not you hire somebody?

Mr. WOMACK. Sure, absolutely.

Mr. TIBERI. How many people could you hire in Ohio if this law hadn't been passed? What was the projection that you had before this law became—this bill became a law?

Mr. WOMACK. Well, our plan from here is to open 12, 13 more restaurants in Ohio, in central Ohio.

Mr. TIBERI. In central Ohio.

Mr. WOMACK. And——

Mr. TIBERI. Thanks for the good news.

Mr. WOMACK. Yes. And we think that, if we have to cease development, if there are no changes and we have to stop development, you're looking at 260 to 300 full-time jobs, and hundreds of part-time jobs. And then there is also, construction and all the other things outside of our company.

Mr. TIBERI. Mr. Olivo, your testimony brought home a call I got right after the election from a constituent. He was on his cell phone screaming at me regarding a meeting that he just came out of with his tax lawyer and his tax accountant. He had 51 employees, and they were giving him a briefing on the new health care law and some other regulations.

And the gist of the meeting was, "If you can, figure out over the next year how to get under 50 to not have to comply with this new regulation, or our recommendation is to put all your employees, if you are still over 50, into the government exchange, rather than continue to provide the health care you provide today," which, obviously, goes against the premise of the debate, which, if you like what you have, you can keep it. Or, that this isn't a bill that disincentivizes entrepreneurs from creating more jobs.

And why he was yelling at me was, with Ohio's unemployment above 10 percent, he is getting advice from his legal professional that he should not hire more people, but figure out how to hire less people. Or, the alternative is to put people into the government exchange, which he didn't want to do.

But from a competitiveness perspective, and cost of doing business, and trying to survive his business—I know you've talked about it already, but can you share with us, as an entrepreneur, how frustrating it is for you, whether it's a state regulation or a federal regulation, inhibits your ability to project long-term growth, and how to grow your business, rather than figuring out how to abide by all these new rules, what that does to your spirit, as an entrepreneur?

Mr. OLIVO. Well, not just spirit. I mean, just to give you an idea, we purchase a new piece of equipment, they are fixed payments. I don't have the luxury of going back to my bank and saying, "Well, geez, my expenses are a little more, my health care costs were more than expected." I have to make those payments. So I have to leave myself a margin in which that—my calculations may not be exact.

When there is this much unknown regarding the health care law, it really causes me to be much more conservative. And it's affecting how much I am willing to invest into the company and grow it——

Mr. TIBERI. All right.

Mr. OLIVO [continuing]. Until I get a better understanding of what's happening.

Mr. TIBERI. Thank you——

Chairman CAMP. Thank you very much——

Mr. TIBERI. Mr. Chairman, I would like to submit for the record, if I may——

Chairman CAMP. Yes.

Mr. TIBERI [continuing]. A letter dated January 18, 2011 from 239 economists. And they write, just one sentence, "We believe the Patient Protection and Affordable Care Act is a threat to U.S. businesses, and will place a crushing debt burden on future generations of Americans."

Chairman CAMP. All right. Without objection.

[The information follows: Mr. Tiberi, Economist Letter:]

Economist

January 18, 2011

The Honorable John Boehner
Speaker of the House
Washington, DC 20515

The Honorable Harry Reid
Senate Majority Leader
Washington, DC 20515

The Honorable Nancy Pelosi
House Minority Leader
Washington, DC 20515

The Honorable Mitch McConnell
Senate Minority Leader
Washington, DC 20515

Dear Speaker Boehner, Minority Leader Pelosi, Majority Leader Reid, and Minority Leader McConnell:

To promote job growth and help to restore the Federal Government to fiscal balance, we, the undersigned, feel that it would be beneficial to repeal and replace the Patient Protection and Affordable Care Act (P.L. 111–148). Too many Americans remain unemployed and the United States faces a daunting budgetary outlook. We believe the Patient Protection and Affordable Care Act is a threat to U.S. businesses and will place a crushing debt burden on future generations of Americans.

A Barrier to Job Growth: The Patient Protection and Affordable Care Act contains expensive mandates and penalties that create major barriers to stronger job growth. The mandates will compete for the scarce business resources used for hiring and firm expansion. The law also levies roughly $500 billion in new taxes that will enter the supply chain for medical services, raising the cost of medical services. At the same time that businesses juggle the potential for higher interest rates or higher taxes, these medical costs will translate to higher insurance premiums, further increasing the cost of operating a business in the United States.

A Massive Spending Increase and a Crushing Debt Burden: The Patient Protection and Affordable Care Act is fiscally dangerous at a moment when the United States is already facing a sea of red ink. It creates a massive new entitlement at a time when the budget is already buckling under the weight of existing entitlements. At a minimum, it will add $1 trillion to government spending over the next decade. Assertions that these costs are paid for are based on omitted costs, budgetary gimmicks, shifted premiums from other entitlements, and unsustainable spending cuts and revenue increases. A more comprehensive and realistic projection suggests that the Affordable Care Act could potentially raise the federal budget deficit by more than $500 billion during the first ten years and by nearly $1.5 trillion in the following decade.

The Patient Protection and Affordable Care Act does not constitute real health care reform. The first step is to remove barriers to stronger job growth and to help restore fiscal balance to the nation's budget by protecting taxpayers, American business, seniors, families, workers, and health care consumers from the damage that the Patient Protection and Affordable Care Act will cause.

Congress should start with a clean sheet of paper and adopt initiatives that would encourage providers to offer higher-quality care at lower costs; reduce the cost pressures that threaten to bankrupt Medicare and Medicaid; and give every American access to more options for quality insurance.

Respectfully,
[Affiliations shown for purposes of identification and do not constitute institutional endorsement.]

Douglas Holtz-Eakin
President, American Action Forum
Former Director, Congressional Budget Office (CBO)

June O'Neill
Professor of Economics, Baruch College
Former Director, Congressional Budget Office (CBO)
First Chair, Board of Scientific Counselors, National Center for Health Statistics

Joseph Antos
Wilson H. Taylor Scholar in Health Care and Retirement Policy American Enterprise Institute
Former Assistant Director, Congressional Budget Office (CBO)

Arlene Holen
Senior Fellow, Technology Policy Institute Former Associate Director Congressional Budget Office (CBO)

Former Associate Director White House Office of Management and Budget (OMB)

Brian S. Wesbury
Chief Economist, First Trust Portfolios LP
Former Chief Economist, Joint Economic Committee of the U.S. Congress

Arthur B. Laffer
Chairman, Laffer Associates
First Chief Economist, Office of Management and Budget (OMB)
Former Member, Economic Policy Advisory Board

Jim Capretta
Fellow, Ethics and Public Policy Center
Former Associate Director, White House Office of Management and Budget (OMB)

James D. Mietus, Ph.D.
Independent Economist and Policy Adviser
Former Economist, Office of Management and Budget (OMB)

Michael Boskin
Professor of Economics, Stanford University
Former Chairman, White House Council of Economic Advisers (CEA)

William Niskanen
Former Action Chairman and Member, White House Council of Economic Advisers (CEA)
Chairman Emeritus, Cato Institute

Earl L. Grinols
Distinguished Professor of Economics, Baylor University Former Senior Economist, White House Council of Economic Advisers (CEA)

Mark H. Showalter
Professor of Economics, Brigham Young University
Former Senior Economist, White House Council of Economic Advisers (CEA)

Scott Baier
Associate Professor of Economics, Clemson University
Former Senior Economist, White House Council of Economic Advisers (CEA)

Larry Lindsey
President, The Lindsey Group
Former Director, National Economic Council (NEC)

Todd G. Buchholz
Managing Director, Two Oceans Management
Former Senior Economic Adviser, The White House Fellow, Cambridge University

Edward C. Prescott
W.P. Carey Chaired Professor of Economics, Arizona State University
Economist, Federal Reserve Bank of Minneapolis
Nobel Laureate in Economics

William Poole
Distinguished Scholar in Residence, University of Delaware
Senior Fellow, Cato Institute
Former President, Federal Reserve Bank of St. Louis

Kevin Hassett
Director, Economic Policy Studies, American Enterprise Institute (AEI)
Former Economist, Federal Reserve Board of Governors

Mario J. Crucini, Ph.D.
Research Associate, National Bureau of Economic Research (NBER)
Senior Fellow, Globalization and Monetary Policy Institute, Federal Reserve Bank of Dallas

Stephen J. Entin President and Executive Director Institute for Research on the Economics of Taxation Former Deputy Assistant Secretary for Economic Policy, Department of the Treasury

Kathleen B. Cooper, Ph.D.
Senior Fellow at the Tower Center for Political Studies, Southern Methodist University
Former Undersecretary for Economic Affairs, Commerce Department

Diana Furchtgott-Roth
Director, Center for Employment Policy
Senior Fellow, Hudson Institute Former Chief Economist, U.S. Department of Labor

Carl J. Dahlman
Senior Economist, RAND Corporation
Former Deputy Assistant Secretary, Department of Defense
Former Deputy Assistant Secretary, Department of Health and Human Services

David Malpass
President, Encima Global
Former Deputy Assistant Secretary, Treasury Department
Former Deputy Assistant Secretary, State Department

Thomas R. Saving
Jeff Montgomery Professor of Economics, Texas A&M University
Senior Fellow, National Center for Policy Analysis
Former Public Trustee, Social Security and Medicare Trust Funds

Timothy Perri
Professor of Economics Appalachian State University

Allan DeSerpa
Professor of Economics
Arizona State University

Nancy Roberts
Professor of Economics
Arizona State University

Clarence R. Deitsch
Professor of Economics and Labor Relations
Ball State University

Courtenay C. Stone
Professor of Economics
Ball State University

John Bethune, Ph.D.
Kennedy Chair of Business
Barton College

E.S. Savas, Ph.D. Presidential Professor School of Public Affairs Baruch College/ CUNY

David VanHoose
Professor of Economics
Baylor University

Kenneth V. Greene
Distinguished Professor of Economics
Binghamton University

E.F. Stephenson
Professor of Economics
Chair, Department of Economics
Berry College

David E. Spencer
Professor of Economics
Brigham Young University

Michael L. Marlow
Professor of Economics
Cal Poly

Donald J. Oswald
Professor of Economics (Retired)
California State University, Bakersfield

Cathleen J. Coolidge
Associate Professor of Economics
California State University, Chico

Charles W. Baird Ph.D. Professor of Economics, Emeritus California State University, East Bay

Alan Rufus Waters, Ph.D Professor Emeritus of International Business California State University, Fresno

G. Michael Phillips, Ph.D. Professor of Finance, Real Estate, and Insurance California State University, Northridge

Allan Meltzer
Professor of Political Economy
Carnegie Mellon University

Yuri N. Maltsev, PhD Professor of Economics Carthage College

Jason E. Taylor
Professor of Economics
Central Michigan University

Dr. Lawrence Brunner
Associate Professor, Economics
Central Michigan University

Arthur T. Denzau
Professor of Economics
Claremont Graduate University

Marc D. Weidenmier
William F. Podlich Associate Professor of Economics
Research Associate, National Bureau of Economic Research (NBER)
Claremont McKenna College

Robert Tamura
Professor of Economics
Clemson University

Phoebus J. Dhrymes Edwin W. Rickert Professor of Economics Columbia University

Charles W. Calomiris
Henry Kaufman Professor of Financial Institutions, Columbia Business School
Columbia University

Richard V. Burkhauser
Sarah Gibson Blanding Professor of Policy Analysis
Cornell University

Antony Davies
Associate Professor of Economics
Duquesne University

Richard E. Ericson
Professor and Chair of Economics
East Carolina University

Minh Q. Dao
Professor of Economics
Eastern Illinois University

Paul H. Rubin Samuel Candler Dobbs Professor of Economics Emory University

Richard F. Muth
Fuller E. Callaway Professor of Economics, Emeritus
Emory University

Ronnie Davis
Graduate Faculty—Economics
Florida Institute of Technology and Averett University

Henry G. Manne
Dean Emeritus George Mason University School of Law

Dr. Anthony B. Sanders Distinguished Professor of Finance George Mason University

James Burnham
Distinguished Service Professor
Duquesne University
Former Staff Director, President's Council of Economic Advisers

Douglas, C. Frechtling
Professor of Tourism Studies

George Washington University

Richard J. Sweeney
Professor of International Finance
McDonough School of Business
Georgetown University

W. Ken Farr
Chair & Professor of Economics, Department of Economics & Finance
Georgia College & State University

Christine Ries
Professor of Economics
Georgia Institute of Technology

Gerald Gay
Professor of Finance
Georgia State University
Former Chief Economist, Commodity Futures Trading Commission

Christopher R. Inama
Senior Adjunct Professor
Golden Gate University

Charles N. Steele, Ph.D.
Associate Professor
Hillsdale College

Gary Wolfram
Professor of Economics
Hillsdale College

Ivan Pongracic, Jr.
Associate Professor
Hillsdale College

Nikolai G. Wenzel, Ph.D.
Assistant Professor of Economics
Hillsdale College

John Lunn
Robert W. Haack Professor of Economics
Hope College

John A. Tatom
Director of Research, Networks Financial Institute
Scott College of Business, Indiana State University

Tom Lehman
Professor of Economics
Indiana Wesleyan University

Richard J. Cebula
Davis College of Business
Walker/Wells Fargo Endowed Chair in Finance
Jacksonville University

Timothy Mathews
Assistant Professor of Economics
Kennesaw State University

W. Mark Crain
William E. Simon Professor of Political Economy
Lafayette College

Nicole V. Crain
Professor of Economics
Lafayette College

James L. Huffman
Erskine Wood Sr. Professor of Law
Lewis & Clark Law School

Richard J. Grant, Ph.D. Professor of Finance & Economics, College of Business, Lipscomb University

Don M. Chance
James C. Flores Endowed Chair of MBA Studies and Professor of Finance
Louisiana State University

W. Douglas McMillin
Mack Hornbeak Endowed Professor in Economics
Louisiana State University

Otis W. Gilley Distinguished Professor of Economics Louisiana Tech University

Frank Spreng, Ph.D. Professor of Economics and Director of the MBA Program McKendree University

John P. Cochran
Dean, School of Business
Professor of Economics
Metropolitan State College of Denver

William R. Hart
Professor of Economics
Miami University (Oxford, OH)

F. Owen Irvine
Professor of Economics
Michigan State University

Michael C. Davis
Associate Professor of Economics
Missouri University of Science and Technology

Richard E. La Near, Ph.D.
Professor of Economics and Finance

Emeritus J.R. Kuhn Professor of Finance
Missouri Southern State University

Stephen A. Tolbert, Jr. Lecturer, Economics Montgomery County Community College

Micha Gisser
Professor Emeritus of Economics
University of New Mexico

James B. Ramsey
Professor, Department of Economics
New York University

R. Morris Coats
Professor of Economics
Nicholls State University

Barry K. Goodwin
William Neal Reynolds Distinguished Professor Economics
North Carolina State University

John Seater Professor of Economics
North Carolina State University
Michael Wohlgenant William Neal Reynolds Distinguished Professor North Carolina State University

Gerald R. Jensen, PhD, CFA Professor of Finance Northern Illinois University

Joseph M. Jadlow, Ph.D.
Professor of Economics
Oklahoma State University

Douglas K. Adie Professor of Economics Ohio University

Richard Vedder Distinguished Professor of Economics, Ohio University Adjunct Scholar, American Enterprise Institute

Paul Evans
Professor of Economics
Ohio State University

Frank Wykoff
Eldon Smith Professor of Economics, Emeritus
Pomona College

David A. Brat
Professor and Chair, Department of Economics and Business
Randolph-Macon College

Fred E. Foldvary
Director, Civil Society Institute
Santa Clara University

David R. Henderson
Research Fellow, Hoover Institution
Stanford University

Dino Falaschetti
Gleed Endowed Chair, Seattle University
Associate Professor of Law and Economics, Florida State University

Norman Lefton, PhD Adjunct Associate Professor at the School of Business Southern Illinois University, Edwardsville

Lawrence J. Belcher, Ph.D.
Professor of Finance
Stetson University

David G. Tuerck
Professor of Economics
Suffolk University

Edgar K. Browning
Professor of Economics
Texas A&M University

Frank Egan
Associate Professor of Economics
Trinity College

Dorla A. Evans, Ph.D.
Professor of Finance, Department of Accounting and Finance
University of Alabama in Huntsville

Larry L. Ross
Professor of Economics
University of Alaska Anchorage

Lawrence Southwick
University Research Scholar, Finance and Managerial Economics Department
University at Buffalo

Leon Wegge
Professor of Economics Emeritus
University of California, Davis

Avanidhar Subrahmanyam
Goldyne and Irwin Hearsh Chair in Finance, Anderson School of Management
University of California, Los Angeles (UCLA)

Lee E. Ohanian
Professor of Economics
University of California, Los Angeles (UCLA)

Richard Roll
Professor of Finance, Anderson School of Management
University of California, Los Angeles (UCLA)

Professor Richard L. Smith
Philip L. Boyd Chair and Professor of Finance
University of California, Riverside

A. Edward Day, Ph.D. Associate Professor of Economics (retired) University of Central Florida

Steven N. Kaplan
Neubauer Family Professor of Entrepreneurship and Finance, Booth School of Business
University of Chicago

