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EXAMINING THE IMPACT OF OBAMACARE ON JOB CREATORS AND THE ECONOMY

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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EXAMINING THE IMPACT OF OBAMACARE ON JOB CREATORS AND THE ECONOMY

Tuesday, July 10, 2012

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The committee met, pursuant to call, at 1:32 p.m. in Room 2154, Rayburn House Office Building, Hon. Darrell E. Issa [chairman of the committee] presiding.

Present: Representatives Issa, Platts, Walberg, Lankford, Amash, Labrador, DesJarlais, Gowdy, Farenthold, Kelly, Cummings, Towns, Maloney, Norton, Kucinich, Tierney, Connolly, Quigley, Davis, and Yarmuth.

Also Present: Representative Keating.

Staff Present: Alexia Ardolina, Assistant Clerk; Brian Blase, Professional Staff Member; Molly Boyl, Parliamentarian; John Cuaderes, Deputy Staff Director; Adam P. Fromm, Director of Member Services and Committee Operations; Linda Good, Chief Clerk; Christopher Hixon, Deputy Chief Counsel, Oversight; Mark D. Marin, Director of Oversight; Laura L. Rush, Deputy Chief Clerk; Cheyenne Steel, Deputy Press Secretary; Noelle Turbitt, Assistant Clerk; Rebecca Watkins, Press Secretary; Beverly Britton Fraser, Minority Counsel; Kevin Corbin, Minority Deputy Clerk; Ashley Etienne, Director of Communications; Susanne Sachsman Grooms, Minority Chief Counsel; Angela Hanks, Minority Counsel; Carla Hultberg, Minority Chief Clerk; Una Lee, Minority Counsel; Suzanne Owen, Minority Health Policy Advisor; Dave Rapallo, Minority Staff Director; and Ellen Zeng, Minority Counsel.

Chairman ISSA. This hearing of the Committee on Oversight and Government Reform will come to order.

The Oversight Committee's mission statement is we exist to secure two fundamental principles: First, Americans have a right to know the money Washington takes from them is well spent. Second, Americans deserve an efficient, effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers because taxpayers have a right to know what they get from their government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

Today's hearing focuses on how the President's health care law affects job creators and the economy, and with our mandate to pro-

tect taxpayers money, now that we know Obamacare is a tax, it is particularly important that we protect that money. This hearing builds on previous hearings conducted during the Congress by Subcommittee Chairman Gowdy, including one this morning.

We know that Obamacare makes labor more expensive. It requires employers of at least 50 full-time workers to offer a more expensive, selected and mandated government health care insurance, or pay an insurance tax of $2- or $3,000 per worker.

The law will discourage 63,000 businesses with between 40 and 59 workers from expanding. If those industry companies below 50 choose not to expand and not to offer or pay the fine, it still won't change the fact that government will, in fact, tax another $2,000 per worker for not buying insurance and, of course, that insurance without an organized health care plan of at least a minimum nature will be inherently more expensive.

Ninety percent of employers report that Obamacare will increase their organization's health care costs. The other 10 percent clearly haven't checked the price. Although some of the cost increases will be passed on to customers, most will be passed on to workers in the form of lower wages or lost job opportunities. Let's make no mistake, competitiveness in a global market does not allow prices to ultimately rise to any point hoping that we can be competitive. There is a darn good reason that you don't buy Greek cars or Greek electronics. Seventy-four percent of small businesses say the President's health care law makes it more difficult to hire additional workers. The Congressional Budget Office projects that the law will lead to 800,000 fewer jobs by the end of the decade.

A paper by economists at Harvard and the University of Chicago finds workers more negatively affected by the law are disproportionately young, female, or minority, and those just starting out in the workforce. Obamacare increases government employment, particularly at the IRS, where thousands of new IRS agents will be charged with enforcing compliance with the law that taxes and mandates.

According to projections, the greatest percentage of growth in Federal health care spending comes from the Federal Government's administration of health care. In other words, Medicare, Medicaid are already, in fact, expensive, and fail to deliver value programs.

Let us make no mistake. Everyone on this dais wants good, affordable health care. Where we differ is on whether or not Obamacare delivers affordable health care or simply mandates a series of nice-to-have, good-to-have, or in some cases, need-to-have requirements but does so in a way that creates some of those 12,000 already produced new pages of regulations.

One part of the law aimed towards assisting small businesses has already failed miserably. Obamacare contained tax credits for small businesses to offer health insurance. So few businesses claimed these credits because it was overly complicated and required businesses to fill out seven different duplicative forms. This failure is symbolic of the bureaucratic approach of the President's health care law.

This single party law is typical of what happens when you produce 2,400 pages of documents—pages of a bill in the dark, bring it to the floor and then say we must pass it so we can find

out what's in it. The law which spends more than $2 trillion over the next decade, increases American taxes and premiums, is unaffordable. I look forward to hearing from business owners, and business owners, remember, are employers. So they are the people who create the private sector jobs that pay for everything, including the government jobs this President is so fond of creating.

For many reasons, tomorrow the House will vote to repeal Obamacare. There is no doubt that our health care system needs reform, but these reforms must lower the price of health insurance rather than increase the burdens on employers and workers with higher taxes and Federal spending and more government red tape.

With that, I recognize the distinguished ranking member, Mr. Cummings, for his opening statement.

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

This week the Republican House leadership has scheduled yet another debate and vote on the House floor to take away access to health insurance coverage for tens of millions of Americans. They also want to eliminate key protections that were passed as a part of the Affordable Care Act.

Without legitimate ideas of their own on how to replace the Affordable Care Act, House Republicans simply want to gut it, and they want to rehash the same debate over and over again. Speaker Boehner proudly highlights on his own Web site that the House has already taken "30 votes to scrap the President's health care law" during this Congress alone.

30 votes. Despite the fact that the Senate has already rejected this legislation, it is difficult to imagine a more monumental waste of time.

The only difference between the first 30 votes and the vote scheduled for this week is that the Supreme Court, in a decision by Chief Justice John Roberts, has now ruled that the Affordable Care Act is constitutional. Nevertheless, this week we will engage in another exercise in futility by spending hours and hours debating vote number 31.

Unfortunately, today's hearing is part of this needless exercise. We are rehashing this exact same ground the House Subcommittee covered a year ago in a remarkably similar hearing entitled "Impact of Obamacare on job creators and their decision to offer health insurance."

As we learned back then, the Affordable Care Act will extend health insurance coverage to 30 million people. Millions of young adults have already gained access to health coverage through their parents' policies. Medicare beneficiaries are paying lower prescription drug costs. And more than 86 million Americans have benefitted from preventive care free of charge, such as mammograms.

At the same time, hundreds of thousands of small businesses are receiving tax credits to maintain and expand health coverage for their employees. And millions of Americans are now receiving rebates under a new rule requiring that insurance companies spend at least 80 percent of their premium dollars on health and medical services or refund the difference.

Imagine that, insurance companies returning your money rather than doling it out to corporate executives. This year alone individuals are expected to receive $426 million in rebates from their in-

surance companies, and small businesses are expected to receive $377 million.

These are significant accomplishments that will help millions of people in very real ways, and there are more changes to come as additional provisions of the Affordable Care Act come online in the next 2 years to reduce the cost of health care further and provide patients with additional protections.

Despite these accomplishments, Republicans will continue the same old scare tactics today, warning about massive job losses and economic ruin should the Affordable Care Act continue.

The main problem with their theory is that it did not happen in Massachusetts. In 2006, then-Governor Mitt Romney signed into law the model for the Affordable Care Act, including subsidies for individuals purchasing coverage, a health insurance exchange, insurance market reforms, and mandates for employers and individuals. As a result, today, more than 98 percent of Massachusetts residents are now insured with no indication of negative job consequences. With a 6 percent unemployment rate, Massachusetts remains significantly lower than the national average.

The fact is that the Affordable Care Act passed by both Houses of Congress, signed by the President of the United States and now upheld by the Supreme Court, is vital to the health of our people and the strength of our Nation, and it will without a doubt save many American lives.

Let's put an end to this pointless political theater. The Supreme Court has spoken and has spoken loudly. It is time to focus on insuring that the law is implemented effectively and efficiently so that the American people can take full advantage of its protections.

Mr. Chairman, I ask unanimous consent that Representative Bill Keating from Massachusetts welcome his Senator from his State.

Chairman ISSA. The gentleman will be recognized to introduce his representative.

With that, we go to the distinguished doctor from Tennessee, Dr. DesJarlais, for an opening statement.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

I would dispute the fact that we have been told that this is an exercise in futility or an unnecessary hearing. We have a number of job creators from around the country, and I have talked to a number in my district in Tennessee who are very concerned about what this Affordable Health Care Act, and it's hard for me to even say that because it has been proven to be unaffordable, will do to their ability to hire employees and expand and grow their businesses. It has done nothing but create more and more uncertainty. It has given us over 12,000 pages of regulation. And why? I think that is a fair question. Why should we bring it to the floor to vote to repeal it again. It has been pointed out that we have made 30 votes already to repeal this.

I think the answer to that question is because this is a law that the American people did not ask for, they didn't want, and they can't afford. Sixty-three percent of the people opposed this law when it was passed in the dark of night behind closed doors without transparency. And they continue to reject it. The majority of Americans still do not like this bill.

So I don't think that we just give up on the American people. I think we continue to fight for them. Now that this has had to go to the Supreme Court, and part of it was ruled unconstitutional, about States having to expand their Medicaid programs, which are already stretched and breaking a lot of States, now we have a chance for maybe some of the Democrats who voted for this the first time to listen to their constituents, the ones who are still left who were not voted out of office in 2010 can do the right thing and vote to repeal this bill now that we know it's a tax.

I don't think anybody sitting up here thinks that this bill would pass again today if it were brought to a vote, because it was done in a fashion that was deceitful. It was clearly called a penalty, and now it's only constitutional because it is a tax. And they still don't want to call it a tax.

This President vowed to not raise taxes one dime on the middle class. Not one dime. But clearly, this is one of the largest tax increases in history. It is one of these bills that Nancy Pelosi said we have to pass to see what's in it. Sometimes maybe you have to pass a bill to see what's not in it. Business owners are going to find, who have over 50 people, that there is no language in this bill that even allows for them to collect the taxes of 3,000 per employee against your companies. If the State does not set up an exchange and the Federal Government comes in and sets up an exchange, there is no language in this bill that allows for them to charge you that. And you have a right to know that.

So this hearing is far from meaningless. We are doing the people's work here, and this is the job of oversight.

With that, I yield back.

Chairman ISSA. With that, I recognize the gentleman from Ohio, Mr. Kucinich, for an opening statement.

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

Prior to the Affordable Health Care Act, at least 50 million American didn't have health care. Why? Because they couldn't afford it. Think about that. These are members of our family, they're our friends, our constituents. They couldn't afford health care. Even with the Affordable Care Act, there are people who will still be hard-pressed. What are we supposed to do in America? Are we supposed to tell people that because they can't afford health care, they are just condemned?

And what about those people that were able to afford health care? If they had a claim, their expenses could be run up to the point where they weren't able to pay the extra expenses associated with an illness. Do you know, about half of the bankruptcies in America are connected to people not being able to pay their hospital bills. So this isn't just a narrow health care issue, this is a societal issue that determines what kind of society are we. Are we a society that is going to drive people into poverty because they get sick?

Illness doesn't respect political parties. You can be a Democrat, Republican, Independent, if you get ill, your house could be on the line. Your life savings could be on the line. Everything you've worked a lifetime for could be on the line. We need to get back to this kind of thinking. We're involved in polemics here. We need to look at the practical application of the law.

Look, like some of my colleagues, I wasn't for the Affordable Care Act in the beginning. Why? Because I'm for universal, single payer, not-for-profit health care. I don't believe in for-profit health care. I think that if you're talking about health care reform, though, we were able to at least prove that reform within the context of a for-profit system was possible. If we couldn't even prove that, then later on, when those of us who want to continue to advocate for a single payer system, when we're told look, it wouldn't be possible, well, how can we challenge that if we had participated in the defeat of the only thing that was in front of the American people at the time.

Is this plan perfect? No. No one is maintaining that. But it is addressing what is a fundamental problem in our society, and that is, lack of accessibility and lack of affordability to health care. We must not lose sight of that.

You know, elections come and go. But the outcome of this election in 2012 may or may not solve the health care problems of tens of millions of Americans.

Now there is another issue here too that I want to put on the table right now that really ought to take place in these discussions about health care, and that is, each one of us does have some responsibility for our own health. Government can't give me health care. I had to change my diet years ago to have a chance at health care. Government couldn't do that for me. I had to make my own decision. The government doesn't tell me what to eat, nor should it.

We have to create a more health-conscious society where people are given more information about the choices that they can make that can lead to better health so that we don't have a situation where through a lifetime of bad choices, people then come to a system that is already overburdened with high costs and add to it.

So there is an element of personal responsibility which should never be ignored, but that, then, goes into how do we redescribe health care? How do we reengineer our health care system to include diet and nutrition, and to include physical education and those kinds of things. We need to broaden the discussion.

Unfortunately, this discussion that we're having here is not going to do that for the most part. It's about polemics, it's about the next election. But sooner or later, we are going to have to come to grips in this country with the fact that we have a fiscally unsustainable health care system, and sooner or later we have to understand that this step that we took in the Affordable Care Act was a step in the right direction, although not by any means the final step. And for those of us who think that everyone should have access to high quality, affordable health care, there is no question that in the long term, and in the medium term, we're going to need to go to a single payer, not-for-profit system if for no other reason than to control costs.

So with that, I want to thank the chair for this opportunity to make that statement, and welcome the witnesses. I hope at some point we can really get into the details of what we can do to make health care available to all Americans, help businesses, help grow the economy and put this highly-charged, partisan debate behind us.

Thank you very much, and I yield back.

Chairman ISSA. I thank the gentleman.

I now recognize the former chairman of the full committee, Mr. Burton, for an opening statement.

Mr. BURTON. First of all, Mr. Chairman, we do have to revise the health care system in this country, but there is an alternative which we have proposed which is not being discussed today because the Obamacare plan is, in effect, law right now, and it needs to be addressed before we can get to a solution that will solve the problem without putting such a burden on the future generations of America.

I look out here today and I see an awful lot of young people in the audience. When you talk about making sure everybody has health care, it sounds pretty good, because it takes care of everybody. We don't have any problems. If you get sick, everything is solved. The government is going to take care of everything. It sounds really good. What we don't say is we are $16 trillion in debt. The interest on the national debt is humongous. These young people out here are never, ever going to be able to live the kind of life that we have because of the cost of government. And this bill is going to run it right through the ceiling.

There is no question that we need to do something about health care, and all of us want to do that. But to create socialized medicine, which Europe is running away from right now, I'm chairman of Europe and Eurasia on the Foreign Affairs Committee. I just got back from over there. And I can tell you right now, those countries are on the brink of disaster. Spain is about to go down the tubes. And I think they probably will, even though it will take a little time. Greece is about gone. Italy is in trouble. France will be in trouble. Ireland is in trouble—because they've had a socialistic approach to government, and socialized medicine only compounds the problem.

Yes, we have problems. And yes, we need to solve them. And yes, they need to be addressed. But they can be addressed in a business-friendly way that will solve the problems of the people of this country. Socialized medicine is not the answer. And to the young people out here who may be favoring this today, 10 years from now, 15 years from now, if this thing remains law, you remember what I'm saying right now because we're loading a burden on your backs that you will not believe. We have already loaded $16 trillion on your backs, and your kids and your grandkids, but this is only going to compound the problem.

I yield back the balance of my time.

Chairman ISSA. The gentleman yields back.

All members may have 7 days in order to place additional opening statements in the record. With that, pursuant to unanimous consent, I would recognize the gentleman from Massachusetts to introduce his witness.

Mr. KEATING. Thank you, Chairman Issa, and Ranking Member Cummings. Before I resume my other duties in another committee, I want to thank you for the opportunity to address this committee and for inviting Senator Dan Wolf, who is not only the co-chair of the Joint Committee on Labor and Workforce Development in Massachusetts in the State Senate and a decorated Cape businessman,

but a constituent of mine and a friend. We welcome him here today to testify.

Cape Air's story is well known in my district, particularly in the Cape Cod area and the island where the company gets its name. I'm pleased that other business owners nationwide will hear this story today and hopefully expand their successes through using the Cape Air model as an example. This example promotes success through carrying for the company's surrounding communities and staff.

Senator Wolf, thank you for being here today. Your testimony in today's hearing is essential to provide a firsthand account of the impact of the health care reform on small businesses directly from a CEO. I can personally attest to the strength of the Cape Air team which has been crisscrossing the globe in Cessna 402s since 1989. Furthermore, the Cape Air team serves as a crucial link to the rest of the country and to the world. For many throughout Massachusetts, it is essential, but particularly for the Cape and islands where tourism in a driving economic force for those who live there year round, like myself.

I know that the airline has been at the forefront of national initiatives like health care and green energy initiatives for years. For this reason, the advent of the health care reform in Massachusetts followed by the Affordable Care Act, and perhaps in the future, a strategy to curb greenhouse gases and switch to renewable energy sources is an investment in preparedness.

Again, I welcome my friend from Massachusetts to the Capitol, and I thank the committee for the opportunity to introduce him here today.

Chairman ISSA. Thank you, Mr. Keating. Thank you for introducing your witness and for being here today.

With that, we will go to the gentleman from Michigan for a similar introduction. And I only barely let you have this. Remember, we are alumni together. The fact that he is a constituent is an accident of current address.

The gentleman is recognized.

Mr. WALBERG. I thank the chairman. When you hear my introduction, you will understand I even have more claim to him than you do as an alumnus of distinguished Siena Heights University in Adrian.

Mr. Jamie Richardson grew up in my home school district of Onsted, Michigan. I watched him as a late high school student and as a student at Siena Heights University, an outstanding student, outstanding athlete, outstanding character. He developed to a point that ultimately after graduation, he became a marketing guru at J Walter Thompson. Ultimately, through a long chain of events, and you can read his resume, he ended up at White Castle Corporation, a family-owned business. And I think this is where it comes to the point of who Jamie is and why it is a privilege for me to introduce him today.

I think what would be the first and foremost statement about Jamie Richardson is that he is married to Cate and has five wonderful kids, that he spends unbelievable amounts of time with intentionally making sure that that happens, even as he is involved in numerous other organizations and entities.

White Castle Corporation is a family-owned business which has its unique benefits as well as challenges in the world in which we live today, especially in relationship now to things like Obamacare. The challenge that we have there for family businesses is very strong.

Jamie is presently the vice president, government and shareholder relations and assistant secretary. He was the gentleman involved in getting White Castle as the first company involved with Undercover Boss and worked with CBS in accomplishing that, indicating how that program would go and demonstrating how employees and employers must work together to complement each other to make business happen. He understands the benefits of job security and the opportunities for people to expand and grow.

White Castle is known for its benefits, its security, its ability to reach youth, single parents, part-time adult workers, et cetera, with a job that has benefits. And ultimately, with this law going into place, if it is carried out, will discourage and very likely do away with those same benefits that people stay at White Castle to work for.

Mr. Richardson evidences his commitment to meeting the needs of people by being involved in directorships, trustees with American Red Cross, Catholic Foundation, YMCA, the Kiwanis, the National Family Enterprise U.S.A., on and on giving back to the community, giving back to society, and making a commitment that ultimately goes again back to the family of Cate, those five kids, and people just like him.

So it is a privilege to have Jamie here today, and I look forward to your testimony.

Chairman ISSA. The gentleman yields back.

Now for those not fortunate enough to have a personal friend on the panel, I will now introduce Mr. Michael Fredrich. He is President and owner of MCM Composites, welcome. Ms. Mary Miller, is CEO of JANCOA Janitorial Services, Inc. And Dr. John Goodman is a health economist and President and CEO of National Center For Policy Analysis.

With that, I would ask you all to rise and pursuant to the committee rules, if you would please take the sworn oath and raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that all witnesses answered in the affirmative.

WITNESS STATEMENTS

Chairman ISSA. Mr. Richardson, being a returning contestant, I will expect you to be so good on this, but for the rest of you, it's like a stoplight. Green means go for some of your 5 minutes. Yellow means, as Mr. Gowdy said this morning, go real quick to get under it before it turns red. And red means stop. If you can stay as close to 5 minutes I will ask member on the dais during questioning to do the same.

Mr. Richardson.

STATEMENT OF JAMIE RICHARDSON

Mr. RICHARDSON. Chairman Issa, Ranking Member Cummings, and members of the Oversight and Government Reform Committee, thanks for the opportunity to testify today on behalf of White Castle and the National Restaurant Association. My name is Jamie Richardson, and I serve as vice president of government and shareholder relations for White Castle. It is an honor to be able to share the impact the Patient Protection and Affordable Care Act is having on businesses like ours and the restaurant and foods services industry in general, particularly on our ability to create jobs.

White Castle is based in Columbus, Ohio, and we first opened our doors in 1921 in Wichita, Kansas. Soon after, we joined the National Restaurant Association as one of its first members. Still, to this day, we are a family-owned business and a privately held company. We employ nearly 10,000 team members. Most work in our 408 restaurants across 12 States. Our culture is one of family, and we proudly began offering health care coverage to our team members in 1924.

White Castle offers a rich, full, medical health benefit package after 6 months of service to any team member who is open to being scheduled for full-time hours which we consider 35 hours per week. Year after year, employees name the benefits package as the reason why they come to work at White Castle and why they stay. White Castle prides itself on listening to team members and responding to their needs by offering benefits they want and use. We have incorporated wellness incentives. And since 2009, we have eliminated employee co-pays for regular checkups to encourage healthy lifestyles and to increase team members' use of their benefits to prevent illness.

Under the law, White Castle and other applicable large employers like us will have to comply with the employer mandate, the automatic enrollment requirement, and extensive and detailed new reporting to the IRS on health plan offerings and each individual to whom it was offered.

In 2014, we estimate our current plan costs could increase by over 20 percent. This estimate is dramatically different than what we have started to experience recently. As it appears, our focus on wellness and preventive care is having a positive effect. Year to date in 2012, our health care costs are trending and estimated to increase less than 3 percent compared with the prior year.

As 2014 and compliance with the employer requirements of the law fast approaches, we will have to balance requirements of the law with employee needs and the ever-increasing cost of health care coverage.

While we work in a castle, in our realm, there is no magic treasure room to cover these increasing costs without sacrificing job creation. The health care law will have an impact on jobs in the restaurant and food service industry. The only questions are: How? And to what extent? Some of the potential impact will be answered once we know the rules with which to comply and the implementing regulation and hence, the impact on our workforce. Everything we have seen has shown current costs will increase. Many in our industry are worried that our slim profits per employee will not be sufficient to cover the additional cost of more employees accept-

ing our offer of coverage or potential penalties that may apply despite our best efforts to provide the required coverage.

For White Castle, the uncertainty associated with the health care law has made us cautious to expand into new markets and impacted the number of jobs we are creating. We have conducted the extensive research necessary to explore expansion into other parts of the country, but have not acted on those plans yet due to the uncertain cost environment. If we were to pursue those potential expansion plans, it would bring 400 to 500 team member jobs, not to mention the construction supplier jobs associated with opening new restaurants.

In our business, we all manage risk. We do it all the time. Whenever we launch a new product, for example. But the uncertainty of increased costs that the health care law brings creates risks that no one can manage against. The result is that the growth and expansion of businesses that drive job creation is put on hold, and so are the jobs.

In conclusion, for White Castle and the restaurant and food service industry, the law cannot stand as is. We need in fact, we crave reform that addresses the unsustainable increases in the cost of coverage. We must find solutions that will allow restaurant operators to offer great health benefits to their employees without excessive cost and regulatory burdens that threaten their businesses.

Thanks again for the opportunity to testify regarding the impact of the health care law on job creators such as White Castle and the restaurant and food service industry. We have great gratitude for your service and all you do for our country.

And we would also like to offer, if anyone wants to come a castle to work behind the counter and meet the hamburger heroes of White Castle firsthand, we would welcome it.

Chairman ISSA. Be careful what you wish for. When you get done with Congress, it may be the best job you have possible afterwards. And it would probably be a move up in how the public would feel about us from 9 to 90 percent, at least.

[Prepared statement of Mr. Richardson follows:]

Statement on Hearing:
"Examining the Impact of Obama Care on Job Creators and the Economy"
Before the
Oversight and Government Reform Committee
By
Jamie Richardson,
White Castle System Inc.
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On behalf of White Castle System Inc. and the National Restaurant Association

July 10, 2012

Chairman Issa, Ranking Member Cummings, and members of the Oversight and Government Reform Committee, thank you for the opportunity to testify before you today on behalf of White Castle and the National Restaurant Association.

My name is Jamie Richardson and I serve as Vice President of Government, Shareholder and Community Relations of White Castle System Incorporated. It is an honor to be able to share with you the impact the Patient Protection and Affordable Care Act ("PPACA") is having on businesses like White Castle and the restaurant and food service industry in general, particularly on our ability to create jobs.

THE RESTAURANT AND FOOD SERVICE INDUSTRY

The National Restaurant Association is the leading business association for the restaurant and food service industry. Its mission is to help its members, such as White Castle, establish customer loyalty, build rewarding careers, and achieve financial success. The industry is comprised of 970,000 restaurant and foodservice outlets employing 12.9 million people who serve 130 million guests daily. Restaurateurs are job creators. Despite being an industry of predominately small businesses, the restaurant industry is the nation's second-largest private-sector employer, employing almost 10 percent of the U.S. workforce.

The restaurant and food service industry is unique for several reasons. First and foremost, small businesses dominate the industry—with more than seven out of ten eating and drinking establishments being single-unit operators. The industry also employs a high proportion of part-time, seasonal, and temporary workers. Restaurants are employers of choice, especially for employees looking for flexible work hours.

Our workforce is typically young, with nearly 40 percent under the age of 25. We also have a high average workforce turnover rate relative to other industries—75 percent average

turnover rate in 2008 compared to 49 percent for the overall private sector. In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.[1]

WHITE CASTLE

Currently based in Columbus, Ohio, White Castle first opened its doors in 1921 in Wichita, Kansas. Still, to this day, we are a family-owned, privately held company. White Castle diversified its operations from the beginning to include several divisions that mainly supply its restaurants: bakeries, meat processing plants, manufacturing plants that produce all the fixtures needed to outfit a White Castle store, as well as frozen food plants to supply the grocery market.

The majority of our nearly 10,000 team members work in our 408 restaurant locations, in 12 states. Our culture is one of family, and we proudly began offering health care coverage to our team members in 1924. White Castle offers a rich, full medical health benefit package to all eligible employees – offering anyone who is open to being scheduled for full-time hours, which we currently consider 35 hours per week, health care coverage after 6 months of service.

Team members come to White Castle because of the benefits and stay because it's a family. Our benefits package is one of the main reasons so many team members remain with the company for so long. Twenty-seven percent of our team members have been with us 10 years or more – many starting with the idea of working with us for a few months, and end up making it a career. Recruitment and retention of employees is a top challenge for operators in every segment of the industry. Reducing a restaurants' annual turnover rate in turn reduces the cost of workforce training, which can be a large portion of a restaurant's labor costs. Last year, 57 percent of White Castle's restaurant division workforce left the company and for those positions we had to rehire and retrain, compared to 75 percent average annual turnover rate for the restaurant and food service industry at large.

White Castle's annual turnover rate – well below the industry average – is a testament to our ability to recruit and retain great team members through the benefits that are offered and tailored to the needs of our workforce. Year after year, employees name their benefits package (health care coverage and pension) as the reason why they come to work at White Castle, and why they stay.

Team members remain with the company for many years and the restaurants have deep roots in the communities they serve. Generations of customers and employees have shared the same experiences and hospitality. White Castle prides itself on listening to team members and responding to their needs by offering benefits our team members want and use. To help us craft the best benefits package we can, the company conducts an engagement survey that measures team loyalty and what drives that commitment to the company. Wellness incentives such as a

[1] *2012 Restaurant Industry Forecast*

non-smoker discount have been incorporated into the health care plan to encourage employees to live a healthy lifestyle and help reduce coverage costs for everyone.

Recently, White Castle eliminated employee co-pays for regular checkups and preventative services to be sure team members are taking full advantage of the benefits they have when they need them. While such a decision may increase company costs in the short term, White Castle sees the greater good of increasing the use of team members' benefits, which in turn lowers long-term costs by identifying and treating illness early.