Eugen F. Fama
Robert R. McCormick Distinguished Service Professor of Finance, Booth School of Business
University of Chicago

Robert E. Lucas, Jr.
John Dewey Distinguished Service Professor of Economics, Department of Economics
University of Chicago

Barry W. Poulson
Professor of Economics (retired)
University of Colorado at Boulder

Jane H. Lillydahl
Professor Emerita, Department of Economics
University of Colorado at Boulder

Sanjai Bhagat
Professor of Finance
University of Colorado at Boulder

Michael Cosgrove Professor, University of Dallas Principle, Econoclast

Eleanor D. Craig
Associate Chair & Professor of Economics
University of Delaware

Richard Agnello
Associate Professor of Economics
University of Delaware

Stacie E. Beck
Associate Professor of Economics
University of Delaware

James B. O'Neill
Professor of Economics
Director, Center for Economic Education and Entrepreneurship
University of Delaware

C. Thomas Howard, Ph.D.
Professor, Reiman School of Finance
University of Denver

Ronald W. Ward
Emeritus Professor
University of Florida

Jeffrey H. Dorfman
Professor, Department of Agricultural and Applied Economics
The University of Georgia

James Moncur Professor Emeritus of Economics
University of Hawaii at Manoa

Paul R. Gregory
Cullen Professor of Economics
University of Houston

Roy J. Ruffin
M.D. Anderson Professor of Economics
University of Houston

R. Ashley Lyman
Professor Emeritus of Economics and Statistics
University of Idaho

Peter F. Colwell Professor Emeritus, Department of Finance
University of Illinois at Urbana-Champaign

William P. Albrecht Professor of Economics
University of Iowa

Michael R. Montgomery
Associate Professor of Economics
University of Maine

Jon Reisman
Associate Professor of Economics and Public Policy
University of Maine at Machias

Richard E. Just Distinguished University Professor University of Maryland—College Park

Ronald. L. Promboin, Ph.D. Adjunct Professor University of Maryland—University College Coldwell Daniel, III
Professor Emeritus
University of Memphis

Michael Connolly
Professor of Economics, University of Miami
Professor of Finance, Hunan University

Christopher Douglas, Ph.D.
Assistant Professor of Economics
University of Michigan-Flint

Mark J. Perry, Ph.D.
Visiting Scholar at the American Enterprise Institute (AEI)
Professor of Finance and Business Economics
University of Michigan-Flint

Stephen Parente, Ph.D.
Minnesota Insurance Industry Professor of Healthcare Finance
Director, Medical Industry Leadership Institute (MILI)
University of Minnesota

William F. Shughart II
F.A.P. Barnard Distinguished Professor of Economics
The University of Mississippi

Joseph Haslag
Professor and Kenneth Lay Chair in Economics
University of Missouri-Columbia

Susan Feigenbaum
Professor of Economics
University of Missouri at St. Louis

Arthur M. Diamond, Jr. Professor of Economics University of Nebraska at Omaha

Robert E. Chatfield Professor of Finance University of Nevada—Las Vegas (UNLV)

Evangelos Otto Simos
Professor of Economics, University of New Hampshire
Editor, Journal of Business Forecasting
Chief Economist, e-forecasting.com

Jim F. Couch
Professor of Economics
University of North Alabama

Alan C. Shapiro
Ivadelle and Theodore Johnson Professor of Banking and Finance Emeritus
Marshall School of Business
University of Southern California

Joel W. Hay, PhD Professor, Schaeffer Center for Health Policy and Economics University of Southern California

John G. Matsusaka
Professor of Finance and Business Economics
Charles F. Sexton Chair in American Enterprise
University of Southern California

Joseph Zoric
Associate Professor of Economics and MBA Director
Franciscan University of Steubenville

Roger Meiners
Professor of Economics
University of Texas at Arlington

Barry J. Seldon, Ph.D.
Professor of Economics and Political Economy
University of Texas at Dallas

Nathan J. Ashby
Assistant Professor of Economics
University of Texas at El Paso

Timothy P. Roth, PhD
A.B. Templeton Professor and Chairman, Department of Economics and Finance
University of Texas at El Paso

Robert Collinge Professor of Economics University of Texas at San Antonio

John E. Murray Professor, Department of Economics University of Toledo
Author, Origins of American Health Insurance

Richard T. Selden
Carter Glass Professor of Economics Emeritus
The University of Virginia

David L. Kendall, Ph.D.
Professor of Economics and Finance
Chair, Department of Business and Economics
University of Virginia's College at Wise

Luke M. Froeb
Associate Professor of Entrepreneurship and Free Enterprise
Vanderbilt University

Larry Van Horn
Associate Professor of Healthcare Management
Executive Director of Health Affairs, Owen Graduate School of Management
Vanderbilt University

Floyd H. Duncan, Ph.D. Roberts Professor of Free Enterprise Economics Chairman, Department of Economics and Business Virginia Military Institute
Robert J. Rossana
Professor of Economics
Wayne State University

Glenn MacDonald
Distinguished Professor of Economics and Strategy
Senior Associate Dean, Olin School of Business
Washington University in St. Louis

William N. Trumbull, Ph.D.
Professor of Economics West Virginia University

Robert D. Seeley
Associate Professor of Economics
Wilkes University

Dr. Jim Clark Associate Dean Associate Professor of Economics Wichita State University

John McArthur
Professor and Chair of Economics
Wofford College

Lawrence W. Lovik, Ph.D.
Senior Fellow
Alabama Policy Institute

Michael Ramlet
Coordinator—Operation Healthcare Choice
American Action Forum

Aparna Mathur
Resident Scholar
American Enterprise Institute

Philip I. Levy
Resident Scholar
American Enterprise Institute

Judy Shelton
Senior Fellow and Co-Director of the Sound Money Project
Atlas Economic Research Foundation

Warren Coats
Monetary Policy Advisory, Central Banks of Afghanistan, Iraq, Kazakhstan, Kenya, and Zimbabwe
Currency Director, Cayman Island Monetary Authority

Grace-Marie Turner
President
Galen Institute

Richard W. Rahn,
Chairman
Institute for Global Economic Growth

Merrill Matthews
Resident Scholar
Institute for Policy Innovation

John W. Diamond
Edward A. and Hermena Hancock Kelly Fellow in Public Finance
James A. Baker III Institute for Public Policy
Chief Executive Officer, Tax Policy Advisors, LLC

Mike Schuyler Senior Economist Institute for Research on the Economics of Taxation (IRET)

Paul Howard, Ph.D
Senior Scholar
Manhattan Institute

Daniel R. Feenberg
Research Associate
National Bureau of Economic Research (NBER)

John C. Goodman
President, CEO and Kellye Wright Fellow
National Center for Policy Analysis

Benjamin Zycher Senior Fellow
Pacific Research Institute

John R. Graham,
Director, Health Care Studies
Pacific Research Institute

Carlos Bonilla
Partner, Airline Forecasts
Former Special Assistant for Economic Policy, President George W. Bush

Robert Genetski
President
classicalprinciples.com

James F. Smith
Chief Economist
EconForecaster.com

Dorsey D. Farr, Ph.D., CFA
Co-Founder French Wolf & Farr

R. David Ranson
President and Director of Research H. C. Wainwright & Co. Economics Inc.

Donald L. Luskin
Chief Investment Officer
TrendMacro

Robert D. Niehaus
President and Principal Economist
Robert D. Niehaus, Inc.

Chairman CAMP. I just want to ask a simple question of both of you. We have heard a lot of testimony today. There has been, some of it, very technical.

Just on balance, does this health care legislation help you create jobs and help you grow your businesses, or does it make it harder for you to grow jobs and expand your businesses?

Mr. OLIVO. From my point of view, what my concern is, is that I know many on this committee want to provide health care coverage for everybody, and would say, "How would I explain to somebody that I would not provide health care coverage for them?"

My fear, as an employer, is going to an employee saying, "I have to eliminate your position, because not only can I not afford your health care, I can't afford your position any more." And that's what my concern is.

Chairman CAMP. All right. Mr. Womack.

Mr. WOMACK. Well, the reality is that this just scares business people to death. And any time you have this level of fear and uncertainty, we quit growing, we tighten up. We have to have a reserve. We can't go out to the edge financially, and then suddenly have $5 gasoline or commodity prices go through the roof and have no margin, no cushion to survive. So it just makes us more and more conservative, and that means trimming, pure and simple.

Chairman CAMP. All right. Thank you. Thank you both. I think at this time all Members present have had a chance to inquire of this panel. And I want to thank you both very much for your thoughtful testimony, and for the efforts you put in to providing livelihoods and prosperity of the employees that you have. And I know the difficult responsibility that is that you carry around every day.

So, I want to thank you for taking the time away from those endeavors to be here, and help enlighten this committee. And with that, this hearing is adjourned.

[Whereupon, at 12:10 p.m., the committee was adjourned.]

[Submissions for the Record follow:]

Rep. Jim McDermott

Statement for the House Ways and Means Committee Hearing on the "Effect of Health Reform on Jobs and the Economy"

January 25, 2011

Mr. Chairman, this hearing is really just a press event for the Republicans to twist the facts of the health care law and attempt to further scare and polarize the American public. It won't work, but we're still going to waste time with this political theater.

I am very sorry to see Doug Holtz-Eakin, the former Director of the Congressional Budget Office, testifying before our committee today. He's here to beat up on his former agency whose conclusions he no longer likes. Railing against the very institution he formerly directed, one that is so essential to our work, does a disservice to the Budget Office, the whole Congress and the American people.

Republicans, like Mr. Holtz-Eakin, have taken to dismissing any non-partisan assessments they don't like. These days, in the eyes of Republicans, CBO is only right when they release reports that validate Republican political rhetoric.

As for the other witnesses who are testifying, I am sorry you believe the new health care law is bad for your businesses. However, there are countless other small, medium and large businesses that like the health care law and believe repealing it is an awful idea.

You don't have to take my word for it. The National Business Group on Health, a collection of nearly 500 big employers, opposes repeal. Helen Darling, the group's President and a former Republican Senate Staffer, has said the following about the

health care law: "I don't think we'll get a better solution in the U.S. in our lifetime. If it gets repealed or gutted, we'll have to start over and we'll be worse off."

As for the impact on small businesses, PolitiFact looked into a U.S. Chamber of Commerce campaign ad that said the health care law was bad for small businesses and said the claims were "perplexing because small businesses can actually qualify for tax *credits* under the new health care law."

PolitiFact went on to say:

> "A vast majority of U.S. firms are smaller than 50 employees and are exempt from the health insurance requirements. The chamber's ad is sweeping, and doesn't account for any of the positive provisions that don't 'crush' small business but actually help them."

It is my hope that we can move beyond Republicans' political theatrics and focus on getting the economy back on track.

Business Roundtable

Hewitt

Health Care Reform:
Creating a Sustainable Health Care Marketplace

A Report to Business Roundtable

By Hewitt Associates

November 2009

Contents

Executive Summary

As federal health care reform proposals work their way through Congress, companies and individuals are increasingly concerned about the price tag—not just to the federal budget, but to their own bottom lines and wallets. Will the proposed initiatives focused on expanding coverage and controlling federal health spending actually make matters better or worse for private-sector employers and the 160 million people who receive employment-based health insurance? The cost estimates for the different bills have primarily focused on the federal budgetary impact of health care reform.

Business Roundtable commissioned Hewitt to prepare this report to evaluate health care reform through the lens of the private sector and to project the likely effect of proposed legislative changes on employer health care costs. This report addresses four key questions:

- Of the reform initiatives currently being considered that intend to curb the rate of health care cost growth, which ones are likely to have a significant impact on the health care economy at large?
- What missing ingredients should be added to current proposals to enhance their potential to reduce future cost trends?
- What are the risks that could undermine the realization of these cost savings?
- What can be done longer-term to restructure the current health care delivery system in order to reduce annual health care cost trend to a sustainable rate, such as the overall rate of GDP growth (approximately 4% per year)?

The Status Quo Is Not Sustainable

In a report for Business Roundtable (BRT) titled "Health Care Reform: The Perils of Inaction and the Promise of Effective Action," Hewitt pointed out the potential benefits of revamping the nation's health care system, if done wisely, and the pitfalls of inaction. Access concerns have rightfully been a big focus of recent national debates. However, for the 98 out of 100 companies (with 200 or more workers) that already provide coverage[1] and for their employees, rising health care costs are the primary concern. The current health care system continues to push spending upward at a pace faster than the growth in the overall economy. If U.S. companies are to remain competitive in an increasingly global marketplace, we must do more and do it faster to bring down the rate of increase in health care costs.

Without fundamental reform, there is little reason to expect that cost increases over the next 10 years will be different from the recent past. If the cost trends of the past 10 years repeat, by 2019, employment-based spending on health care at large employers will be 166% higher than today on a per-employee basis. This equates to an average of $28,530 per employee when employer subsidies, employee contributions, and employee out-of-pocket costs are combined. We estimate that if enacted properly, the right legislative reforms could potentially reduce that trend line by more than $3,000 per employee, to $25,435. If we are able to enact broader market reforms that eventually lower future cost increases to an average of 4% per year, we could potentially reduce average per-employee costs further to $23,151 per employee by 2019.

Current Legislation Provides Opportunities for Real Savings

A number of the proposed reforms offer real promise, not only to save federal dollars, but also to reduce the rate of increase in private-sector spending if adopted and implemented appropriately. Promising ideas include proposed delivery system reforms such as value-based purchasing, Innovation Centers to experiment with alternative methods of provider reimbursement, accountable care organizations, payment bundling, and financial penalties for avoidable hospital readmissions. We estimate that these and other sound reforms could potentially reduce the rate of future health care cost increases by 15% to 20% when

fully phased in by 2019. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers follow by implementing similar measures in a disciplined and timely way.

The current proposals are missing some ingredients needed to drive the type of system-wide change that can "bend the future trend" significantly and permanently. Most important, current reform provisions must be broadened if we hope to achieve a more "normal" market dynamic for health care costs across all stakeholders, both public and private. For example, value-based purchasing initiatives should be expanded beyond hospitals to include other services, such as outpatient services, rehabilitation services, and long-term care. Comparative effectiveness research is vital, but we must find ways to encourage providers to adhere to evidence-based guidelines and encourage purchasers to adopt evidence-based plan designs. And release of Medicare professional services claims data, with full protection of patient privacy, should be authorized in the final legislation. By making this broader set of claims data available to employer-provided health plans, consumers will be able to consider the cost and quality of services rendered by providers and make informed decisions about their treatment. The Innovation Center concept run by the Centers for Medicare & Medicaid Services to test models for delivering and reimbursing care differently should be embraced and the scope expanded to assess the interactions with private health plans and create new options for both the public and private sectors. And medical liability reforms should be included, which are now largely missing from the leading health care reform proposals.

Risks Could Jeopardize Cost Reductions

The cost-savings initiatives can only be fully realized as a part of comprehensive health care reform that is extended through the efforts of private insurers and the employer-sponsored system. The report identifies a number of risks that could undermine expected savings or shift more costs to the private sector, including:

- Delayed or watered-down implementations;
- Future legislative reversals of potential cost-saving provisions;
- Continuation of the practice and related costs of defensive medicine and the cost to providers of malpractice insurance;
- Failure to implement a strong individual mandate to minimize cost increases in the health insurance exchange plans due to adverse selection;
- Unintended consequences as health plans take steps to keep the cost of health coverage below the threshold for the proposed excise tax on high-cost plans or as employers are unable to live within the cap as it gets relatively tighter over time;
- Increases in the cost of health care to individuals from changes to flexible spending arrangements or actions that discourage consumer-engaged decision making; and
- Cost shifting to the private sector from reductions in federal reimbursements to providers and from a public plan option if included.

Avoiding these risks will require both changes to some of the current legislation and discipline in how reform is ultimately implemented in both the government and employer-sponsored health care system.

True Market Reform Can Yield Even Greater Savings

Beyond the current legislative proposals, the biggest opportunities for cost savings in the long term would come from a continuous improvement process to make the current system function more like a true market system. This could lead to growth rates akin to the growth of the overall economy, which we assume to be about 4% annually. The cost or savings from the current list of reform initiatives, as estimated for Congress, focus on the budgetary impact to the federal government. From the perspective of the private sector, this is really just the starting point of what is needed if businesses, as well as the government, are to realize

sustained savings. If we can reduce employer (only) contributions to an annual growth rate of 4% per year through more comprehensive reform efforts, Hewitt estimates the cumulative savings to large employers by 2019 would be equivalent to the wage and benefit costs of 102,000 additional employees for each one million employees currently in the workforce.

If our collective goal as a nation is to "bend future trend," the steps we take now must effectively manage the three key drivers of health care cost: price, utilization, and behavior. If not addressed, any one of these three forces could prevent the health care market from ever mirroring more traditional economic models. This report identifies a set of representative market-driven reforms. Most of these ideas are not new, but we believe that now is the time to take bolder steps to build decisively on the constructive legislative reforms under consideration. True market reform will:

- Encourage initiatives that give individuals greater accountability for discretionary health care spending decisions, including health reimbursement arrangements and health savings accounts;
- Make information on the cost and quality of care from physicians and hospitals readily available to patients so they can make more informed decisions as health care consumers;
- Develop payment system reforms that reward high quality and cost-efficiency;
- Eliminate regional variation in practice patterns to reduce overall spending by as much as 20% to 30%;
- Promote wellness and prevention programs and expand financial incentives to participate in specific programs to reduce lifestyle-related illness;
- Mandate an interconnected health care information system to lower administrative costs, reduce redundant tests, reduce medical errors, and improve coordination of care; and
- Create incentives to produce more primary care physicians before the looming shortage becomes a crisis.

Taken together, legislative reforms and broader market transformation can create the game-changing efficiencies needed in the health care sector. But the need to make the "right" decisions is more important than ever if we are to leverage legislation and the activities of the private sector to realize sustained reductions in future cost trends. The focus must not only encompass an analysis of the impact of reform on federal costs, but also incorporate an understanding of the potential risks and improvements that will flow to the employer-based system that provides coverage for the vast majority of Americans.

The Status Quo Is Not Sustainable

A poorly functioning health care "market" is the cause of the rapid growth of health care costs well in excess of growth rates in other industries. In fact, the health care system does not act like a traditional market at all. Traditional forces of supply and demand are muted by a third-party, fee-for-service payment system and significant cost shifting between payers. By adopting significant market changes, it is possible to lower medical cost trends further than currently proposed reforms alone.

Exhibit 1: Comparison of Alternative Health Care Cost Rates: Status Quo, Legislative Changes, and Restructured Marketplace

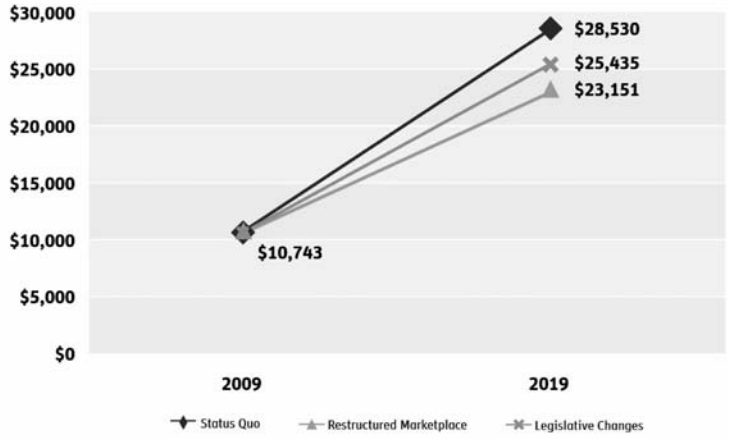


Exhibit 1 illustrates per-employee health care costs at large employers under three different scenarios:

- Continuation of the status quo, i.e., if the trends in growth in employer and employee contributions and employee out-of-pocket costs continue to rise at the same rate as they have in the past decade.
- A 15% to 20% reduction in those trends by 2019, assuming successful implementation of the legislative changes under discussion that offer the potential for real cost savings and avoiding the risk factors that could jeopardize such potential savings. Exhibit 1 illustrates the midpoint of that 15% to 20% reduction in future trend in 2019.
- Assuming broader restructuring beyond current legislative proposals that would lower future per-employee cost growth to an annual rate of 4% through more expansive improvements, resulting in a restructured health care marketplace.

Fundamentally changing a $2.4 trillion industry will take time. As reflected in the chart above, the effects of market improvements may start out slowly. But with meaningful restructuring in place by 2019, the impact of a more efficient health care marketplace on the global competitiveness of American business and the overall U.S. economy would be both measurable and significant.

To illustrate the potential impact, Hewitt estimates that for every one million people covered by large-employer health benefit plans, large-employer health contributions alone will be approximately $6.9 billion in 2009, rising to $14.6 billion in 2019 without meaningful reform. However, if trend rates for employer (only) contributions could be lowered from the current 7.7% annual rate to 4% by 2019, the cumulative savings to these companies would amount to $9 billion (exhibit 2). Assuming a salary and benefit cost per employee of approximately $69,000[2] in 2009, by 2019 these cumulative savings would be roughly the equivalent of the wage and benefit costs of 102,000 additional employees (exhibit 3). This does not even measure the real wage growth that workers would enjoy over this same period. In fact, wage growth is currently being stifled by double-digit annual increases in payroll contributions and out-of-pocket health care costs. This is the potential incremental power of health care reform—to stimulate business growth. Companies can then reinvest in jobs and innovation. Employees with higher take-home pay will spur consumer demand. And American companies can be more competitive in the global market.

Exhibit 2: Estimated Annual Large-Employer Health Care Spending per One Million Employees ($ Billions)[3]

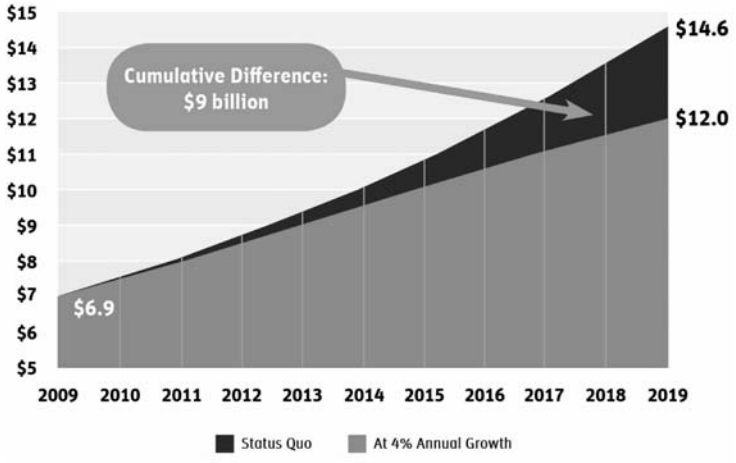
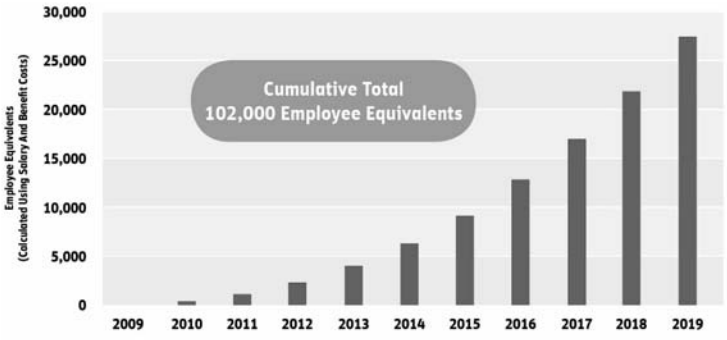


Exhibit 3: Health Care Savings Relative to Employee Salary and Benefit Costs Per Million Employees[4]



To achieve such results, health care reform must be continuous and extend beyond the current list of "scored" initiatives that have been identified as potential cost-saving opportunities. Incremental efforts, like those proposed by House and Senate Committees, will undoubtedly be helpful over the long term. But on their own, they will not bend the cost curve as much as is needed to approximate the overall growth rate in the economy, and they could easily become sabotaged by the same risks that have plagued cost-control initiatives for decades. The current dynamics of the health care market are often akin to "squeezing the balloon"—saving money in one area only to see costs reappear in another. This is the danger of making incremental changes without taking a total-systems view.

In this report, we identify the key proposed health care reform provisions that are likely to generate a measurable financial impact. We also propose additional reform initiatives that could drive true market change if enacted.

The report makes these assessments with several key questions to answer:

- What impact will the current reform initiatives being considered have on starting to control the rate of growth of health care costs, not just for the federal government, but for the economy at large?
- What missing ingredients should be added to the current proposals to enhance their potential to reduce future cost trends?
- What are the risks that could undermine or nullify the potential for cost savings for the private sector in the short term and in the long term?

The changes we identify are meaningful, but even with timely and complete implementation, they still leave health care cost trends significantly higher than growth rates in the rest of the economy. To avoid yet another missed opportunity for sustainable, long-term cost control, we must fundamentally restructure the way that care is delivered. We must restore the connection between price and value with transparency of information, properly aligned financial incentives, and rewards for quality. We make suggestions below for what might be done longer-term to significantly modify the current health care delivery system.

Current Legislation Provides Opportunities for Real Savings

In our previous report for Business Roundtable, "Health Care Reform: The Perils of Inaction and the Promise of Effective Action," Hewitt identified a wide range of economic and social benefits that could result from effective health care reform. These included an important expansion of health insurance coverage and the introduction and creation of new markets in the form of health insurance exchanges coupled with insurance market reforms. But we also said that simply expanding coverage without delivery system and other reforms to improve the efficiencies of the health care market could cause major problems. "Expanding health insurance coverage is critically important, but simply adding more people to an ailing system and spending more money will only make the existing cost problems worse."

Now we are taking the analysis one step further and evaluating a broad range of legislative initiatives that could have a positive material impact on "bending" the future trend line for health care costs, to the order of 15% to 20% by 2019. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers implement similar measures in a disciplined and timely way.

Value-Based Hospital Purchasing

Proposed health care reforms can build on the success of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative. This hospital value-based purchasing (VBP) program in Medicare would move beyond pay-for-reporting on quality measures, to paying for a hospital's *actual performance* on these measures. This would be a powerful incentive for reducing future health care cost increases.

For example, under the Senate Finance Committee's America's Healthy Future Act, funding for value-based incentive payments for qualifying acute-care hospitals would be generated by reducing Medicare inpatient prospective payment system (IPPS) payments to the hospitals. Predetermined IPPS rates that reimburse hospitals for acute-care hospital inpatient stays would be reduced to fund an incentive pool and would be phased in as follows: 1.0% in FY2013, 1.25% in FY2014, 1.5% in FY2015, 1.75% in FY2016, and 2.0% in FY 2017 and beyond.

The Senate Finance Committee (SFC) bill also calls for expansion of a similar program for physicians—one that pays for *reporting* data, but not for actual *outcomes*. Other provider payment provisions call for reducing payments by 5% for providers at or above the 90th percentile in resource use and taking steps to pay providers based on quality measures.

The Congressional Budget Office (CBO) scores these actions as having the potential to save the federal government $1.5 billion over the next 10 years. We believe that it will yield continuing savings beyond 2019. Neither CBO nor others have quantified the impact beyond 2019.

Changes in payment methodology under the Medicare program will act as a catalyst for broader market reforms. Once VBP becomes an accepted payment methodology under Medicare, private payers will be able to negotiate similar incentive structures for their commercial portfolios. This will create total savings from this initiative that would be a multiple of the savings accrued to the federal budget.

Incentives for Continuous Improvement and Innovation

Some of the proposed health initiatives are aimed at achieving the kind of continuous improvement that is necessary to yield long-term savings. Comparative effectiveness research is a good example. Such research can lower cost and improve quality. And even though the "scores" associated with comparative

effectiveness result in some cost to the federal government for conducting the research, the rewards are likely to be realized longer-term and in both the public and private sectors.

Another example of a step in the right direction can be found in the SFC provision that calls for the development of an "Innovation Center" run by the Centers for Medicare & Medicaid Services (CMS). This Center would be required to test models that drive change in at least one aspect of how care is delivered and/or reimbursed. CBO scores the funding of this Center, and its resulting impact, as a net savings in Medicare spending of $1.4 billion over 10 years. This projection is heavily back-end loaded, however, with early years showing a net cost.

The Innovation Center will build for the future by testing and improving the Medicare system on a continuous basis. The strategies can then be emulated by the private sector to produce multiples of Medicare's benefit savings across the marketplace. Some of the more promising models that would be tested under the Center include:

- Strengthening the primary care system and testing the concept of "medical homes";
- Varying payments to physicians who order advanced diagnostic imaging studies, with payment based on the appropriateness of these studies;
- Supporting IT-enabled networks and tele-health capabilities;
- Funding nurse practitioners and physician assistants to manage chronically ill patients;
- Aligning evidence-based treatment guidelines with Medicare reimbursement levels; and
- Allowing states to experiment with all-payer systems to eliminate cost shifting between public and private-sector programs.

These initiatives are all good examples of the kinds of practice innovations that will be required if reform is to accomplish its goals. As indicated by CBO, success will be measured over a long period of time and will likely involve successful local or regional demonstration projects before expanding to a national scale. The economic impact of these experiments on private-sector employers will depend on the priority of development, the speed of change, and the breadth of application.

Accountable Care Organizations

The House and Senate health care reform bills include the creation of accountable care organizations (ACOs). Medicare has had practical experience with ACO-like organizations. The Medicare physician group practice (PGP) demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, created pay-for-performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients.

CMS selected 10 physician groups on a competitive basis to participate in the demonstration, favoring multi-specialty physician groups with well-developed clinical and management information systems. The 10 physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than 2% were allowed to share in the savings they generated to the Medicare program.

In the most recent year of the PGP demonstration, all participants demonstrated improvements in quality and achieved below-average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the 2% threshold. By 2019, CBO scores the SFC initiative as saving $1.2 billion annually for the Medicare program.

Hewitt has conducted proprietary studies that find that private-sector savings from initiatives such as these can be very positive. These virtual adaptations of the original vision of coordinated-care plans offer reimbursements tied to overall performance and outcomes rather than to the amount and intensity of services. In 2007 and 2008, Hewitt conducted two proprietary studies of the financial efficiency of HMOs compared with other plans, based on data from the Hewitt Health Value Initiative™ (HHVI™) database of large-employer plans over a 10-year period. These studies showed that, in general, HMOs are 1% to 5% more efficient than PPOs, primarily because of greater provider discounts available in closed-panel models. However, the study also showed that specific HMOs—California HMOs in general and group/staff models in particular (Kaiser Permanente and Group Health of Puget Sound, for example)—were as much as 10% to 15% more efficient than PPOs.[5] These organizations shared several key characteristics that drove this additional efficiency:

- The presence of coordinated-care teams;
- Investments in health IT infrastructure to transfer information quickly and accurately across care teams;
- Financial arrangements with providers involving capitation payments per patient or straight salary; and
- Dissemination and adherence to evidence-based practice guidelines, including step therapy for branded medications.

Financial efficiency was not due to age, sex, geography, plan design, or health risk of the population. These plans performed better because the controlled environment allowed them to realign the incentives for superior performance. The Hewitt data shows the savings potential for private-sector employers to be much greater than the federal savings scored by CBO, especially as prevalence of these models increases to cover more geographies and employee populations.

Payment Bundling

The prevailing payment system under Medicare (especially Part B) is to reimburse providers on a fee-for-service basis, rather than paying for services based on an episode of care. Similarly, under private health insurance, where the group health plans with the largest enrollments tend to be PPO plans, services are also accessed, charged, and reimbursed on a fee-for-service basis. Establishing bundled payments would create more incentives for efficient treatments and could be adjusted based on outcomes. Health care reform proposals are moving toward bundled payments. Both the House and the Senate include provisions that focus on improved quality of care and patient outcomes. The SFC plan requires the Secretary of Health and Human Services to develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot. The program is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013.

The pilot program may cover the following services: acute-care inpatient hospitalizations; physician services delivered inside and outside of the acute-care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute-care hospital readmissions; home health; skilled nursing; inpatient rehabilitation; and long-term care. The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge.

The Secretary of Health and Human Services would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems but are held jointly accountable for the quality and cost of care provided to Medicare patients.

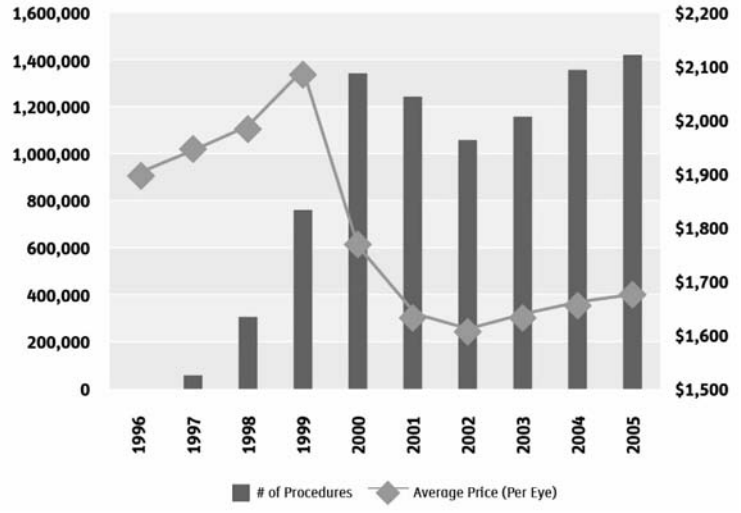
The pilot program's bundled payment would be made to a Medicare provider or another entity composed of multiple providers to cover the costs of acute-care inpatient and outpatient hospital services, physician services, and post-acute care. The comprehensive bundled payment would include the costs of any

readmissions that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute-care payments made over the hospitalization period for the patient.

CBO does not score savings for this provision, mainly because the language above suggests that Medicare will pay the same as it would otherwise have paid, instead of some lower amount per episode. Over time, however, we believe substantial savings can be achieved by both removing the financial incentive to provide marginally effective services, as well as through the active management of the rate of increase in the bundled reimbursement rate.