RESTAURANT INDUSTRY CHALLENGES IMPLEMENTING THE LAW

Under the law, White Castle is considered an "applicable large employer" subject to the Shared Responsibility provision[2] of the law. The employer mandate, as it's commonly known, requires employers with 50 or more full-time equivalent employees to offer their full-time team members, based on 30 hours of service per week, health care coverage that is "affordable" and of "minimum value," or face potential penalties.

In addition, as an employer of more than 200 full-time employees, White Castle will be subject to the automatic enrollment requirement under the law.[3] The law also includes extensive reporting requirements for applicable large employers to provide the Internal Revenue Service with detailed information regarding health plan offerings and each individual to whom it was offered and for how many months.[4]

These are just a few of the requirements within the law that apply to White Castle and other restaurant operators like us. In 2014, we estimate that our current plan costs could increase by over 20 percent. This estimate is dramatically different than what we have started to experience recently, as it appears our focus on wellness and preventive care is having a positive effect - YTD in 2012 our health care costs are trending and estimated to increase less than 3 percent compared with the prior year.

As 2014 and compliance with the employer requirements of the law approaches, our company and other restaurant and food service operators will have to balance the requirements of the law with employee needs and the ever increasing cost of health care coverage. It is becoming more and more difficult to maintain or increase benefits in such an environment.

There are many decisions our company and those across the nation will have to consider. Restaurateurs cannot afford just any cost for health care benefits for their employees. Yet, without controlling costs, the law places requirements on what employers must offer their employees or face penalties, while limiting employers' ability to address the rising cost of coverage with the only lever employers have to use – plan design including premium contribution levels.

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[2] §1513, Shared Responsibility for Employers, PL 111-148 and PL 111-152.
[3] §1511, Automatic Enrollment for Employees of Large Employers, PL 111-148 and PL 111-152.
[4] §1514, Reporting of Employer Health Insurance Coverage, PL 111-148 and PL 111-152.

In addition, if we offer too rich a plan, the federal government will tax the plan at a rate of 40 percent on the value of the plan above $10,200 for single and $27,500 for family coverage.[5] Employer-sponsored health care coverage is like a balloon that is being squeezed on all sides. If you force a constriction in one area, another grows to compensate. In the end, it will be squeezed until the business cannot afford the costs, and tough decisions will have to be made.

IMPACT ON JOBS

The health care law will have an impact on jobs in the restaurant and foodservice industry. The only questions are; how and to what extent? Some of the potential impact will be answered once we know the rules with which to comply in the implementing regulations, and, hence, the impact on our workforce. Many in the industry are worried that our slim profits per employee will not be sufficient to cover the additional cost of more employees accepting our offer of coverage or potential penalties that may apply despite our best efforts to provide the required coverage. The uncertainty created by new regulations has also made many restaurant operators more cautious regarding new opportunities for growth of their restaurants until they see the impact on their current business.

This is unfortunate, as restaurants are job creators and, in fact, are engines of job growth for the U.S. economy even when many other industries shed jobs. In 2011, the restaurant and food service industry outpaced job growth in the overall economy for the 12th consecutive year. While the rest of the private-sector lost jobs, eating-and-drinking places increased jobs by 19 percent, including through two recessions. This substantial growth occurred despite back-to-back job losses in 2009 and 2010, when the restaurant industry was negatively impacted by the recession.[6]

For White Castle, the uncertainty of the last several years, and associated with the health care law in particular, has impacted our ability to create jobs by postponing expansion plans into new markets for our brand. We have conducted the extensive research necessary to explore expansion into other parts of the country, but have not acted on those plans yet due to the uncertain cost environment. If we were to pursue our expansion plans of breaking into a new market, it would bring 400-500 team member jobs, not to mention the construction and supplier jobs associated with opening a new restaurant. For every $1 million in restaurant industry sales, 34 jobs are created in the broader economy.

However, we at White Castle cannot proceed with plans for restaurants in new markets right now because of the uncertainty created by PPACA. In the restaurant business, we all manage risk – we do it all the time whenever we launch a new product, pick a new real estate location, or lock into a long-term contract for cleaning supplies – but the uncertainty of the increased costs the health care law brings, not to mention a variety of regulations on other issues, creates a risk that no one can manage against. The result is that the growth that drives job creation in our industry is put on hold, and so are the jobs.

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[5] §9001, Excise Tax on High Cost Employer-Sponsored Health Coverage, PL 111-148 and PL 111-152.
[6] *2012 Restaurant Industry Forecast*

REGULATORY IMPLEMENTATION

As we witness the implementation of this law by the agencies, the industry has discovered troubling challenges that must to be addressed. While White Castle and the National Restaurant Association would prefer repeal of PPACA, we continue to actively participate in the regulatory process to address these challenges.

As the regulators move forward in writing the rules to implement this law, there are still many unanswered questions. More than two years after PPACA was signed into law, restaurant operators cannot predict how the law will fully impact their businesses as we do not have any formal guidance or rules on what we must do to comply.

Most critical are the rules surrounding the definition of full-time employee; how restaurants will calculate hours of service to determine who is full-time for a workforce with flexible and variable hours; and then determine who must be offered coverage. In addition, many restaurant operators are very concerned about the potential burden of the employer reporting requirements under the law. The statute lays out the requirements in general terms but we need rules or guidance to know the exact timing, form and detailed substance of what we must report to the Internal Revenue Service as applicable large employers.

These are essential questions that must be answered for us to produce an informed budget and for our 2014 health coverage planning that has also already begun for many other restaurant and food service operators. In many cases, it will take 18 months to plan for and set up internal systems or hire outside vendors to comply with the various requirements of the law by January 1, 2014. In addition, the answers to these critical questions are necessary as we plan what and how to communicate with our employees regarding the various required changes to our health care plans and how such changes may impact them and our benefits plan.

It is extremely important for the regulatory agencies to examine the employer provisions of the law as a whole when developing regulatory guidance because they are inextricably linked together and that is how we as employers look at compliance with the law – comprehensively. As we look at all of the employer requirements together, it is clear that they will have significant consequences for us and our ability to maintain flexible work options and affordable health coverage for their employees. Through the National Restaurant Association's regulatory work, we continue to urge that the regulations regarding the employer requirements be issued in tandem, rather than piecemeal, so that restaurateurs may have a comprehensive view of the requirements under the law and take definitive steps towards implementation and compliance.

HEALTH CARE REFORM RESTAURANTS SUPPORT

We must have health care reform that controls costs and in turn makes affordable coverage available to more people. One of the key factors of cost-reduction is informed consumer choice in health care product purchasing.

White Castle and the National Restaurant Association support allowing purchasing of health care coverage across state lines. For many years, the industry has supported health care pooling arrangements that provide small businesses increased options for affordable health care. Pooling statewide or nationwide would work to achieve lower rates for employees' health care coverage.

Unfortunately, the health care law also limits the use and flexibility of Health Savings Accounts (HSA), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). No longer can over-the-counter medicines be reimbursed by these cost-reduction tools without a prescription by a doctor. We support expansion of the flexibility in use and contribution amounts of these accounts as a means to give consumers the ability to control and reduce their own health care costs.

We also support health insurance coverage portability options that place control of health care decisions in the individual consumers' hands. To provide coverage to a mobile workforce, allow uninterrupted coverage, and extend coverage to the uninsured, tax laws and insurance regulations should permit employees to take their coverage with them when they change jobs. Given that restaurant employees change jobs more often than other workers, such an option would be of great benefit to them.

CONCLUSION

The law cannot stand as is. We support repeal of this law and the development of health care reform that promotes an affordable health insurance system that functions well for low-profit per employee, labor-intensive, industries, such as the restaurant and food service industry.

Restaurants like White Castle, and the industry at large, need reform that addresses the unsustainable increasing costs in coverage restaurant and food service operators face each year. Our goal is to lower the cost of employer provided, and employee accessed, health insurance. We must find solutions that will allow restaurant and food service operators to provide better health care coverage options to their team members without excessive costs and regulatory burdens that threaten their businesses. The restaurant and food service industry wants health care reform that helps us create jobs and grow the national economy, but this law was not the solution.

Thank you again for this opportunity to testify today regarding the impact of the health care law on job creators such as White Castle and the restaurant and food service industry broadly. White Castle and the National Restaurant Association look forward to working with Congress and the Administration to enact laws that address the increasing cost of health care coverage so that restaurant operators may offer their employees health benefits that are affordable for both, and continue to be an engine of job creation for the U.S. economy.

Chairman ISSA. Mr. Fredrich.

STATEMENT OF MICHAEL FREDRICH

Mr. FREDRICH. Thank you, Mr. Chairman and Ranking Member Cummings. Thank you for having me today.

I bought MCM in 2001. We closed on the business 45 days after 9/11, so there was a bit of uncertainty. And certainly the economy right after we closed did not serve us well. We also had the disadvantage of, I call it being too smart to not know what you don't know. And so we had a big learning curve right after we bought the business. But we made it. We made it at least up until 2009, and 2009 was just a god-awful year. Our revenues were cut in half. We got down to 43 employees. We have 58 right now. We lost customers. We were working 2 days a week. All the salaried people got 60 percent of their salary. We just couldn't do it any other way. We had to balance cash. So we worked through that.

Last year, they say there is a recovery, there's not. I would call it treading water. You can see that in the fundamentals of our business, where things like customers are delaying orders. They will place a order and then they will call and say don't ship that. That is a good indicator that it is not good in the economy, and that is across all of our customer base. Also, there is not much investment in new tooling. All of our parts are made with tools that are owned by our customers, and so we have an early look at what their investment strategies are, and they are just not making any. The largest investor that I can see right now is actually a German company, and they're building $1 million worth of tools, and it is in the aerospace business, and that will be good for us, but that is a small segment.

So on top of this, we made last year, we did $7 million in sales. We made $138,000 which is peanuts. It is barely eking out a profit. I think this year will be about the same. Our revenue is about the same. So I'm not optimistic.

And on top of that, we now face something I was praying we would never have to face, which is this new health care law which is going to create God knows what. I mean, it is going to be a burden to be sure, and it is going to be costly and it is going to affect companies like ours and larger companies in hiring and the business. I think it will be a general depressant on the entire economy.

So what do we do? I mean, we will have to live with it. We have persevered before and we will persevere again. But what this Act does is it changes our focus. We right now need to focus on our business. We need to expand our customer base. My time would be better served today calling on some prospects and trying to generate some more business. But my focus is here because this is a real threat to us.

It's adding—it is going to add cost. I don't see how it can't add cost to the health care system. It doesn't do anything to address the basic problem which is it is a dysfunctional market. And it has been dysfunctional since 1942, and what you've done here with this law, you have made it more dysfunctional. You've taken a step in the wrong direction. And that is, unfortunately, what we are going to have to deal with.

So what do we do? I look at our company. We have, as I said, 58 employees. We are kind of on the bubble. We could get down to 50 and not be subject to this law and shrink our business. Well, who wants to do that? Think about it, why in the heck would you be in business so you can shrink your business? You want to grow your business and add people. So that's not a very good option.

We could continue on with the plan we have. Do nothing and hope for the best. I think eventually we'll lose our plan. It is a high deductible HSA. It sounds like the Secretary of HHS will determine whether that is acceptable, which to me is repulsive in the first place. That somebody is going to tell us what is acceptable and what isn't, I don't like it.

The third option is on the first day, is drop our coverage completely and leave all of our employees. We have 43 out of 58 who take the coverage, and just drop the coverage. And we are not going to do that because we will not do that to our employees. There is enough turmoil going on, I don't need to add turmoil to their live. I am not going to do it. So, we have to do something. Somehow we have to adjust to this. I can only plead, I guess, with the committee that you go in the direction of the free market and to trust the free market. It works everywhere else.

I was talking to Mr. Richardson, and I said why are hamburgers so cheap? And I was being facetious. He actually was going to tell me why, but they are so cheap because people compete in the hamburger business. The government doesn't run the hamburger business, not yet.

I see my time is up, so I appreciate the time. And thank you very much and look forward to your questions.

Chairman ISSA. Thank you for noting that.

[Prepared statement of Mr. Fredrich follows:]

"The Impact of the Patient Protection and Affordable Care Act on Job Creators and the Economy"

Testimony of:

Michael Fredrich

President and Owner

MCM Composites

Manitowoc, Wisconsin

Before the

Committee on Oversight and Government Reform

United States House of Representatives

July 10, 2012

The Honorable Darrell Issa, Chairman

The Honorable Elija Cummings, Ranking Member

Good afternoon Chairman Issa, Ranking Member Cummings and members of the Committee. Thank you for hosting this important hearing today and for your invitation to provide testimony. My name is Michael Fredrich, President of Manitowoc Custom Molding, LLC (MCM Composites). MCM Composites produces a wide range of precision products from many different raw materials. We specialize in thermoset plastic molding, enabling us to focus our capital and effort on continually improving our thermoset knowledge, expertise and technical capabilities.

Company Background MCM Composites is a small manufacturing company located in Manitowoc, Wisconsin. Our business is the custom molding of thermoset composites parts, which are used in a variety of applications across a broad spectrum of industries ranging from cookware to aerospace. We do not have our own product line. All of our products are used in other manufacturers' products and therefore we must compete with companies not only in the USA but also around the world.

In 2011 our revenue was $6.9 million on which we managed to eke out a pre-tax profit of $138,000. I emphasize pre-tax income because MCM, like most small companies, is structured as a pass-through entity for tax purposes, e.g. the profits are passed through to the owner's individual tax return so my taxable income is increased by the profit of the company.

MCM currently has 58 non-union employees. Over the past several years we have added 12 people in production -- none in support. We, like all small businesses, only hire people when the demand for our products increases and we need additional people to fill orders. New employees are generally brought in through a temporary help firm. The highest salary in our company is $83,000 (not me). The lowest entry-level wage is $8.50 per hour and the highest hourly wage is $22.00 per hour. The average is $12.40. In addition to salaries and hourly wages we have performance incentives. Hourly employees can earn an additional $100 per month and salaried employees receive a bonus based upon pre-tax income. We are a typical small business.

Health Insurance Many times in company meetings I have told our employees that I did not buy MCM to be in the health insurance business, yet here we are today. It is not a market-based system. I believe the system is where it is today because it lacks market discipline, incentives and competition. MCM offers a Health Savings Account (HSA) plan with a deductable of $2,500 for single coverage and $5,000 for family and limited family coverage. Preventative care is covered with no deductable. Monthly premiums are $335 for single, $703 for employee/spouse, $653 for employee/children, and $1,021 for family. MCM pays 70% of the premium and employees pay 30%. Our employee participation rate is 43%. This does not mean that 57% are uninsured. Many have insurance through their spouse.

When HSA plans became available we converted our health insurance to an HSA plan immediately. It was, and still is, my firm belief that the only solution to rising health care costs is a market-based system. Our employees were skeptical because they felt they were paying a premium and getting nothing in return. The simple rebuttal was they pay a premium for auto and home insurance and receive nothing in return unless they have an accident or their home is damaged. There is a cognitive disconnect when it comes to health insurance. Many consumers do not look at it like auto or home insurance. My employees very much appreciate their HSAs, especially the flexibility it gives them. We need to build on this successful model.

MCM and the Patient Protection and Affordable Care Act (PPACA) Now that the U.S. Supreme Court has ruled PPACA constitutional, I must begin serious planning to protect MCM Composites and all the jobs and livelihoods that PPACA threatens.

Given our size of 58 employees we are close enough to the "large employer" cutoff of 50 employees to have three apparent options (all bad) if the law stands.

These options include:

Option #1—Cut Employees

We could reduce our total employee count to 49 or lower and never allow it to increase above the cut-off. It would be hard to explain to the employees we cut that the reason they are being terminated is due to a federal mandate that makes it uneconomical to employ them.

It would be our plan to continue our current health insurance as long as it is affordable and available. As the market (such as it is) adjusts, it is doubtful that our plan will remain available, affordable, or even legal under PPACA -- in which case we will discontinue offering health insurance.

The downside to this option is the damage done to the people discharged. They have done nothing wrong and will not understand that we must do what is necessary to protect the remaining jobs. Some of our customers will suffer as we may not be able to continue to supply their parts. MCM Composites will be less competitive in the global marketplace. Our senior managers will suffer because we will not be able to grow our business, which will affect their bonuses and career upside. The company will suffer as we will stagnate. The community will suffer because stable jobs are not that easy to find.

Option #2----Keep Employees and Keep Plan

Assuming our current plan is available, affordable and legal we could continue on as we are now. Undoubtedly, however, we will have employees who will apply for and receive credits for exchange coverage, which will trigger the $3,000 penalty. We currently have employees who have access to our health insurance but instead receive the overly generous Wisconsin Medicaid (a/k/a BadgerCare). Some of our employees have refused to accept pay increases or asked us to not include overtime earnings when we report their earnings so they can qualify for the program (we report such earnings, of course.) The same behavior will exhibit itself under PPACA. Ultimately people will migrate to the exchanges as our plan becomes

more expensive, or is unavailable.

Option #3---Keep Employees and Eliminate Insurance

On paper this is the best option. Our gross annualized premium is $141,000. Our net premium is $98,700 (company pays 70% employee pays 30%). The penalty for not offering insurance is $2,000 per employee for the number of full-time employees over 30. At our current count (58) our penalty would be (58-30) x $2,000 or $56,000. Our savings would be $42,700. I suspect many companies will stop at this level of analysis because that is what is seen. What is not seen is that nothing has been done to reduce the cost of health coverage or medical care. The costs have only shifted and the problem still festers. MCM Composites does not plan to exercise this option unless we have no other choice. Among my business peers, this is a very real option. It is clear that this penalty is actually an incentive to move previously insured people into the exchanges. I view the exchanges as an interim step to a single payer system.

How did we get to this point? Our system of employer-supplied health insurance is a result of wage and price controls instituted during World War II. This, coupled with favorable tax treatment, which allows employers to deduct the cost of employee health insurance while not treating the benefit provided to employees as income, has created a dysfunctional market -- a market where third-party payers dominate and the users and suppliers of the service do not know the cost of the service.

On top of this, mandated benefits and regulations at the state level are driving up costs, and small business owners cannot buy health coverage across state lines. We are being held captive to the "market" within our state boundaries, which is not competitive and often unaffordable. The U.S. does not have a competitive health insurance market. Competition – a true national marketplace, coupled with universal HSAs (or, other consumer-directed innovations) and a liberated market will bring consumers the types of plans they need,

and can afford.

PPACA will do nothing to change the fundamental flaws in the health care system. It will exacerbate all the problems it is designed to fix. In fact, it already has. Costs continue to rise, and I don't see how PPACA will lower costs in the future. MCM Composites does not qualify for the small business health care tax credit – we are discriminated against because we employ "too many people" and pay our employees "on average" more than what the government says we should in order to qualify. You would think the government would want to encourage and reward small manufacturing firms like MCM Composites for growing, hiring people and paying them decently. MCM Composites is the type of business the government needs to be rewarding and incentivizing, not punishing. Under PPACA, we are being punished.

I am also concerned about the compliance costs associated with PPACA. Already, tax code and regulatory compliance are costly line items for my company. I believe I am correct in assuming that paperwork and compliance costs -- where we will need to document number of employees, the value of health insurance provided, proof that we are providing "acceptable coverage" as well as other requirements will be quite burdensome for small to mid-size firms.

In my opinion, the best fix for more choices and affordability in health coverage is more competition – real competition. The "largest supercomputer" in the world -- the free market system -- and its billions of iterations per second will work. It always works.

Small business owners across the country are facing the same set of challenges as MCM Composites. Thousands of small businesses across the U.S. taking similar actions as my company in response to PPACA means less growth, fewer jobs, low business confidence and economic stagnation. The impact is real, and has serious consequences for U.S. competitiveness and the future of entrepreneurship.

Thank you and I look forward to your questions.

Chairman ISSA. Ms. Miller.

STATEMENT OF MARY MILLER

Ms. MILLER. Chairman Issa, Ranking Member Cummings, and distinguished members of the committee. Thank you for inviting me to testify before you today on the impact of the health care reform on job creators and the economy.

My name is Mary Miller and I am the CEO of JANCOA Janitorial Services headquartered in Cincinnati, Ohio. I am honored to be here today on behalf of the U.S. Chamber of Commerce.

This year, we are celebrating our 40th year in business at JANCOA. We are a family business with literally clusters of small families within our business. My husband was a student at the University of Cincinnati when his economics professor casually mentioned vendor contracting such as janitorial services. Noticing how dirty the floors were at the local bar, he thought cleaning would be a way to pay for bar tabs. With going to school full-time and working another job already, he started hiring friends to help him. When his father, Bill, went to have heart surgery, Tony promised to take care of the family. His father died, and at the age of 19, Tony left school and created JANCOA to support his mother and three siblings. Today our company has 320 full-time employees and we clean more than 10 million square feet just in the greater Cincinnati area.

One of our most important duties is to attract, train, and motivate quality employees. Our business model helps us do this. Unlike the majority of janitorial companies, we rely on full-time employees. In fact, 98 percent of our employees are full-time and we have very low turnover, nearly half of the industry's national average. We find most people in our community want full-time work, and our company does better with full-time employees. This is an important win/win.

By hiring nearly exclusively full-time employees, we are better able to recruit, retain team members and improve efficiency, productivity, and quality. We also offer good benefits, including vacation pay, paid holidays, health insurance coverage, and what we call the dream manager program. Although our dream manager program is a source of great pride for our company, given the brevity of my time and the focus of the hearing, I will limit my remarks on it and simply say that the dream manager program has been responsible for many of our employees realizing the American dream. It has helped our employees become homeowners, achieve economic independence through starting their own small business, and further their education by earning GED and/or college degrees. In short, it exemplifies our mantra of taking the "dead end" out of dead end jobs and to let our employees grow. I hope you will read more about it in my written testimony.

One of the benefits we offer which very few of our employees take advantage of is health care coverage. We offer a PPO to all of our full-time employees and pay an average of 85 percent of the premiums, but less than 6 percent of our employees take advantage of this coverage. The vast majority of our employees have historically chosen to take home their earnings as wages to pay their bills. The coverage that we can afford to provide is subject to a

$6,000 annual limit, and it is a limited benefit plan. Our issuer got a waiver so that we can continue to offer this coverage to our employees until 2014.

Sure, this is not an ideal coverage, but it is what we can afford to offer and allows them an option of some coverage at a very reasonable price, $20–30 a month. However, come 2014, when the employer mandate and the individual mandate kicks in, neither our company nor our employees will be able to make these choices about health insurance. Our company will no longer have the option of offering this type of plan to our employees, will no longer have the freedom to choose how to spend their wages. Even worse, the law will force my husband and me to choose between several impossible options in order to remain in business. This will jeopardize our ability to offer jobs that our employees value. We face additional costs that exceed $1.4 million in premium cost increases, over 400 percent, because of this law. It's a devil's choice. No matter what we do, our company and our employees will suffer as a result.

As many in the service industry know, for me, raising prices is not an option. Most janitorial companies rely on part-time employees and therefore will not be subject to such penalties and employer mandate. It certainly seems to me like the law creates very perverse incentives, particularly in this economy when jobs are on everyone's mind. Why would you penalize businesses for hiring full-time employees and provide a competitive advantage to those businesses that limit their hours their employees can work? These perverse incentives will negatively impact businesses such as ours that want to hire full-time employees. Regardless of how much better my services are, there's only so much a customer is willing and able to pay.

In conclusion, although my employees prefer full-time employment, and I prefer to hire full-time workers, this law may force me to reduce the majority of my team members to part-time employment. This will destroy the foundation upon which my company was built, and the quality of life we are trying to help our employees achieve. Regrettably, for me and my employees, the new health care law is a dream killer.

Thank you.

Chairman ISSA. Thank you.

[Prepared statement of Ms. Miller follows:]



100 Years Standing Up for American Enterprise

U.S. CHAMBER OF COMMERCE

Statement of the U.S. Chamber of Commerce

ON: **"Examining the Impact of ObamaCare on Job Creators and the Economy"**

TO: **The House Committee on Oversight & Government Reform**

BY: **Mary Miller, CEO**
JANCOA Janitorial Services, Inc.

DATE: **July 10, 2012**

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.

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

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. As a result, we are particularly cognizant of both the problems with which smaller businesses grapple, as well as those 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 across many varied types of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. In addition to the Commerce's 115 American Chambers of Commerce abroad, an increasing number of our member companies engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors greater 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. More than 1,000 business people participate in this process.

Statement on
"Examining the Impact of ObamaCare on Job Creators and the Economy"
Submitted to
THE HOUSE COMMITTEE ON
OVERSIGHT & GOVERNEMNT REFORM
By
Mary Miller, CEO
JANCOA Janitorial Services, Inc.
5235 Montgomery Road
Cincinnati, Ohio
on behalf of the
U.S. CHAMBER OF COMMERCE
July 10, 2012

Chairman Issa, Ranking Member Cummings, and distinguished members of the Committee, thank you for inviting me to testify before you today on "Examining the Impact of ObamaCare on Job Creators and the Economy." I am grateful to you for holding this important hearing to better understand the effects that the health care law will have on businesses like mine. I know, for my company, the health care law will hinder our ability to grow and create full-time jobs.

I am Mary Miller, CEO of JANCOA Janitorial Services, Inc., a family-owned business headquartered in the Cincinnati, Ohio area. Along with my husband Tony, I am responsible for the day-to-day management, employee relations and business acquisition at JANCOA. Our employees and community are extremely important to us. I have the privilege of working with many different associations and am proud to be serving: my second term as a Board Member of the Building Operators and Managers Association; as a member of the Women Excel Leadership Team; and on the Middle Market Advisory Board at the Cincinnati USA Chamber of Commerce. I am also honored to serve on the Board of Directors for the Goering Center for Family and Private Business at the University of Cincinnati and to have our company certified by the

Women's Business Enterprise National Council. I am on the board of directors for Bridges for A Just Community which focuses on incorporating racial, ethnic and religious diversity into the community, as well as on the Women's Leadership Council for the United Way. Our company is committed to charity work with the American Heart Association (AHA) for which I serve on the Go Red Women Leadership Team. Our Dream Team completed the 5K in the 2012 Cincinnati Heart Walk and raised more than $1,200 for the AHA. I am here to speak with you today on behalf of the U.S. Chamber of Commerce.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, the Chamber is particularly cognizant of the problems of smaller businesses, as well as the issues facing the business community at large.

Company Background

JANCOA Janitorial Services, Inc. was founded in 1970 when Tony Miller Sr., a 19 year-old student at the University of Cincinnati, took on a second job cleaning local taverns after one of his professors commented on the growing "services" sector, including janitorial services. When his father passed away in 1972, Tony transformed the company to a full-time operation in order to financially support his family.

Initially working out of the basement in their home, Tony handled operational issues, his mother Jeannette handled office functions, and his brother Bill took on the task of obtaining new

business. His pioneering efforts not only sustained the Miller family, but laid a strong foundation upon which today's award-winning company stands.

Approximately 20 years later, I joined the team to form a dynamic partnership of operations, sales, and leadership that has seen JANCOA grow to a company with more than 320 full-time employees, cleaning more than 10 million square feet daily in the Cincinnati area alone. For the past three years and with the help of our talented management, sales, and operations teams, JANCOA has experienced annual 5-10% increases in revenues, while operating in a commercial real estate market that has been battling steady decreases in occupancy. By creating processes that provide value and efficiencies for our customers, business partners, and team members, JANCOA continues to be the industry leader in the Greater Cincinnati commercial cleaning market.

Our primary business activity is to provide award-winning cleaning services to commercial facilities in and around the Cincinnati, Ohio area. Much of our work centers in providing cleaning services for Class "A" office space of 50,000 square feet or more. We also work with a large number of schools and medical buildings to provide a clean and healthy environment for the people to learn and work.

Cincinnati is my home, I was born and raised here, and while it is important for us as a sustainable company to make a profit, it is also important to my husband and me to give back to our community. The following are a list of awards that we have been honored to have received in recognition of our involvement with the community and our business integrity:

Awards for Exceptional Service

- JANCOA has been nominated for the *Goering Center at the University of Cincinnati 12th Annual Tri-State Family and Private Business Awards*.
- JANCOA Janitorial Services Inc. has been nominated for *The Enquirer Media Top Workplaces for 2011* award.
- The 2003 *Cincinnati USA Chamber of Commerce Small Business of the Year.*
- The 2002 *William R. Burleigh Leadership Award*, from the Tri-State Chamber Collaborative, based on our leadership and support in the Hispanic Community.
- The 2002 *Cincinnati USA Chamber of Commerce Commitment to Excellence Award.*
- The 2001 *Cincinnati USA Chamber of Commerce Commitment to Excellence Award.*

Leadership Awards

- Mary Miller, JANCOA CEO, has been nominated for the esteemed *YWCA Career Women of Achievement* award. An independent panel of community leaders will judge the nominees based on their outstanding career achievements, strong leadership qualities, and ability to serve as role models. The eight finalists were recognized at the YWCA Salute to Career Women of Achievement luncheon held on Thursday, May 19th, at the Duke Energy Convention Center.
- Mary Miller was a finalist in the Ernst and Young Entrepreneur of the year for the *South Central Ohio and Kentucky Entrepreneur of the Year Award* for 2011 and 2012.
- Mary Miller was the *Ohio Hispanic Business Summit Business Person of the Year* Award for 2011.

- The 2010 *Cincinnati USA Regional Chamber's Fifth-annual WE Celebrate* was awarded to Mary Miller, JANCOA CEO, for winning the *Woman of the Year – Entrepreneur* category.

Dedication to Employees

For Tony and me, one of our most important duties is to attract, train, and motivate qualified employees or team members. It is our team members that carry the banner of our company and maintain our high level of customer service. Without their hard work and commitment, we would not have been able to gain the notoriety and the level of success that we have obtained. That is why we are dedicated to the well-being of our team members. Unlike most companies in the janitorial services industry who hire primarily part-time employees, JANCOA's business model relies on full-time employees. Ninety-eight percent of our employees are full-time and we offer benefits that they value including vacation pay, paid holidays, and health insurance coverage and what we call the Dream Manager Program.

While we may have started out 40 years ago as a janitorial service, we see ourselves today as a human development company. We are all about helping our team members realize their potential for the future, be excited about the future, and go after their dreams. We accomplish this through a program we started called the Dream Manager program.

The Dream Manager program is fundamentally about connecting with our employees from the first day they are hired, and then inspiring and helping them to achieve their dreams. Through one-on-one coaching sessions and group classes, employees are encouraged to identify their dreams and take real action steps to realize those dreams. Each JANCOA employee is a valuable team member. We want them to recognize their value not only to our company, but also the community at large and then remove the limits they place on themselves so they can become

all they can be in life. Our Dream Manager program has been so successful that Matthew Kelly chose to tell our story in a *New York Times* best-selling book, "The Dream Manager."

It is amazing the hidden talents you can unleash when you can you encourage your employees to believe in themselves and achieve their dreams. Over the years, our Dream Manager program has been responsible for many of our employees realizing the American Dream of home ownership, achieving economic independence through starting their own small business, and furthering their education by earning a GED and/or college degree. Through the program, our employees not only enjoyed continued career growth within JANCOA, but have also benefitted in fitness and wellness through team and individual efforts and smoking cessation. Each of our team members is different and we help each of them to uniquely fulfill specific individual goals. Our mantra has been to take the "dead-end" out of "dead-end jobs" and let our employees grow.

And by the way, this is resonating with our employees. One of the reasons we began our Dream Manager program was to help reduce turn-over, which in the janitorial services industry is very high. The industry average turn-over is 360% and now our company's turn-over rate is 186%, roughly half of the national average.

Health Care

While our business model is built on opening the doors of opportunity for JANCOA and our employees to grow and achieve success, the new health care law will do just the opposite. According to the health reform law, we are a large employer. The bulk of our employees are low-wage, low income and, at least initially, low-skilled workers. We offer health insurance to all of our full-time employees, which again, 98% of our employees are, and pay on average 85% of the premiums. Despite this offering, less than 6% of our workers elect this coverage. The vast

majority of our employees have historically chosen to take home their earnings as wages to pay for their bills. Our employees look to us for work. They want full-time opportunities that will allow them to pay their bills and that is what we strive to offer them. Despite well-meaning intentions, the employer mandate in the Patient Protection and Affordable Care Act will harm employers and their employees.

The health coverage that we currently offer and largely finance for our employees provide health care coverage subject to an annual limit. The plan is a limited benefit plan for which our issuer obtained a waiver to permit us to continue to offer this coverage to our employees given the law's new restrictions. But very few of our employees choose to elect this coverage; the majority of our employees prefer to use take their wages home to pay for other expenses. Even with such small employee premium contributions, most of our employees do not enroll. However, come 2014 when the employer mandate and the individual mandate kick in, neither our company nor our employees will be able to make these choices about health insurance. For our company, we will no longer have the option of offering these types of plans and our employees will no longer have the freedom to choose how to spend their wages. What is even worse, the law will force us to choose between several impossible options in order to remain in business and will jeopardize our ability to offer the types of jobs our employees value.

Our options are to:

1. Pay nearly $4,400 to provide coverage to each of our full-time employees that satisfies the mandate which will be nearly $1.4 million.
2. Stop offering coverage and pay $2,000 per full-time employee in penalties which will be instead $640,000.

3. Or transition all of our staff to part-time status in order to avoid the exorbitant increase in costs, which would be virtually impossible given that we are a responsible union company.

These three options are not options that I can consider if I want to keep JANCOA's doors open. JANCOA will face costs that at the very least exceed half-a-million dollars. It's a devil's choice. No matter what we do, our company and our employees will suffer.

As many in this service industry know, for me, raising prices is not an option. The majority of janitorial service companies rely on part-time employees and, therefore, will not be subject to penalties under the employer mandate. I may be a business woman from the mid-west, but it certainly seems to me like the politicians enacted a law with very perverse incentives. Particularly in this economy, when jobs are on everyone's mind – why would you penalize businesses for hiring full-time employees and provide a competitive advantage to those businesses that limit the hours their employees can work. These perverse incentives will translate into dramatic differences in the bids that companies in my industry can offer to do the same work. Regardless of how much better my services are, there is only so much a customer is willing pay.

My employees prefer full-time employment and I prefer to hire full-time workers. However, one of the few options that I am now forced to consider is reducing the majority of my team members to part-time employment, in order to reduce the amount that I will be penalized. This, in effect, will put an end to our very successful Dream Manager program. Regrettably, for me and my employees, the new health care law is a "dream killer."

In Conclusion

As you can see from the options that I am facing because of the employer mandate, the health reform law will force many employers to stop offering the coverage that they currently offer and encourage employers to consider restructuring their businesses and moving their employees to part–time status in order to remain in business. This is not good for employees, it is not good for business and it surely won't help our economy.

We hope our Dream Manager program at JANCOA will help our team members identify and achieve their dreams; much like a janitorial job did for a fellow Cincinnatian. As you may know, this Cincinnatian was working his way through night school as a janitor when he met his now wife of 35 years after emptying her trash bin before growing up to be the Speaker of the House. We have helped many of our employees excel: they have bought homes, sent children to college and gone back to school themselves. It is human nature; people will work hard and excel when they realize that they have the opportunity to do better. As one of our customers recently told me "we have a great staff. When they are given further challenges, they simply just rise to the occasion. When people see there is a reason to work hard for something, they do. That is just human nature." Why would our leaders ever pass a law that would undermine this?

I understand that given the existing political realities in Washington, DC, a total repeal of the health care law by Congress is an unlikely proposition for now. However, I am hopeful that this Committee and your colleagues in the House and Senate will eliminate the more onerous mandates and provisions which saddle businesses with burdens that actually encourage us not to expand our business and astoundingly discourage job creation. The bottom line is that your decisions can help or hinder us. By that I mean the laws you create will either foster an environment that gives business owners greater confidence and certainty to grow and generate

new jobs, or one that does just the opposite. Regrettably, this new health care law is already doing the latter and Congress must take the necessary action to rectify it.

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

Chairman ISSA. We have 15 minutes on a vote on the House floor, so counting 5 and 5, I can get you both done if you stick to the 5.

Senator Wolf.

STATEMENT OF HON. DANIEL WOLF

Mr. WOLF. Thank you, Mr. Chairman.

Good afternoon. My sincerest thanks to the committee for the opportunity to testify on such an important issue for the American people. I come before you today to share the perspective of a person who, thanks to the hard work and dedication of a team of remarkable individuals, has achieved amazing success in one of the most challenging industries in the country, the airline industry.

25 years ago, as a trained and licensed aircraft mechanic and pilot, my dream was to start an airline in Massachusetts. And with one airplane, one route, and six employees, Cape Air flew our first flight in 1989. Today, headquartered in Massachusetts, Cape Air operates in 11 States, four U.S. territories and commonwealths, and three foreign countries. We will carry over 725,000 passengers this year, and generate more than $105 million of revenue.

As a member of the Alliance for Business Leadership, Cape Air now offers nearly a thousand full-time jobs with about 500 of them based in Massachusetts, and they are full-time jobs. Nearly 300 of our employees have been with the company for more than a decade, and our employees share the ownership in the company with us.

Cape Air's success allowed me at the age of 52 to enter government 2 years ago, and the voters from the Cape and Islands chose me to represent them in the Massachusetts State Senate.

My primary goal in this capacity is to help government and private business partners in ways that make our communities healthier and make our economy stronger. They are not mutually exclusive. And what is also informing my perspective, other than the Cape Air experience, is 6 years on the Federal Reserve Board Advisory Council for New England, the chairman of the board of one of the largest Chambers of Commerce in the Commonwealth of Massachusetts, and I also serve as the trustee of the largest mutual bank in the region. Cape Cod Five Cents Savings Bank.

From all of these vantage points, I have come to realize that one of the most important values that we must embrace is that every American should have access to affordable and excellent health care, and I am really proud that we have come a long way towards accomplishing that goal in Massachusetts. We have done so without stunting business growth, and we have done so without cutting jobs.

One of the reasons I'm here today is to debunk some of the myths and distill fear and misunderstanding about the 2006 Health Care Reform Act that Massachusetts enacted with strong bipartisan support, and I stress strong bipartisan support. In the State Senate, the vote was 40–0 to enact that law in Massachusetts. It is also the template for much of the Affordable Care Act now sanctioned as the law of our land.

From Cape Air's first day in business, we have offered health care coverage knowing that affordable health care coverage helps us to retain a great workforce. And it has. This year, Cape Air's

health insurance premium will cost close to $3 million, roughly 3 percent of the company's gross income. The company will pay just over half of that cost and the employees will pay the rest.

In 2007, when Massachusetts' health care reform went into effect, there were dire predictions of the impact on businesses like Cape Air. Here is what really happened to our business. We added some new dependents under 26 years of age to those of us in our company who had family plans. Beyond that, the transition was seamless for us. There was no bureaucracy, no heavy lifting in the front office.

Since then, we have added a solid 15 percent more Massachusetts-based jobs with our total revenue growing far faster. Health care reform in Massachusetts has not stifled business. Health care reform was designed to ensure access, not curtail costs. And with landmark legislation now close to passage, building on the success of the 2006 Act, Massachusetts is on the verge of implementing new strategies to contain costs while continuing to provide coverage for more than 98 percent of our Massachusetts residents, and that bill is now in conference committee in the Massachusetts legislature.

I can also report that health care costs have not spiraled because of this plan. They have not spiraled. This year, Cape Air saw a 5 percent increase in premiums, too much, but far from the 15 to 20 percent increases we saw year after year before this reform took effect. Last year, our increase was 4 percent. The previous year, we were able to negotiate a 5 percent decrease in premiums. That is after the passage of the law.

Our success should be taken in the State context. Unemployment in Massachusetts has dropped from 8 percent in 2009 to 5.8 percent in May of this year. That is 2.4 percent below the national average. Since January 2007, Massachusetts has ranked third in the Nation in economic performance as defined by our gross State product. And our bond rating in the State is AAA bond rating, the best in the United States.

Meanwhile, additional State spending for health care programs resulting from payment reform only represented 1.4 percent of the State budget in 2011. Again, with more than 98 percent of our residents covered, which includes a 400,000 net increase in the number of non-elderly insured residents.

Chairman ISSA. Senator, your entire statement will be placed in the record, if you can please wrap up

Mr. WOLF. I just have four paragraphs.

Chairman ISSA. Pick one.

Mr. WOLF. I will read them quick.

As important and positive as enacting the Affordable Care Act is now and will be, it's not the last word. Just as Massachusetts is now moving forward with cost containment initiatives, there will be more opportunities to continue and reform our health care structure. Access is only one of the pillars on which great health care is built. The others to address are cost, complexity, outcomes and transparency.

I look forward to a national conversation about all of them, and especially a better understanding of the link between a healthy business climate and access to health care for all.

Chairman ISSA. Thank you, Senator.
[Prepared statement of Mr. Wolf follows:]

Statement for the House Committee on Oversight and Government Reform
July 10, 2012

"The Impact of the Patient Protection and Affordable Care Act on Job Creators and the Economy"

Testimony of the Honorable Daniel A. Wolf, CEO and Founder of Cape Air, Massachusetts State Senator

Good afternoon and my sincere thanks to the committee for the opportunity to testify about such an important issue for the American people.

I come before you today to share the perspective of a person who, thanks to the hard work and dedication of a team of remarkable individuals, achieved amazing success in one the most challenging businesses of today, aviation.

Twenty-five years ago, as a trained mechanic and pilot, my dream was to start an airline in Massachusetts. With one plane, one route, and six employees, Cape Air flew its first scheduled flight in 1989.

Today, headquartered in Massachusetts, Cape Air operates in 11 states, 4 U.S. territories and commonwealths, and 3 foreign countries. We will carry 725,000 passengers this year, and generate $105 million in revenue.

Cape Air now offers nearly 1000 full-time jobs, with about 500 of them based in Massachusetts. Nearly 300 of our employees have been with the company for more than a decade.

Cape Air's success allowed me, at age 52, to enter government and two years ago, voters from the Cape and Islands chose me to represent them in the Massachusetts State Senate.

My primary goal is to help government and private businesses partner in ways that make our communities healthier and our economy stronger, and what's informing my perspective includes 6 years on the Federal Reserve Board's Advisory Council for New England, Board Chair of one of the largest Chambers of Commerce in Massachusetts and a trustee of the largest mutual bank in the Cape and Islands region.

From all these vantage points, I've come to realize that one of the most important values we must embrace is that every American should have access to affordable, excellent health care.

We have come a long way toward accomplishing that goal in Massachusetts, and we have done so without stunting business growth, and without cutting jobs.

I'm here to debunk myths, and dispel fear and misunderstanding about the 2006 health care reform act that Massachusetts enacted with strong bipartisan support. It also is the template for much of the Affordable Care Act now sanctioned as the law of our land.

From Cape Air's first day in business, we offered health care coverage, knowing that affordable health care coverage helps us retain a great workforce. This year, Cape Air's health insurance premiums will total close to $3 million, roughly 3 percent of the company's gross income. The company will pay just over half of that cost, employees the rest.

In 2007, when Massachusetts health care reform went into effect, there were dire predictions of the impact on businesses like Cape Air.

Here's what really happened:

We added some new dependents under 26 years of age to family plans. Beyond that, the transition was seamless. There was no bureaucracy or heavy lifting in the front office.

Since then we've added a solid 15 percent more Massachusetts-based jobs, with our total revenue growing far faster.

Health care reform has not stifled business.

The Massachusetts Health Care Reform was designed to ensure access, not curtail cost. With landmark state legislation now close to passage, building on the success of the 2006 act, Massachusetts is on the verge of implementing new strategies to contain costs, while continuing to provide coverage for more than 98 percent of Massachusetts residents.

But I can also report that health care costs have not spiraled because of the plan, far from it.

This year, Cape Air saw a 5 percent increase in premiums – too much, but far from the 15 to 20 percent increases we saw year after year before reform took effect. Last year, our increase was 4 percent. The previous year, we were able to negotiate a 5 percent DEcrease.

So Cape Air's success should be seen in a state context.

Unemployment in Massachusetts has dropped from 8 percent in 2009 to 5.8 percent in May of this year. This is 2.4 percent below the national average.

Massachusetts ranks 8th in the nation in job creation this year, adding 37,800 new jobs through May.

Since January, 2007, Massachusetts ranks third in the nation in economic performance.

Meanwhile, additional state spending for health care programs resulting from payment reform only represented 1.4 percent of the state budget in 2011 -- again, with more than 98 percent of our residents covered, which includes a 400,000 net increase in the number of non-elderly insured residents.

And the Health Connector – the Massachusetts version of the health insurance exchanges in the Affordable Care Act – has reduced premiums in the last 2 years by 10 percent.

These facts explain why surveys consistently find that about two-thirds of our residents support the state's health reform.

As important and positive as enacting the Affordable Care Act is and will be, it's not the last word. Just as Massachusetts is now moving forward with cost containment initiatives, there will be more opportunities to continue to reform our health care structure.

Access is only one of the pillars on which great health care is built. The other issues to address are cost, complexity, outcomes and transparency.

I look forward to a national conversation about all of them, and especially an understanding of the link between a healthy business climate, and access to health care for all.

Chairman ISSA. Dr. Goodman.

STATEMENT OF JOHN GOODMAN

Mr. GOODMAN. Mr. Chairman and members of the committee, the Affordable Care Act will impose very high costs on the private sector of our economy. The minimum health benefit for a family will cost almost $6 per employee per hour. When you combine that health minimum wage with a money minimum wage, it means that employees will have to produce at least $13 of goods and services every hour or they'll be priced out of the labor market. That's why hundreds of thousands of low-skilled workers are in danger of losing their jobs.

The Act will impose about $500 billion in new taxes over the first 10 years, and it will do so in ways that will reduce investment, reduce output, and reduce employment. The Act creates very high marginal tax rates for moderate income families. And if we can have the first slide to demonstrate that, moderate income families are going to discover that they get to keep less than 40 cents of each additional dollar they earn as a result of the phasing out of the subsidies for health care as well as other taxes.

In addition, the Act creates a bizarre system of subsidies. There is no help in the legislation for a $10–15 an hour workers at McDonald's and Wendy's and Wal-Mart, corporations like that, no additional help at all. And yet if one of these employers decides to completely end its health plan, all of those workers can go over to a health insurance exchange and get from $10 to $15,000 in subsidies, and maybe even more. These subsidies, by the way, are in danger of causing a complete restructuring of business, not for sound economic reasons, but just in response to the subsidies.

If I can have the second slide, economists at Stanford and the University of Chicago have created an uncertainty index, and they have found that we are now at the highest point that we've been over the past 30 years. They have concluded that public policy uncertainty is responsible for the loss of 2.3 million jobs over the last 4 or 5 years. And one of the reasons for that is the Affordable Care Act.

If I could have the final slide. Employers are responding to these conditions in certain ways that create a jobless recovery. What has happened is hours of work have actually increased. In terms of the number of hours employees are working, the recession is over. We are back to normal. What is not normal are the number of people being hired. In terms of being hired, it is as though the recovery has not even begun.

Under the Affordable Care Act, there is no penalty for having employees work additional hours. There are penalties for hiring additional employees.

Let me just say something about the Massachusetts experiment, because I have looked at it. It hasn't bothered employers very much because all of the expansion is in terms of subsidized insurance. All of the newly insured people are either in Medicaid or they are getting subsidized insurance. They are not getting additional insurance from employers.

And contrary to the statement you just heard, nobody is getting more health care in Massachusetts today. There are no more doc-

tors. There are no new nurses, there are no new clinics. The same amount of health care is being delivered now as was delivered 4 or 5 years ago. More people are going to hospital emergency rooms than before the reform was passed. More people are going to the community health clinics. Basically, people are going to the same places they went before, and they're getting the same care they got before, and all that is happening in Massachusetts is we are just moving a lot of money around.

Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

[Prepared statement of Mr. Goodman follows:]

Statement of

John C. Goodman

President and CEO

National Center for Policy Analysis

Senior Fellow

Independent Institute

Author of

Priceless: Curing the Healthcare Crisis

on

The Impact of the Patient Protection and Affordable Care Act on Job Creators and the Economy

Committee on Oversight and Government Reform

United States House of Representatives

July 10, 2012

Mr. Chairman and members of the Committee, I am John Goodman, president of the National Center for Policy Analysis (NCPA). A nonprofit, nonpartisan public policy research organization, the NCPA is dedicated to developing and promoting private alternatives to government regulation and control, and solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

The Patient Protection and Affordable Care Act (ACA) will radically transform the U.S. health care system.[1] Arguably the most radical piece of legislation ever passed by Congress, the law will affect everyone with private insurance, every senior on Medicare, everyone on Medicaid. The bill will create 159 new regulatory agencies. Its first 10-year cost is close to $1 trillion. It is intentionally designed to fundamentally alter the way medicine is practiced in this country.

In this testimony, I address the impact of the legislation on the economy.

Costs

The Congressional Budget Office (CBO) estimates the average annual cost of a minimum benefit package at $4,500 to $5,000 for individuals and $12,000 to

[1] *Patient Protection and Affordable Care Act of 2009*, HR 3962, 111th Congress, 1st session.

$12,500 for families in 2016.[2] That translates into a minimum health benefit of $2.28 an hour for full-time workers with individual coverage and $5.89 an hour for full-time employees with family coverage.

The law does not specify how much of the premium must be paid by the employer versus the employee — other than a government requirement that the employee's share cannot exceed 9.5% of family income for low- and moderate-income workers, and an industry rule of thumb that employers must pick up at least 50% of the tab. But the economic effects are the same, regardless of who writes the checks.

In another year and a half, the minimum cost of labor will be a $7.25 cash minimum wage and a $5.89 health minimum wage (family), for a total of $13.14 an hour or about $27,331 a year. You can see already that few firms are going to want to hire low-wage workers with families.

Economists have been studying the labor market for years and there are three principles that are well established in the literature:

1. Total employee compensation tends to equal the value of what workers produce — that is, what they add to overall output, at the margin.

[2] Many people will opt for more comprehensive plans. See Douglas W. Elmendorf, "Letter to Honorable Olympia Snowe," Congressional Budget Office, January 11, 2010. Available at: http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf.

2. Noncash benefits (e.g., health insurance) substitute dollar-for-dollar for cash wages.
3. If the minimum compensation required is higher than what workers are able to produce, they will be priced out of the labor market.

To confirm these principles, economists use sophisticated mathematical models and conduct elaborate statistical tests. But these conclusions are what ordinary common sense would predict anyway. Imagine you are an employer. You certainly aren't going to pay an employee more than his value to the organization, and competition from other employers will tend to prevent you from paying less. If the government forces you to spend more on health insurance, you will spend less in wages in order to pay for the mandated benefits.

For above-average-wage employees, expect wage stagnation over the foreseeable future, as employers use potential wage increases to pay for expanded (and mandated) health benefits instead. At the low end of the wage scale, however, the effects of this new law are going to be devastating.

Ten-dollar-an-hour workers and their employers cannot afford $6-an-hour health insurance. If they bought it, only $4 would be left for cash wages and that would

violate the (cash) minimum wage law. This is not a small problem. One-third of uninsured workers earn less than $3 above the minimum wage.[3]

Further, although health economists have known for decades that these are the workers that most need help in obtaining insurance, there are no new subsidies to help employees at places like Wal-Mart or McDonald's or Denny's buy health insurance. These workers and many others are at risk of losing their jobs.

Almost one in four teenagers is already unemployed (23.7%) and among black teenagers the unemployment rate that is more than one in three (39.3%).[4] The ACA will make these conditions worse.

Taxes

Americans and American businesses will face more than $500 billion in 19 new types of taxes and fees over the next decade to fund health reform.[5] Some of the new taxes will be indirect and will be passed on to consumers in the form of higher prices, higher premiums, or lower wages. Families will pay other taxes directly. According to the Joint Committee on Taxation, about 73 million taxpayers earning

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[3] Katherine Baicker and Helen Levy, "Employer Health Insurance Mandates and the Risk of Unemployment," *Risk Management and Insurance Review* 11 (2008): 109–132. doi: 10.1111/j.1540-6296.2008.00133.x.

[4] "The Employment Situation — June 2012," Bureau of Labor Statistics, New Release, July 6, 2012.

[5] Congressional Budget Office, "Estimate of the Effects on the Deficit of the Reconciliation Proposal Combined with H.R. 3590, as Passed by the Senate."

less than $200,000 will see their taxes rise as a result of various health reform provisions.[6]

Tax on Medical Devices. Beginning in 2013, a 2.3 percent tax will be imposed on the manufacture and importation of medical devices. Devices typically sold by retailers to consumers — including toothbrushes and bandages — are exempt from the tax, whereas devices purchased from wholesalers by health care providers, such as tongue depressors and ultrasound equipment, will be taxed. Though seemingly small, the tax on medical devices will collect nearly $20 billion over the next decade. The tax will prompt the loss of about 45,661 jobs across the medical device industry, according to Diana Furchtgott-Roth, former chief Labor Department economist.[7]

Taxes on Capital. The Medicare payroll tax will increase by almost one-third for some people—from 2.9 percent today to 3.8 percent on wages over $200,000 for an individual or $250,000 for a couple. Much of this income consists of a return on investment for small business entrepreneurs. In addition, the 3.8 percent

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[6] Keith Hennessey, "How Would the Reid Bill Affect the Middle Class?" December 10, 2009. Available at: http://keithhennessey.com/2009/12/10/reid-bill-middle-class/. For a discussion, see John C. Goodman, "Who is Taxed? Who is Subsidized? Senate Version of ObamaCare," John Goodman's Health Policy Blog, March 16, 2010. Available at: http://healthblog.ncpa.org/who-is-taxed-who-is-subsidized-senate-version-of-obamacare/.

[7] Devon Herrick, "The Job-Killing Medical Device Tax," National Center for Policy Analysis, Issue Brief No. 106, February 15, 2012. The source of the calculations are by Diana Furchtgott-Roth and Harold Furchtgott-Roth, "Employment Effects of the New Excise Tax on the Medical Device Industry." September 2011. Available at http://www.chi.org/uploadedFiles/Industry_at_a_glance/090711EmploymentEffectofTaxonMedicalDeviceIndustryFINAL.pdf

Medicare payroll tax will be levied on investment income (capital gains, interest, and dividend income) at the same income levels. Taxing capital is in general a bad idea. The reason: A tax on capital is ultimately paid by labor. By making the capital stock smaller, taxes on capital make workers less productive. And since workers tend to be paid a wage that reflects their marginal product, taxes on capital tend to lower employee incomes.

Implicit Marginal Tax Rates

Numerous provisions of the law impose high effective marginal tax rates on middle- and low-income families as income-based subsidies and benefits are withdrawn. There are also high marginal penalties for small business employers.

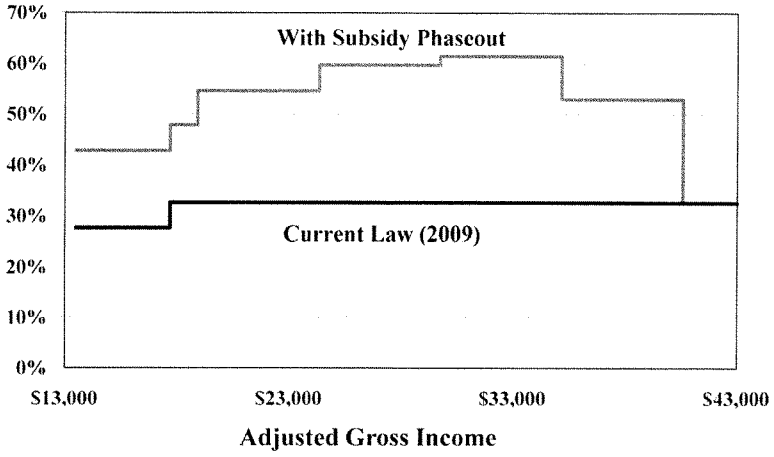
High Marginal Tax Rates for Families. Starting in 2014, subsidies in the health insurance exchanges will be available to families with incomes between 133% and 400% of the federal poverty line. The range is from $31,389 to $93,699 for a family of four.

Figures I and II show the implicit marginal tax rates that individuals and families can expect to pay under the new law, on the average. The "marginal tax rate" refers to the steep withdrawal of health insurance subsidies (in the exchange) as income rises, as well as income and payroll taxes. Note that the highest marginal

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tax rates fall on moderate-income earners. As the two graphs illustrate, the Affordable Care Act will create marginal tax rates in excess of 60% for workers earning as little as $20,000 to $30,000.[8] These individuals will face a marginal tax rate substantially higher than the rate paid by Bill Gates or Warren Buffett.