The market for cosmetic surgery, particularly LASIK eye surgery, provides a real-market example of this effect. Unencumbered by a third-party payment system, LASIK surgery has developed as its own consumer market. Fees are bundled because this is how consumers purchase the procedure. As demand increased, competition also increased, driving prices down and quality up—just like any other "rational" consumer market (exhibit 4).

Exhibit 4: Market Maturity of LASIK Surgery



At least for discretionary services, the health care market can behave like a consumer marketplace—but only if the financial incentives are aligned to provide quality and value. The private sector is eager to move to a bundled payment arrangement to reward quality and shift away from fee-for-service-based payments, creating an efficient and consumer-centric health care marketplace.

Preventable Readmissions

The pending health care reforms in the House and Senate include provisions to reduce hospital payments for preventable readmissions. For example, the SFC bill includes provisions to reduce hospital payments by 10% to 20% if a preventable readmission occurs. This only applies to the hospitals with the 25% worst readmission rates. CBO expects this action to save about $2.1 billion over 10 years, with $500 million per year in 2019, coupled with another $500 million in federal savings per year from a transitional care program to reduce preventable readmissions.

The House Tri-Committee bill includes a more aggressive provision to reduce hospital discharge payments by up to 5% for the occurrence of preventable readmissions. This adjustment will apply to the payment for all discharges from any hospital that has excessive readmissions, as defined in the bill. CBO expects this payment adjustment to save about $19.1 billion over 10 years, with $3.6 billion per year in 2019.

While the rate of hospital admissions is highest in the elderly population, systemic improvements to minimize hospital readmissions will produce savings for the private sector as the programs put in place to avoid these readmissions are applied to all patients.

Medicare Commission

Congress is also considering the idea of creating an independent Medicare Commission that recommends changes in provider reimbursement. Details vary, but the Commission's recommendations would go into effect unless Congress acts to prevent it.

Under the SFC bill, beginning with the 2013 report of the Medicare Trustees, the CMS Office of the Actuary (OACT) would be required to project whether the Medicare per-capita growth rate in 2015 will exceed the average of the growth rates in the Consumer Price Index (CPI) and the Consumer Price Index for medical care (CPI-M) projected for 2015.

If the projected excess cost growth is estimated to be greater than the average of CPI and CPI-Medical, the Commission would be required to submit a proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015, as estimated by the OACT. The SFC plan would require the Commission to make additional proposals on January 1 of 2015, 2016, and 2017, based on the procedures described above. However, the targeted level of Medicare savings would increase each year. The proposal delivered to Congress in 2015 would be required to reduce excess cost growth by 1.0 percentage point in 2016. The proposal delivered to Congress in 2016 would be required to reduce excess cost growth by 1.25 percentage points in 2017. The proposal delivered to Congress in 2017 would be required to reduce excess cost growth by 1.5 percentage points in 2018. The growth target in 2019 and beyond would be GDP per capita plus 1%.

CBO estimates that this concept could yield substantial savings of $22 billion over 10 years and $7 billion per year in 2019. Unfortunately, there do not appear to be any specifics on what would actually have to occur to achieve those results. It is also unclear whether the efforts to reduce Medicare spending in accordance with the SFC bill would be accomplished through direct or indirect cost shifting to the employer-driven private insurance market, a risk that could increase non-federal health care costs. Private employers can, however, take additional steps to ward off the potential for full cost shifting, and it is possible (though impossible to quantify) that some of the same provisions that would reduce Medicare spending would also help to keep Medicare payroll taxes lower than what they otherwise might have been in their absence. Such savings would accrue to employers and employees who share the payroll tax, or fully to employees if, as economists often assert, health care subsidies by employers are reflected in foregone wages.

The proposed Medicare Commission, combined with the other provisions for delivery system reforms and for continuous improvement and innovation in Medicare, sets a framework for positive reforms of the

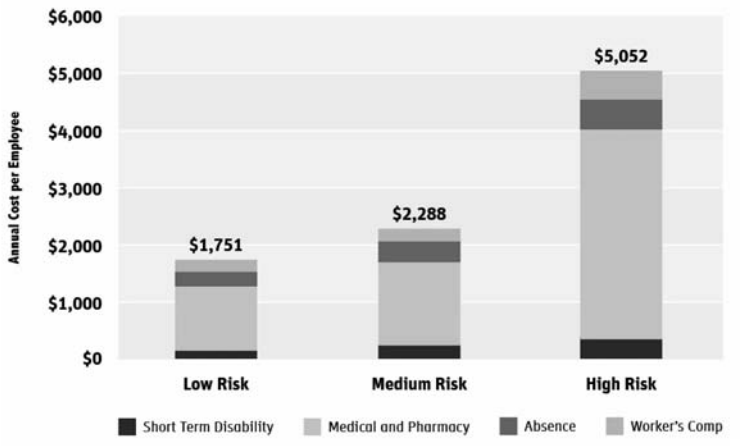
Medicare payment system and, by extension, enhances the ability of commercial payers to adopt these reforms system-wide.

Promoting Wellness and Prevention

Over the long term, the largest potential savings in health care may come from behavioral change. The idea is that individuals become personally engaged in maintaining their health by taking appropriate actions to avoid preventable conditions and detect other conditions as early as possible. Health care reform proposals take a step in this direction. Under the SFC bill, Medicare will reimburse for a personal wellness planning visit each year, which includes the administration of a health risk questionnaire (HRQ). The SFC bill also calls for a removal of cost sharing for preventive services in Medicare. In addition, there is a provision that Medicare will fund a small healthy lifestyle incentives program, giving beneficiaries credits for participating in these programs. Overall, CBO scores these provisions as about a $4 billion cost over 10 years. We believe that while the costs of additional services can be easily quantified, the savings that will likely accrue from improved prevention and wellness relative to chronic health care conditions are important to recognize—even if they would be harvested over a longer period of time and probably outside the 10-year CBO budget projection period. Large employers have come to believe that targeted improvements in wellness and prevention can improve health outcomes and reduce the costs of chronic illness, improving not only the company's cost profile, but also the productivity of their workforce.

In addition, the provisions of the SFC and Senate HELP bills that permit health plans to grant higher discounts from premiums for those who participate in programs that promote healthy behaviors can provide a powerful incentive for healthy behaviors. Employers use wellness programs and incentives to encourage individuals to improve lifestyle risks, such as eliminating tobacco use and increasing physical activity. Exhibit 5 demonstrates how lifestyle-related illnesses directly affect the cost of employment-based benefits. Individuals with high risks have benefit costs that are nearly three times that of low-risk individuals. Prevention of lifestyle-related risk and associated illness can have a significant impact not only on the cost of providing employment-based *health care* benefits, but also on the cost of providing *all* employment-based benefits.

Exhibit 5: Increased Employment-Based Costs for Lifestyle-Related Illness[6]



Strengthening Primary Care and Other Workforce Improvements

The SFC bill proposes to pay physicians and health care systems more to encourage primary care and general surgery versus specialty care. This is a change that is directionally positive for improving the health care system. These and similar initiatives have costs associated with them, estimated by CBO at about $4.2 billion over 10 years, but these are also changes that will be needed if health care is to be moved in the direction of more coordinated care and an emphasis on treating more patients with greater efficiency.

Missing Reform Elements Needed to Drive System-Wide Change

Many of the health care reform initiatives under consideration will have a positive material impact on "bending the future trend" line for health care costs. But the current bills exclude some ingredients necessary to drive the type of system-wide change that can lower significantly and permanently. Current reform provisions must be broadened if we hope to achieve a more "normal" market dynamic for health care costs across all stakeholders, both public and private. For example:

- Value-based purchasing (VBP) initiatives should be expanded beyond hospitals to include other services, such as outpatient services, rehabilitation services, and long-term care. CBO has scored these as having only a minimal impact on costs in the 10-year projection period. However, when coupled with hospital and physician initiatives, these VBP efforts further underscore the notion that health care dollars should be spent where outcomes are favorable and value is high. This is a key directional change pointing to more of a health care *market* in which price (or reimbursement) reflects value and quality.
- Health providers must be encouraged to adhere to evidence-based guidelines and encourage purchasers to adopt evidence-based plan designs. Health care cost increases occur when more expensive technologies and treatments are prescribed without solid evidence identifying which treatments work best

for which patients. Comparative effectiveness research can close that gap, but the savings are contingent upon actually changing provider behavior in ways supported by the evidence.

- Release of Medicare professional services claims data, with full protection of patient privacy, should be authorized in the final legislation. By making this broader set of claims data available to employer-provided health plans, consumers will be able to consider the cost and quality of services rendered by providers and make informed decisions about their treatment.
- The Innovation Center concept run by the Centers for Medicare & Medicaid Services to test models for delivering and reimbursing care differently should be embraced and the scope expanded to assess the interactions with private health plans and create new options for both the public and private sectors.
- Medical liability reforms should be included, which are now largely missing from the leading health care reform proposals. In the "Health Care Reform: The Perils of Inaction and the Promise of Effective Action" report, we discussed the potential merits of medical liability reform and provided examples of how certain state reforms have enabled medical providers to redirect savings from lower medical malpractice premiums toward safer and better patient care for more people. We also suggested a system in which physicians who practice according to evidence-based guidelines would enjoy a "safe harbor" from litigation to eliminate the growing tendency to practice defensive medicine. Effective tort reform could directly reduce federal spending. In response to a request from Senator Orrin Hatch (R-UT), CBO released its score of tort reforms that would include a cap for economic damages, a cap on punitive damages, offsets for income from other savings, and a statute of limitations. CBO has estimated the direct and indirect value to federal programs of these tort reforms at $54 billion over 10 years. The impact on the total health care system could easily reach $100 billion over this same period.

Summary

While the preceding discussion presents those reform initiatives that are likely to have a favorable financial impact, there are other key reform provisions that will add costs to the system. These include expanded health insurance access and coverage, federal subsidies to make premiums affordable for more people, and, in some cases, richer benefits that individuals may be able to purchase in the individual market today.

But when all savings opportunities (and corresponding investments) are taken into account, the delivery system changes as scored by CBO can potentially generate more than $30 billion in Medicare savings over 10 years and align Medicare spending with the growth rate of GDP plus 1%. In the decade beyond 2019, CBO has also projected that the SFC bill, for example, will reduce the federal budget deficits by one-quarter to one-half of GDP, which translates into several hundreds of billions of dollars in deficit reduction.

But the current reform provisions must be broadened if we hope to achieve a more "normal" market dynamic for health care across all stakeholders, public and private. The private sector will need to take additional steps to translate the government savings to private-plan savings. And, private-sector employers and their health plans will need to be especially diligent to guard against increased pressure on providers to shift costs to private plans, thereby "squeezing the balloon" and failing to generate sustainable cost savings for the overall system.

Risks Could Jeopardize Cost Reductions

The cost-saving initiatives under discussion can be fully realized only as a part of comprehensive health care reform that is extended through the efforts of private insurers and the employer-sponsored system. The final bill will need to be carefully crafted and subsequently implemented to minimize the risks to achieving meaningful health care reform. Following are key risks that could undermine or nullify efforts to bend the cost curve, or potentially aggravate the current cost problems:

- **Modifying timelines or requirements or reversing legislative actions could dilute savings.** The projected savings assume that programs are implemented as described in the various bills. If the implementation timeline is delayed, so too will be the savings. Furthermore, if Congress loosens requirements for quality improvements or payment reforms throughout the implementation process, the savings opportunities could be significantly diluted. For example, the sustainable growth rate (SGR) provisions for Medicare provider payments were enacted in 1997 to protect the Medicare program's fiscal sustainability. But Congress has consistently overridden the payment cuts required by SGR. If similar triggering mechanisms envisioned in the proposed legislation do not occur on schedule and in full, health care reform is at risk for increasing federal deficits and failing to curb costs for employers and employees.

- **Without medical liability reform, providers will not have the protections needed to reduce unnecessary care.** Medical liability reform would foster greater freedom to create alternative treatment models for routine triaging that rely less on direct physician involvement. These models would not only affect cost favorably by encouraging greater use of lower-cost providers, but it would also enable primary care physicians (PCPs) to spend more time on patient care management. Unless actions are taken to bolster the ranks of PCPs, such alternative treatment models may prove critical to enhance overall care management and encourage the type of patient-physician interaction that leads to true behavior change. Absent tort reform, creative advancements could be tempered or abandoned altogether.

- **Without a strong individual mandate, adverse selection will raise costs for those enrolling in exchange plans.** Today, individual health insurance is either not available or not affordable to those who need it the most. In each of the health care reform bills, health insurers would be required to offer guaranteed-issue coverage with no preexisting condition exclusions, eliminating discrimination against individuals with prior or existing health risks. For this new guaranteed-issue insurance to be affordable, insurers must be able to spread risk across a diverse population, including the young and healthy. By requiring all Americans to purchase health insurance, a robust individual mandate will guarantee that this risk spreading occurs. If the penalty for ignoring the individual mandate is too weak, individuals who have limited health risks may still choose to go without insurance. This raises the cost of insurance for those who do buy insurance, because the overall risk pool is more costly. In the SFC bill, only 23 million individuals are expected to enroll in the exchanges, compared to the House Tri-Committee bill, where 30 million individuals are expected to enroll in the exchanges, according to CBO.

  In addition to stabilizing the insurance premiums in the individual market, a robust individual mandate that significantly reduces the number of uninsured Americans will also reduce the cost shifting of uncompensated-care costs to employer-provided insurance.

  Under the current system, the cost of health care for employers offering good health coverage to their employees is higher than it should be. One of the reasons for this is the cost of uncompensated care. A recent CBO report put the cost of uncompensated care at 5% of hospital costs and 1% of physician costs.[7] We believe it is reasonably conservative to assume that the additional cost incurred by private plans to offset provider costs for uncompensated care is about 2% to 3% of an employer's health care costs. Based on the current data, economists do not agree, with some projecting higher ranges and some projecting lower ranges.[8]

Ultimately, a weak requirement for individuals to purchase coverage could result in less savings from reductions in the costs of uncompensated care, as well as higher premiums and higher federal subsidies in the health insurance exchanges as the younger and healthier individuals choose to decline coverage.

There is an active debate about how much individual insurance costs will increase without a strong individual mandate, and we will not attempt to quantify this amount with any degree of certainty. We are confident, however, that insurance costs *will* rise without a plan that spreads risk across the pool. Every attempt should be made to encourage even the healthiest individuals to purchase coverage. This will minimize cost shifting from uncompensated care to employer-based coverage and result in more affordable coverage for everyone.

- **Revenue raisers such as the high-cost tax may make health insurance costs worse for affected plans and employees.** The most important controllable factors affecting an employer's health plan costs are the amount that employees contribute toward the cost of the plan, the plan design itself (e.g., coinsurance, copays, and deductibles), geographic location, and the health status of the covered population. The proposed tax on high-cost plans does not take into account that some health plans may exceed the cap because of factors like the age, health status, and geography of their workforce, rather than an overly generous plan design. Employer plans with participants in these situations could see their health costs increase as the costs of the high-cost tax are paid by the health plan, passed directly to employers, and then passed on to health plan participants.

  There is little doubt that the tax paid by the health plan will be passed to the employer in full. In fully insured plans, one need only look at state premium tax assessments as evidence that insurers include taxes in their expense formulae. In self-insured plans, third-party administrators do not collect enough in administrative fees to offset any portion of tax payments, and the taxes paid would undoubtedly be assessed directly to the plan sponsor. If the employer pays the tax, it would be at the expense of wage growth or normal increases in employer subsidies for health care. If the employer assessed the employee participating in the plan, it would translate into a direct reduction in take-home pay, further restraining economic growth.

  There would also be effects on existing coverage. Some of these effects are aligned with the intent of the tax—to provide incentives for employees to elect lower-cost plans—and as this occurs, it will lower overall system costs as long as the modified plan under the cap does not create financial barriers to getting preventive and maintenance care. While the health care reform proposals all admirably seek to expand use of prevention and wellness in the coverage options, changes in tax treatment could inadvertently undermine or nullify this effort. The tax also changes the relative efficiency of employer-provided health insurance as a part of the employer's total rewards package. Under the current tax code, the preferred tax treatment of employer-provided health insurance means that a dollar of health insurance benefit is worth 20% to 30% more than a dollar of wages. The high-cost tax will dilute this relative efficiency and could cause some employers to eliminate health insurance benefits.

  Furthermore, the current interpretation of this tax will cause disparities among employers and employees relative to geographic location, age, and health status. Most large employers price at least one of their options on a national basis, without regard to geographic variation. There may be other options, such as local HMOs, that have some built-in geographic disparity. Any high-cost tax cap proposal that does not account for wide geographic variation could be considered inequitable by enrollees. This could lead to unintended shifts in coverage, with complex and unpredictable effects.

  Unless exceptions are made, a dollar-denominated tax cap would have a disparate impact on employers with an older workforce and could also raise intergenerational equity issues. Health care costs typically rise with age, and that alone would tend to push the cost of health coverage above the cap in companies with relatively older workforces. Even within the same company, the high-cost tax could raise equity

issues, as younger employees would receive more premium increase passed through than they otherwise would if the pass-through tax were imposed on the cost of coverage for their age group. Small companies may pay age-related premiums, unlike large employers where premiums are expressed as a flat dollar amount by coverage tier.

Assuming that the indexing of the cap would not keep pace with medical inflation, the impact of the high-cost tax will get tighter and tighter over time. Employers and employees would be forced to decide which benefits to drop or curtail to remain beneath the tax threshold. Dental and vision plans might be dropped without regard to the effects on health status. Flexible spending arrangements and health reimbursement arrangements would be another likely target, further increasing employee costs and taking away a key tool in the consumer health movement.

Clearly, the impact will vary based upon how the tax is applied and on how insurers and employers respond. CBO and others believe the cap would have a powerful effect on reducing the future rate of increases in health care costs, based on the assumption that most employer health plans will try to stay below the cost threshold that would trigger the tax. But regardless of the method, this tax imposes extra costs on employer-sponsored plans which will likely lead to two unintended consequences: Employers will raise out-of-pocket costs for employees to mitigate the impact of the tax, and certain employers will drop employer-sponsored coverage as the cost of providing additional benefits exceeds the cost of paying their employees more in cash.

- **Changes to flexible spending arrangements will raise costs for individuals.** Almost all large employers, including the federal government, offer a flexible spending arrangement through which employees can pay health care and dependent care expenses on a tax-free basis. The Flexible Spending Accounts for Federal Employees (FSAFEDS) program offers three different flexible spending accounts (FSAs): a health care flexible spending account, a limited expense health care flexible spending account, and a dependent care flexible spending account.

  In general, these programs have never had large participation, primarily because of the annual use-it-or-lose-it requirement. Employees who do choose to participate find the benefit very valuable. In 2008, the average enrollment percentage in the plans that Hewitt administers was 3% for dependent care reimbursement accounts and 23% for health care reimbursement accounts. The average pay of workers using these accounts is approximately $72,700. The health care FSA balances may be used for other covered dependents of the employee and for the employee's spouse. Note, however, that accounts used for health care expenses will be widely tested for nondiscrimination for the first time in 2009. This means that these accounts must follow strict rules so that workers who are highly compensated (for 2009, those making more that $110,000 annually) do not receive more generous benefits than those making less than that amount. In other words, these accounts are required to benefit a broad cross-section of workers.

  According to Hewitt data, three-quarters of FSA expenses are for prescription drugs and medical treatments, which is an important source of funds for maintenance care and medications. Reducing the availability of the benefit will make care more costly for the employee, particularly for those needing maintenance care related to chronic conditions and for those whose health needs are not covered by the medical plan, such as dental and vision care.

  Recommendations to place statutory limits on health care FSA contributions are probably not necessary. Employers have both economic and policy reasons for voluntarily adopting such limits. Hewitt data shows that 92% of large employers allow $5,000 or less to be contributed to a flexible spending arrangement that is used for health care, and there is a statutory limit of $5,000 already in place for dependent care.

- **Discouragement of health reimbursement arrangements.** Health reimbursement arrangements (HRAs) were introduced through an IRS ruling in 2002 and were the first arrangement to allow a rollover of funds from year to year. HRAs do not allow employee salary reduction contributions. However, because they allow an employee to save employer contributions over time, they provide a strong incentive to avoid unnecessary care and create a potential future source of funds that can be directed toward future expenses or for retiree medical coverage if the employer provides that coverage. Including HRA employer contributions toward the high-cost tax threshold could create additional disincentives for employers to offer such plans, eliminating one of the powerful ways employers can reinforce good consumer behaviors and for employees to begin saving money for retiree health care expenses.

- **Cost shifting from the public plan option.** There has been much heated debate about the merits of a public health insurance option to compete with private insurance plans. While some legislative proposals would create a public plan option for both individuals and small businesses through the exchanges, the market dynamics of any public plan will likely extend to large employers outside the exchanges.

  It is well known that private payers are subject to higher costs because hospitals and doctors charge them more to compensate for below-market reimbursements from Medicare and Medicaid. Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents "cost shifting" from public to private plans. But the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example, according to a 2008 Milliman actuarial study,[9] Medicare reimburses hospitals at an average of 70% of private-plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private-plan rates and pays physicians at an average of 53% of private-plan rates. And the Lewin Group estimates that Medicare reimburses hospitals 71% of private-plan payments (for doctors it is 81%).[10] Structuring a public plan option with payments equal to or slightly greater than Medicare rates risks exacerbating current cost shifting. As private-plan costs continue to rise under this pressure, more employers will be squeezed out of the employer health care system as coverage becomes unaffordable. Over time, this cost-shifting cycle could risk unraveling the entire employer-based system. Even if it is not fiscally feasible to close this gap in public-private reimbursement rates to providers, at a minimum, health care reform should ensure that the payment differential does not worsen further, because this would create even more cost-shifting pressure on private payers and potentially lead to a two-tier system where employers offering their own plans are at a significant cost disadvantage.

  In light of the significant risks to private health insurance coverage associated with a public plan and the expected availability of competitive options through the exchanges, the potential savings from reductions in federal spending could have the adverse impact of significantly raising private health plan costs for employers and for employees.

- **The impact of reform will be limited without adoption by employers and private insurance companies.** The cost savings opportunities in the proposed reform bills are directed at the Medicare program. This will directly serve to reduce federal health care spending. It is natural for Medicare to lead these reform changes. Medicare has proven that it can demand payment reform and quality-of-care reporting from its provider base. However, if trends in the employer system are going to be reduced, these initiatives need to be implemented in the private insurance market as well. (In fact, employers have been at the forefront of innovation for improved quality of care, as well as cost and quality transparency.) Only then will total health care expenditures moderate and true health care market reform be possible.

Expansion of health care reforms beyond Medicare programs requires aggressive actions on the part of employers and private insurance companies. Employers and private insurance companies must build on health care reform by taking positive action to adopt and fully leverage the improvements that Medicare brings forth as a result of health care reform. This includes such aggressive changes as defining an acceptable cost trend and limiting provider reimbursements to those increases, including such factors as increases in utilization and intensity of services. Such changes in the private system would seem completely revolutionary were it not for Medicare leading the way. Employers must be willing to follow Medicare's lead and pursue uncompromising cost and quality management in order to bring about meaningful and sustainable trend mitigation. This means accepting the consequences of providers dropping out of their networks if they are not willing to accept new payment methods such as bundled payments and limited budget increases for accountable care organizations.

Summary

These risks do not represent an exhaustive list of factors that could impede realization of the cost-savings potential of pending health care reforms. They are also not a justification to halt health care reform. Rather, they suggest that the cost-saving components of any final legislative measure, and of any subsequent legislative and regulatory changes, must be implemented in a way that minimizes the very real risks that could undermine or nullify overall savings across the system.

True Market Reform Can Yield Even Greater Savings

In a well-functioning market, a prospective buyer chooses among competing sellers to purchase a product or service. Information is gathered with respect to relative quality and cost, and the buyer pays the seller directly. The dynamics of supply and demand govern the market price for a particular product or service. In the current health care system, the dynamics of supply and demand, as well as information transparency, break down. The seller (the physician) tells the buyer (the patient) what and how much needs to be purchased, sets the price, and submits the bill to an outside third party for payment. At no point in this exchange do the buyer and seller discuss price. And the patient does not have a choice to make a value-based purchase decision even for services for which the physician has no financial interest, such as hospital services, laboratory, imaging, and prescription drugs. Under this economic model, double-digit growth in costs is inevitable.

Current reform efforts seek to address access issues, certain aspects of provider payment, and some elements of how services are delivered. While these are important, they do not by themselves create a shift in the underlying economic structure of health care delivery. To successfully reduce future health care cost trends to something approximating the overall rate of growth in the economy, more is required than the 15% to 20% reduction in future trend that Hewitt estimates may result from full implementation of the delivery system reforms and related changes in the various health care reform bills. Using the basic tenets of reform, employers need to embrace and drive a broader set of changes that can begin to create greater economic balance to our flawed health care model.

To further underscore this issue, many of the ideas being considered in reform legislation can serve as "enablers" that enhance the ability of private payers to realize greater efficiencies and improvements in quality. However, they are not sufficient to radically bend the cost curve to levels that the private sector may consider desirable and attainable. This is not to say that the elements of constructive health care reforms should not be adopted, but rather that they should be considered in concert with a broader vision.

The following represent the market-driven reforms that we believe are necessary for a well-functioning health care marketplace:

- **Individual accountability.** As Nobel prize-winning economist Milton Friedman once said, "Nobody spends someone else's money as wisely as he spends his own." A third-party payment system that insulates both the provider and the consumer of care from the financial consequences of purchase decisions is doomed to perpetuate a cost-rising spiral. Some would argue that health care spending is not a consumer good—it is emergent, it is often life-threatening, and the purchase decision must be made when the patient is in a vulnerable state of mind. However, many health care decisions are discretionary: whether to take a generic or brand-name drug, which imaging center to use, and which physician provides the best balance of high quality and cost efficiency for routine care. These discretionary decisions should require active participation of the patient, with financial incentives aligned for the best possible outcome at a reasonable cost. There comes a point where health care is not discretionary, and health benefits should provide protection from catastrophic loss. But well-structured benefit plans should contain cost-sharing provisions that encourage patients to seek the right care at the right time in the right place.

  Empirical evidence is emerging from consumer-driven experiments using health reimbursement arrangements and health savings accounts as consumer-enabling vehicles. In many of these studies, utilization levels have dropped significantly without any corresponding decrease in quality of care. Efforts

to mandate minimum benefit levels without the right incentives for providers and consumers will ultimately contribute to uncontrolled utilization that will drive the cost of these benefits to unaffordable levels.

Individual accountability also extends to the responsibility to purchase and maintain comprehensive health insurance coverage. There can be no "free riders" in an efficient marketplace. The cost of health care has reached a level where sometimes not even higher-income employees can afford to pay for acute-care services directly, and medical bankruptcy is a term that has unfortunately become all too real for many Americans. To deliver on health care reform's goal of eventual universal coverage, every participant in the health care system must be required to maintain insurance coverage sufficient enough to pay for the services they may consume for which their own assets cannot cover.

- **Full transparency and dissemination of cost and quality information.** Active participation by patients in discretionary purchase decisions is possible only when there is full transparency of cost and quality information. Most providers are well educated on the efficacy of various treatments but do not necessarily know the full cost of these treatments. Patients deserve to know the quality of the physician and hospital providing treatment to them and their families. Ironically, the federal government has within its power the ability to significantly advance this effort by making available the comparative quality information on physicians reimbursed through the Medicare program. This robust data set, if available in a way that preserves patient privacy, would transform the measurement of physician quality far beyond any private effort that has been attempted to date.

- **Reducing the variation in practice patterns.** For more than 20 years, the Dartmouth Atlas project has measured the variation in Medicare spending across every major market in the United States. The discrepancies are wide and often explained by differences in the geographic cost of providing services, by differences in health, and by variance in available technology. However, the study's authors conclude that differences in spending are largely due to "discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources—and a payment system that rewards growth and higher utilization."[11] As Princeton economist Uwe Reinhardt aptly said, "How can the best health care in the world cost twice as much as the best health care in the world?" The pending health care reform proposals take steps to encourage comparative effectiveness research, but a broader effort to eliminate regional variations in practice patterns could reduce overall health care spending by as much as 20% to 30%.

- **A focus on health, not illness.** The most effective way to control health care costs is to prevent or reduce the need for health care in the first place. Upwards of 50% of all health care spending is related to lifestyle-related illness. In order to realize the potential of an efficient health care system, we must reverse that trend. Promoting workplace wellness and prevention, strengthened by the provisions in the SFC and the Senate HELP bills to expand financial incentives to participate in specific wellness programs, is an important first step—but it is only a first step. The very behaviors that create chronic disease need to change, and this will take efforts beyond what is possible by any one employer or federal program. We need to embrace a public health revolution around changing the way we live our daily lives.

- **Further investments in adoption of information technology.** The fact that the United States uses more sophisticated technology to ship packages across the country than it uses to transmit medical records across town is a reflection of how far the health care system needs to go to realize the efficiencies that information technology investments can bring. There has been no mandate to create these efficiencies because there has been insufficient price competition to demand it. While one of the primary beneficiaries of health information technology would be insurers, the burden of investing in this technology has fallen to providers. A fully wired and interconnected health care system would not only significantly lower administrative costs, but would also reduce redundant tests, speed effective treatment, reduce medical errors, and improve coordination of care. The technology is available, but to fully enable a

digital health care system, it will take uniform federal standards for interoperability and data exchange, safeguards to protect patient privacy, and financial incentives for compliance.

- **Addressing professional service capacity.** According to The American Academy of Family Physicians (AAFP), the United States will have a shortage of 40,000 primary care physicians by the year 2020. Long hours, low relative compensation, and an average debt burden of $150,000 per graduate have driven medical school students toward higher-paid specialty practices instead of primary care. As we cope with the baby boom generation entering its high health care consumption years, the current shortage of primary care physicians will only get worse. A national strategy for addressing the looming primary care physician shortage is required. This should include greater equity between primary care and specialty care reimbursements, increased payment for evaluation and management services, debt relief for students entering primary care services, and greater utilization of nurse practitioners, physician assistants, and other allied health designations.

If our collective goal is to "bend the future trend," the steps we take now must effectively manage the three key drivers of health care cost: price, utilization, and behavior. If left unchecked, these elemental forces will prevent the health care market from ever mirroring more traditional economic models. To reach a successful market reform solution, an optimal set of outcomes will be to:

- Transition from paying for volume to paying for value;
- Differentiate provider performance based on objective data;
- Hold providers accountable for managing their patients' overall health; and
- Encourage individuals to take more ownership of the lifestyle and health care purchasing decisions they make.

Together, these principles are "game changing" events. The pending health care reforms may embrace these concepts incrementally and, depending on their provisions, point us in the right direction. However, meaningful and sustainable improvements in the cost and quality of health care will require a continuous improvement process focused on more sweeping changes to how care is acquired, delivered, and reimbursed.

Conclusion

The health care reform legislation being considered by Congress contain some critical components that will address several of the key limitations of our current health care model. If fully implemented and sustained, they will eventually permit a potential reduction in future cost trend of an estimated 15% to 20% if private payers also leverage the effects of potential cost saving and quality improvement measures and the legislative and implementation risks of jeopardizing such cost reductions are avoided.

With the reform effort focused primarily on health programs delivered by the federal government, we should not expect these efforts on their own to create the system-wide changes needed to drive substantive costs out of the private system. However, the legislative underpinnings will, if adequately, accurately, and consistently implemented, encourage employers and other payers to leverage these same concepts into the private insurance market. These changes will have a material impact in four ways:

- Transition to a value-based delivery/payment model;
- Create the ability to differentiate providers based on performance;
- Implement models that hold providers accountable for effective care; and
- Provide incentives and an infrastructure that enable individuals to make more informed health care purchasing and lifestyle decisions.

But as noted in this report, cost savings of a significant magnitude are by no means guaranteed. Some of the potential will not be realized if policymakers do not also pay close attention to the risk that health care reform may deviate from the form analyzed in this report, either in final legislation this year or in subsequent years when continued tough choices are needed.

If current health care reform is the enabling event that facilitates substantial change, we can begin to transform health care into a "more normal" economic model with a cost structure that approximates the overall trend in GDP. Clearly, doing so requires bold actions that may force individual constituencies out of their comfort zone. Health care has evolved into a $2.4 trillion enterprise. Any efforts to shrink that business enterprise means that some parties will suffer income erosion, even if partially offset by the movement toward more universal coverage. The degree of change needed to create a healthy health care market that can achieve and sustain a 4% cost trend must be far more than incremental. One should expect that there will be pockets of significant resistance as the process proceeds. That said, without comprehensive reform, it is difficult to foresee circumstances under which win-win combinations will otherwise be achieved.

Methodology and Endnotes

Methodology

Hewitt reviewed proposed health care legislation (as amended) to identify health care reform provisions that offer the potential for real cost savings. Where they were available, we relied on estimates from the Congressional Budget Office (CBO) to quantify the cost or savings to the federal budget associated with a particular provision or amendment.

Future modified health care costs were projected in two ways:

- We assumed that discretely identified savings opportunities found in health care reform could, when fully implemented, reduce the overall health care trend by 15% to 20%. Using historical annual health care trend of 10.2% for per-employee costs of large employers from 2001 to 2009, the revised trend rate would be 8.3% to 8.8%, including employer and employee contributions and employee out-of-pocket costs. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers implement similar measures in a disciplined and timely way.
- Going beyond discrete health care reform proposals and assuming implementation of structural changes in health care delivery and reimbursement, such changes could enable the health care marketplace to behave more like a "normal" market, growing at a rate similar to the long-term growth rate of GDP (approximately 4% annually).

---

[1] Kaiser Family Foundation/HRET, Employer Health Benefits Annual Survey, September 2009.

[2] This assumption is not dissimilar from estimated salary and benefit costs for large employers like BRT member companies.

[3] ***Notes:***

a) Status quo trend from 2009 to 2019 assumed at 7.7% annual increase in employer contributions only (and not including employee contributions and employee out-of-pocket expenses.

b) With reforms, trend assumed to decrease from 7.7% in 2009 to 4.0% in 2019 on a straight-line basis.

c) Major-employer employment assumed static at 10 million full-time employees.

d) Source for cost data: Hewitt Health Value Initiative™ database of 325 employers representing $50 billion of health care spending.