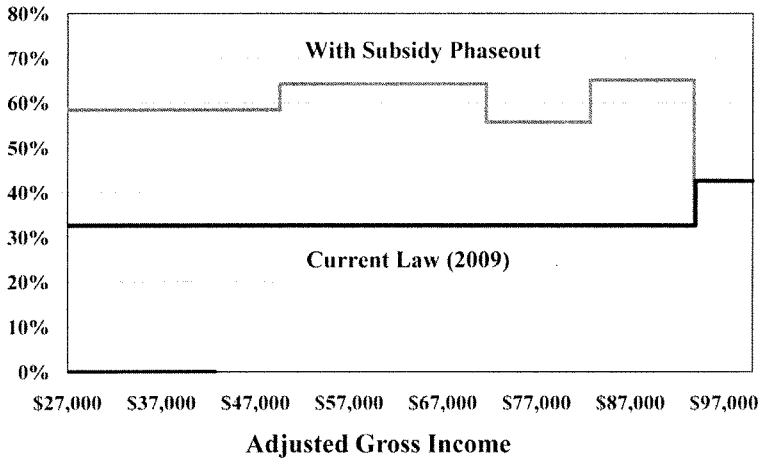
Figure I: Effective Marginal Tax Rates with the Phaseout of the Health Exchange Subsidies (Single Individual)



Source: Michael Schuyler, "Health Exchange Subsidies Would Impose High Marginal Taxes," National Center for Policy Analysis, Brief Analysis No. 697, March 3, 2010. Available at: http://www.ncpa.org/pdfs/ba697.pdf.

[8] Michael Schuyler, "Health Exchange Subsidies Would Impose High Marginal Taxes, Brief Analysis No. 697, National Center for Policy Analysis, March 3, 2010. Available at: http://www.ncpa.org/pdfs/ba697.pdf.

Figure II: Effective Marginal Tax Rates with the Phaseout of the Health Exchange Subsidies (Couple with Two Children)



Source: Michael Schuyler, "Health Exchange Subsidies Would Impose High Marginal Taxes," National Center for Policy Analysis, Brief Analysis No. 697, March 3, 2010. Available at: http://www.ncpa.org/pdfs/ba697.pdf.

Michael Schuyler, who produced these estimates, describes them as follows:

> The charts actually understate the spikiness of the marginal rate "skyline." They are drawn as though the subsidy smoothly phases out between the pairs of incomes for which CBO provides subsidy estimates. In practice, the phase-out would have "cliffs," in which a few dollars of added income would cut the subsidy by hundreds or thousands of dollars, resulting in stratospheric marginal tax rates in the immediate vicinity of the cliffs.

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What is the highest marginal tax rate a family could face? An analysis by Daniel Kessler finds that health coverage will cost $23,700 for a family of four headed by a 55 year old living in a high-cost region.[9] Although premiums for health insurance sold in the exchange are capped at 9.5 percent of income for families earning between 350% and 400% of poverty, there are no subsidies for families earning more than 400 percent of poverty. That means premiums would be capped at $8,901— resulting in a subsidy of $14,799 ($23,700-$8,901) for a family earning $93,699 (400% of poverty). But if the family earns $1 more ($93,700), they no longer qualify for a subsidy. Thus, $1 in additional income results in a subsidy loss of $14,700, for an *implicit tax rate of 1.47 million percent.*

As is well known by economists and policymakers alike, when people get to keep only one-third of each extra dollar they earn, they react in all kinds of ways that are harmful to the economy. They will choose more leisure and less work; they will substitute untaxed fringe benefits for taxable wages; they will disguise consumption as a business expense; and they will substitute unreported (and, therefore, untaxed) income for reported income.

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[9] Daniel P. Kessler, "How Health Reform Punishes Work," *Wall Street Journal*, April 25, 2011. Available at: http://www.hoover.org/news/daily-report/76401. Kessler's calculations are provided by the Kaiser Foundation, at: http://healthreform.kff.org/SubsidyCalculator.aspx.

High Marginal Tax Rates for Employers. Employers also face the equivalent of high marginal tax rate "cliffs" from provisions in the Affordable Care Act. Firms that employ fewer than 51 fulltime workers will be exempt from penalties for failing to offer health coverage. The fifty-first worker, however, could be a very expensive hire. For firms that employ 51 workers or more, failure to provide insurance will subject them to a tax penalty of $2,000 for each uninsured employee beyond the first 30 employees. Growing from 50 to 51 uninsured workers would subject employers to a fine of $42,000 [(51-30) x $2,000] for adding the last worker. This fine, however, will be much smaller than the cost of providing 51 employees with the insurance mandated under the Affordable Care Act. The fine is much smaller if a firm hires a significant number of part-time workers (those working less than 30 hours per week). In the example above, if 20 of the firm's 51 workers were replaced by part-time workers, the firm's penalty would fall from $42,000 to only $2,000.[10] One implication: Many workers who want full-time work may only find part-time work instead.

Bizarre Subsidies

The Affordable Care Act offers radically different subsidies to people at the same income level, depending on where they obtain their health insurance — at work or

[10] "Employer Mandate Penalties: Calculations," National Federation of Independent Business, undated. Available at: http://www.nfib.com/LinkClick.aspx?fileticket=8lmj3UFCpy0%3D&tabid=1083.

through an exchange. These subsidies are arbitrary, unfair, and in some cases even regressive. Along with the accompanying mandates, they will cause millions of employees to lose their employer plans and perhaps their jobs as well.

Subsidies With Perverse Incentives. Take the maids, waitresses, busboys, custodians and groundskeepers at a hotel, each making about $15 an hour. The only subsidy available for health insurance is the provision in the current tax code: employers can pay health insurance premiums with pre-tax dollars. Yet because employees at this income level make too little to be subject to federal or state income taxes, they will avoid only a 15.3 percent (FICA) payroll tax, amounting to a subsidy of about a $2,800 for family coverage.

Now consider a standard family plan offered in a health insurance exchange. If these $15-an-hour employees are eligible for such a plan, the government will pay anywhere from 90 to 94 percent of the premium depending on the age of the employee and the region of the country. This government subsidy would amount to about $13,617.[11]

Which is better from the point-of-view of the employee: a $13,617 subsidy or a $2,800 one? If the hotel didn't send its low-wage workers to the exchange and a

[11] The Kaiser Family Foundation, "Health Reform Subsidy Calculator," June 22, 2010. Available at: http://healthreform.kff.org/SubsidyCalculator.aspx.

competitor down the road did so, the hotel would face about 50 percent higher labor costs than its competitor.

Although low- and moderate-wage employees get generous subsidies in the health insurance exchange, higher income employees get no subsidy at all. If they obtain employer-provided insurance, however, they can take full advantage of the current tax law provisions. When the hotel buys insurance for a manager, for example, the premiums not only avoid the 15.3 percent payroll tax, but they also avoid a 25 percent federal income tax and, in some cases, a 5 or 6 percent combined state and local income tax. The upshot: through this tax subsidy, government is "paying" for almost half of the cost of the insurance.

Incentives to Restructure Business in Inefficient Ways. Below-average wage workers will want to work for a company that pays higher wages rather than offering a health insurance benefit. Above-average wage workers will have the opposite preference. In competition for labor, therefore, companies and entire industries will reorganize. Low-income workers will congregate in companies that do not provide insurance; high-income employees will work for firms that do provide it. Firms that ignore these worker preferences will not survive.

This implies two bad results: (1) much higher burdens for taxpayers as millions more take advantage of the subsidies than the Congressional Budget Office (CBO)

has predicted and (2) an entire economy whose structure is based not on sound economics, but on gaming an irrational subsidy system.[12]

Subsidies That Are Regressive and Unfair. Quite apart from the perverse economic incentives the subsidies create, they are also arbitrary and unfair. A $31,389-a-year family (about 133 percent of poverty) getting health insurance at work gets less than one-fourth as much help from the government as a family making nearly three times that much income and getting insurance in the exchange.

Uncertainty

If current law remains unchanged, on January 1, 2013, American taxpayers will be hit with a large tax increase (mainly the expiration of the Bush tax cuts) and a major decrease in government spending (the result of last year's budget deal) as well.[13]

All told, we're looking at a $500 billion fiscal shock to the economy. Higher taxes and reduced spending might dampen economic activity and slow down the current recovery. You can think of the January 1st fiscal tsunami as a New Year's Day

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[12] John Goodman, "Four Trojan Horses," Health Alerts, John Goodman's Health Policy Blog, April 15, 2010. Available at: http://healthblog.ncpa.org/four-trojan-horses/.

[13] Benjamin Page, "Economic Effects of Reducing the Fiscal Restraint That Is Scheduled to Occur in 2013," Congressional Budget Office, May 2012. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/FiscalRestraint_0.pdf.

"anti-stimulus" package. The Congressional Budget Office is predicting that the price we will pay for that package is a "double dip" recession.

But here is something even more disturbing. It turns out that uncertainty — not knowing what Washington is going to do about all this — is worse than the reality. Will President Obama and the Congress agree to put off the tax increases? Will they agree to delay the spending cuts? Not knowing the answers to those questions appears to have more impact on the decisions of businesses and consumers than if everyone simply agreed to go ahead and let the bad things happen.

Historically, "uncertainty" has been a slippery concept in the vocabulary of economists. Everyone kind of knows what it means. But until recently there was no numerical measure. Economists at Stanford University and the University of Chicago developed an index of uncertainty and they have tracked it over time for several decades.[14] Here's what they found. Their measure of uncertainty soared during the Obama years, where it has been at its highest levels in the past 30 years [See Figure III]. It's not just uncertainty about what will happen next January that is a problem. Arguably, the economic policies of the Obama presidency are the problem. Public policy uncertainty alone is the apparent cause of a peak decline of

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[14] Scott R. Baker, Nicholas Bloom and Steven J. Davis, "Measuring Economic Policy Uncertainty," White Paper, University of Chicago, October 10, 2011. Available at: http://economics.uchicago.edu/workshops/Davis%20Steven%20J%20-%20Measuring%20Economic%20Policy%20Uncertainty.pdf.

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3.2% in real GDP, a 16% decline in private investment and the loss of 2.3 million jobs over the past five years.[15]

Here is what Nobel prize-winning economist Gary Becker has to say on uncertainty:[16]

> [S]ome of the uncertainty during this financial crisis was avoidable if Congress and the president had not passed an ineffective stimulus package over a divided Congress, if they had resolved the budget deficit and debt ceiling issues (especially by trying to get entitlements under control), if agreement on tax policy toward broader and flatter taxes had been achieved, and if clearer policies were adopted about which companies would be allowed to go bankrupt and which would be bailed out.

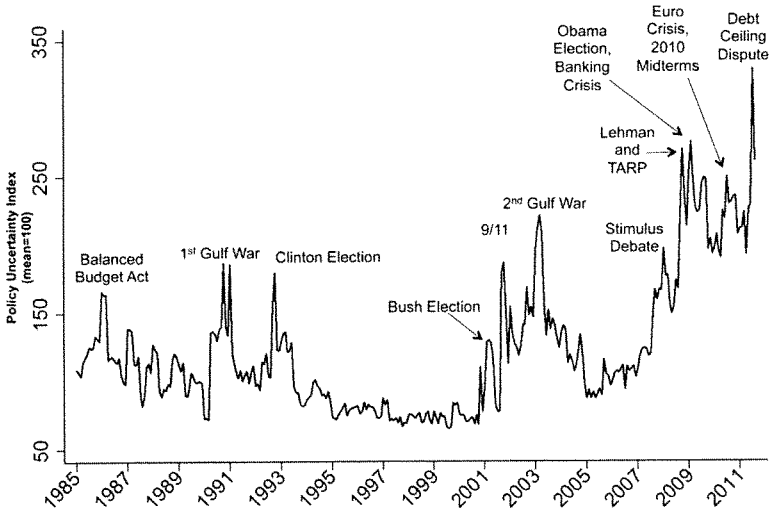
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[15] Ibid.

[16] Gary Becker, "Why Has the Recovery in Employment in the U.S. Been so Slow?" The Becker-Posner Blog, May 6, 2012. Available at: http://www.becker-posner-blog.com/2012/05/why-has-the-recovery-in-employment-in-the-us-been-so-slow-becker.html.

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Figure III: Index of Economic Policy Uncertainty



Notes: Index of Policy-Related Economic Uncertainty composed of 4 series: monthly news articles containing uncertain or uncertainty, economic or economy, and policy relevant terms (scaled by the smoothed number of articles containing 'today'); the number of tax laws expiring in coming years, and a composite of interquartile ranges for quarterly forecasts of federal government expenditures and 1-year CPI from the Philadelphia Fed Survey of Forecasters. Weights: 1/2 Google News, 1/6 tax expirations, 1/6 CPI disagreement, 1/6 Federal expenditures disagreement after each index normalized to have a standard-deviation of 1. Google query run August 11, 2011, updated Sept 25. Index normalized to 100 mean before.

Source: Scott R. Baker et al., "Measuring Economic Policy Uncertainty," October 2011.

This uncertainty is one of the reasons employers are not hiring like they have at the end of past recessions. When an employer hires a full-time worker, the employer thinks of the relationship as long term. During an initial training and learning period, the employer probably pays out more in wages and benefits than the company gets back in production. But over a longer period, the hope is to turn that around and make a profit.

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When employers hire new employees, they are making a gamble. They are betting that, over time, the economics of the relationship will pan out.

The problem in the current economy is that hiring new workers and committing to new production has become risky. An employer who hires workers today has no way of knowing the company's future labor costs; its building and facility costs; its cost of capital; or its taxes.

Employers could decide to drop their health insurance altogether; and if they do so they must pay a fine of $2,000 per employee per year. Yet if a lot of employers do this (and apparently a lot of them are thinking about it[17]), it is likely the federal government will respond by making the fine a lot higher.

Uncertainties about future tax and health care costs could be inhibiting permanent job growth, shifting more of the labor force to temporary and part-time employment. Overall, since 2007 there has been a net loss of 9.8 million full-time jobs, but a gain of 2.3 million part-time jobs. The increase in part-time employment is not entirely voluntary. About 31 percent of current part-time workers would prefer full-time jobs. According to the Bureau of Labor Statistics,

[17] Shubham Singhal, Jeris Stueland and Drew Ungerman, "How U.S. Health Care Reform Will Affect Employee Benefits," McKinsey Quarterly, June 2011. Available at: http://www.mckinseyquarterly.com/How_US_health_care_reform_will_affect_employee_benefits_2813.

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from April 2006 to August 2011, the number of part-time workers seeking full-time employment increased from 3.6 million to nearly 8 million.[18]

The red line in Figure IV is a monthly index of the employment-to-population ratio, normalized to a value of 100 in December 2007, when the recession began. In this series, each employee counts the same, regardless of how many hours worked. The blue line shows the average number of hours worked by employees with private sector jobs. In this series, only people with jobs are included in the calculation.[19]

University of Chicago economist Casey B. Mulligan had this to say about the labor market: [20]

> By one measure, the labor market has not recovered at all. By another, the recovery is complete…Unlike the employment-to-population ratio, average work hours have largely recovered since 2009. Earlier this year, the average hours series reaches 100, which was its value for much of 2007.

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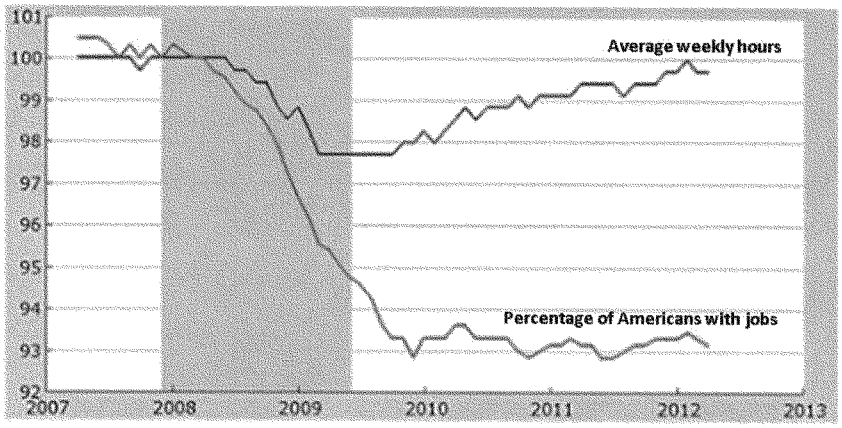
[18] Pamela Villarreal and Peter Swanson, "Temporary Employment: The New Permanent?" Brief Analysis No. 754, National Center for Policy Analysis, October 10, 2011. Available at: http://www.ncpa.org/pdfs/ba754.pdf.

[19] Casey B. Mulligan, "The Asymmetric Recovery," *New York Times*, Economix Blog, May 30, 2012. Available at: http://economix.blogs.nytimes.com/2012/05/30/the-asymmetric-recovery/.

[20] Ibid.

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Figure IV: Average Weekly Hours of All Private Employees and Civilian Employment-to-Population Ratio



Source: Federal Reserve Bank of St. Louis.

Mulligan cites the ACA as a possible explanation for this phenomenon. The reason: Nothing happens to the employers' health care costs if people work additional hours. There is a substantial increase in health care costs, however, if the employer hires one more worker.

Chairman ISSA. The committee will stand in recess until approximately 10 minutes after the last vote, which should be in about the 3:15 time frame.

Chairman ISSA. The committee will come to order. I want to thank you all for your patience. As members return, they will be called by their seniority in the order in which they arrive.

I will now recognize myself for the first round of questions.

Ms. Miller, in your case, many of your employees are exactly the people who didn't have health care unless they had a job that provided health care, isn't that true?

Ms. MILLER. Yes.

Chairman ISSA. And I'm going to ask you a question that I asked in this morning's hearing. If Obamacare had said that you have to give $2,000 to every one of your employees whether they wanted it or not in the form of a health savings account, they could spend any way they wanted, but that you had to give that, or be taxed, would you be here today?

Ms. MILLER. No, sir.

Chairman ISSA. Mr. Fredrich?

Mr. FREDRICH. I would much rather put cash in the hands of people and that will encourage the private-sector market. Absolutely.

Chairman ISSA. Mr. Richardson?

Mr. RICHARDSON. We would feel the same way.

Chairman ISSA. Dr. Goodman. I know yours is an economic question. Well, let me ask you the other question, though. When you look at the uncertainty, if the—if, in fact, Obamacare said that you have to not cost shifts, so you have to provide a minimum amount of dollars intended to prevent, if you will, total uninsured behavior, would we have lowered the uncertainty by having instead of 12,000 pages of new regulations, and growing, out of a 2,400-page document, if we had simply had a very straightforward, no-cost shifting provision without a mandate of various and sundry, would that have dramatically lowered or eliminated the uncertainty that came out of Obamacare that led to what you see as a loss of jobs being created?

Mr. GOODMAN. Well, I'm not quite sure what you have in mind, but what we could do——

Chairman ISSA. In other words, if there were certainty as to the cost of Obamacare, regardless of what it was, I use $2,000 because that is the amount that employers know that they can just pay and get out from underneath it, but it doesn't change the total cost of Obamacare because of the 21 other taxes and so on.

Mr. GOODMAN. I think we can afford to give every American a $2,000 refundable tax credit. It could come through the place of employment, or if they weren't employed it could just go to them directly. And we can, in fact, probably even be a little bit more generous than that, and replace all of the existing tax and spending subsidies. That would create certainty. It would be adequate for most people, and it wouldn't destroy jobs.

Chairman ISSA. One of the—one of the questions I guess, Mr. Richardson, is not only obviously you would prefer something that went to your employees, but your company, since before you were born, has provided health care at least at that level, haven't they?

Mr. RICHARDSON. That's correct, Mr. Chairman.

Chairman ISSA. So your employees enjoyed exactly what was described as the problem of Obamacare, meaning with the exception perhaps of 25-year old adult children being covered, but depending upon the State, you already provided a level of care that was what had justified the need for Obamacare, isn't that right?

Mr. RICHARDSON. Correct.

Chairman ISSA. So in a sense, you are a victim of overregulation when, in fact, you were not part of the problem?

Mr. RICHARDSON. That's how we feel.

Chairman ISSA. Well, when you look at those 21 new taxes, medical device tax, that is going to raise cost and is not going to help health care, when you look at essentially a whole new tax on capital gains and other income, is any part of that going to help you build your business?

Mr. RICHARDSON. No. It just added to a lot of uncertainty and indecision.

Chairman ISSA. Now, Mr. Fredrich, you mentioned that, and this was particularly interesting, because I started off in manufacturing in Ohio, and a lot of—made a lot of products with my employer's or my customer's tools. So I was often working with the tool and die shops to create the tool that would be the least cost for me to then manufacture their products.

If your costs go up, and your tooling go up—we will forget about your 49, 51 employees—what is likely, the likelihood that that German company will simply either move the tool making overseas, or, in fact, move the entire production to another country?

Mr. FREDRICH. Most of our customers are large companies and what they have the ability to do is outsource, and their market is the world. So we don't compete just against companies in the U.S. We compete against companies all over the world, China, India. So they are going to source it somewhere else. And the reason they buy from us is because of good service, good quality. They can buy it in smaller lot numbers. They don't have to buy container loads full of handles or something. But without question, if we become—and they are very price conscious. But if our price gets out of line, they go somewhere else; not in this country. They go somewhere else in the world to source it.

Chairman ISSA. Okay, Senator Wolf, you certainly made a good case for why you support Governor Romney's bipartisan effort in Massachusetts. But let me ask you a different question. You compete down in the Virgin Islands and so on. I noticed your flights go into those places. If your cost of fuel, your cost of pilots, your cost of maintenance, your cost of Cessna 400 series aircraft, if all of those go up, are you, in fact, likely to do less business, or can you simply pass it on?

Mr. WOLF. To a degree, we can pass it on. But if the costs go up significantly, obviously, that does have an impact on business. So I would say the answer to that is it depends. I will say, though, that the variability of health insurance is a lot less than the variability of some of the other cost factors that we face, fuel being a primary one, if you look at that volatility.

Chairman ISSA. Sure, no, I understand the volatility of fuel, but no cost in America has equaled the increased cost of health care,

and I want to preface this in closing, before or after Obamacare. There is no question that healthcare costs led the cost increases in the years before Obamacare, and of course, in the years since it has been passed. So for any of you here, what is it in the President's health care, in ACA, that in fact, in your estimation will lower your cost of doing business?

In other words, what in those taxes, what in those regulations, if anything, is actually going to lower your cost of health care for your employees? Anything?

Mr. WOLF. Is this for any of us?

Chairman ISSA. Well, I am getting noes from everybody, so I will give you, Senator Wolf, what is it in the President's health care that will actually cause health care costs to go down? Because nothing has happened so far. They have to—they would have to drop about 20 percent from where it is today to get back to where it was, isn't that correct?

Mr. WOLF. For our company that has always provided the benefit, a portion of our premium dollars is going to provide health care for people who are uninsured. That is pretty accepted in the industry. So.

Chairman ISSA. But you were already in a State that prevented that. You already had all of that, so you wouldn't see any of that. And yet, Massachusetts, where you operate, you are paying additional taxes even though you had already implemented effectively Obamacare, isn't that correct?

Mr. WOLF. I think one of the reasons that our health insurance premium rates have stabilized is because we are not any longer cross-subsidizing the 16 percent nationwide that do not have health insurance, but is in our Commonwealth right now.

Chairman ISSA. Right, but your State, people in your State, are seeing additional taxes, substantial additional taxes, $87 billion from the increase in Medicare payroll tax alone, and the list goes on and on for $1 trillion, your constituents as a State senator are going to pay that tax even though you are not part of the problem under Obamacare, isn't that correct?

Mr. WOLF. It is. The case that the increase in cost in the State budget, since the implementation of this bill, has been de minimis. And when I say de minimis——

Chairman ISSA. No, no, Senator, I appreciate now that you are now a State senator. Your constituents, though, are going to pay these taxes. The estimated $123 billion, $87 billion, $60 billion, $52 billion, $46 billion, these were all from taxes that Obamacare expects the people who make appliances, parts for the medical industry that ultimately, you know, the thing that goes into your bones when you are having an artificial limb and so on, all of those are enjoying a tax that is expected to be billions of dollars. Your constituents of their manufacturing are paying that even though your State was not part of the problem. I recognize my time is up, and I recognize the ranking member for his opening questions.

Mr. CUMMINGS. Let me pick up where it was left off here. Senator, first of all, I want to thank you for—I am going to thank all of you for being here. I want to thank you, Senator, and you and Governor Romney for the Massachusetts law.

And I mean that very sincerely. I'm not—it is not a political statement. It is that I see the people who don't get health care.

I'm assuming that when this law, when you all did this, there must have been a moral issue here somewhere. It seems to get lost up here. The person, the lady that came up to me in my community not long ago who had colon cancer and said I have no where to go. We ended up sending her to NIH. You know, or my neighbor, who died. The last thing he said on his death bed to his wife is, Ruth, I got to get up out of here because we ain't got no insurance.

Was that a part of the consideration, because it seems to get lost up here. The fact that people die, and I'm not—and I'm saying this for a reason. I'm trying to figure out as a former businessman, I understand the other side of it too, trying to make sure that you keep costs down so you can make a profit, so that you can employ people, and I have no problem with things that these folks have said, and I know you don't, because you understand. You are a business person just like them.

In some kind of way, I'm trying to figure out where—how did you all come to the conclusion that, first of all, you needed to do something? Was there a moral consideration in this, and do you believe you have saved lives? Do you believe you have saved needless suffering and pain, and do you believe that it's been worth it? In some kind of way, we had got to—we have to figure that out.

I guess the question of who we are as a society, some of my constituents, somebody said to me in a debate, Cummings, you know, if you—you ought to tell the people and apologize for voting for the Affordable Care Act. And I told my constituents, I said if you—if you expect me to apologize for not leaving somebody on the side of the road to die, then I'm your wrong candidate. You need to vote for somebody else. And I just wondered, where did that come in? And I believe that Governor Romney had a compassion. There was some compassion there. And any time you are going to get 40 votes in a Senate, bipartisan, that's something serious. So help me with this.

Mr. WOLF. Thank you for the question. And as an employer, I will tell you that since the primary way to procure health care in this country historically since 1942 has been through employment, we have always seen that as a responsibility.

I could tell you stories that would make you come to tears about employees of ours who came to us with preexisting conditions prior to this law who were not able to procure health insurance on our plan, or employees who became sick and had to leave our company and were unable to get insured after they left. The law in Massachusetts has fixed that. And I think that is right, and I think it is compassionate. It is also smart business.

So that I think part of it is a moral obligation that we have to make sure that everybody has access to both preventative health care, and health care in crisis, and I think that we have a responsibility A, as an employer, now that I am a senator, I see that responsibility carrying through to all of the citizens of the Commonwealth who I represent.

Mr. CUMMINGS. And so when you're—the argument, and I know you, I know you empathize with the comments of your fellow busi-

ness folks there. I mean, and you are head of a Chamber of Commerce? You were, is that right? Is that what you said?

Mr. WOLF. Yeah.

Mr. CUMMINGS. You know, the thing that I guess you all have—you all have tried it, and it seems to be working, but I mean, what's the—and Mr. Goodman basically said all you are doing is moving money around, something to that effect, whatever you said. I mean, do you agree with all of that? Can you talk about some of the things that he said in complaining about the plan, and how it—he said people are getting the same kind of treatment. You heard the things he said, and I just want you to answer those.

Mr. WOLF. A couple of facts in the statement which I would just like to address or correct. First of all, the statement was made that more Massachusetts businesses did not offer it after the plan and that's not the case. Prior to this bill going into effect, 69 percent of the businesses in Massachusetts offered health care. At this point, 77 percent of all those employers that have more than three employees offer health care, so that's been a success.

The other statement that I would like to address is a statement about people still going to emergency rooms for primary care. Since enacting this legislation, we have saved $118 million by diverting folks from emergency rooms as their source of primary care treatment back to primary care clinics and primary physicians. So both of those aspects I think have been a success as well.