[4] ***Note:*** Estimated wage and benefit costs calculated based on an approximate $69,000 average total compensation (salary + benefits) for major employers in 2009, indexed at 3% annually to 2019, and savings from health care programs noted above.

[5] Hewitt Associates LLC, Hewitt Health Value Initiative proprietary data, 1997–2008.

[6] Chart based on data drawn from Wright, Beard, Edington, *Journal of Occupational and Environmental Medicine*, 44(12): 1126–1134, 2002.

[7] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* report, December 2008.

[8] For different views on the degree to which uncompensated care increases the cost for private payers, see, for example, The Kaiser Family Foundation analysis at http://www.kff.org/uninsured/upload/7809.pdf and the Families USA report at http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html.

[9] Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers study, December 2008.

[10] The Cost and Coverage Impacts of a Public Plan: Alternative Design Options, The Lewin Group, April 2009.

[11] Dartmouth Institute for Health Policy & Clinical Practice, "Health Care Spending, Quality and Outcomes," 2009.

July 30, 2010

Dear Representative:

On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business organization, I am writing to urge you to support H.R. 5982, the "Small Business Tax Relief Act." **A vote in support of the H.R. 5982 may be considered an NFIB Key Vote for the 111th Congress.**

Businesses are already overburdened with tax paperwork and reporting requirements. Unfortunately, the expanded information reporting requirement included in the Patient Protection and Affordable Care Act will only further increase the cost and complexity of complying with the tax code. Specifically, beginning in 2012, the new healthcare law requires businesses to send Form 1099s for every business-to-business transaction of $600 or more for both property and services – creating a tremendous new paperwork compliance burden for small businesses.

The cost of tax compliance falls most heavily on small businesses. On average, small businesses spend more than $74 per hour on their tax compliance obligations, which represents the most expensive paperwork burden that the federal government imposes on small business owners. Small business owners typically lack in-house finance departments to track this kind of reporting. A Small Business Administration Office of Advocacy report found that complying with the tax code is already 67 percent more expensive for a small business than a large business.

At a time when our economy needs small businesses to help our country grow out of this recession, saddling them with expensive new requirements and paperwork burdens will only further hamper their ability to aid in our economic recovery. Small businesses need certainty and H.R. 5982 will take immediate steps to eliminate this new burden.

We urge you to support H.R. 5982, and thank for your commitment to repealing this burden.

Sincerely,

Susan Eckerly

Susan Eckerly
Senior Vice President
Public Policy

National Federation of Independent Business
1201 F Street NW * Suite 200 * Washington, DC 20004 * 202-554-9000 * Fax 202-554-0496 * www.NFIB.com

Campaign to End Obesity Action Fund

The Campaign to End Obesity Action Fund is dedicated to reversing one of America's costliest diseases. Today, two-thirds of U.S. adults *and* nearly one in three children struggle with overweight or obesity. Taxpayers, governments and businesses spend billions on obesity-related conditions, including an estimated $168 billion in medical costs every year. The trends for obesity—and the costs associated with it—are ominous: as recently as 1990 not a single state had an obesity rate greater than 15 percent; today 49 states have obesity rates greater than 20 percent, with 9 of those topping 30 percent.

Ending the epidemic requires change—in individuals, institutions and communities. The Campaign convenes leaders from industry, academia, public health and associations to speak with one voice for federal policies to reverse the obesity epidemic and promote healthy weight in children and adults. From changes to nutrition policy, education policy, health policy, to environment and transportation policy, the Campaign promotes measures that support and facilitate obesity prevention and treatment for all Americans.

Spending on Obesity and Chronic Diseases Linked to Obesity is Unsustainable

From a purely economic standpoint, the cost of addressing the obesity epidemic is staggering and will only become worse unless quick, aggressive action is taken to address obesity. The fact is obesity is one of America's costliest diseases: nearly one of every five dollars spent on healthcare in the United States will be attributable to obesity and obesity-related conditions within the next decade.

Without serious efforts to reverse this epidemic, ***American taxpayers will incur ever-increasing costs*** as obesity is linked to a number of chronic diseases, including diabetes, heart disease, hypertension and others that require expensive treatments. Currently, Medicare pays out approximately $45 billion for Medicare patients suffering from diabetes and its complications. However, given the dramatic projected growth in diabetes, Medicare's spending on diabetes-related treatments is projected to skyrocket to $75 billion by 2019 and $170 billion by 2034 (*www.nmqf.org/presentations/10**Huang**EJCP3.pdf*).

According to the Centers for Disease Control and Prevention, "the cost of cardiovascular diseases in the United States, including health care expenditures and lost productivity . . . is estimated to be more than $503 billion in 2010" (*http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm*). Medicare spending in 2006 totaled $24 billion; Medicaid figures for that year were only slightly lower, and the projections for Medicare and Medicaid spending on heart disease are also expected to rise dramatically.

These two examples illustrate that trends in spending for chronic conditions related to obesity are unsustainable. ***Taxpayers have a real stake in addressing—and combating—these chronic diseases before they occur.***

The Obesity Epidemic Threatens our Economic Prosperity

Congress is rightly focused on the economy and jobs. One of the most effective ways to increase the productivity of Americans and lower costs to U.S. businesses—both of which would contribute to job growth—would be to reverse the devastating economic impact obesity has on the nation's economy. Simply put, healthy workers are more productive workers and American workers are increasingly unhealthy. The Centers for Disease Control estimates that medical expenses for obese employees are 42 percent higher than for a person with a healthy weight.

In 2005, the cost of the obesity epidemic was estimated to have cost American private sector businesses an estimated $142 billion, including $76 billion in medical costs and another $66 billion in lost productivity. By way of comparison, in 1994, private sector medical costs associated with obesity were only $13 billion.

Every year, American workers lose more and more time on the job due to obesity and related conditions: Obesity is associated with 39 million lost work days, 239 million restricted activity days, 90 million bed days and 63 million physical visits. This dramatic level of lost productivity is a serious drag on the economy and negatively impacts America's ability to compete in a highly competitive global marketplace. It is vital to America's economy that the obesity epidemic is reserved; our Nation's future economic well-being is at stake.

The Obesity Epidemic Threatens our Children's Future and Military Readiness

For the first time in our nation's history, the current generation of children faces the likelihood of living shorter life spans than their parents, due in significant part to the complications they face from overweight and obesity.

The obesity epidemic has brought other tolls for our children who suffer from a growing list of emotional disorders associated with obesity, such as depression, social stigmatization and poor academic performance. We must work to curtail this troubling trend. Among minority and underserved populations, the data is even more dire: 23.4 percent of Hispanic children and 23.8 percent of black children have obesity, compared with 12.9 percent of Caucasian children. (Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health,* Data Resource Center for Child and Adolescent Health website. Retrieved 12–14–09 from *www.nschdata.org*)

The nation's overweight and obesity epidemic even threatens our military readiness—a 2010 report noted that nearly nine million potential recruits are too heavy to serve; becoming overweight is one of the leading causes of medical discharges of active duty personnel. (http://www.missionreadiness.org)

Health Care Reform Marked a Beginning

The Campaign to End Obesity supported enactment of the Patient Protection and Affordable Care Act, which made important strides in bolstering the array of available obesity prevention and treatment options for adults and children. Broadly speaking, the Affordable Care Act created the first statutory imperative for measuring and tracking "body mass index" (BMI) as a way to prevent obesity. More specifically, some of the most important anti-obesity provisions of the Affordable Care Act are:

- **Section 2713—Coverage of Preventive Health Services.**
- **Section 4004—Education and Outreach Campaign Regarding Preventive Benefits.**
- **Section 4103—Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan, including BMI Screening.**
- **Section 4106—Improving Access to Preventive Services, including BMI Screening, for Eligible Adults in Medicaid.**
- **Section 4306—Funding for Childhood Obesity Demonstration Project**

More is Needed

Given the alarming trends in taxpayer-provided funding of obesity related chronic diseases and in order to optimize the benefits of the new policies of the Affordable Care Act, the Campaign urges Members of the Committee to advance a number of additional policy changes, including:

1. ***Recognize Obesity as a Disease***

One of the most important steps that federal policymakers—both in Congress and at the Centers for Medicare and Medicaid Services ("CMS")—can take is to recognize obesity as the disease that it is. Doing so will facilitate needed prevention and treatment options for children and adults with obesity or at risk of having obesity. Not only is obesity a disease, but it is in fact one of America's costliest medical condition. Until our policies reflect this fact, clinicians will be discouraged from diagnosing cases in children and adults that must be recognized in the doctor/patient/family dialogue before the disease prompts the onset of other, dangerous conditions. In fact, today there is a perverse ***disincentive*** for doctors to address obesity with their patients since there is no reimbursement for such services/treatment. Thus, many doctors wait until their patients become very sick—often with devastating and costly diseases like diabetes, heart disease, etc.—because there is no reimbursement for treating a major contributing factor: the patients' obesity.

2. ***Expand Medicaid's EPSDT to Cover BMI Screening for Children***

As noted above, the Campaign is pleased by the inclusion of BMI screening in Medicare Annual Wellness visits and for eligible adults under Medicaid. Coupled with Section 4004's language, that should provide improvement in one vital area: education about being overweight or obese. The fact is most Americans do not know whether they or their children are at a healthy weight, and thus many do little or nothing to fight the disease they have or may soon have. The more information parents and children have early on, the better their chances of making improvements. That is why every opportunity to conduct a simple BMI screening should be supported by federal programs. As noted, minority children are most at risk when it comes to being overweight or obese. Thus, the Campaign would encourage Medicaid to also cover BMI screenings for children because the tragic fact is obese children typically grow into obese adults. This could be done by adding a BMI screening to the Early Periodic Screening, Diagnosis and Treatment guidelines issued by HHS.

3. ***Expand Coverage for Treatment Options***

While the Affordable Care Act made solid progress in authorizing new obesity education, prevention and treatment options, the Campaign would urge coverage for a greater number of treatment options. Obesity is a complex disease that is caused by many different factors. Given that, there is no "one-size-fits-all" treatment solution for obesity. The Campaign urges Congress to direct Medicare and Medicaid to cover a broad range of accepted treatment options. Specifically, upon a diagnosis of a BMI level of 30 (obese) or a level of 25 (overweight), when accompanied by other chronic conditions, coverage would be triggered for treatment benefits. Treatment would include services in medical nutrition therapy services, physical therapy or exercise training, behavioral health counseling as determined by a National Coverage Determination Process and CMS-deemed appropriate medical interventions, including both pharmacological and surgical options.

4. ***Improve CMS Communication to States Concerning Obesity Prevention and Treatment Options***

Currently, CMS issues guidelines to States to inform them of the existing opportunities for covering child obesity prevention and treatment services under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines and offering them model guidance to State providers. As noted above, the Campaign believes adding a BMI screening for all children under the EPSDT would be beneficial. CMS has, up to now, insufficiently communicated to States that the screening and treatment services proposed in the standard benefit package can already be provided and reimbursed under EPSDT services. There is wide variation between States as to the degree to which they have offered specific guidance to providers on the coverage and how to bill for these services. The most successful States have issued provider guidance specifically on pediatric obesity services.

The Campaign strongly recommends that CMS issue national guidance clarifying that obesity prevention and treatment services are currently covered for pediatric populations under Medicaid. CMS should also issue model guidelines that State Medicaid programs can issue to providers. Finally within two years of issuance of the CMS national guidance, CMS should release a list of those States that have and have not issued their own guidelines to practitioners. These critical actions can be achieved by CMS without any legislative action by Congress.

5. ***Fully Fund Anti-Obesity Initiatives Included in the Affordable Care Act***

While Congress is under pressure to cut spending and reduce costs in the coming months, there is no denying that the cost of America's obesity epidemic is extremely high and some predict that it will become much worse. Just a year ago, a comprehensive the UnitedHealth Foundation, the American Public Health Association and the Partnership for Prevention ("America's Healthy Rankings") predicted that if current trends continue, the nation will spend an estimated $344 billion in obesity-related health care costs by 2018. More needs to be done in the area of obesity education, prevention and treatment if this alarming figure is to be rolled back in any meaningful way. Thus, the Campaign strongly urges Congress to fully fund the key obesity related programs included in the Affordable Care Act.

The Campaign to End Obesity Action Fund stands ready to work with the Committee and Congress to advance these and similar efforts that are designed to help more Americans achieve and remain at a healthy weight, but also to help reduce the enormous economic, social and physical toll obesity currently takes on our nation and our communities. We appreciate the opportunity to share our views and welcome the opportunity to engage further on this important subject.

James T. Lette

It appears that the 500 billion taken from medicare to fund Medicaid is wrong and to take away our paid for benefits is wrong.

Please exempt medicare from Obamacare and repeal it and start all over

Thanks

JAMES T. LETTE

LumaCorp

February 2, 2011

Dear Congressman Johnson;

You have invited employers within your district to "weigh in" on the new healthcare law and I am writing in response to your invitation. The focus of the reform should be on the development of strategies to allow for coverage to affordable for employers while at the same time allowing for quality of care. We all agree the cost of the care is too high and each year it continues to increase.

While employers struggle to stay competitive in their respective markets, healthcare costs make up a very large portion of their overall cost of doing business. Healthcare costs have a direct bearing on the local, state and national economies. At the same time in our very own district the quality of medical care can vary widely by provider. Unfortunately, because our current system is designed to serve the health care system rather than the end user (the consumer paying for the service), the system is based on volume versus outcome. We have an epidemic of lifestyle related chronic diseases being treated by quantity, not quality.

My consultant often speaks of an example in her enrollment meetings of how employees purchase their cars. Consumers have access to plenty of data on the quality and reputation of autos they might purchase. No one goes out to spend $20,000 to $40,000 without "shopping around" and having done their homework up front. Yet when it comes to our own healthcare, how many of our employees ask how much a surgical procedure or an office visit is going to cost before the procedure is performed? This lack of information results in very little competition in the medical profession based on cost or quality. This is no surprise when the end consumer is typically so poorly informed.

One of the other issues that we have to face is recognizing that we have been our own worst enemies as a result of creating "first dollar benefits". Under the healthcare reform package, in order to be "grandfathered" an employer plan cannot have a significant change in its current benefits or it will lose its "grandfathered" status. If an employer currently has doctor office co-pay or an RX co-pay, and he needs to remove that feature from the plan in order for the plan to survive economically, he is unable to do so. The new law going forward will not allow employers' plans to have higher than a $2,000 deductible in the year beginning 2014! If we had all been better stewards of our healthcare plans and had not bent to competition, we would have kept our employees involved in their health care costs by having them share in smaller medical expenses. This could have been done through employee participation in "up front" deductibles. If properly incented, employees would make it their business to know exactly what doctors were charging for doctor office visits and what pharmacies charges for prescription drugs. We would have a better educated consumer and they would be more involved in the decision making process. As it stands now we have to make decisions based on whether or not to stay "grandfathered" versus putting our employees in a position to be better stewards of their benefit dollars. If an employer makes the decision to remove the upfront doctor office co-pay, the largest deductible that he can have moving forward beyond 2014 is $2,000. Who will be able to afford a $2,000 deductible in the year 2014 when we will have to pay for all of the preventative benefits slated to take effect if we are not grandfathered at 100% with no co-pay?

The combination of increasing obesity and sedentary lifestyle cause much of the chronic disease in our country, and it is reaching epidemic proportions. It is one of the factors driving our costs, and of course the employees understandable want to have everything covered at little or no cost to them. When we combine that with the way we have our system structured we have a perfect storm or escalating costs. Our doctors and hospitals have to treat based on a defensive medicine mentality. It is clear this results in unnecessary care and higher costs. At the same time, it does not guarantee high quality, just more procedures. It just shields the provider from fiscal responsibility and increases demand and results in higher delivery of medical care and continued cost escalation.

What we really need is the flexibility to design our own plans, suited to our own needs, the needs of each and every group of employees. It is not relevant what the government thinks is best for us, but rather what we can afford as employers. Let the free market system work. Allow us to provide services in the marketplace to our employees such as patient advocates—services where by the employee can glean critical information about the cost of a procedure beforehand and actually have incentives to do so through plan design. Let us give the empowerment back to the consumer. Put the competition back where it belongs, and make medical providers compete for patients based on cost and quality like any other efficient good or serv-

ice. For a true transformation to really happen, consumers have to have information about the services being offered to them. They have to know how much procedures cost and know the quality of the care being given to them. There are programs available that deliver just that (knowledge up front). Using them will create better health care consumers while promoting cost reductions and improved quality.

Let us truly use the word transparency in our medical plans and make information available for the employees to use. The only way to get them involved is to allow for redesigning benefit plans to remove doctor office co-pays without being penalized. Let us truly have what was promised. Allow us to have OUR health care plans, not ones run by the government. All of the health reform legislation you can throw at us will not work at obtaining better outcomes in the long run if you do not recognize the actual impediments to those better outcomes. We have to shift our benefits to reward good outcomes, and to truly do that we must give individuals the tools to better manage their health and their care, and make them responsible for each.