Mr. CUMMINGS. And so that the fact that they, you know, are diverted from the emergency rooms, you know, I hear from my hospitals all the time, their concerns and whatever, and I am just curious, I mean, has that had an effect on their, I'm sure it has, bottom line, and how does that affect the program overall? Do you follow me?

Mr. WOLF. Well, if we get people to get treatment and preventative treatment prior to emergency rooms, it is going to ultimately cost less for everybody. So it is not only more humane, but it is also a more cost-effective way to do it.

As a business person who looks at efficiency every day in the business that we run, there is so much inefficiency in our health care system, that just as important as addressing the access issue which this bill does, we need to very aggressively go after the cost issue. There is a lot of low hanging fruit to wring cost out of this industry while providing a better and more humane health care system.

Mr. CUMMINGS. Now, do you all have a similar provision in your bill to the ones in the Affordable Care Act where if the insurance company spends more than a certain percentage on things other than direct health care, that money has to be refunded to the insured?

Mr. WOLF. We do. That is a great question. Our target in Massachusetts is 90 percent, so that the insurance companies are expected to spend 90 percent or more on what we call the loss, the direct loss, or the payment, the claims. And that would leave 10 percent for administrative.

Mr. CUMMINGS. And so what happens if they go over?

Mr. WOLF. There is a rebate.

Mr. CUMMINGS. I see. Thank you very much, Mr. Chairman.

Mr. GOWDY. [Presiding.] I thank the gentleman from Maryland. I now recognize the gentleman from Michigan, Mr. Walberg.

Mr. WALBERG. Thank you, Mr. Chairman. Mr. Richardson, could you inform the committee what White Castle's employee retention rate is?

Mr. RICHARDSON. Yeah, we have tremendous loyalty among our team members. We are really proud to say that we had only a 57 percent turnover rate among our hourly employees, but then with our management team last year, it was only 6 percent compared to an industry average, probably closer to 25, 30 percent.

Mr. WALBERG. So seemingly some significant satisfaction there?

Mr. RICHARDSON. We are able to measure that as well, and we do that by doing surveys, and measuring that engagement and do very well in that area.

Mr. WALBERG. Where does your benefit package, specifically health care come in on that?

Mr. RICHARDSON. The biggest thing about our health care focus is providing what we call freedom from anxiety, so that is something we have been focused in on since 1924. That benefit specifically is rated one of the highest in terms of why people come to White Castle, and why they continue to stay.

Mr. WALBERG. Prior to Obamacare's passage, businesses had significant concerns about providing workplace coverage. What was the primary concern of employers like you?

Mr. RICHARDSON. The primary concern was increasing cost as we saw the landscape changing, and big increases each year.

Mr. WALBERG. Does the Patient Protection Affordable Health Care Reform Act alleviate any of those concerns?

Mr. RICHARDSON. No, unfortunately, to us it adds more uncertainty because we can see looking ahead to 2014, significant increases coming down the pike.

Mr. WALBERG. Ms. Miller, wherever I go in my district in talking to employers, I hear concern about rising health care costs, and Obamacare. You told, as reported here, in CNN, you told them "We are afraid to spend because we don't knee what the big scary monster around the corner looks like."

Ms. MILLER. Correct.

Mr. WALBERG. Would you have invested and spent more if the health care law had not been enacted?

Ms. MILLER. Definitely. We are a company of 40 years that we have always invested money back into the business and spending in a way to grow our business and create innovation, and we have never had the cash on hand we have today because we are not spending money, because we don't know exactly what that looks like before this came down, the penalty if we don't do anything being $640,000 for us. We pay over 320 employees.

I have to make sure I have enough money on hand as this goes into play until we can figure out how to make this work. Because it is not going to be an easy process to make these changes.

Mr. WALBERG. Is there any estimate at the Chamber or any business organization you know of, estimate of how much capital is sitting on the table, under the table, behind the table?

Ms. MILLER. I do not have a number like that, sir.

Mr. WALBERG. That would be significant at this point.

Ms. MILLER. I'm sure they can find that number for you and get back to you on that.

Mr. WALBERG. Okay. Thank you. Mr. Goodman, do we know how many people will lose their health insurance because of the government takeover of health care?

Mr. GOODMAN. No, we don't, but it could be as high as 80 million. I assume you mean lose their employer-sponsored?

Mr. WALBERG. Employer-sponsored.

Mr. GOODMAN. Yes, it could be very high, much higher than the Congressional Budget Office has estimated.

Mr. WALBERG. Taking that into consideration, what will be an overriding economic impact of the takeover of health care to our economy, to our businesses?

Mr. GOODMAN. Well, as I said we are imposing heavy labor costs on every employer in America, and if they don't bear that cost, and they have to pay a pretty substantial fine, we have $500 billion in new taxes which the way they are imposed is going to reduce investment, reduce growth, reduce output, and as you point out, people are going to have to switch where they are getting their health insurance because employers are going to find, in many cases, it is just cheaper to pay the fine and send the employees to an exchange where they can get very, very substantial subsidies.

Mr. WALBERG. Does this—does this potentially add, based upon economic impact, add to a significant increase in debt crisis simply because of the health care reform bill?

Mr. GOODMAN. Well, the Affordable Care Act is not paid for, and that's the point that hasn't been made yet in this hearing. Half the cost of the Affordable Care Act is paid for by cuts in Medicare spending and yet the chief actuary of Medicare has said that if you go ahead and do this, you are going to have one out of seven hospitals go out of business before the end of the decade, and senior citizens won't be able to find a doctor.

And the prediction, apparently by the actuary's office and by the Congressional Budget Office, they don't put it quite this way, but they keep putting out these alternative forecasts. And what they are really saying is, we don't believe Congress will stick with this. You didn't really pay for this bill. Okay.

Mr. WALBERG. That's an amazing balloon in the sky with all sorts of uncertainty, isn't it?

Mr. GOODMAN. Yeah.

Mr. WALBERG. Except the certainty that we can't pay for it.

Mr. Richardson, or any of you, I would be glad for you to address this. When asked what he believed to be the single—I see my time has expired.

Mr. GOWDY. Unanimous consent, for 30 seconds if you want to ask one more——

Mr. WALBERG. I appreciate that.

Mr. GOWDY. Okay.

Mr. WALBERG. The cofounder of Home Depot, Bernie Marcus responded when asked what was the single greatest impediment to job growth today, he said the U.S. Government.

Asking business people here at the table, would you agree with him and why?

Mr. RICHARDSON. We would tend to agree because what we are seeing right now is more uncertainty than we have ever encountered. I think as we look at the landscape, this is an aggressive program in terms of health care reform. The cost of health care reform have come at the absolute worst time and the fact that we can't even calculate what the costs are going to be make it impossible for restaurants like White Castle to be able to plan for the future.

So you can't commit to opening new restaurants and going into new markets if you don't know what you are going to be paying a year and a half from now as far as your costs go. So we find ourselves in the unenviable position of having to make the unconscionable choice between violating our conscience, or mortgaging our future in a way to continue to provide the benefit our team members have become accustom to. So it is paralytic.

Mr. FREDRICH. I actually think that it's our single greatest risk right now for our business. We are in the country. We have nowhere to go, and we are borrowing $4 billion a day. You, not our company, obviously. And that is not a good long-term plan. And if you don't address that seriously, we are right with Greece, Spain, and nobody is going to bail us out. We are too big.

Ms. MILLER. My husband and I have had a conversation more than once that when he started this business 40 years ago, he thought it was about cleaning toilets and mopping floors. And today we have to spend a large percentage of our time dealing with government compliance, and paying taxes and figuring that out, rather than focusing on how to make our business better, to grow our employee base, and take care of customers, to create jobs, and to create more revenue. And it takes us away from what it takes to run a business.

Mr. WALBERG. Thank you.

Mr. WOLF. Can we all answer that?

Mr. WALBERG. It's up to the chairman, but I'm willing to listen.

Mr. GOWDY. Yes.

Mr. WOLF. I think the question is, is the biggest threat to our growth, is it overregulation or is it government? I operate a business in the most highly regulated industry in the country, which is the airline industry, and we have found that regulation is not what gets in the way of our growth. I will tell you, if I had the opportunity to come down here and talk about how do we level and make predictable energy costs, for example, in an industry where there are profits being made hand over fist without any effort to make that a predictable cost, I would have showed up a lot earlier for that hearing.

This is 3 percent of our company's expense. And it is not a significant mover relative to whether we continue to grow. And by the way, we have grown 75 percent as a company since 2007, since the law was enacted in Massachusetts as far as gross revenue.

So the answer would be no. I do not think the regulation of health care is an inhibitor at all to our business growth.

Mr. WALBERG. Thank you, Mr. Chairman.

Mr. GOWDY. Thank you. The chair would now recognize the gentlelady from the District of Columbia, Ms. Holmes Norton.

Ms. NORTON. Thank you, Mr. Chairman. I really want to thank each and every one of you for your testimony. I have listened very carefully, and I think I understand what you are feeling, particularly about uncertainty.

Remember, we are talking about a bill, major parts of which don't go into effect until 2014, and yet we are here trying to calculate how many jobs it makes or doesn't make.

The—I also appreciate your concerns about whether it will slow job growth, notwithstanding the CBO, which has repeatedly said that it will slow the increase in the cost of health care. But I know that I want to ask Senator Wolf a set of questions.

You come from various States, Texas, as I understand it, Columbus, Ohio; Cincinnati, Ohio; Wisconsin, so you are pretty representative of at least some parts of the country. But I tell you, we have seldom had in the Congress, a real-time example as any kind of model when we have enacted legislation by which to measure what we are doing, and that's what the State laboratory of Massachusetts has given us.

It has given us, as it turns out, a Republican model from a Republican governor who made it a bipartisan bill in a Democratic State.

And in these he had to prove himself. It's the model as it turns out as Mr. Wolf said, that the country has embraced since the early 1940s, which is, hey, look, just use the existing system. Preserve insurance, and build around it. That's what that is. That is all that is, is what we have always had. So let me ask Mr. Wolf who has some real-life experience from which we can draw some conclusions. Mr. Wolf, Senator Wolf, I'm sorry, in your State, there is a free rider prohibition or penalty on both the employer, and the employee, as I understand it. Is that not correct? So let me ask you straight away. Did the employer mandate and the company penalty cause a drop in employer-based jobs of health care, or in jobs in your State? And if they didn't, why not? Since all the predictions are for catastrophe on that score, why in the world didn't that happen in Massachusetts, if it did not happen in Massachusetts?

Mr. WOLF. Because in Massachusetts, we are overcoming that with a lot of other government assistance through education, and workforce training. I mean, it is a State that is looking very hard at our economy. We have cut taxes. In fact, this year we cut both income tax at a personal level and at a corporate level, part of the healthy economy story. But again, Massachusetts is eighth in job creation so far this year with almost 38,000 jobs created. We are third in gross State product growth since 2007 when this bill was enacted. It is clearly not inhibiting business health and growth, and I will repeat what I said before too, that when this bill went into effect, 69 percent of the businesses in Massachusetts with more than three employees gave this benefit. Now, 77 percent do.

So it has incentivized more businesses to give this, and very few businesses are paying a penalty because most businesses are complying with the law.

Ms. NORTON. Well, the other—the other speculation, and again, I want to go with real experience for a change. The Massachusetts experience seems to contradict. According to your testimony, you had a 15 to 20 percent increase in health care before this bill, your

bill took effect, and the last year, as I recall, as I read your testimony, your increase had gone from 15 to 20 percent down to 4 percent, and that you were actually able to negotiate a 5 percent decrease.

Would you explain that in light of the parade of horribles we have heard here, all speculation, all before the bill has gone into effect, as the Massachusetts bill already has.

Mr. WOLF. Yeah, it—the bill has allowed for premium rates to stabilize in Massachusetts. The personal experience of Cape Air, again, as you point out, is 2 years ago we were able to negotiate a 5 percent decrease in premiums, and the last 2 years, the increase has been about 4.

Ms. NORTON. Did the fact that you had a larger pool of people who are in health care, help to bring down the cost of health care? This is economics 101. The smaller the pool, the greater the cost. When you had a larger the pool, did that help to bring down the cost.

Mr. WOLF. It did, and one of the things that Massachusetts has done is we have implemented a pool opportunity for up to 85,000 employees for small business to actually get together and accumulate their employee groups so that they can go with a bigger number and try to get reduction. So we are also addressing the fact that, yeah, there is a scaling issue which is that if you can put more employees together to negotiate for that, then the rates will come down.

Ms. NORTON. Senator Wolf, this may explain why if you look at every economy in the world, when countries choose to offer health care, and by the way, almost all countries do, even the developing countries, they use not a system we use, we are respecting the old system with employer-based health care. They use some kind of single payer. Singapore, which is not exactly, which is perhaps everybody's example of a free market unregulated economy, single payer, sometimes a single payer is sometimes employer based, but it is always single payer. And the reason I think comes down to the fact, if you put the sick and the well, and all of us together in one pool, the basic theory of insurance, the basic theory of economics is, we bring down the costs for everyone. Thank you very much, Senator Wolf.

Mr. GOWDY. Thank you, gentlelady from the District of Columbia. The chair would now recognize the gentleman from the great State of Oklahoma, Mr. Lankford.

Mr. LANKFORD. Thank you, Mr. Chair. I have enjoyed all of the conversation from both sides of the aisle today praising Governor Romney. I will look forward to their support in November as well, and I'm the same voice on that. I also appreciated some of the conversation about other countries.

And in my area in Oklahoma City, let me tell a couple of stories. In Oklahoma City, there is a surgical hospital there that does a flat-fee surgery. It is a tremendous hospital, very popular. When they started several years ago, the owner of the hospital said the surprise that he had is once they posted their fees on line and started competing and opened up, the first folks that started to call them were the Canadians, who would rather fly to Oklahoma City,

stay there, pay for the surgery, and fly home than wait 6 months for the exact same surgery back home.

Another story, there is a cancer radiation treatment center in Oklahoma City; two really fantastic ones that are there, stellar. Twenty-five percent of their business is from the U.K. because we have more advanced cancer treatment in Oklahoma City than they have in all of the U.K.

So while we talk about perspectives here, it is interesting for me to look at and say, we will get some flat amount that everyone will get access to, but the world is still coming here. And the lines are apparently very long overseas, and those who have the money and can fly out and go cut the line get it, and those who don't, suffer and wait.

So that the promises that are built into this have been interesting to me to be able to track. The promise that you are going to be able to keep your health care. If you like it, you can keep your plan.

Now we are going hearing from the administration up to 80 percent of the small business plans will not be acceptable and will not be grandfathered in. Up to 80 percent. Up to 64 percent of the larger employer plans will not be grandfathered in and we will have to make some sort of change. The cost has changed in the last 2 years from $800 billion to $1.8 trillion, in 2 years, and it has not been fully implemented yet. And now we hear from CBO, that they estimate in the next 10 years, 800,000 jobs will be affected by this; 800,000 lost jobs. Now, may I remind everyone in June or economy only created 80,000. So we are talking about 800,000 lost jobs.

Now, my concern is is that there seems to be some assumption that health care is complicated and difficult, and if we would only give it to the Federal Government, it would be so much easier and more efficient and faster.

And I think that is where I struggle with the process on this. It is—it is the thought that there's something that the States do that if the Federal Government did it, it would be better. If there is something that private business did, if the Federal Government did it, it would be better, and I just struggle with that, personally. Does anyone know of an example of a State regulation that went to Federal that was so much more efficient and cheaper and faster, or of a private business that when it was federalized, it suddenly got cheaper and faster and more efficient?

I don't either. And I'm not anti-government. But there seems to be this assumption that it will be so much more efficient, it will be so much cheaper, it will be so much better if we will just federalize this.

Mr. WOLF. Is that a rhetorical question?

Mr. LANKFORD. No, it was an actual question.

Mr. WOLF. I do have an answer to that. Again, it is the industry that I'm in. I cannot imagine air transportation commerce being regulated State by State.

Mr. LANKFORD. Now, I can understand that, even though.

Mr. WOLF. Do you want an answer to the question?

Mr. LANKFORD. No, no, here is the thing on that. There is a difference between setting the boundaries, State highway department, aviation, whatever it may be, and if instead weaken your business,

as you mentioned before with health care costs or with energy costs, you mentioned that, the fluctuating cost of the energy. If we went in and did a mandate on energy, we were going to lock in the fees, my question to you, you know, I'm on the Aviation Subcommittee for Transportation. I could bring up a bill for aviation, say you know what, let's go into all the—because I don't like paying the different prices. I have noticed different months, different prices for aviation. I would like to lock those down and just have one price and I'm going to set it.

In fact, I'm going to come to all of the aviation groups and I'm going to say, I don't like how much advertising you do. I see it all the time. It is a waste. So I'm going to say, 95 percent has to go to the passenger. I need 95 percent of the money. You can keep 5 percent for administration. You would be ticked at that point because you run a great company, apparently, and you should have the flexibility to run a great company and provide a great service, and compete and win.

And the concern is that somehow if we federalized it, if we went into your company, not just set boundaries for safety but went into, not just regulating, but running your company, it would somehow make it better.

Now, I do want to ask a question of Mr. Richardson. You brought up an interesting thing, you said 400 to 500 jobs have not been created because you all have hesitated on expanding business. Would you clarify that for me as well?

Mr. RICHARDSON. Yeah, for the past several years we have been looking to expand into new territories so we have done market research to explore that. In looking towards that, we are concerned about what our cost curves are going to look like, so we have held back on any expansion at this point.

Mr. LANKFORD. So right now you are just on pause until what? Until we get to 2014 and try to figure out what the costs are going to be, and then try to see where to move from there, so at least 2 more years of pause?

Mr. RICHARDSON. We are a family-owned business in the restaurant industry, so by nature, we are optimistic. But I think we are really trying to sort out and understand. We know for certain, so it isn't speculation on our part, we can look and model out that our costs are going to increase more than 20 percent when it comes to health care. That is $7 million-plus. That is a lot of money that could go into building new restaurants, creating new jobs, and providing more benefits for our team members.

Mr. LANKFORD. Thank you. With that, I yield back.

Mr. GOWDY. I thank the gentleman, from Oklahoma. The chair would now recognize the gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman. I want to thank all of our witnesses for being here today, and Senator Wolf, I want to thank you in particular, because I—you are the one that has experience with the real program. You are a little bit like a skunk at a lawn party. Everybody else is talking about myths, and fear, and speculation, and then you throw a little cold water on it and talk about reality, but you go right back to the myths, and fear, and

speculation, because that narrative is something people apparently don't want to change.

But the, you know, one of the things we talk about is what has been happening in our State, Massachusetts, at least, those 64 million-plus residents in Massachusetts with Medicare have saved—I'm sorry, residents in Massachusetts saved under Medicare, $64 million in prescription drug costs. Right?

Mr. WOLF. Yep.

Mr. TIERNEY. 1,324,000 in Massachusetts with private health insurance gained preventative service coverage with no cost sharing, right? We have a better value for our premium dollar through the 80/20 rule. You have a 90 percent rule in your law in Massachusetts, so an average of $140 for 85,000 families in Massachusetts, right? And we have an ability to scrutinize the premium increases. Will you tell us a little bit what the governor did with the legislative support on premiums?

Mr. WOLF. Well, I mean I can—yeah, but I can also give you some real data which is that when premiums are considered as a percentage of household income in Massachusetts, we are now 48th out of the 50—51, out of the 50 States plus the District of Columbia; 48th as far as the percentage of premium relative to household income. And that has gone down dramatically since the implementation of this law.

Mr. TIERNEY. So I was a former local chairman of the Chamber of Commerce, as well. Do you agree with me that as far as our small businesses at a local level this is good for them?

Mr. WOLF. I think that CNBC is about to announce this afternoon, I hope, that Massachusetts is considered to be the number one place in the United States to do business. If this, what we are talking about on a national basis was so deleterious to the economy and to small business growth, how is it possible that the one State that implemented it would be named as the best State in the country to do business? It just doesn't make sense.

Mr. TIERNEY. That won't deter anybody, though. But Ms. Miller, let me ask you some questions. You have a policy you say that you offer to your employees, correct?

Ms. MILLER. Yes, sir.

Mr. TIERNEY. How much on an hourly basis does your newest, lowest-level employee make?

Ms. MILLER. $9.80.

Mr. TIERNEY. $9.80 an hour. So take-home pay somewhere around $6.80, $6.75.

Ms. MILLER. Somewhere around there.

Mr. TIERNEY. All right, and how much would their share of a premium cost for health care cost on a dollar basis?

Ms. MILLER. That's $20 a month, sir. This is what our minimum is.

Mr. TIERNEY. So the $6, they work 40 hours a week, what are they bringing home?

Ms. MILLER. Bringing home net, yes.

Mr. TIERNEY. How much are they bringing home on a net basis on a weekly?

Ms. MILLER. I'm not a mathematician.

Mr. TIERNEY. Well, 40 times $6.00, so $240 or $300, or whatever. And your plan is limited, you said, right?

Ms. MILLER. Yes, sir.

Mr. TIERNEY. So limited in a sense is a big copay?

Ms. MILLER. No, small copay, just max is $6,000 a year, sir.

Mr. TIERNEY. Oh, and that's it. So a lifetime cap and an annual cap?

Ms. MILLER. Correct.

Mr. TIERNEY. Deductibles?

Ms. MILLER. It is a low deductible. I can't remember the number off the top of my head. But it is like a copay to go to the doctors is like $10 to $15.

Mr. TIERNEY. Out of that $6-an-hour job, all right, and the deductibles?

Ms. MILLER. I only know that it is a $6,000 max a year.

Mr. TIERNEY. It is any surprise to you that 85 percent of your employees don't take advantage of this plan?

Ms. MILLER. Yes, sir, it is a surprise.

Mr. TIERNEY. Really?

Ms. MILLER. Because it covers basic health care.

Mr. TIERNEY. Well, I mean, I think that, you know, I have seen people that bring home that amount of money and there isn't a lot left over for playing with deductibles and copays and that kind of a share on it, or whatever, so it is no surprise to me—and people that were in my Chamber wouldn't be surprised, and Senator Wolf, I suspect people in your Chamber wouldn't be surprised. Am I right?

Mr. WOLF. Yes.

Ms. MILLER. Sir, the costs would go up quite a bit higher with the new plan.

Mr. TIERNEY. Well, let me suggest what the market was doing before we had the Affordable Care plan. In the last 10 years before we had the Affordable Care plan, the premiums more than doubled, a rate three times faster than wage increases. From 2004 to 2007, 12.6 million adult Americans, 36 percent of those who tried to purchase a policy from an insurance company in the individual market were denied coverage, charged a higher rate, or discriminated against because of a preexisting condition; 8.6 millions more Americans were uninsured. So it went from 38.4 million to 47 million.

If we don't act, if we hadn't acted, it was estimated the cost of employer-sponsored family health insurance plans would reach $24,000 just by 2016. That would be an increase of 84 percent. Most American households would be spending 45 percent of their income on health insurance. Family premiums would be expected, without the Affordable Care Act to rise on an average of $1,800 a year.

So those people that work for you for $6.25 or $6.75 an hour would have to pick up an extra amount of that every year, $1800. Fourteen million more Americans would be expected to be uninsured. So we go from 47 million to 61 million. Small businesses, in the 10 years before we had the Affordable Care their premiums were rising at 129 percent. I know it because I saw it in my business. Senator Wolf, I suspect you saw it in yours, and Ms. Miller, I think you saw it in yours as well.

If we hadn't acted on the Affordable Care Act, premiums would have increased more than doubling in most States. It would have risen by 60 percent in the best cases, and small businesses were projected to lose more than $52 billion in profits due to high health costs. So for the last 10 years before we had the Affordable Care Act, our national health care spending increased 90 percent.

So if you want to see damage done to our economy and to young people, and what the effect would have been, that would be it. So Senator Wolf, I will say once again, give you a last opportunity to wrap up here. That was the projection without a health care plan like the one in Massachusetts, the Affordable Care Act. With the plan in Massachusetts, what have you seen in reality?

Mr. WOLF. Well, both our company, but also statewide, as I said, we have seen the amount being spent on premiums as a percentage of household income drop significantly since the implementation of the plan. And I think that's probably the best measure because, if you look at absolute dollars, you then have to adjust it for different regions and the cost of living, and all of that stuff. So I think the best measure is the cost to a family as a percentage of their household income. And I think in Massachusetts, that's been a success story since the implementation.

Mr. TIERNEY. Thank you very much. I yield back.

Ms. MILLER. Sir, may I respond to your earlier question, please?

Mr. GOWDY. It's your question.

Mr. TIERNEY. Give me the time, sure.

Ms. MILLER. Right now out——

Mr. TIERNEY. I mean, I saw the young lady hand you the note. Would you like her to testify?

Ms. MILLER. No.

Mr. TIERNEY. Is she from the Chamber of Commerce?

Ms. MILLER. She's doing the calculator for me.

Mr. TIERNEY. Is she from the chamber of commerce?

Ms. MILLER. Yes, sir.

Mr. TIERNEY. Oh, of course.

Ms. MILLER. As I said, our policies, our benefits cost between $20 to $30 a month, so average of $25 a month; 12 months, it is $300 a year cost, for minimal coverage, but it is coverage. With the new plan it would cost them $1,500 a year.

Mr. TIERNEY. Well, you don't have a new plan under this plan. It hasn't gone into effect yet.

Ms. MILLER. But it would be.

Mr. TIERNEY. So it is your speculation?

Ms. MILLER. Yes, sir.

Mr. TIERNEY. That's my point. If you want a reality, Senator Wolf is sitting right next to you. Thank you, I yield back.

Mr. GOWDY. The chair would now recognize the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman. I'm just sitting here listen to all of these numbers rattle through my head, and I think Massachusetts care just sounds almost too good to be true.

We are about to implement a law that, in my experience in health care, cannot bring down costs when you are adding more recipients and not ration care in some form or another. We have got—something has got to give when it comes to the cost of health

care because the Affordable Health Care Act does not do anything to address cost containment. Health care costs are rising, so I don't know how this is going to be cheaper, but we are fortunate to have a number cruncher on the panel, Dr. Goodman. Maybe you can explain, you know, whether or not Obamacare is really affordable for this country and why is the care in Massachusetts so much better than what we are projecting for this?

Mr. GOODMAN. Well, I want to start with Mrs. Miller's company and her employees. There is nothing in the Affordable Care Act that does anything to help her or her employees afford a $15,000 family policy. There is nothing. There is no new subsidy, no new tax break. It is just a law that says that if she and her employees can't come up with $15,000 for a health plan, they are going to be fined. How does that help anyone? It doesn't.

Now, in Massachusetts, again, the expansion, the way they cut the uninsured in half was not by going out and forcing employers to provide a lot of new health insurance. They cut their health insurance, uninsurance rate in half by putting most of the people in Medicaid, and the rest of them are getting highly subsidized insurance from the State. So this isn't affecting employers very much, but also, we need to correct the impression that a lot of people are getting additional care because they are not. And a lot of people in this room are confusing health insurance with health care.

I was in Massachusetts last year and I talked to a woman cab driver and I said, how is the health plan working? And she said, well, she is on Mass Health which is Massachusetts Medicaid. She said, well, I had to go down a list of 20 doctors before I could find one that would see me. I said, are you going down the Yellow Pages? She said, no, this is the list that Medicaid gave me.

You can't give people more health care if you don't create more doctors, more nurses, more clinics or deregulate the market so that it can more efficiently provide services. So Massachusetts made the same mistake that Obamacare is making at the Federal level.

In Texas, we have 25 percent of our population uninsured. Now, we can go put them all on Medicaid, but where are they going to find the doctors? Where are they going to get more care? They are not. And so we are creating a promise of more access to care but we are not going to be able to deliver, and they haven't done it in Massachusetts. And I will repeat again, more people are going to hospital emergency rooms in Massachusetts today than ever before, and the same number of people going to community health centers are still going there even though they now are insured, and they are not getting more care.

Mr. DESJARLAIS. Senator Wolf, your company sounds fantastic. I mean, when all of these airlines are going bankrupt you are just thriving and increasing profits and that is wonderful. Congratulations. How many employees do you have?

Mr. WOLF. About 1,000.

Mr. DESJARLAIS. 1,000, and do you offer all of these employees health care?

Mr. WOLF. They are all offered and some of them are covered under other plans, but yes, they are all offered it.

Mr. DESJARLAIS. What does it cost you approximately per employee to provide health care for them?

Mr. WOLF. The total policy, or our portion of it?

Mr. DESJARLAIS. Your portion of it.

Mr. WOLF. An individual policy is between $5- and $6,000. Generally, we pay 60 percent of it.

Mr. DESJARLAIS. Okay, well, you sound like a very shrewd businessman. So you said not all thousand are on it but about $6,000. So you are spending, if you are insuring all of them, $6 million a year in health care coverage.

Mr. WOLF. Our total premium dollars are somewhere just over $3 million. A lot of our employees——

Mr. DESJARLAIS. Okay, now, 3 percent of your company's budget.

Mr. WOLF. That's right.

Mr. DESJARLAIS. Okay, now, what are you going to say to your accountants who come in and said do you realize if you pay the tax that President Obama is proposing, you can cut that cost in half? I mean, you are doing well right now, but what if times get tough? Are you going to keep those employees on that health care?

Mr. WOLF. We think it is our obligation as an employer, since that is how human beings get health coverage, and I agree, we are confusing health insurance with health care, but the fact is health insurance is the gateway into health care. And we just don't think it is a humane workplace to have employees who either personally or family crisis drives them on to the street or into bankruptcy.

Mr. DESJARLAIS. So you think it is a right to have health care?

Mr. WOLF. We will do whatever we have to do to continue to provide that for our employees.

Mr. DESJARLAIS. Okay, how about our business folks here? Is that a similar experience that you are having, Mr. Richardson.

Mr. RICHARDSON. Seventy-five percent of our team members who are eligible for health care, all of our full-time team members are eligible; 75 percent participate in the program. Our cost is $30 million a year, a significant investment. We have been making a similar investment over the decades. We have seen that cost increase, but for us, it is about the dignity of each person, providing that as something that is part of that special relationship we have between an employer, and an employee. I guess where we are concerned is, to us, it hasn't been speculation, but it has been a fear because we see a semi-truck of extra costs about 3 feet away about to hit us and every one of our restaurants in each one of our neighborhoods, so we are really struggling with how are we going to be able to make ends meet to be able to continue what we have done for almost 90 years.

Mr. DESJARLAIS. It may be humane, but if your company is broke, you are not going to be able to provide health care or wages.

Mr. RICHARDSON. The choice I referred to earlier was that, yeah, this is a difficult position we are in.

Mr. DESJARLAIS. All right, well, my time is expired and I thank the panel.

Mr. GOWDY. Thank you, the gentleman from Tennessee. The chair would now recognize the gentleman from Virginia, Mr. Connolly.

Mr. CONNOLLY. Thank you, Mr. Chairman. Senator Wolf, first of all, I assume you represent Falmouth?

Mr. WOLF. Actually, no, the Senate president represents the great town of Falmouth.

Mr. CONNOLLY. So you are not quite, my family's State senator, but close. You would like to represent Falmouth.

Mr. WOLF. I would love to represent Falmouth.

Mr. CONNOLLY. Well, I am a fellow Bay Stater by birth and child rearing, and so I'm glad to have you here today.

I'm confused. We heard unbelievably dire predictions about what would happen if the Affordable Care Act were adopted, and if it were to be implemented. Would it be fair to say similar dire predictions about unemployment, investment, budget busting, and whether it was efficacious to begin with were similarly echoed in Massachusetts at the time of the adoption of Romneycare?

Mr. WOLF. To some degree, yes. However, because it was a bipartisan effort, the message from government was, we have come together, both parties, to do what we think is right for the citizens of the Commonwealth. And I think the message matters from government as we roll out a plan like this.

Mr. CONNOLLY. Senator Wolf, your business credentials, you are not some wide-eyed, lefty, commie, pinko, are you, I mean? I mean, you were in fact——

Mr. WOLF. I choose not to answer that question.

Mr. CONNOLLY. Yeah, on the grounds that it may incriminate somebody. But you served as the chair of one of the Chambers of Commerce in Massachusetts, is that correct?

Mr. WOLF. I was on the board of the Cape Cod Chamber of Commerce for 15 years. I served as the chair from 2005 through 2007.

Mr. CONNOLLY. And you are also or were a trustee in one of the largest mutual banks?

Mr. WOLF. Still am, yes.

Mr. CONNOLLY. Still are.

Mr. WOLF. Yes.

Mr. CONNOLLY. Other than that, you sound like a communist. So those dire predictions that some made and some are making now, what—let me ask you this: Is it true that 98 percent of the residents in Massachusetts now have health insurance?

Mr. WOLF. It is true, yes.

Mr. CONNOLLY. What was it before Romneycare was adopted?

Mr. WOLF. We went from about, I believe about 88 percent to 98 percent.

Mr. CONNOLLY. Is there any other State in the Union that has 98 percent health insurance coverage?

Mr. WOLF. The rest of the country has on average of 16 percent not employed—I mean, I'm sorry, uninsured.

Mr. CONNOLLY. Uninsured. Versus 2 in Massachusetts, correct.

Mr. WOLF. That's correct.

Mr. CONNOLLY. Well, the unemployment rate, though, must have skyrocketed because of this hobnailed boot of government on the backs of business.

Mr. WOLF. The unemployment rate has dropped since the recession in 2009 from 8 percent to 5.8 percent.

Mr. CONNOLLY. So you have actually been creating jobs?

Mr. WOLF. We have been creating jobs.

Mr. CONNOLLY. Against all predictions? Well, premiums, premiums, health care premiums must have skyrocketed, because we all know, as we have heard from testimony here today, health care costs are going to spiral up with no matter what we predicted, no matter what the various experts predicted in the adoption of the Affordable Care Act. What happened to premiums after Romneycare got adopted in Massachusetts?

Mr. WOLF. As I said before, the premiums for us and statewide have leveled off and relative to other States, are actually doing really well.

Mr. CONNOLLY. Now, there is a debate going on about whether it is a tax, or a penalty, and you know, somebody with a little bit of a theological background, it's almost a little bit like how many angels can dance on the head of a pin. But in Massachusetts, I received an email from somebody close to me and he said, in Massachusetts, the statute passed and signed into law by Governor Romney, requires every Massachusetts resident to file a certificate with the annual State income taxes that they have to file, proving you have insurance. If you don't have insurance, then you get hit with a penalty. It's the exact same plan. Is that an accurate description, Senator Wolf?

Mr. WOLF. Yes, it is.

Mr. CONNOLLY. Well, is that a tax, or a fee, or a penalty?

Mr. WOLF. That sounds to me like a semantic discussion, which I don't necessarily—I don't have an answer for that.

Mr. CONNOLLY. Well, certainly Governor Romney, when he was governor, vetoed this.

Mr. WOLF. No.

Mr. CONNOLLY. He didn't?

Mr. WOLF. No.

Mr. CONNOLLY. You mean he signed that into law?

Mr. WOLF. Yes, that was signed into law.

Mr. CONNOLLY. Well, he criticized it at the time when he signed it, right?

Mr. WOLF. Not that I remember.

Mr. CONNOLLY. Hmm. Well, would it be fair to say, is it your understanding that when President Obama and Congress, those of us who participated in the Act, used Massachusetts as a model for the national Affordable Care Act, is that your understanding?

Mr. WOLF. Yes, the Massachusetts law was used as a template, and I think there are a lot of similarities. There are some differences as well.

Mr. CONNOLLY. Including an individual mandate?

Mr. WOLF. Yes.

Mr. CONNOLLY. My time is expired, but I thank the good senator for his testimony.

Mr. GOWDY. Thank you the gentleman from Virginia. The chair would now recognize the gentleman from Idaho, Mr. Labrador.

Mr. LABRADOR. Mr. Chairman, thank you. Mr. Wolf, you said something that is really interesting. The message matters. The government, when you rolled out the Massachusetts health care plan, you actually had bipartisan support for this plan, isn't that correct?

Mr. WOLF. Yes.

Mr. LABRADOR. Don't you think that was one of the biggest mistakes that was made here in Congress that they didn't look for a bipartisan solution to a health care crisis that we have in the United States; instead we looked for a one-party solution?

Mr. WOLF. I——

Mr. LABRADOR. Be honest about this.

Mr. WOLF. No, I cannot pretend to understand how this works down here. I can just tell you how it works in Massachusetts.

Mr. LABRADOR. But what did Governor Romney do in Massachusetts? He talked to the senators, to the Democratic leadership, because it was controlled by Democrats in Massachusetts, and he was able to find a bipartisan solution that he believed worked in Massachusetts. Isn't that what he did?

Mr. WOLF. The belief in Massachusetts that was a genesis of this plan, was that as close as possible, every citizen of the Commonwealth should have access to affordable and good health care.

Mr. LABRADOR. But you believe the only way to get to that solution was by involving both parties; isn't that correct?

Mr. WOLF. That's where the dialogue started. There was bipartisan belief that every citizen of the Commonwealth of Massachusetts should have access to affordable health care.

Mr. LABRADOR. Wait, that's not my question, you're not answering my question. The belief was in order to have a solution that would work for Massachusetts, you would need to have both parties actually work, not just one party working on the solution; and the answer is yes, I think you have already have said.

Now, there was a study done by Gogan from Stanford and Hubbard from Columbia that said that the Massachusetts plan has caused health insurance to rise 5.9 percent more per year than the rest of the United States; isn't that true?

Mr. WOLF. It may be true that the study says that. That is not what my numbers show.

Mr. LABRADOR. So you disagree with that study?

Mr. WOLF. I disagree with that study.

Mr. LABRADOR. Dr. Goodman, can you talk about that study and talk about where the disagreement is here?

Mr. GOODMAN. Well, Massachusetts has some of the highest health insurance premiums in the whole country. It is right up near the very top. It was a very misleading statement by Senator Wolf when he divided by State income. It also is a high income State. But their premiums are among the highest in the whole country. They have not controlled health care costs and they admit they have not controlled them. There is nothing in the Massachusetts health reform project that even tries to control costs. But now they are threatening the State with a global budget. What a global budget means is they will give you a certain amount of money and make you ration health care. That is what Massachusetts is very seriously considering right now.

Mr. LABRADOR. Senator Wolf is nodding his head no. Dr. Goodman, why is he nodding "no" as you are making that statement?

Mr. GOODMAN. Well, John Gruber and everybody involved, including Governor Romney admitted they didn't have any cost control that they put in place. They acknowledge that. Just as the Obamacare legislation, there is no cost control in the Affordable

Care Act. They just pushed that aside. They have some demonstration projects. The CBO has three times said that what you are doing in these demonstration projects is not going to control costs. So in Massachusetts, they are going to fall back on global budgets. They have been pretty open about that is the road that they want to take.

Mr. LABRADOR. You stated that Massachusetts actually has the highest health insurance costs; is that correct?

Mr. GOODMAN. Yes. But they also had very high costs before Romneycare.

Mr. LABRADOR. Has this made it the lowest cost or the middle?

Mr. GOODMAN. No, still the highest in the country. Near the very top.

Mr. LABRADOR. Would you not agree, Senator Wolf, that Massachusetts has some of the highest health care costs?

Mr. WOLF. Massachusetts has some of the best teaching hospitals and research centers for medical care.

Mr. LABRADOR. Again, you're not answering the question. I know you're a senator and you're a politician, but just answer the question, please.

Mr. WOLF. I will consider that a compliment.

Massachusetts, relative to its income, has the 48th out of 51 States. So if you look at absolute costs, yes. But the cost of living in Massachusetts is overall higher. So relative to the impact on an individual family's ability to make ends meet, Massachusetts is the third best in the United States of America today.

Mr. LABRADOR. Because it has the third highest income, correct?

Mr. WOLF. Because as a percentage of family income——

Mr. LABRADOR. The income is the third highest in the United States. So if you want to play semantics and play with the numbers, but the reality is your health care costs are higher than 48 other States?

Mr. WOLF. Let me try it this way: Massachusetts, 9.8 percent of a family's annual income is towards health care. The annual average now is close to 15 percent. I would rather live in Massachusetts then.

Mr. LABRADOR. That's good. And you are doing a good job representing Massachusetts, but it is still the third highest in the United States; isn't that correct? The cost of health insurance?

Mr. WOLF. We are going to keep doing this.

Mr. LABRADOR. Just answer the question. It is a simple question. I could be wrong; I could be right.

Mr. GOODMAN. You're correct. I'll answer it for him.

Mr. WOLF. The question was asked of me, and I'm going to answer it, if you will, please. Massachusetts relative to income, is 48 of 51 States.

Mr. LABRADOR. I have heard you say that five times, five times you have said the same thing, but you are not answering the simple question that Dr. Goodman just answered, which has the third highest cost of health insurance in the United States. That's all I was trying to ask.

Thank you.

Mr. GOWDY. The chair thanks the gentleman from Idaho, and the chair now recognizes the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Dr. Goodman, you mentioned at one point that people are still going to emergency rooms and community health centers. I don't know necessarily about the emergency rooms, but I believe they are still going to the community health centers because they get good care and they can afford it. I think they are one of the best approaches to providing health care, especially primary care, to large numbers of low income people that we know are in this country.

Senator Wolf, let me read portions of an op-ed that Jonathan Gruber wrote, and I'm going to quote. He worked for Governor Romney on his health plan. He is an MIT economist, and I'm reading directly what he said. He said that "Lately, critics of the Affordable Care Act have been promoting a different claim, that Obamacare is a job killer. Specifically, they say it will stifle the economy with regulations and taxes. But the economic literature doesn't support this claim. If anything, it suggests the opposite. The Affordable Care Act will boost the economy."

Senator Wolf, does the Massachusetts experience support the conclusion that the ACA will boost the economy?

Mr. WOLF. My experience in Massachusetts, as I said in my testimony, is that it has not had a deleterious effect on the economy or in job growth in the Commonwealth, and the statistics that we look at will bear that out, sir.

Mr. DAVIS. He went on to say that the law will result in more than 30 million additional Americans getting health insurance but what few realize is by expanding insurance coverage, the law will also increase economic activity. Many uninsured consumers are forced to set aside money in low interest liquid accounts to make sure that they have enough to cover unexpected medical costs. With the security provided by health insurance, they can feel free that money up for consumption that is much more valuable to them, more purchases of consumer goods will provide short-run stimulation to the economy and more hiring. Would you agree with this comment?

Mr. WOLF. Yes.

Mr. DAVIS. I also agree, and I find it difficult to understand what people are talking about when they talk about the increase in need for health care, given the fact that many more people will be seeking it. That has to increase the economy, and if it doesn't right away—and I see, Dr. Goodman, you're shaking your head. It's amazing to me that as more people seek health care, as more people live longer and receive care, as more doctors and nurses and medical technologists and other health personnel are needed, how could this not increase the economy?

Mr. GOODMAN. First of all, there is no provision in the Affordable Care Act to create more doctors, more nurses, more health care. It's all about health insurance. It is not about expanding the supply of medical resources. You have to remember that every dollar spent on the Affordable Care Act on health insurance for those 30 million people is a dollar that has to come from somewhere else. It's a dollar you take away from the seniors on Medicare, the disabled on Medicare or the device makers or the people who go to tanning salons. And when you take dollars away from those people, then they are not spending the dollars. I'm surprised that Jonathan Gruber

would say what he said because I do have respect for him. But just shifting money out of one pocket into another does not increase total spending.

Mr. DAVIS. As people are living longer, as they are consuming consumables, as they are using food, as they are using housing, does not this expand the economy?

Mr. GOODMAN. Not if the dollars that they spend are taken from somewhere else. And there is also nothing in the Affordable Care Act that will make people live longer because there is nothing in the Affordable Care Act that expands the supply of health care.

Mr. DAVIS. Well, if they receive more health services and they are adequate and good, I think they will live longer, as I've seen people who die prematurely for lack of care, and I yield back.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair will now recognize himself for 5 minutes of questions.

The gentleman from Ohio, Mr. Kucinich, who incidentally enough is widely viewed as being a very genial, very popular Member of Congress who is very devoted to his political ideology—I happen to disagree with his political ideology—but nonetheless he is a very devoted, very genial man, and I was listening to his opening statement and he talked about the virtues of universal care, and it just struck me while he was talking that it is counterintuitive to believe that an entity can give you something and also not place limits on how you can use it or extract commitments from you on how you can use it.

It is just counterintuitive. I mean, cliches are cliches for a reason, because they are universally accepted as being true. And the cliche that there is nothing free in life is true.

So against that backdrop, let me ask you this, Senator Wolf. Are there things that States can do that Congress cannot do?

Mr. WOLF. I would say that there are appropriate roles for States to play that are not appropriate at the Federal level. And that's an opinion, but, yes.

Mr. GOWDY. Well, it is an opinion that is also shared by our Framers. Ours is a limited powers government. The Constitution limits the powers of the Federal Government, and that is why we have a 9th and 10th Amendment. So whatever is not specifically given to the Federal Government is reserved either to the people or to the States. So you would agree with me that there are things that the State of Massachusetts can do that Congress cannot do?

Mr. WOLF. Yes, I would agree with that.

Mr. GOWDY. All right. Can Congress tax Mr. Richardson's business for not providing dental insurance to his employees?

Mr. WOLF. I think a higher power than I, which would be the Supreme Court of the United States, has answered that question.

Mr. GOWDY. No, I said dental insurance; I didn't say health insurance. I'm trying to see what the limits of the power of the Federal Government are. You're right, it was a 5–4 decision. I think it is tragic that decisions that impact generations of Americans to come, whether it is capital punishment decision or whether it is a health care decision would be decided by one person. But nonetheless, you're right, to the surprise of many conservatives, Chief Justice Roberts provided that fifth vote that said that while we can't make you do it, and that's important, if you read his commerce

clause analysis, we cannot make you do it, but we can tax you if you do not do it.

So my question is: Can Congress tax Mr. Richardson's business for not providing dental insurance to his employees?

Mr. WOLF. My belief is, based on the experiment in Massachusetts, which has been successful, and based on the Supreme Court ruling, that it is appropriate for the Federal Government, for the Congress, to pass legislation that both covers health and dental.

And by the way, I have always supported dental care. It is the one orifice that everything that enters our body goes through. And I have never understood why dental care is not considered as part of health care. So yes, I believe it is appropriate.

Mr. GOWDY. Just so we are clear, good oral health is tantamount to good overall health. I will spare everyone the studies that support that. But you believe it is within Congress' power to tax employers who do not provide dental insurance? It is not a trick question. I just want to make sure that the answer is yes.

Mr. WOLF. I believe that the law as written is appropriate for Congress to enforce. That's my answer to that question. You're choosing the word "tax." I'm not using the word "tax." I'm not choosing to use it. Or the word penalty or anything, because as I said before, to me that is semantics. I believe the implementation and enforcement of this law is appropriate at the Federal level.

Mr. GOWDY. The only reason I use the word "tax" is because that is the only power by which Congress can do it. The Supreme Court said you can't do it on the commerce clause. One of my colleagues asked you about your line of work, and you correctly cited the commerce clause as the reason that we don't have 50 different sets of systems for air traffic control and for airplanes because it is inherently interstate commerce. The Supreme Court specifically rejected that analysis. There are limits on what Congress can do via the commerce clause. I'm trying to decide whether there are any limits to what government can do via the tax clause.

I think you would agree with me that exercise and good diet are tantamount to good health. So can Congress tax Mr. Richardson for not providing a free gym membership to his employees; and if not, why not?

Mr. WOLF. I hate to keep frustrating you people by saying the same thing over and over again, I'm going to answer you the same way I did before, which is, I believe based on the law passed and signed by the President and the Supreme Court ruling that the Federal Government has the right to pass and enforce the law that is now the law of this land, and has been sanctioned.

Mr. GOWDY. I'm not being argumentative. I'm genuinely trying to determine what limits, if any, you believe exist on Congress's authority to dictate to businesses what they have to do? You are a business owner, a successful one, which I laud you for. My question to you is those of us sitting here, can we tax you for not providing a free gym membership? Are there any limits on what we can do in Congress with respect to health care?

Mr. TIERNEY. Mr. Chairman, just a point of clarification, are you questioning Senator Wolf as a constitutional legal expert, because I wasn't aware that was his background? I thought he was in the airline industry.

Mr. GOWDY. I'm not a constitutional legal expert so it would be impossible for me to ask any questions about that. I'm asking him as a businessman, if he believes, and I think he made, and I stand to be corrected by the gentleman from Massachusetts, I think he made a reference to the recent Supreme Court case. I don't think that you have to be a constitutional legal expert to understand it. If so, I wouldn't have been able to read it.

Mr. TIERNEY. Well, I guess my question was, he made a reference to the case as to what existing facts are. You are asking him a hypothetical on something that I think perhaps would take a legal scholar to answer. I'll let him answer if you want. I don't know what the value of his opinion would be——

Mr. GOWDY. He has been markedly more successful in life than I have been, so I think he is able to answer the question. And if he can't, he'll say what all witnesses say, which is "I can't answer the question." It's not a trick question. I am genuinely trying to understand the intersection between government power—and you represent a State, we represent Congress—the intersection between State power, Federal power, and personal responsibility. It is not a trick question, and if it comes across as one, I apologize to you. I want to know what are the limits to what we can do next session, to your business, to your business, and to your business. If exercise is good for you, why can't we tax you for not doing it?

Mr. WOLF. My answer to that, and what interested me and got me into politics after a successful career in business, is much more about how we can partner the private sector and the public sector. Not a question of limitation, but looking for opportunities to work together to provide the future. And that involves health care. In my case, it involves transportation. It involves a whole slew of issues. Some of those will be challenged as we move forward public and private sector together, and that is appropriate. There is a process to do that. This is part of that process and I am very fortunate and very grateful to have been a part of it.

Mr. GOWDY. My time is up; and I now recognize the gentleman, my friend from Kentucky, Mr.Yarmuth.

Mr. YARMUTH. I thank the chairman, and I appreciate the testimony of all the witnesses.

Mr. Richardson, I want to especially welcome you and thank you for nourishing me through most of my life. I happen to represent a district that brags about having the largest White Castle store in the country.

Mr. RICHARDSON. Castle number 7.

Mr. YARMUTH. I'm glad to see you here, and I appreciate your testimony.

Senator Wolf, you mentioned during your response to a question, you said you want to make sure, you will continue to do this as long as you can because this is how people get their insurance. You are speaking specifically of the United States, I assume, that is the historical pattern, at least in modern history in the United States?

Mr. WOLF. That's correct.

Mr. YARMUTH. Mr. Fredrich, you referenced something about—well, you talked about, and I think your quote was that you would prefer to see a market-based health care system, health care insurance system, and you said it works everywhere else. I assume you

were talking about in other segments of the economy and not in other geographic jurisdictions?

Mr. FREDRICH. It works in this country. And as long as we have a free market with limited controls, it works just fine.

Mr. YARMUTH. What would you describe as the system we have had up until now?

Mr. FREDRICH. For health care?

Mr. YARMUTH. Yes.

Mr. FREDRICH. It is a system that developed out of a bad bad choice, trying to regulate the amount that people could pay in wages in 1942 during the war, and that's what started this. We don't have the same problem with home care or auto—I mean, home insurance and auto insurance. You have to ask why. Why is it so different and why are we here talking about how difficult it is to control costs when it is so obvious how you control costs? You don't have the user of the service buying the service. It is that simple. The user of the service is me if I'm sick. The buyer of the service is the insurance company, and you don't have that. It is the only way this will ever get fixed.

Mr. YARMUTH. Doesn't the free market theory rely on an equal amount of power, the buyer and the seller? You can't have a truly free market if demand is something you can't control; is that correct? Would you agree or disagree?

Mr. FREDRICH. I disagree.

Mr. YARMUTH. So when you're sick or in an accident, you have the same freedom to make intelligent choices as when you're well?

Mr. FREDRICH. You mean if I'm awake? I assume somebody is going to take me to a hospital.

Mr. YARMUTH. Exactly. Do you know any place in the world where there is a free market health care system that you can point to as evidence that what you would prefer to see is effective?

Mr. FREDRICH. Yes. You see islands of free market health care. You see—Singapore, I think, has a hospital where people fly to. Thailand has a hospital.

Mr. YARMUTH. People fly to. But the citizens of Singapore are under a government-run system; correct?

Mr. FREDRICH. But that is an indication of what a free market will do, so why not use it? I don't get the fact that just because it is health care, that the government has to run it. It doesn't run anything well.

Mr. YARMUTH. The question is not whether the government has to run it, but the question is whether the free market can organize it effectively, and there has never been a situation that I have been able to find and you have been able to indicate to me, that there is evidence that that can work?

Mr. FREDRICH. Other than the rest of the entire economy? So this is just a special thing that just doesn't work?

Mr. YARMUTH. There are many people who actually believe that.

Mr. FREDRICH. Well, it sure doesn't seem to be working, does it?

Mr. YARMUTH. No, it is not working. I happen to believe with Congressman Kucinich. I'm a single payer person.

Ms. Miller, I want to ask you a question as well. You talked about a very small number of your employees actually use the insurance system, avail themselves of it because they can't afford it?

Ms. MILLER. No. They choose. They can afford it. Our employee base averages a $10-an-hour rate. So that is higher than a lot of other cleaning companies that only hire part-time employees. We went to full-time employees so they could have health insurance. We found policies that cost between $20 to $30 a month, so it is an affordable policy. There are only 6 percent of our employees that choose.

Mr. YARMUTH. Okay. I was actually looking at it from the other direction.

I'll ask one further question of Dr. Goodman. You talked about 25 percent of Texas residents being uninsured. You said that without any indication that that's a bad thing. What happens to those 25 percent who are uninsured when they get sick? Do they die? Do they suffer, or do they use the same health care facilities and essentially have a subsidy and let the rest of the people subsidize them?

Mr. GOODMAN. Well, they use safety net institutions, just like they do everywhere else. I don't advocate that. I like the idea of the universal refundable tax credit that allows everybody to have private insurance.

May I respond to the free market for health care? The international market for medical tourism is a free market and it is growing very fast. Thailand is competing in it. India and Singapore. But also, we are getting closer to home. We also have within the United States a domestic medical tourism market, and that is what the Canadians participate in. When they come here, they pay half of what you and I would pay for a knee replacement. They get package prices, and they can compare prices and compare quality.

Cosmetic surgery, that's a free market. Lasix surgery, that's a free market. Mediclinic is a free market. So there are many individual health care markets that give you an indication of how a market can work in health care.

Mr. YARMUTH. If we were only talking about elective procedures and procedures that people could afford, none of us would be here. This wouldn't even be a conversation.

Mr. GOODMAN. Yes. But if we gave everyone a refundable tax credit and gave them a financial means to have decent catastrophic coverage and a health savings account, then people would have the wherewithal to participate in a free market for health care.

Mr. YARMUTH. How much would that cost?

Mr. GOODMAN. I think we could replace all of the existing tax and spending subsidies with a tax credit, let's say $2,500 for an adult, maybe $8,000 for a family, and that's enough.

Mr. YARMUTH. Thank you. I yield back.

Chairman ISSA. [Presiding.] I thank the gentleman. I might note as a native Clevelander like Mr. Kucinich that, in fact, the Cleveland Clinic is an example where they are not taking emergency rooms, they are really not taking health care insurance, but people are flocking there from all over the world. The private system does work if you either have excellence or a low cost. But Mr. Kucinich will probably go to the Cleveland Clinic if he needs really great care. He will not go to Canada.

With that, I recognize the former chairman of the full committee, Mr. Towns, for 5 minutes.

Mr. TOWNS. Thank you very much, Mr. Chairman, and I appreciate you having this hearing.

Let me begin by asking you, Mr. Richardson and Mr. Fredrich and Ms. Miller, is there anything that you like about the Affordable Care Act? Anything?

Mr. RICHARDSON. Thank you, Congressman. I think for us, it has always been about the dignity of the individual. So our founder, Bill Ingram, started our business with that in mind. He wanted people to have freedom from anxiety. So as we developed and grew the business, that was a primary focus in terms of how do we provide that in any way that we can.

That freedom from anxiety in 1924 started with a health insurance plan. And after that, we came up with a defined benefit pension plan, and then a profit sharing plan. And then each year we take a percentage of sales up to 1 percent and give that back to team members because we wanted to have that be part of everything that we are doing.

So when we look at the Affordable Care Act, what we see is a wall that is being placed between ourselves and our employees because we have been able to have that conversation with them on a daily basis. Every year we do surveys to find out what is on their mind. We listen intently, and we modify those benefits. We have done that over time. Now we feel like there has been a barrier placed between us that tells us how we have to do that, something we have been doing very successfully.