Thank you,

Sherry Jordan
Regional Supervisor
sjordan@lumacorp.com

Main Street Alliance

Statement for the Record
J. Kelly Conklin & David Borris
On behalf of the Main Street Alliance

House Committee on Ways & Means
Hearing on Health Law's Impacts on Jobs, Employers, and the Economy
January 26, 2011

Statement for the Record, Committee on Ways & Means Hearing on Health Law Impacts
J. Kelly Conklin and David Borris, Main Street Alliance Executive Committee
January 26, 2011

Chairman CAMP. and Members of the Committee,

We appreciate this opportunity to provide written testimony on behalf of the business owners in the Main Street Alliance network for the January 26 hearing on the health care law's impact on jobs and the economy.

The Main Street Alliance is a national network of small businesses dedicated to ensuring that small business owners have the opportunity to speak for themselves on issues that impact their businesses, their employees, and their local economies. In 2009, we both had the opportunity to testify before the Committee on Ways & Means on the topic of health care, sharing our personal stories and speaking about the urgency of reforming health care to make it work for small businesses.

The January 26 hearing was called to explore the impact of the new health care law on economic growth and job creation. From our perspective, this impact is clear and positive: from the new small business tax credits to new protections like rate review and a value for premiums requirement, the health law is already throwing a lifeline to small businesses and creating opportunities for businesses to offer health coverage, save money on premiums, and plow those savings back into business investment and job creation.

While some may raise concerns about the employer responsibility requirement for businesses with more than 50 workers, the fact remains that 95 percent of our nation's businesses have less than 50 workers (and so would not be subject to this requirement), and 95 percent of businesses with more than 50 workers already offer health coverage. Indeed, this provision only reinforces what the vast majority of larger employers already do, and ensures that responsible employers who offer good-paying jobs with health benefits aren't undercut by competitors who shun these responsibilities.

A much bigger issue—indeed, a true threat to small businesses and our ability to create jobs—is runaway health insurance rates. For example, in early 2010 (before the health care law was passed), one of us received a letter from our insurer offering to renew our current coverage at an increase of 124 percent. The escalation of health insurance rate increases is simply not sustainable for small businesses. Thankfully, the health care law includes a series of provisions that will begin to rein

in these increases and cut costs for small businesses like ours. These provisions include:

Small Employer Health Premium Tax Credits

Business owners in our network from Portland, Maine to Portland, Oregon are already benefiting from the new tax credits effective for tax year 2010. Jim Houser, owner of Hawthorne Auto Clinic in Portland, Oregon with 15 employees, expects to receive a credit of over $10,000 on his health insurance bill. That's serious savings for a small business. Jim has described the tax credit as a "time machine," turning the clock back on his insurance rates.

Premium Rate Review

After years of enduring double-digit rate increases with no recourse, small businesses like ours are encouraged that our states have new tools and new resources to review insurance rates and require insurers to provide justification for unreasonable rate increases. This is one of the most direct ways to protect small businesses and help us do our part to create jobs and grow the economy. There is a high level of market concentration in the health insurance industry and true competition—competition based on consumer value rather than competition based on cherry-picking risk pools—is largely absent. That is why we need robust rate review—to ensure that we're getting a fair shake.

Medical Loss Ratio Requirements

As small business people, we understand that the most important thing about a business is the value you provide to your customers. Yet the insurance industry has lost sight of that. The new minimum medical loss ratio requirements will restore a focus on providing us with value for our premium dollars. And if insurers fail to meet this basic standard, insurance customers like us will receive cash rebates starting next year—potentially to the tune of hundreds of millions of dollars.

State Insurance Exchanges

The state insurance exchanges due to come online in 2014 will level the playing field for small businesses. By creating a mechanism whereby we can band together and shop for coverage in one large pool, the exchanges will give us bargaining power, risk pooling, and greater choice.

The repeal of the health law or the undermining of its core provisions would cause serious harm to small businesses (see attached fact sheet). Certainly, there are improvements that can and must be made to the law. For example, the 1099 reporting provisions and the paperwork burden they would create demand immediate attention. We were heartened that a majority of House members voted to fix this problem last summer (HR 5982, 7/30/2010), and we are confident that the current Congress will get this problem fixed with appropriate speed. We are also confident these types of improvements can be made without undermining the core cost containment provisions and other protections contained in the Affordable Care Act.

The year 2010 saw a dramatic uptick in the percentage of small businesses offering health coverage: among businesses with 3–199 employees, the offer rate increased by 9 percentage points; among those with 3–9 employees, the offer rate increased 13 points, from 46 percent to 59 percent. This is a promising trend, and we need to keep forging ahead, not return to the flawed health care system of the past.

With proper implementation of the health care law, we can truly level the playing field for small businesses like ours. The law promises to benefit small businesses and the American economy by stabilizing our health insurance costs and allowing us to focus on what we do best: creating jobs and providing important goods and services to communities across America.

Thank you,

J. Kelly Conklin
Owner, Foley-Waite Associates, Inc.
Bloomfield, NJ

David Borris
Owner, Hel's Kitchen Catering
Northbrook, IL

Bad for the Bottom Line: How Rolling Back the Affordable Care Act Would Harm Small Businesses

Small Businesses are Moving Forward on Health Care

The percentage of small businesses offering health coverage to their employees rose significantly in 2010. For businesses with 3–199 employees, the health insurance offer rate increased 9 percentage points. This increase was driven by an even greater spike among the smallest businesses: the offer rate among businesses with 3–9 workers rose 13 percentage points, from 46 percent to 59 percent.

Repeal of the Affordable Care Act Would Harm America's Small Businesses

Attempts to cast repeal of the Affordable Care Act (ACA) as "good for small businesses" obscure what repeal would actually do. Here are the facts:

Repeal would raise taxes for small businesses that qualify for the new premium tax credits.

Starting for tax year 2010, small businesses may be eligible for health premium tax credits valued at $38 billion over a ten year period. As many as 4 million businesses may qualify for a credit, and about 1.2 million businesses could qualify for the maximum credit of 35 percent of their insurance contributions (increasing to 50 percent in 2014).

Up to 16.6 million people are employees of small businesses that will be eligible for the credit between 2010–2013.

Repeal would leave small businesses vulnerable to continuing price gouging by insurers.

The ACA gives states new tools and resources to require insurers to justify their rate increases.

Without robust rate review, insurers will continue to raise rates at their whim. The most recent example: Blue Shield of California, which recently announced combined rate hikes of up to 59 percent, and then thumbed its nose at the state's insurance commissioner when he attempted to delay the hikes.

Repeal would eliminate the guarantee of a basic standard of value for premium dollars.

Under the ACA, if insurers fail to meet new minimum medical loss ratios (MLR), they'll owe a rebate to customers.

Projections for the small group market give a mid range estimate of $226 million in rebates, or about $312 per person receiving a rebate, for 2011. Individual market estimates add another $521 million.

Repeal would gut consumer protections for small business owners, employees, and their families.

The ACA puts in place important consumer protections: for example, a ban on pre-existing condition exclusions, new limits on insurance caps, and the ability to keep children covered up to age 26. These protections directly benefit health insurance customers in the small group and individual markets where small businesses get coverage.

Repeal would renege on the promise of choice, bargaining power, and risk pooling in insurance exchanges.

Starting in 2014, small businesses with up to 50 employees (100 in some states) and self-employed people will be able to band together to shop for coverage in state insurance exchanges, gaining bargaining power and leveling the playing field with insurers. An estimated 29 million people will get coverage through the exchanges by 2019 (5 million in small businesses that buy in as a group, and 24 million more buying in on their own).

Repeal would be bad for our national bottom line.

The Congressional Budget Office estimated the repeal bill would add $230 billion to the federal deficit over 10 years, and much more over the following decade.

The final word on health care repeal: It's bad business for small business.

Contact Information

J. Kelly Conklin
Foley-Waite Associates, Inc.
225 Belleville Avenue
Bloomfield, NJ 07003–3666
(973) 743–0700

David Borris
Hel's Kitchen Catering
3027 Commercial Avenue
Northbrook, IL 60062
(847) 205–5125

The Main Street Alliance
3518 S. Edmunds St.
Seattle, WA 98118
(603) 831–1835

The National Business Group on Health

Chairman Camp, Ranking Member Levin and Members of the Committee, thank you for the opportunity to submit testimony for the record on the large employers' perspective on the impact that the Patient Protection and Affordable Care Act (Affordable Care Act) will have on the U.S. economy and employers' ability to hire new workers and retain existing employees.

The National Business Group on Health (Business Group) is a member organization representing 314 mostly large employers—including 65 of the Fortune 100—that provide coverage to more than 55 million U.S. workers, retirees and their families. The Business Group is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues.

Employers are Currently Implementing the Employer Provisions of the Affordable Care Act

Employers are currently implementing provisions of the Affordable Care Act that take effect now and planning for future provisions as much as they can given the uncertainty. They have already implemented a number of the early provisions required under the health care law, including accounting for retiree drug subsidy (RDS) taxes; deciding whether or not plans should maintain their grandfathered status; eliminating lifetime limits; applying for the early retiree reinsurance program; adding adult dependent coverage; implementing health account changes for over-the-counter drugs; and providing break times and accommodations for nursing mothers. The Federal Government has also begun to implement a number of the health care payment and delivery reforms. The health care law's big changes—the employer mandate, the employee vouchers, the exchanges, tax credits, and the "Cadillac" tax—don't come on line for several years. Nevertheless, employers are reviewing the comprehensiveness and affordability of their benefits, but also assuring that benefits are not too rich so they do not trigger the 40% excise tax on amounts above specified thresholds in 2018.

More immediately, employers are preparing for a number of upcoming requirements, including reporting the aggregate value of health benefits on all employees' W–2 forms, the automatic enrollment of new full-time employees in health plans, and the new plan summary and benefits requirements.

Employers Health Care Costs Continue to Increase

U.S. employers continue to face the challenge of the rising cost of health care for their employees.

- National average health care spending for a family of four in 2010 was $18,074—up 7.8% from 2009.[1]
- Overall employers' health care costs grew an estimated 6.9% in 2010. Large employers, those with 500 or more employees, experienced a sharper cost increase than smaller employers, growing at 8.5%. Self-insured employers experienced higher growth in costs because of increased utilization and actual costs that exceeded predicted costs. Employers attributed roughly 2% of this increase due the recent changes mandated by the Accountable Care Act in 2010 and 2011.[2]
- Employers expect high cost increases again in 2011. With no changes to their plans and benefits, employers expected costs to increase 10%. They plan to hold their actual cost increases to 6.4% by making changes to plan design or changing plan vendors.[3]

---

[1] 2010 Milliman Medical Index. Available at: *http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf*.

[2] Mercer. Health benefit cost growth accelerates to 6.9% in 2010. November 17, 2010. Available at: *http://www.mercer.com/print.htm?indContentType=100&idContent=1400235&indBodyType=D&reference=*.

[3] Ibid.

Employers Made a Variety of Changes in Plans and Benefits to Reduce Costs in 2010

Employers continued to shift away from more traditional plan offerings to consumer-directed health plans (CHDPs)—increasingly fully replacing traditional plans with CDHPs. Employers also reduced retiree medical plan offerings. More employers also provided financial incentives to employees to take better care of their health. Most common among these were incentives for taking health risk assessments (offered by 69% of large employers), enrolling in disease management programs (73%), and participating in lifestyle modification programs (50%).[4]

Responding to the uncertainty of the impact of the Affordable Care Act, employers stated a recent Towers Watson survey that if the health care law increases plan costs:

- 88% would pass on the increase to employees;
- 74% would reduce health benefits and programs;
- 33% would absorb cost into their business;
- 20% would pass on the increase to consumers;
- 12% would eliminate or reduce wellness/health promotion programs;
- **12% would reduce employment;**
- 11% would reduce employer contributions to retirement plans; and
- 7% would reduce salaries/direct compensations.[5]

Smaller employers are more likely than larger employers to reduce employment positions or shift employees to part-time positions if the Affordable Care Act increases their costs because they have fewer options and less leeway among the options listed.

In our own National Business Group on Health survey of members, 53% of respondents continued making planned changes to reduce health care costs and provide effective, affordable coverage to their employees despite the loss of grandfathered plan status.[6]

In the Towers Watson survey, 88% of employers expected to continue to offer health care coverage when the free rider assessment takes effect in 2014 while only 3% are planning to pay the new penalty.[7] 43% (18% very likely, 25% somewhat likely) of plans believe they will be subject to the "Cadillac" tax in 2018, which could force them to make additional changes to their plans and further delay hiring of additional employees.[8]

Clearer "Rules of the Road" for Employer Provisions in the Affordable Care Act Will Reassure Employers Who Want to Resume Hiring

Uncertainty or the lack of clarification regarding "the rules of the road" and the true total costs to implement the law has led many employers to hold off on hiring new employees and to reduce the amount of full-time positions. One of the key sources of confusion is the fact that many of the provisions were designed for the individual and small group health insurance market, but the law applies them to large employer and self-funded health plans as well. For example, the law's rescissions provision created confusion and conflicted with employer requirements under COBRA. In some cases where COBRA requires retroactive termination of plan participants who are no longer eligible for employer coverage, employers were confused about whether or not they could adhere to COBRA rules without running afoul of the Affordable Care Act's new prohibition on rescissions of coverage. Fortunately, the Department of Labor (DoL) later issued clarifications that plans should follow COBRA rules and the DoL would not consider plans' retroactive termination of coverage as rescissions. We are encouraged and pleased that in recent months, the Administration and the Departments have reached out to employer plans and sought to address some of the unintended consequences and clarify rules. For example, we have provided recommendations on the upcoming requirements to auto-enroll new hires into health plans and to report the value of health benefits on employees' W–2 forms.

---

[4] Ibid.

[5] Towers Watson, Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards, 2010.

[6] National Business Group on Health, Large Employers' 2011 Health Plan Design Changes, August 2010.

[7] Towers Watson, Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards, 2010.

[8] Ibid.

Employers are Concerned the Affordable Care Act Does Not Address Their Chief Concerns

Going into the health care reform debate and for many years earlier, employers emphasized the need for us as a nation to radically change the way we pay for and deliver care. Without fundamentally changing these, expansion of access will be illusory as we cannot long sustain the increases in overall costs for care that is often ineffective and provided inefficiently. A survey by Towers Watson of 650 mid- to senior-level benefit professionals provides an early snapshot of how employers think the Affordable Care Act will achieve the goals that are most important to them.

Specifically:

- Only 14% of respondents think health care reform will help contain health care costs;
- Only 25% think health care reform will encourage healthier lifestyles; and
- Only 20% believe health care reform will improve the quality of care.[9]

The Federal Government Should Aggressively Adopt Fundamental Changes in the Way We Pay for and Deliver Health Care

In addition to clarifying regulations going forward, employers believe that it is vitally important for the long-term health of the economy that the Federal Government aggressively adopt changes in the way it pays for and delivers health care in Medicare, Medicaid, and other government programs in ways that do not merely shift costs to the private sector, but rather take costs out of the system. Reforms should reward improvements in primary and preventive care, the effectiveness and quality of care, efficiency of care delivery, and appropriate utilization. Congress and the Department of Health and Human Services (HHS) need to build off of the positive developments in the Affordable Care Act to achieve these goals, including:

- Creating effective Accountable Care Organizations (ACOs) that significantly improve quality and efficiency and employ payment reforms based on performance, not volume, without creating undue market power;
- Enabling providers, patients and plans to effectively incorporate the findings of the Patient Centered Outcomes Research Institute in their decisions to assure that care reflects the latest medical evidence,
- Determining an "essential health benefits" package for the exchange, individual, and small group markets that not only provides comprehensive coverage, but also promotes evidence-based, effective care and the triple financial goals of assuring people affordable coverage, protecting them from catastrophic financial losses when faced with serious illness and helping them to avoid unnecessary costs; and
- Establishing efficient state health insurance exchanges that adopt national standards and uniform processes wherever state-by-state variation would add costs and complexity without adding significant incremental value in order to offer affordable health choices to employers and employees.

Employer Recommendations as the Government Embarks on a Significant Expansion of Access to Coverage in Medicaid and Subsidized Exchange Plans

Aggressive cost management, consumerist strategies and attention to health improvement have had the most successful impact on employers' bottom line. Health care, unlike most other industries, is too often driven by perverse financial incentives in which consumers and physicians decide what health care might be needed or wanted and totally separate party—the employer, insurer or government agency—pays for that care after the fact. The health care reform debate has distracted us from remembering that costs rise because Americans are using more and more services at ever rising prices.

Unfortunately in the U.S., health care consumers believe that:

- More health care is better than less care;
- The more expensive, the better it must be;
- There are no trade-offs in health care;
- Consumers only pay 20% and don't care that other payers have to pay 80%;
- Nor do they understand that all benefits are foregone wages or other benefits; and
- Tax costs are "hidden".

[9] Towers Watson, Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards, 2010.