It almost feels like we're trying to communicate with an orange juice can and string versus being able to go direct like we were. That is what has us concerned because as we are looking to the future, we are very concerned about the cost implications that this has for us and our ability to continue to do that. We are put into a bit of a box where really the only way that we can continue to offer the benefit that our team members have come to depend upon us for and that we have a great relationship with them on is to reduce the quality of the benefit. So to us it seems like we're walking around in paradox alley just trying to understand it.

Mr. TOWNS. Thank you.

Mr. FREDRICH. My answer is, no. There is nothing about it. To me, it is a step in the wrong direction because I believe the only solution to this is a market-based system, and it is just moving away from that.

Mr. TOWNS. You are not impressed with the testimony of Senator Wolf who indicated that 98 percent of the people in the State of Massachusetts are now covered? That doesn't impress you in any way?

Mr. FREDRICH. Not a bit. I seriously doubt the numbers. I didn't study Massachusetts, but I think we are playing with numbers here, and that is easy to do. And makes statistics look real good, but I don't believe it.

Mr. TOWNS. Mr. Chairman, I think what we have here is fear. I think people who really have not had any dealings because this has not been implemented, and I think there is fear here. When I listened to Senator Wolf, who has had experience with this, I mean he is now living it. And, of course, what he is saying to me is very different from what I am hearing coming from all of you.

Ms. MILLER. Mr. Towns, if I may answer that also, you're right. I have a lot of fear about this plan. I don't know all of the details, but when they tell me that I have three options. Basically I can get health insurance for all of my employees under this plan, and it would cost me based on the numbers put out there, $1.4 million. I'm a cleaning company. I don't get the kind of rates that airlines can get in Cape Cod. I am a cleaning company in Cincinnati, and I think I average and represent more businesses than an airline in Cape Cod would represent.

I also have the opportunity to go to all part-time employment and that doesn't help my employee base because then they would have to have two or three jobs to be able to cover their costs. Or I could drop it and pay just the penalty or tax or whatever you want to call it. And that would cost me still $640,000. That is not in my budget anywhere. I do have fear.

Our focus has been for the past 20 years to improve the quality of life for our employees, to encourage them to go after the dreams, improve their quality of life, and do what they want in their life. They have to have a job first before they can worry about health care. So you're right, there is a lot of fear here.

Mr. TOWNS. Let me just run down a couple of things, Mr. Chairman. Many small business owners across the country have expressed strong support for the Affordable Care Act. Let me give just give you a couple. For example, Mike Roach, the co-owner of Paloma Clothing in Portland, Oregon, said: Despite everything I've heard said about the Affordable Care Act, what I have never heard anyone argue about is the tremendous problem health care has been and continues to be for small businesses. The costs have been crushing. If nothing was done about health care costs, we would either have to cut benefits or lay some of our employees off, neither of which we want to do. The fact of the matter is the new law has already started helping us. Overturning the law now would not help us, it would hurt us. We want the law fully implemented with support from across the board.

And then Mr. Wolf, who—let me give you another example. Betsy Burton is the owner of King's English book shop in Salt Lake City, Utah. Here is what she said. "Before health care reform passed, I faced the very demoralizing decision to either drop my business health plan or lay off employees to contain costs. But we received tax credits through the Affordable Care Act which took that decision off the table. We are able to afford our insurance and have not had to lay off any of our valued employees."

And this is from Ken Weinstein, Mr. Chairman.

Chairman ISSA. Oh, no. Take all the time you want.

It is interesting that a Federal subsidy is how the bookstore was able to stay in business. I guess if we subsidized everybody, it would be perfect.

Mr. TOWNS. We are talking about creating jobs, aren't we? That's a job that is created. If that is what this is about, and I want to make certain that I am at the right hearing.

Chairman ISSA. Absolutely. As long as the Chinese keep loaning us the money.

Mr. TOWNS. Ken Weinstein, owner of Charlie Card Diner in Philadelphia, Pennsylvania: "Anyone opposing the new law obvi-

ously does not understand small businesses. Small businesses cannot afford the system under the status quo. Health care reform was needed to help bring down costs and level the playing field with large businesses."

Mr. Wolf, a study commissioned by Families U.S.A., and the small business majority found that more than 3.2 million small businesses employ 19.3 million workers across the Nation will be eligible for this tax credit this year. To me, this sounds like small businesses are finally getting the help they need.

So I want to say, first of all, Mr. Wolf, Senator Wolf, that I really appreciate your sharing with us today, and I think you are helping us a great deal, because you have been involved with it, you have lived it, and of course you understand it. And I think once we get over the fear, we can recognize the fact that the Supreme Court has spoken. They have spoken. And you're right, in this hypothetical question to you, I think the only thing you should have added is that the Supreme Court has spoken and when that happens, that's the law of the land.

I yield back.

Chairman ISSA. I thank the gentleman.

I would now ask that the GAO report of May of 2012, small employer held tax credit, factors contributing to low use and complexity be placed in the record.

Chairman ISSA. Mr. Towns, this, in fact, is where it is shown that because of the complexity, less than a quarter of those anticipated in what you just read ever took advantage of it. In fact, the program, that is a good example of an abysmal failure where you have to fill out at least seven different forms in order to take advantage of that credit, so most companies have not done it. But I appreciate the fact that it had good intentions. Perhaps we can work to fix it during these waning days.

Mr. TOWNS. Yes. I think we need to have another hearing and eliminate the forms.

Chairman ISSA. Mr. Chairman, this is why we were such good friends during your chairmanship.

As we close, I would like to thank our witnesses. And I would like to thank my good friend, Mr. Towns, because during his tenure as chairman, we did work hard to try to reduce a lot of forms. Like most Federal officers we try, we fail. All of you as employers know, including Senator Wolf, the one thing government is not good at is reducing the complexity of paper filing. And if we go electronic, we still manage to have you have to do redundant entry.

I might note in closing, General President George Washington died while being bled. His doctors felt that they needed to bleed him more, and so they did. In retrospect, they probably bled him to death. The American people are going to be taxed heavily for this program that has no cost controls. That ultimately is going to be one of the questions: Can America's competitiveness sustain a system that, as well intended as the President's flagship health care program is, ultimately has no cost controls, taxes in at least 21 additional places, and is likely to run up the cost.

Senator Wolf, I have only one thing for you, and one question in closing because I am the keeper of the record. Could you please cite the source of 98 percent of all of Massachusetts being insured?

Mr. WOLF. As they say in pilot lingo, stand by one.

Chairman ISSA. Yes, sir. People loved it so much we needed to get that in the record.

Mr. WOLF. And it is an important number, so I want to make sure that we give you the right citing.

Chairman ISSA. Because we have been looking at the 2006 and the 2010, and we don't get close to that number.

Mr. WOLF. So this is the Massachusetts Taxpayers Foundation, Massachusetts health reform spending 2006 through 2011, an update on the budget buster myth by the Massachusetts Taxpayers Foundation.

Chairman ISSA. Okay. I ask unanimous consent that be placed in the record. Without objection, so ordered.

Chairman ISSA. I believe you have all done a very good job of making clear what you find in your businesses. The reason we have had a second hearing in which we had business people specifically on this health care initiative is that ultimately the success or failure will be found in your balance sheets.

If we are right on what is your right, you will see higher costs and lower profits. If they are right on your left, we will all be pleased that, in fact, a health care initiative worked as well as Senator Wolf believes it has in Massachusetts.

I, for one, will join with my good friend, Mr. Towns and say I hope Senator Wolf is right. And with that, we stand adjourned.

[Whereupon, at 4:36 p.m., the committee was adjourned.]

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Opening Statement
Rep. Elijah E. Cummings, Ranking Member

Hearing on "Examining the Impact of ObamaCare on Job Creators and the Economy"

July 10, 2012

This week, the Republican House leadership has scheduled yet another debate and vote on the House floor to take away access to health insurance coverage for tens of millions of Americans.. They also want to eliminate key protections that were passed as part of the Affordable Care Act.

Without legitimate ideas of their own on how to replace the Affordable Care Act, House Republicans simply want to gut it, and they want to rehash this same debate over and over again.

Speaker Boehner proudly highlights on his own website that House Republicans have already taken "30 votes to scrap the president's health care law" during this Congress alone. Thirty votes—despite the fact that the Senate has already rejected this legislation. It is difficult to imagine a more monumental waste of time.

The only difference between the first 30 votes and the vote scheduled for this week is that the Supreme Court, in a decision by Chief Justice John Roberts, has now ruled that the Affordable Care Act is Constitutional.

Nevertheless, this week, we will engage in another exercise in futility by spending hours and hours debating Vote Number 31.

Unfortunately, today's hearing is part of this needless exercise. We are rehashing the exact same ground the Health Subcommittee covered a year ago in a remarkably similar hearing entitled, "Impact of Obamacare on Job Creators and Their Decision to Offer Health Insurance."

As we learned back then, the Affordable Care Act will extend health insurance coverage to 30 million people. Millions of young adults have already gained access to health care coverage through their parents' policies. Medicare beneficiaries are paying lower prescription drug costs. And more than 86 million Americans have benefited from preventive care free of charge, such as mammograms.

At the same time, hundreds of thousands of small businesses are receiving tax credits to maintain and expand health care coverage for their employees.

And millions of Americans are now receiving rebates under a new rule requiring that insurance companies spend at least 80% of your premium dollars on health and medical services or refund the difference. Imagine that—insurance companies returning your money rather than doling it out to corporate executives. This year alone, individuals are expected to receive $426 million in rebates from their insurance companies, and small businesses are expected to receive $377 million.

These are significant accomplishments that will help millions of people in very real ways. And there are more changes to come as additional provisions of the Affordable Care Act come online in the next two years to reduce the costs of healthcare further and provide patients with additional protections.

Despite these accomplishments, Republicans will continue the same old scare tactics today, warning about massive job losses and economic ruin should the Affordable Care Act continue.

The main problem with their theory is that it did not happen in Massachusetts. In 2006, then-Governor Mitt Romney signed into law the model for the Affordable Care Act, including subsidies for individuals purchasing coverage, a health insurance exchange, insurance market reforms, and mandates for employers and individuals.

As a result, today more than 98% of Massachusetts residents are now insured, with no indication of negative job consequences. With 6% unemployment, Massachusetts remains significantly lower than the national average.

The fact is that the Affordable Care Act—passed by both houses of Congress, signed by the President, and now upheld by the Supreme Court—is vital to the health of our people and the strength of our nation.

Let's put an end to this pointless political theater. The Supreme Court has spoken. It is time to focus on ensuring that the law is implemented effectively and efficiently so the American people can take full advantage of its protections.

Thank you.

United States Government Accountability Office

GAO

Report to Congressional Requesters

May 2012

SMALL EMPLOYER HEALTH TAX CREDIT

Factors Contributing to Low Use and Complexity



GAO-12-549

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Highlights

Highlights of GAO-12-549, a report to congressional requesters

May 2012

SMALL EMPLOYER HEALTH TAX CREDIT

Factors Contributing to Low Use and Complexity

Why GAO Did This Study

Many small employers do not offer health insurance. The Small Employer Health Insurance Tax Credit was established to help eligible small employers—businesses or tax-exempt entities—provide health insurance for employees. The base of the credit is premiums paid or the average premium for an employer's state if premiums paid were higher. In 2010, for small businesses, the credit was 35 percent of the base unless the business had more than 10 FTE employees or paid average annual wages over $25,000.

GAO was asked to examine (1) the extent to which the credit is claimed and any factors that limit claims, including how they can be addressed; (2) how fully IRS is ensuring that the credit is correctly claimed; and (3) what data are needed to evaluate the effects of the credit.

GAO compared IRS data on credit claims with estimates of eligible employers, interviewed various credit stakeholders and IRS officials as well as academicians on evaluation, compared IRS credit compliance documents with the rules and practices used for prior tax provisions and IRS strategic objectives, and reviewed literature and data.

What GAO Recommends

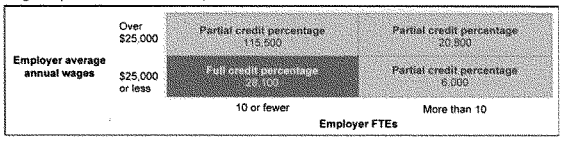
GAO recommends that IRS (1) improve instructions to examiners working on cases on the credit and (2) analyze results from examinations of credit claimants and use those results to identify and address any errors through alternative approaches. IRS agreed with GAO's recommendations.

View GAO-12-549. For more information, contact James R. White at (202) 512-9110 or whitej@gao.gov.

What GAO Found

Fewer small employers claimed the Small Employer Health Insurance Tax Credit in tax year 2010 than were estimated to be eligible. While 170,300 small employers claimed it, estimates of the eligible pool by government agencies and small business advocacy groups ranged from 1.4 million to 4 million. The cost of credits claimed was $468 million. Most claims were limited to partial rather than full percentage credits (35 percent for small businesses) because of the average wage or full-time equivalent (FTE) requirements. As shown in the figure, 28,100 employers claimed the full credit percentage. In addition, 30 percent of claims had the base premium limited by the state premium average.

Number of Small Employers Claiming the Full and Partial Credit Percentages, by FTE and Wage Requirements for the Credit, Tax Year 2010



Source: GAO analysis of IRS data on Form 8941.
Notes: This information is based on the approximately 170,300 small employer claims. Numbers are rounded to the nearest hundred. Numbers don't add up because of rounding.

One factor limiting the credit's use is that most very small employers, 83 percent by one estimate, do not offer health insurance. According to employer representatives, tax preparers, and insurance brokers that GAO met with, the credit was not large enough to incentivize employers to begin offering insurance. Complex rules on FTEs and average wages also limited use. In addition, tax preparer groups GAO met with generally said the time needed to calculate the credit deterred claims. Options to address these factors, such as expanded eligibility requirements, have trade-offs, including less precise targeting of employers and higher costs to the Federal government.

The Internal Revenue Service (IRS) incorporated practices used successfully for prior tax provisions and from IRS strategic objectives into its compliance efforts for the credit. However, the instructions provided to its examiners (1) do not address the credit's eligibility requirements for employers with non-U.S. addresses and (2) have less detail for reviewing the eligibility of tax-exempt entities' health insurance plans compared to those for reviewing small business plans. These omissions may cause examiners to overlook or inconsistently treat possible noncompliance. Further, IRS does not systematically analyze examination results to understand the types of errors and whether examinations are the best way to correct each type. As a result, IRS is less able to ensure that resources target errors with the credit rather than compliant claimants.

Currently available data on health insurance that could be used to evaluate the effects of the credit do not match the credit's eligibility requirements, such as information to convert data on number of employees to FTEs. Additional data that would need to be collected depend on the questions policymakers would want answered and the costs of collecting such data.

United States Government Accountability Office

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Abbreviations

CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act
FTE	full-time equivalent
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
JCT	Joint Committee on Taxation
MEA	Math Error Authority
MEPS	Medical Expenditure Panel Survey
NFIB	National Federation of Independent Businesses
PPACA	Patient Protection and Affordable Care Act
SBA	Small Business Administration
SBM	Small Business Majority
SB/SE	Small Business and Self-Employed Division
TEGE	Tax Exempt and Government Entities Division
TETR	Telephone Excise Tax Refund
TIGTA	Treasury Inspector General for Tax Administration

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United States Government Accountability Office
Washington, DC 20548

May 14, 2012

The Honorable Olympia J. Snowe
Ranking Member
Committee on Small Business and Entrepreneurship
United States Senate

The Honorable Sam Graves
Chairman
Committee on Small Business
House of Representatives

Many small employers do not offer health insurance to their employees. This is particularly true for small employers paying low wages. According to data from the Medical Expenditure Panel Survey (MEPS)[1] about 17 percent of employers with less than 10 employees who earn low wages (50 percent or more of their employees earn $11.50 per hour or less) offered health insurance to their employees in 2010, while about 90 percent of employers with 100 to 999 employees who earn low wages did.

To provide an incentive for small employers to provide health insurance, and to make insurance more affordable, Congress included the Small Employer Health Insurance Tax Credit (referred to in this report as the credit) in the Patient Protection and Affordable Care Act (PPACA).[2] The credit is available for tax years beginning after December 31, 2009 to certain employers with employees earning low wages— small business and tax-exempt entities—that pay at least half of their employees' health insurance premiums. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) jointly estimated that the credit would

[1]MEPS is a set of large-scale surveys. MEPS is administered by the Agency for Healthcare Research and Quality in the Department of Health and Human Services. The 2010 Insurance Component survey had a response rate of about 83 percent for private establishments, and 38,409 respondents, including for-profit, and nonprofit employers; government units are excluded from these statistics.

[2]Pub. L. No. 111-148, §§ 1421, 10105, 124 Stat. 119 (Mar. 23, 2010), (codified at 26 U.S.C. § 45R).

cost $2 billion in fiscal year 2010 and $40 billion from fiscal years 2010 to 2019.[3]

You asked us to review the implementation of the credit. Specifically, we examined

- to what extent the credit is being claimed and what factors, if any, limit employer claims, and how these factors can be addressed;
- how fully the Internal Revenue Service (IRS) is ensuring that the credit is correctly claimed by eligible employers; and
- what data are needed to evaluate the effects of the credit.

To describe the extent to which the credit is being claimed, we reviewed IRS data on the claims for tax year 2010. To identify any factors that may limit credit claims and to assess how they could be addressed, we interviewed IRS officials as well as groups representing employers, tax preparers, and insurance brokers, and worked with them to assemble discussion groups on the credit. To assess how these factors could be addressed, we analyzed our interview results as well as relevant documents. Where possible, we identified IRS or MEPS data related to the factors. To assess how IRS is ensuring that the tax credit is correctly claimed by eligible employers we reviewed its compliance plans for the credit and compared them to practices used successfully for prior tax provisions[4] and IRS strategic objectives. We interviewed IRS officials on their compliance efforts. To assess what data would be needed to evaluate the effects of the credit, we conducted a literature review and interviewed interest groups and subject matter specialists from government, academia, research foundations and think tanks. We found the data we used to be sufficiently reliable for the purposes of our report.

We conducted this performance audit from July 2011 through May 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

[3]CBO, letter to the Honorable Nancy Pelosi, Speaker of the U.S. House of Representatives (Washington, D.C.: Mar. 18, 2010).

[4]For example, see GAO, *Tax Refunds: Enhanced Prerefund Compliance Checks Could Yield Significant Benefits*, GAO-11-691T (Washington, D.C.: May 25, 2011).

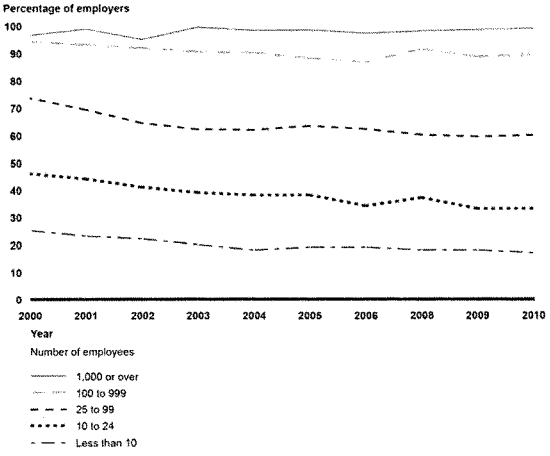
the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. (See app. I for our scope and methodology.)

Background

Small Employer Health Insurance Market

Small employers with low-wage employees do not commonly offer health insurance, compared with large employers with low-wage employees, as shown in figure 1.

Figure 1: Percentage of Employers with Low-Wage Employees That Offer Health Insurance, 2000 through 2010, by Employer Size



Source: MEPS 2000 to 2010 data.

Notes: Figure includes for-profit and nonprofit (tax-exempt) entities but not government entities. A low-wage employer is defined as an employer that has 50 percent or more of its employees earning a low wage (earning $11.50 per hour or less, which is an annual salary of, at most, about $23,920). Data were not collected for the MEPS Insurance Component for 2007.

A combination of factors explains why small, low-wage employers tend not to offer health insurance.[5]

- For very low-wage employees, such as minimum wage employees,[6] health insurance drives up total compensation costs for employees.
- Low-wage employees working for small employers generally prefer to receive wages over insurance benefits as part of total compensation. On one hand, while employees pay both income and employment tax on wages, employees do not have to pay income or employment taxes on premiums paid by their employers for health insurance. However, for low-wage employees, the income tax exclusion is worth less relative to cash wages than for higher-income employees because low-wage employees may be in a lower income tax bracket.[7]
- Insurers of small employers face higher per-employee fixed costs for billing and marketing[8] and are less able to pool risk[9] across large numbers of employees. As a result, plans offered to small employers

[5]For additional description of challenges for small employers providing coverage, see GAO, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage,* GAO-02-8 (Washington, D.C.: Oct. 31, 2001).

[6]In general, the federal minimum wage is $7.25 per hour. Many states also have minimum wage laws and minimum wages vary from state to state.

[7]See Quantria Strategies/Small Business Administration, *Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives* (Cheverly, Md.: September 2011).

[8]CBO estimated that for firms with 25 or fewer employees, 26 percent of premiums goes toward insurers' administration costs, compared with 7 percent for firms with at least 1,000 employees; see CBO, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, D.C.: December 2008).

[9]Risk pooling spreads risk across a group; a larger pool stabilizes the average insurance costs. Smaller risk pools raise costs because insurers run the risk of insuring those with relatively high health care needs. As a result, insurers may increase premiums to better ensure that they can cover unexpectedly large health care costs.

are likely to have higher premiums or have less coverage and higher out-of-pocket costs than plans offered to large employers.[10]

IRS Implementation and Requirements for Calculating and Claiming the Credit

IRS's Small Business and Self-Employed Division (SB/SE) and Tax Exempt and Government Entities Division (TEGE) are primarily responsible for implementing the credit. IRS works with the Department of Health and Human Services (HHS) and the Small Business Administration (SBA) on implementation tasks, such as outreach and communication.

To be eligible, an employer must:

- Be a small business[11] or tax-exempt employer[12] located in or having trade or business income in the United States and pay premiums for employee health insurance coverage issued in the United States.
- Employ fewer than 25 full-time-equivalent (FTE)[13] employees in the tax year (excluding certain employees, such as business owners and their family members).[14]

[10]The average deductible in 2010 per employee enrolled in a single (employee only) health insurance plan was $1,421 for employers with fewer than 10 employees; $1,420 for employers with 10 to 24 employees, $1,513 for employers with 25 to 99 employees, $1,155 for employers with 100 to 999 employees, and $738 for employers with 1,000 or more employees, according to MEPS. A deductible is the amount of expenses that must be paid out-of-pocket before an insurer will pay any expenses.

[11]For purposes of this credit, a business includes those that are corporations in a controlled group of corporations, or members of an affiliated service group, as well as partnerships, sole proprietorships, cooperatives and trusts. A sole proprietor is an individual who owns an unincorporated business but may employ others.

[12]The credit is available to tax-exempt employers described in 26 U.S.C. § 501(c) and exempt from tax under 26 U.S.C. § 501 (a).

[13]To calculate FTEs, the total hours of service must be determined for all individuals considered employees. There are a number of methods that can be used to determine the hours worked, but the hours are limited to 2,080 per employee. The total number of hours of service is divided by 2,080 to arrive at the FTE number.

[14]Other exclusions are seasonal employees, unless they work for the employer on more than 120 days in the tax year, and ministers who are deemed to be self-employed. Leased employees are included in FTE calculations.

- Pay average annual wages of less than $50,000 per FTE in the tax year.[15]
- Offer health insurance and pay at least 50 percent of the health insurance premium under a "qualifying arrangement." This means that the employer uniformly pays at least 50 percent of the cost of premiums for enrolled employees, although IRS did develop relaxed criteria for meeting this requirement for tax year 2010.[16]

The President's fiscal year 2013 budget request contains a proposal for expanding the credit's eligibility criteria to include employers with 50 or fewer FTEs and removing the uniform contribution requirement.

Limits on the Credit Amount

The amount of the credit that employers can claim depends on several factors. Through 2013, small businesses can receive up to 35 percent and tax-exempt entities can receive up to 25 percent of their base payments for employee health insurance premiums; these portions rise to 50 percent and 35 percent, respectively, starting in 2014. Employers can receive the full credit percentage if they have 10 or fewer FTEs and pay an average of $25,000 or less in annual wages; employers with 11 to 25 FTEs and average wages exceeding $25,000 up to $50,000 are eligible for a partial credit that "phases" out to zero percent of premium payments as the FTE and wage amounts rise. Figure 2 shows the phaseout of the credit for small businesses; the phaseout for tax-exempt entities follows a similar pattern, up to 25 percent of health insurance premiums.

[15]Wages for the employees included in the FTE calculations are included in average wage calculations except for minister's wages which are not subject to Social Security or Medicare tax.

[16]IRS offered a transition rule on the "qualifying arrangement" criteria for tax year 2010 and for satisfying the uniformity requirement. IRS Notice 2010-44.

Figure 2: Phaseout of the Credit for Small Businesses as a Percentage of Employer Contributions to Premiums, for 2010 to 2013

Number of FTEs	Average wage: $25,000 and less	$30,000	$35,000	$40,000	$45,000	$50,000
10 and fewer	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: Congressional Research Service.

Note: GAO adapted the graphic from Congressional Research Service, *Summary of the Small Business Health Insurance Tax Credit Under PPACA (P.L. 111-148)* (Washington, D.C.: Apr. 5, 2010).

Further, the amount of the credit is limited if the premiums paid by an employer are more than the average premiums determined by HHS for the small group market in the state in which the employer offers insurance. The credit percentage is multiplied by the allowable premium to calculate the dollar amount of credit claimed. For example, in Alabama, the state average premium was $4,441 for a single employee in 2010. If an employer claiming the credit in Alabama paid $5,000 for a single employee's health premium, the credit would be calculated using the state average premium of $4,441 rather than the actual premium paid. Appendix II shows the average premiums by state.

The proposal in the President's Budget suggests beginning the phaseout at 21 FTEs, rather than 11, as well as providing for a more gradual

combined phaseout for the credit percentages and removing the state market limits.

Process for Claiming the Credit

Employers are to calculate the credit amount on IRS Form 8941, "Credit for Small Employer Health Insurance Premiums." Small businesses are to claim the credit as part of the general business tax credit (on Form 3800), and use it to offset actual tax liability. If they do not have a federal tax liability, they cannot receive the credit as a refund but may carry the credit forward or back to offset tax liabilities for other years.[17] Credit amounts claimed by partnerships and S corporations are to be passed through to their partners and shareholders, respectively,[18] who may claim their portions of the credit on their individual income tax returns.[19] Tax-exempt entities are to claim the credit on Form 990-T, "Exempt Organization Business Income Tax Return," and receive the credit as a refund even though the employer has no taxable income.

Employers that claim the credit can also deduct health insurance expenses on their tax returns but must subtract the amount of the credit from the deduction. Employers can claim the credit for up to 6 years—the initial 4 years from 2010 through 2013 and any 2 consecutive years after 2013 if they buy insurance through the Small Business Health Option Programs, which are part of the insurance exchanges to be established under PPACA.[20]

[17]The unused credit for small businesses may be carried back 1 year or forward up to 20 years. Credits cannot be carried back to a year prior to the effective date of the credit; any unused credit amounts for 2010 can only be carried forward. See IRS Notice 2010-44.

[18]Owners of S corporations are referred to as shareholders. S corporations are corporations that "pass through" gains and losses to shareholders' individual tax returns without generally paying taxes at the entity level. Similarly, partners receive pass through income and losses from a partnership.

[19]For partners and shareholders, the credit is to be entered on the Schedule K-1 to be filed with an income tax return.

[20]PPACA requires the establishment of exchanges in each state by January 1, 2014, which are to help eligible individuals and small employers compare and select insurance coverage from among participating health plans. See Pub. L. No. 111-148, § 1311(b), 124 Stat. 119, 173 (Mar. 23, 2010).