There is also substantial evidence over many years that somewhere around 20–30%, of care, conservatively, is either not clinically appropriate, not effective, and may even be downright harmful for over $1.2 trillion in identified waste, including behavioral (obesity/overweight, smoking non-adherence, alcohol abuse), clinical (defensive medicine, preventable hospital admissions, poorly managed diabetes, medical errors, unnecessary emergency room visits, treatment variations, hospital acquired infections, over-prescribed antibiotics) and operational (claims processing, ineffective use of IT, staffing turnover, paper prescriptions).[10] As a nation, we have to have a constant process of evidence generation, and feedback to care management and benefit design to be sure that all patients are protected from wasteful and some downright harmful practices. A properly structured learning health care system will enable such continuous assessment of actual effects on patients.

The Federal Government and employers have to use all of the tools and resources available to us to help consumers understand, "It's all about what's in it for them." To improve quality and control costs, we must work to ensure that Medicare and the Affordable Care Act's Medicaid expansion and exchange plans change the health care delivery system by ensuring:

- A culture of quality and patient safety throughout health care system;
- Payment systems that reward outcomes not just utilization;
- Payment systems that support primary care and care coordination;
- Transparency of health care costs and quality information;
- Comparative effectiveness research of health care interventions (including information garnered from the new Patient Centered Outcomes Research Institute);
- Evidence-based medicine whenever possible, and patients who make informed decisions with help of their doctors;
- A secure, nationwide electronic health information network;
- Portable, personal health records for all;
- Systems that support evidence-based preventive care;
- Capital spending *only* where truly needed;
- Personal responsibility for health and engagement in care decisions; and
- Comprehensive reform of the health care legal system.

Conclusion

Thank you again for this opportunity to share the National Business Group on Health's views for the record on the employers' perspective on the impact the Affordable Care Act will have on the U.S. economy and employers' ability to hire new workers and retain existing employees.

Employers look forward to continuing to working with Congress to clarify the Affordable Care Act's provisions to reduce the administrative burdens on American employers and aid them as they look expand their businesses and potentially hire new employees. Our economic future and prosperity depends upon Congress' focusing on real health care payment and delivery reforms that take costs out of the system for all people and all payers and significantly improvement the quality and effectiveness of care.

National Partnership for Women & Families

Supportive Workplace Policies Are Critical for Nursing Mothers

Written Statement of
Debra L. Ness, President
National Partnership for Women & Families
and
Robin W. Stanton, Chair
United States Breastfeeding Committee

for "Hearing on Health Care Law's Impact on Jobs, Employers, and the Economy"

Committee on Ways and Means
U.S. House of Representatives
January 26, 2011

The Affordable Care Act (ACA) gives millions of nursing moms the support and protection they need. The law is an important step in making sure the nation's workplaces meet the needs of working women and their families. The National Part-

[10] PricewaterhouseCoopers, 2010

nership for Women & Families and the United States Breastfeeding Committee would like to clarify the scope of this important new provision in the law and address some misconceptions expressed during the Ways and Means Committee hearing.

Every year roughly four million women give birth in the United States, and more than 75 percent of them choose to breastfeed. Study after study has shown that breastfeeding has tremendous value in protecting both mothers and children from a number of acute and chronic diseases and conditions. And research shows that employer support—which could include breastfeeding education, counseling, private lactation rooms, and breast pumps—makes a tremendous difference in a woman's ability to breastfeed. According to one study, such supports helped as many as 98 percent of working mothers start breastfeeding, and 58 percent continued for six months or longer. There is no question that these policies work.

Unfortunately, a lack of supportive workplace policies and laws has forced too many nursing mothers to quit breastfeeding (or never start). Some new mothers have found their employers to be outright hostile, while others simply face work environments that offer nowhere private or sanitary to express breast milk.

Congress and the Obama administration have taken a key first step to improve workplace laws for nursing mothers. For the first time, federal law now explicitly protects nursing mothers in the workplace. Section 4207 of the Patient Protection and Affordable Care Act gives covered female employees the right to reasonable break times and a private location, other than a bathroom, to express milk at work. This means that employers must provide nursing mothers a reasonable amount of break time and functional space to express milk. This provision applies to employers of all sizes but, in certain limited instances, those with fewer than 50 total employees may not have to comply with the law if they face undue hardship in meeting these basic requirements. The Department of Labor (DOL) is in the process of developing guidance on this issue and has published a Request for Information.

Although we cannot know the exact contours of the requirements set by this provision of the law until that guidance is completed, we believe that the overwhelming majority of employers will have absolutely no difficulty complying. Indeed, the provision simply builds on the laws that several states have already established—laws that are familiar to employers. Fourteen states and the District of Columbia already require private employers to provide nursing employees with reasonable break time and/or a place other than a bathroom to express milk at work. In addition, employers with FLSA-covered employees should already have policies in place regarding break times.

Unfortunately, there is a substantial amount of misinformation about the scope and application of the provision. For example, at the Ways and Means Committee hearing, Representative Lynn Jenkins expressed concern that an employer would have to provide a lactation room if it had only three male employees at a worksite and no nursing mother. The DOL has already clearly indicated that it does not intend to impose this requirement on employers. In fact, in the Frequently Asked Questions the DOL has provided to the public about the law, it specifically addresses this issue:

> Do employers have to provide a lactation space even if they don't have any nursing mother employees?
>
> ANSWER: No. The statute requires employers to provide a space for a nursing employee "each time such employee has need to express the milk." If there is no employee with a need to express breast milk, then the employer would not have an obligation to provide a space.

The National Partnership for Women & Families and the United States Breastfeeding Committee strongly support workplace policies that allow women to continue breastfeeding, and we applaud Congress and the President for adopting language in the ACA to promote breastfeeding. Workplace breastfeeding support is a "win-win-win" for employers, mothers and babies. Employers that support nursing mothers not only help their employees transition back to work, but also reduce turnover, absenteeism and health care costs, and increase employee satisfaction, loyalty and productivity.

When new mothers' needs are met, they are better able to meet the dual demands of work and motherhood. Those who choose to breastfeed need break time and a private space to express milk when they return to work. For the thousands of working mothers who have had to rush to their cars during a lunch break, hide in a bathroom stall or closet, or negotiate for break time with an unsympathetic employer, the new protections are life-changing and long overdue. We hope that Representative Jenkins and all members of the Ways and Means Committee will stand up for

new mothers who choose to breastfeed and voice their support for this new provision and all protections like it that make it easier for mothers to be both good caregivers and family breadwinners.

Contact Information

Debra L. Ness
National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650
Washington, DC 20009
Phone: 202.986.2600
Email: rlyons@nationalpartnership.org

Robin Stanton
United States Breastfeeding Committee (USBC)
2025 M Street, NW, Suite 800
Washington, DC 20036–3309
Phone: (202) 367–1132
Email: mrenner@usbreastfeeding.org

National Private Duty Association

Statement of the National Private Duty Association
in connection with Hearing on

Health Care Law's Impact on Jobs, Employers and the Economy
January 26, 2011

Committee on Ways & Means
U.S. House of Representatives
Washington, DC

Submitted By

Sheila McMackin
President
National Private Duty Association
941 East 86th Street, Suite 270
Indianapolis, IN 46240
317 663 3637
sheila@homecarechicago.com

The National Private Duty Association, a trade association representing over 1,200 companies with 250,000+ employees throughout the United States, thanks the U.S. House Ways & Means Committee for holding a hearing on the impact of the Patient Protection and Affordable Care Act (PPACA) on jobs, employers and the economy. The PPACA will impose a substantial new cost burden on employers in low-margin, labor-intensive industries such as private duty home care. It will likely force NPDA member companies to shift to part-time employees, raise our clients' costs, and/or, in some cases, cease operation altogether.

This in turn will give many clients—primarily elderly and/or people with disabilities—no alternative but to give up their struggles to remain independent in their own homes for as long as possible. Instead, they will have to move into institutionalized and far more expensive care.

Private duty home care may be medical or non-medical care. When providing non-medical care, caregivers keep their clients company, take them to doctors' appointments, run errands such as grocery shopping or pick-up of prescriptions, assist with light housekeeping, prepare and serve meals, help with personal tasks such as dressing or bathing, and generally make sure that a senior individual can age in place, at home, in dignity and comfort. This is crucial to the emotional and often physical well-being of our older citizens. It is also considerably more cost-effective than the alternative—institutionalized care often paid for through Medicaid or some other government program.

NPDA members are companies who employ these caregivers. NPDA members pay wages, usually above but always at least at the federal minimum wage level. Our member companies absorb the cost of employment—they withhold and pay income taxes, pay workers compensation, and pay FICA taxes for their workers. Often there are benefits such as vacation and/or sick time. While many home care agencies provide "mini-med" plans for their employees, the PPACA's benefits package mandates

and discrimination rules will invalidate many of these existing employer-provided health insurance plans.

Our member companies work hard to establish and maintain important industry standards. NPDA identifies and disseminates information on "best practices" within the home care industry. It develops core training and education programs for caregivers, resulting in caregivers who are professional, caring and knowledgeable about the specialized needs of those who are aging or disabled. NPDA also educates the public about the benefits to seniors who seek in home companion care about receiving that care through caregivers who are trained as well as compassionate, and whose work lives are protected by employment laws.

Whether these in-home services are paid for by the seniors themselves or by their families, the service recipients are the beneficiaries of a company that can and will provide substitute quality care when a primary caregiver gets sick or takes vacation. This is very important because, as you know, a senior citizen's need for help with the tasks of daily living do not stop when the person who is assisting the senior needs to take time off.

Private duty home care is a labor-intensive, low-margin industry. The expense of a companion caregiver is almost always borne in its entirety by the service recipient and/or his or her family. While there is no such thing as a "typical" rate charged to service recipients—it varies geographically as well as by whether any live-in or sleep-over time is required, an illustrative charge for a senior seeking regular but not full-time assistance is $20/hour, for a three or four hour minimum service block, plus the cost of traveling to the service recipient's home. Accordingly, even a minimum service contract can and often does run into $1000 or more every month. And for many of our clients, the costs are even higher because the senior citizen in need of care requires more than the minimum time block, or needs it on a daily or more frequent basis. Many of our member companies provide their clients with competent, caring, professional caregivers who are on premises 24 hours each day. This is a huge expense for the senior. Most simply cannot afford a significant increase in the cost. The result will be having to give up hours of help and relying on family members, friends and neighbors—or worse, sitting alone without the assistance they need. The alternative—which is anathema to many aging Americans—is being forced into institutionalized care.

Of course, institutional care may take less from an individual senior's limited pocketbook, but its cost to society and the U.S. government is significantly higher. Even without taking into account the crucially important emotional health and dignity that comes from finding a way to let a senior citizen age in place in his or her own home, the cost to society to forcing institutionalization as the only alternative is very high. Medicaid and other government programs absorb the bulk of these costs. At these times of State and federal budgets stretched to and beyond their outer limits, this is a result that is not good for anyone.

The PPACA, while laudable in its goal—we all support the notion of affordable health care coverage for all Americans—it will have a seriously adverse impact on jobs in the private duty sector, and on the very people—the caregivers themselves—whom it is crafted to help. The additional cost to either providing health insurance or paying fines for failure to do so will cripple the industry. It will result in jobs downsizing to part-time status, and/or jobs lost due to clients no longer able to afford the services NPDA companies offer.

NPDA does not have empirical data on this, but we do have anecdotal evidence of the deleterious impact of the PPACA. Our companies—from Michigan, California, Illinois and other states—tell us uniformly that they will be forced to raise prices, reduce their employees' hours to part-time status, and in some cases they project having to go out of business altogether.

NPDA companies are usually not "small" as defined by most "small business" measures. Therefore the small business tax credit and other small business special rules in the PPACA do not mitigate the situation for them. Most of our companies have revenue in the millions, with employee rosters of 100 or more. Typically their profits are less than $50,000 in any given year. Our member companies are projecting—with inadequate cost data currently available—that the cost of compliance with the PPACA will be 10 percent or greater. This of course translates into the potential for an increase of 10 percent or more in what they charge their clients. As clients find they cannot afford these additional costs, they will cease doing business with NPDA member companies, thus accelerating the job loss that will come as a result of lost business, and threatening the existence of these low-margin high labor cost businesses.

There are very specific and difficult problems arising from the PPACA, as well as the more general concerns described above. Under the employer responsibility rules of the health reform law, by 2014 employers will have to choose between offer-

ing a mandated package of health insurance benefits or paying a fine. Employers cannot calculate either the cost of the fines—they are based on whether a worker qualifies for a federal subsidy, or "affordability." Both the subsidy and "affordability" are calculated by measuring an as yet known cost of insurance (and employer contribution to that cost) against an individual's household income. The employer has no way of knowing an individual's household income—which includes spouse's and children's income. This is something no employer can know with respect to any individual employee. And thus no employer can ever know, in advance, whether it will be liable for fines or whether its contribution to the cost of employer-provided health care will be enough for the insurance to be "affordable" as defined under the PPACA.

Likewise, at this stage the cost of the mandated package of health insurance benefits is not only unknown, it is also at this point unknowable. Insurers are adjusting prices to reflect the cost of new mandatory benefits and compliance responsibilities. The actual package of benefits is still under development by relevant federal agencies. Therefore the actual benefits package—and its consequent cost—cannot be calculated. As a result, no employer can make plans to meet the cost of insurance, or is potential liability for assessments for not offering health insurance at all, or for not offering it on what the government decides is an "affordable" basis.

Given the historical cost of health insurance, it is likely many employers will simply choose to pay fines. An employer can calculate its maximum potential exposure to fines, but not its actual exposure, since it will have no way of knowing whether one of its employees will qualify for a federal subsidy—the trigger for fine liability. One resulting option open to an employer that has little to no profit margin to spare will be to reduce its workforce to minimize the potential for liability for fines.

Of course, reducing a work force means reducing the ability to provide services, and that means losing business. This will drive a private duty company out of business even faster than the significantly large new cost of health insurance or fines. Accordingly, many companies will instead shift to hiring employees who will not trigger assessments. This can be done by restricting an employees work hours to no more than 29 hours per week (30 hours per week is the hours worked measure that triggers fine liability). Although "part time equivalence" will assure that companies with part-time workers are subject to the employer responsibility rules, fines are assessed only on full-time workers (assuming at least one is eligible for a federal subsidy for purchasing individual health insurance through an exchange). This acts as a powerful incentive to companies facing a huge new cost that its slim profit margins simply cannot absorb to hire employees to work fewer than 30 hours per week. This will drive up a company's administrative costs, and it will diminish the jobs available in the industry. But the cost of using full-time employees will, in many instances, simply be prohibitive. This loss of full-time jobs with benefits will hurt caregivers as well as the service recipients we serve.

Another no doubt unintended consequence of the PPACA's employer responsibility rules is the fact that they will encourage a shift away from home care provided by trained, professional caregivers who are employees of a private duty company to a system of referrals of individuals who are working on their own—without benefit of training, supervision or back-up. These "independent contractors" frequently have no idea about how to pay their taxes and they have no protection from workers compensation, unemployment insurance or paid sick or vacation time. The seniors and their families who hire them also have no idea of their responsibilities as employers of these caregivers. The result is an anticompetitive underground business that ultimately hurts the U.S. economy as well as the workers and the service recipients they serve. This could not possibly be a result that is tolerable to those who crafted the PPACA.

In summary, early indications from NPDA members (and other employers in other industries) suggest that many employers are exploring whether to drop or decline to offer health insurance when the employer responsibility rules take effect in 2014. This is because of the interaction of two primary factors: (1) individual workers will have access (often subsidized by the government) to health insurance through the new law's exchanges, thus relieving employers of their sense of responsibility for providing coverage to their workers; and (2) the cost of assessments for not providing coverage may be significantly lower than the cost of providing health insurance, and will certainly be more predictable. Predictability of expense is a serious issue for private sector companies. An equally serious problem unique to industries like private-pay non-medical in-home companion care is the fact that the employer responsibility rules may prove to be an incentive to companies to use a workforce comprised of independent contractors rather than employees. This will be adverse to the interests of both workers and the companies that hire them—and potentially

also to the seniors and people with disabilities who are served by private-pay non-medical in-home companion care companies.

NPDA seeks Congressional help in crafting a solution to the serious economic and policy-based problems posed by the current employer responsibility rules. We want to work together with lawmakers to develop alternative approaches that will result in expanded coverage, without driving up the cost of in-home companion care to a level that is unaffordable for our clients, and that threatens our continued ability to stay in business. An alternative approach is crucial to prevent severe limitation on jobs growth and possibly even the continued viability of the private duty industry

In short, the PPACA's employer responsibility rules are likely to cause significant job loss in the private duty industry. This in turn will force many service recipients into more costly (and less emotionally healthy) institutional care. It will cause a shift to use of part-time employers. It will encourage a caregiver to look at self-employment, without knowledge of the legal responsibilities such a choice brings both to the caregiver and to the person who hires that caregiver. It could drive some private duty companies out of business.

NPDA encourages Congress to revisit the PPACA's employer responsibility rules. Repeal of those rules, or modification of them to accommodate low-margin, labor-intensive industries such as ours is imperative to avoid yet more jobs loss (or jobs diminishment) along with loss of an important option for aging in place, in dignity and comfort.

NPDA extends our thanks to the Ways & Means Committee for its willingness to explore this difficult issue. We are happy to provide any expertise the committee may seek as it works through this problem.