Fewer Small Employers Claimed the Credit Than Were Thought to Be Eligible Because of Factors Such as Credit Size and Complexity

Actual Credit Claims Were Much Lower Than Initial Rough Eligibility Estimates

Fewer small employers claimed the credit for tax year 2010 than were thought to be eligible based on rough estimates of eligible employers made by government agencies and small business groups. IRS data on total claimants, adjusted to account for claims by partners and shareholders, show that about 170,300 small employers made claims for the credit in 2010.[21] (See app. III for adjustments to determine claims filed by employers.) The average credit amount claimed was about $2,700. Limited information is available on the distribution of claim amounts for business entities because IRS focuses its data collection on the taxpayers filing credit claims, who may be partners or shareholders claiming their portions of a business entity's credit. Appendix III provides additional detail.

Selected estimates, made by government agencies and small business groups, of employers eligible for the credit range from around 1.4 million to 4 million. However, data limitations mean that these estimates are necessarily rough. Based on our review of available data sources on the three basic eligibility rules for the credit—involving wages, FTEs, and health insurance—it is not possible to combine data from various sources to closely match these rules. (See app. VI for details.) Though statistical modeling corrects for imperfect data to match these rules, models are not precise. While acknowledging the data limitations, several entities produced estimates of the number of employers potentially eligible for the credit. The Council of Economic Advisors estimated 4 million and SBA

[21]The number of employees who had their premiums paid by employers that claimed the credit was about 770,000.

estimated 2.6 million.[22] Other groups making estimates included small business groups such as the Small Business Majority (SBM) and the National Federation of Independent Businesses (NFIB). Their estimates were 4 million and 1.4 million, respectively.[23]

A similar pattern is seen when the dollar value of credits actually claimed is compared to initial estimates. The dollar value of claims made in 2010 was $468 million compared to initial cost estimates of $2 billion for 2010 (a CBO and JCT joint estimate).[24]

Most Small Employer Claims Were Reduced Because of the Phaseout Rules and Some Were Reduced by the State Average Premiums

Credit Phaseout

(In reference to the phaseout) "People get excited that they're eligible and then they do the calculations and it's like the bottom just falls out of it and it's not really there. It's almost like a wish that they might get it and then they do the calculations and it's not worth it for them." --Health insurance discussion group participant

Most of the claims were for less than the full credit percentage. Of the approximately 170,300 small employers making claims for tax year 2010, 142,200—83 percent—could not use the full credit percentage. Usually employers could not meet the average wage requirement to claim the full percentage, as about 68 percent did not qualify based on wages but did meet the FTE requirement. (See fig. 3.)[25]

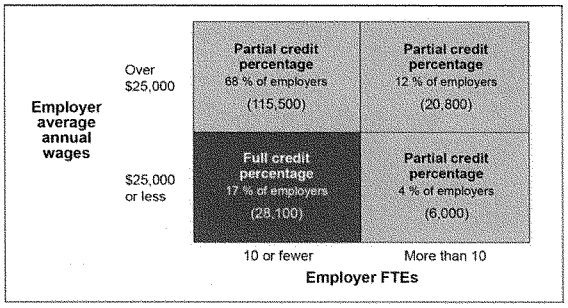
[22]The Council of Economic Advisors is an agency within the Executive Office of the President charged with offering objective advice on the formulation of domestic and international economic policy, and SBA is a government agency that offers a variety of programs and support services to help small businesses.

[23]The estimate for SBM and SBA included nonprofits. The estimate for NFIB was only for small businesses; it is not known whether the estimate for the Council of Economic Advisors included nonprofits in addition to businesses.

[24]CBO and JCT recently reduced their original estimates of the future costs of the credit to a cost of $1 billion in 2012 and a cost of $21 billion from 2012 to 2021. These estimates were previously $5 billion in 2012 and $40 billion from 2012 to 2021.

[25]See app. IV for a graph of claimants with fewer than 10 FTEs and the amount of full credits.

Figure 3: Percentage and Number of Small Employers Claiming the Full and Partial Credit Percentages, by FTE and Wage Requirements for the Credit, Tax Year 2010



Source: GAO analysis of IRS data on Form 8941.

Notes: This information is based on the approximately 170,300 small employer claims. Numbers are rounded to the nearest hundred. Numbers and percentages do not add to totals because of rounding.

State Averages as Caps on the Credit

"I don't know where that number (the state average) comes from but that's supposed to be the average cost, and that seems pretty low, which is reducing that tax credit amount they would qualify for." –Health insurance discussion group participant

State average premiums also reduced some credit amounts by reducing the amount of the premium base against which the credit percentage is applied. This premium base may be reduced when it exceeds the state average premiums for small group plans,[26] as determined by HHS. If so, small employers are to use the state average amount, which in essence caps the premium amount used to calculate their credit. According to IRS data, this cap reduced the credit for around 30 percent of employer claims. For example, a nonprofit representative told us that her credit dropped from $7,900 to $3,070 because of the cap in her state. (See app. II for small group average premiums in all states.)

[26]A small group plan is a health coverage plan sponsored by small employers for the employees.

Most Small Employers Could Not Meet the Health Insurance Requirement for the Credit and the Credit Was Not Seen as an Incentive to Start Offering Insurance

Small, Low-Wage Employers Not Commonly Offering Health Insurance

"Very few people are going to pay 50 or 100 percent of the health insurance for someone making $25,000 or less. We just don't have that many clients who even start to qualify." –Tax preparer discussion group participant

As already discussed, small employers do not commonly offer health insurance. MEPS estimates that 83 percent of employers who may otherwise be eligible for the full credit[27] did not offer health insurance in 2010 and that 67 percent of employers who could be eligible for the partial credit[28] did not offer insurance. Our discussion groups and other interviewees confirmed this, with comments and examples of small, low-wage employers not offering health insurance to employees.

Furthermore, the small employers do not likely view the credit as a big enough incentive to begin offering health insurance and to make a credit claim, according to employer representatives, tax preparers, and insurance brokers we met with. While some small employers could be eligible for the credit if they began to offer health insurance, small business group representatives and discussion group participants told us that the credit may not offset costs enough to justify a new outlay for health insurance premiums. Related to this concern, the credit being available for 6 years overall and just 2 consecutive years after 2014 further detracts from any potential incentive to small employers to start offering health insurance in order to claim the credit.

Complexity Deterred Small Employer Claims, According to Discussion Groups

Complexity of the Credit

"Any credit that needs a form that takes 25 lines and seven work sheets to build to those 25 lines is too complicated." –Tax preparer discussion group participant

Most discussion group participants and groups we interviewed found the tax credit to be complicated, deterring small employers from claiming it. The complexity arises from the various eligibility requirements, the various data that must be recorded and collected, and number of worksheets to be completed.

A major complaint we heard centered on gathering information for and calculating FTEs and the health insurance premiums associated with those FTEs. Eligible employers reportedly did not have the number of hours worked for each employee readily available to calculate FTEs and their associated average annual wages nor did they have the required health insurance information for each employee readily available.

[27]This MEPS statistic is based on employers—both profit and nonprofit—with fewer than 10 employees that pay annual wages of $24,000 or less to over half of their employees.

[28]This MEPS statistic is based on employers—both profit and nonprofit—with 10 to 25 employees that pay annual wages of $24,000 or less to over half of their employees. Because the employers eligible for the partial credit can pay up to $50,000 in wages, this is a less precise estimate than using MEPS to estimate insurance offerings for the full credit.

Exclusions from the definition of "employee" and other rules make the calculations complex. For example, seasonal employees are excluded from FTE counts but insurance premiums paid on their behalf count toward the employer's credit. Incorporating the phaseout also complicates the credit calculation.

Gathering Information for the Credit Calculation

(Small business owners) "Are trying to run their businesses and operate and make a profit, and when you tell them they need to take 2, 3, 4 hours to gather this information, they just shake their head and say, 'no, I'm not going to do it' "–Tax preparer discussion group participant

In our discussion groups with tax preparers, we heard that small business owners generally do not want to spend the time or money to gather the necessary information to calculate the credit, given that the credit will likely be insubstantial. Tax preparers told us it could take their clients from 2 to 8 hours or possibly longer to gather the necessary information to calculate the credit and that the tax preparers spent, in general, 3 to 5 hours calculating the credit.[29] We did hear from a couple of participants—a small business owner and a nonprofit representative—that they did not find the credit overly burdensome.

Tax preparers we interviewed said that IRS did the best it could with the Form 8941 given the credit's complexity. IRS officials said they did not receive criticism about Form 8941 itself but did hear that the instructions and its seven worksheets were too long and cumbersome for some claimants and tax preparers. On its website, IRS tried to reduce the burden on taxpayers by offering "3 Simple Steps" as a screening tool to help taxpayers determine whether they might be eligible for the credit. However, to calculate the actual dollars that can be claimed, the three steps become 15 calculations, 11 of which are based on seven worksheets, some of which request multiple columns of information. Figure 4 aligns IRS's "3 Simple Steps," with the seven worksheets in the instructions for Form 8941 and the lines on Form 8941. (See app. V for full text for this figure.)

[29]The National Society of Accountants conducted a survey in 2008 that estimated the hourly tax preparer fee to be $122 an hour. Tax preparers may not necessarily charge for the credit, according to some discussion group participants.

Interactive graphic **Figure 4: Form 8941 and Credit Calculations on Worksheets Related to IRS's "3 Simple Steps" for Determining Potential Eligibility**

Directions:

Roll over the buttons below to reveal the worksheets necessary to calculate credit totals needed for lines on IRS Form 8941.

Step 1	Step 2	Step 3	
Determine the total number of employees (FTEs)	Determine the average annual wages paid to employees	Determine if you pay at least of half insurance premiums for employees	Additional calculations (FTE and wage phase out)

Form **8941** — Credit for Small Employer Health Insurance Premiums

Department of the Treasury
Internal Revenue Service

▶ See separate instructions.
▶ Attach to your tax return.

OMB No. 1545-2198

2010

Attachment Sequence No. 63

Name(s) shown on return | Identifying number

1	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions)	1	
2	Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12	2	
3	Average annual wages you paid for the tax year (see instructions). If you entered $50,000 or more, skip lines 4 through 11 and enter -0- on line 12	3	
4	Premiums you paid during the tax year for employees included on line 1 for health insurance coverage under a qualifying arrangement (see instructions)	4	
5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions)	5	
6	Enter the **smaller** of line 4 or line 5	6	
7	Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 25% (.25) • All other small employers, multiply line 6 by 35% (.35)	7	
8	If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions	8	
9	If line 3 is $25,000 or less, enter the amount from line 8. Otherwise, see instructions	9	
10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	10	
11	Subtract line 10 from line 4. If zero or less, enter -0-	11	
12	Enter the **smaller** of line 9 or line 11	12	
13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1 for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (see instructions)	13	
14	Enter the number of full-time equivalent employees you would have entered on line 2 if you only included employees included on line 13	14	
15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	15	
16	Add lines 12 and 15. Partnerships and S corporations, stop here and report this amount on Schedule K, all others, go to line 17	16	
17	Credit for small employer health insurance premiums included on line 16 from passive activities (see instructions)	17	
18	Subtract line 17 from line 16	18	

Source: GAO analysis of IRS information.

Print instructions To view and print full noninteractive versions of IRS Form 8941 and worksheets included in this graphic, go to appendix V.

Given the effort involved to make a claim and the uncertainty about the credit amounts, a few discussion group participants said it would be helpful to be able to quickly estimate employers' eligibility for the credit and the amount they might receive; this would help them to decide whether the credit would be worth the effort, although this would not reduce the complication of filing out Form 8941 because, to fill out the form, full documentation would need to be reviewed. IRS's Taxpayer Advocate Service[30] is developing a calculator for IRS's website to quickly estimate an employer's eligibility, but this will still require gathering information such as wages, FTEs, and insurance plans. We also heard concerns that a calculator could cause confusion for clients who find they are eligible when quickly estimating the credit but then turn out to be ineligible or find they are eligible for a smaller credit when their accountant fills out Form 8941.

The Extent to Which Lack of Awareness Is a Factor Limiting More Claims Is Unknown, Although IRS Did Significant Outreach

Many small businesses reported that they were unaware of the credit. The NFIB Research Foundation[31] and the Kaiser Family Foundation both estimated that approximately 50 percent of small businesses were aware of the credit, as of May 2011, or more than 1 year after Congress authorized this credit.[32]

The extent to which being unaware prevented eligible employers from claiming the credit for tax year 2010 is not known. Some discussion group participants raised concerns about unawareness, but they also cited other factors limiting credit claims for tax year 2010. If 50 percent of small businesses knew about the credit, then the approximately 170,300 claims is a relatively small proportion of those that were knowledgeable. This indicates that other factors contributed to employers not claiming the credit. Further, it is hard to interpret the impact of awareness on claims because these surveys included an unknown number of small business

[30]The Taxpayer Advocate Service is an independent organization within the IRS that helps taxpayers who are experiencing economic harm; are seeking help in resolving problems with IRS; and believe an IRS system or procedure is not working as it should.

[31]The NFIB Research Foundation is a nonprofit affiliated with NFIB.

[32]NFIB conducted this survey in April and May 2011 of 750 small employers of firms with 50 or fewer employees. The Kaiser Family Foundation conducted its survey from January through May 2011 of 3,184 public and private firms with 3 or more employees and its questions about the credit were directed to employers with 50 or fewer employees.

employers that would not be eligible for the credit regardless of their awareness. For those employers that were unaware, the surveys did not account for their accountants or tax preparers that may have known about the credit but did not tell their clients about it because they did not believe their clients would qualify or because the credit amount would be very small. In addition, the surveys did not cover tax-exempt entities.

To raise awareness of the credit, IRS did significant outreach. IRS developed a communication and outreach plan, written materials on the credit, a video, and a website. IRS officials also reached out to interest groups about the credit and developed a list of target audiences and presentation topics. IRS officials began speaking at events in April 2010 to discuss the credit and attended over 1,500 in-person or web-based events from April 2010 to February 2012. Discussion of the credit at the events varied from being a portion of a presentation covering many topics to some events that focused on the credit with a dedicated discussion period.

IRS does not know whether its outreach efforts actually increased awareness of the credit or were otherwise cost-effective. It would be challenging to estimate the impact of IRS's outreach efforts on awareness with a rigorous methodology; however, based on ongoing feedback they received from interest groups, IRS officials told us they believe their efforts have been worthwhile. IRS used some feedback from focus groups of tax preparers and from other sources[33] to revise its outreach efforts. For example, IRS modified its outreach from initially focusing on tax preparers and small employers to including insurance brokers in 2012.

Addressing Factors and Expanding Credit Use May Require Substantive Design Changes

Given that most small employers do not offer insurance and what we heard about the size of the credit not being big enough to incentivize offering health insurance,[34] it may not be possible to significantly expand credit use without changing the credit's eligibility. Most claims were for partial credits and many people we spoke with view the credit amount as

[33]Each focus group in 2011 consisted of 12 tax preparers. IRS issued a report on the focus groups' results on October 14, 2011.

[34]Given the previously discussed lack of knowledge or awareness, it is not clear that increasing outreach would increase credit usage.

too small and temporary to justify providing health insurance when none is provided now. In addition, given that IRS has conducted extensive outreach about the credit, it is not likely that more outreach would significantly increase the number of businesses claiming the credit. Amending the eligibility requirements or increasing the amount of the credit may allow more businesses to take advantage of the credit,[35] but these changes would increase its cost to the Federal government. Options include the following:

- Increasing the amount of the full credit, the partial credit, or both.
- Increasing the amount of the credit for some by eliminating state premium averages.
- Expanding eligibility requirements by increasing the number of FTEs and wage limit allowable for employers to claim the partial credit, the full credit, or both. This expansion would not, however, likely affect the smallest employers which do not offer health insurance.
- Simplifying the calculation of the credit in the following ways:
  - Using the number of employees and wage information already reported on the employer's tax return. This could reduce the amount of data gathering as well as credit calculations because eligibility would be based on the number of employees and not FTEs. A trade-off with this option would be less precision in targeting the full and partial credit amount to specific small employer subgroups.[36]
  - Offering a flat credit amount per FTE (or number of employees) rather than a percentage, which would reduce the precision in targeting the credit.

[35]Three bills were recently introduced to amend the small employer health insurance credit to increase the maximum number of FTEs to 50, modify the phase out of the credit amount, and repeal the limitation based on state health insurance premium averages. H.R. 4324, Small Business Employee Health Insurance Credit Expansion Act of 2012, also would repeal the 2-year limit after 2014, making the credit available indefinitely. H.R.4252 and S.2227, both titled Small Business Health Care Tax Credit Improvement Act of 2012, propose to increase allowable average annual salaries paid to employees to $28,500 to claim the full credit.

[36]Using the number of employees instead of FTEs would require an increase in the number of eligible employees in order to reach the same population of small employers. For example, two part-time employees working 20 hours per week count as one FTE, making the employer appear larger than if FTEs were counted.

The data limitations that made it difficult to estimate the number of businesses eligible for the current credit also make it difficult to estimate the impact of any design changes.

IRS Is Implementing Several Practices from Prior Compliance Efforts, but Additional Steps Could Be Taken

IRS Incorporated Practices from Strategic Objectives and Prior Compliance Efforts

IRS's compliance efforts for the credit incorporate practices that have been shown effective in helping to ensure compliance with other tax provisions or are consistent with IRS strategic objectives. Some of those practices were used for the Telephone Excise Tax Refund (TETR)[37] and Consolidated Omnibus Budget Reconciliation Act (COBRA) subsidies for health insurance for the unemployed, according to IRS officials.[38] Specifically, IRS is doing the following:

- Using computerized filters to review credit claims on Forms 8941 for certain errors or potential problems that may trigger an examination of the claim.
- Transcribing more lines of data from Form 8941 into IRS computer systems which should make the filters more effective. Although transcribing more lines increases processing and data storage costs, IRS plans to transcribe more lines for tax years 2011 and 2012 claims to ensure better verification of eligibility.

[37]We found that that IRS's compliance plans for the TETR were consistent with good management practices in previous reports. See GAO, *Tax Administration: Telephone Excise Tax Refund Requests Are Fewer Than Projected and Have Had Minimal Impact on IRS Services*, GAO-07-695 (Washington, D.C.: Apr. 11, 2007).

[38]We tested IRS's internal controls for the COBRA unemployment subsidies in the American Recovery and Reinvestment Act and found that IRS was able to identify all five fictitious companies used to fraudulently apply for the subsidies. See *GAO Proactive Testing of ARRA Tax Credits for COBRA Premium Payments*, GAO-10-804R (Washington, D.C.: June 14, 2010).

- Freezing refunds of tax-exempt entities whose returns have been selected for examination, which avoids the costs of trying to recover funds.[39]

- Considering the documentation burden on claimants. IRS did not require claimants to submit documentation on health insurance premiums with their Form 8941 because IRS officials said they will review examination results and may revisit the decision not to require documentation if results suggest that such documentation would improve compliance checks.

- Modifying filters, as needed, in response to observed trends. For example, a filter that applies to tax-exempt organization claims was tripped by about a quarter of claimant organizations, as of December 31, 2011. IRS officials said some eligible tax-exempt entities tripped the filter because it was too broad. To address this, IRS modified the filter to more clearly identify qualifying tax-exempt organizations.

- Completing a risk assessment on compliance issues related to the credit. The assessment identified risks involving refunds for tax-exempt entities, difficulties verifying employment tax return information for certain employers, and not using existing Math Error Authority (MEA).

- Considering the costs and benefits of MEA for the credit.[40] IRS officials identified three filters whose type of errors could be addressed with MEA. They noted that less than 1 percent of Forms 8941 tripped one or more of those filters,[41] which IRS officials said

[39]See GAO, *Tax Gap: Complexity and Taxpayer Compliance*, GAO-11-747T (Washington, D.C.: June 28, 2011).

[40]The Internal Revenue Code provides IRS with MEA to assess additional tax or otherwise correct tax return errors in limited circumstances when an adjustment is the result of mathematical or clerical errors on the return. In these cases, IRS can avoid costly audits and IRS is not required to provide taxpayers a right to appeal MEA assessments, although they may file a claim to ask IRS to reduce the assessment if they believe IRS erred. See 26 U.S.C. § 6213(b). Over the years, Congress has granted MEA for specific purposes and those purposes are listed in section 6213(g)(2).

[41]These three IRS filters are to check whether credit claims are consistent with eligibility requirements subject to computation criteria.

does not justify the costs to develop procedures to use MEA, if it were granted.[42]

Filters Check Some Eligibility Criteria, but Are Limited by Available Data

IRS developed 21 filters for Form 8941, some of which apply differently to SB/SE and TEGE taxpayers. The filters cover some of the eligibility requirements for the credit. Errors on about 3.5 percent (11,763) of Forms 8941 for tax year 2010 tripped 1 or more filters; almost half of those forms were from tax-exempt entities. According to IRS officials, the filter failure rate is consistent with other recent tax credits.

The filters do not cover all of the credit's requirements for several data-related reasons.[43] In one case, data are not included on Form 8941 but may be included on worksheets required to be retained by claimants (e.g., information on business owner family members or seasonal employees included in credit calculations); in another case, certain data are not transcribed (e.g., the credit amount for certain claimants). For other requirements, IRS officials stated that reasonable filters cannot easily be developed because of challenges with matching data.

Some Form 8941 filters also face limitations mainly because of problems with data or IRS's systems.

- Filters are mutually exclusive, meaning that filters on related requirements are viewed in isolation. However, according to IRS officials, IRS has ways to identify whether a form failed more than one filter, which IRS considers when identifying returns for potential examination.
- Some filters may mistakenly target eligible claimants because the filters rely on general thresholds in Form 8941 data or, in some cases, other IRS data (such as employee-level data) that are not exact matches to data on the Form 8941.

[42]We previously recommended that Congress should consider broadening IRS's ability to use MEA, with appropriate safeguards against misuse. See GAO, *Recovery Act: IRS Quickly Implemented Tax Provisions, but Reporting and Enforcement Improvements Are Needed*, GAO-10-349 (Washington, D.C.: Feb. 10, 2010).

[43]We do not describe the filters and the eligibility requirements not being covered in detail because of concerns about revealing IRS's compliance approach and criteria.

Data on Forms W-2 (employees' annual Wage and Tax Statement) could provide additional data for filters once the provision in PPACA is implemented that requires employers to report the cost—including both employer and employee contributions—of certain types of health insurance provided to an employee.[44] IRS officials said the data have limited use because, among other things, they would not provide details for determining whether an employer met the credit's requirements for health insurance; therefore, IRS officials will not pursue using the data at this time. Nevertheless, the data could be used in a filter to identify claimants who reported no health insurance contributions on Form W-2 and therefore may not be offering health insurance. In the absence of other documentation or third-party reporting on health insurance, using Form W-2 data in a filter could be a cost-effective, rough indicator of whether a claimant is paying employee health insurance premiums, without increasing taxpayer burden. However, IRS provided transition relief to employers that file fewer than 250 Forms W-2 per year, and issued guidance stating that these employers will not be required to report the data until further guidance is issued. As a result, it is unlikely that the data could be useful before 2014, the year when the credit will only be available to employers for any 2 consecutive years.

Examination Instructions Cover Most Eligibility Requirements, but Gaps Exist

After the filters are run, IRS creates lists of claims to consider for further examination. SB/SE wanted enough examination cases to spot check different filters and claims from different regions, to enable them to establish a field presence and to learn about compliance risks with the credit, according to an SB/SE official.[45] Examination staff in SB/SE and TEGE are to follow a set of instructions when doing examinations.[46]

SB/SE's examination instructions address all of the credit's requirements for small businesses to claim the credit except that they do not include

[44]See 26 U.S.C. § 6051(a)(14), which generally requires employers to report the aggregate cost of employer-sponsored coverage they provide for an employee on Form W-2.

[45]TEGE established two mandatory filters that if failed, automatically trigger an exam; only 16 forms tripped these two filters, as of December 31, 2011.

[46]Examiner instructions consist of several types of documents, such as worksheets and checklists on the credit's eligibility requirements; we also refer to these documents as examination "guidance."

specific instructions for examiners on determining eligibility of claimants with non-U.S. addresses. An employer located outside of the United States with a business or trade interest in the United States may claim the credit only if the employer pays premiums for coverage issued in and regulated by one of the states or the District of Columbia. Without a prompt in examination instructions, IRS examiners may overlook claimants that do not comply with the address requirements. An SB/SE official said IRS has no instructions for examiners to review claimants with non-U.S. addresses during an examination on the credit because potential compliance problems with businesses with non-U.S. addresses exist for other tax credits. This, however, was not IRS's approach for another general business tax issue relevant to the credit—whether claimants that carry back the credit to offset tax liabilities in previous years did so properly. Near the end of our work, SB/SE added guidance to one of its examination instruction documents to cover the carry back issue.

Instructions for TEGE examiners also address most of the eligibility requirements to claim the credits, but, like SB/SE's, TEGE examination instructions do not address how to review claimants with non-U.S. addresses.[47] Further, TEGE instructions for some of the credit's requirements have less detail compared to SB/SE's instructions. TEGE's instructions provide steps on how to determine if an employer's insurance premiums paid met "qualifying arrangement" and other criteria, but they provide less detail than SB/SE instructions. For example, SB/SE guidance instructs examiners to review health insurance policies and invoices to confirm premium payments, and to review other documentation to check whether the employer offers health benefits that are not eligible for the credit. TEGE instructions do not suggest these steps and also do not provide a prompt for examiners to ensure that insurance premiums paid on behalf of seasonal employees are included in calculations.

According to IRS officials, the TEGE examiners are trained specifically for doing examinations on the credit and therefore need less guidance than SB/SE examiners, who work on multiple issues simultaneously. However, TEGE examination documents contain detailed guidance in a workbook

[47]Tax-exempt entities with non-U.S. addresses must pay health insurance premiums for an employee's coverage issued in and regulated in one of the states or the District of Columbia.

format for these trained examiners on other credit requirements. Without detailed guidance for TEGE examiners that instructs them on how to examine health insurance documents, examiners may not consistently identify noncompliance, which could lead to erroneous credit refunds. This could particularly be the case as examining health insurance documents to check eligibility for this new credit has not been typical work for these examiners.

Examinations Under Way, but IRS Needs to Develop a Plan for Efficiently Analyzing Results on Credit Compliance

For tax year 2010, SB/SE plans to conduct over 1,500 examinations related to the credit, and TEGE anticipates about 1,000 examinations. An SB/SE official said the number of examinations is expected to provide initial compliance information and allow IRS to establish a compliance presence without committing too many resources initially. TEGE selected its number of examinations based on resource decisions, before tax year 2010 claims began. Neither SB/SE nor TEGE adjusted the number of examinations once actual claim numbers were known. As a result, the percentage of TEGE claims being examined is high, according to a TEGE official. Table 1 summarizes the status of IRS's examinations on the credit.

Table 1: Examination Actions for Form 8941 as of February 2012, for Tax Year 2010

Number of:	SB/SE[a]	TEGE	Total
Examinations initiated	500	570	**1,070**
Additional examinations anticipated	1,000	430	**1,430**
Closed examinations	119	88	**207**
Closed examinations resulting in a change to the credit amount	46	22	**68**

Sources: SB/SE and TEGE officials.

[a]For examinations, SB/SE does not distinguish between examinations on business or individual claimants.

IRS's database on examination results tracks the aggregate dollar amount of tax changes as a result of the examination but does not contain the reason a change is made. Consequently, IRS is not able to isolate and analyze examination results related to the credit versus other tax issues. This is particularly a problem for SB/SE examinations, which may cover issues other than the credit.[48] Instead, as initial examinations

[48]TEGE examinations will only cover the credit, according to IRS officials.

have closed, IRS officials said that management has spoken with examiners about findings related to the credit. This has been possible because of the relatively low initial volume of cases, but this approach may not be feasible as results accumulate. Therefore, it is not clear how IRS can efficiently analyze results to decide whether changes are necessary in how it examines the credit or how it educates small employers about how to comply with the credit's rules, and whether it committed too many or too few resources to examinations of the credit.

Furthermore, IRS does not have criteria for deciding whether the resources spent on examinations of the credit are appropriate, given the amount of errors found. IRS officials said that for future years they plan to select the number of credit examinations based on past results, identified compliance risks, and available resources. However, without criteria to assess the results in concert with these risks and resources, IRS is less able to ensure that examination resources target errors with the credit, rather than examining compliant claimants.

For example, early examination results (as of February 2012) show that 67 percent of the examinations completed were closed without changing the credit amount. Examinations without a change burden taxpayers and use IRS resources. We recognize that few of the planned examinations have been completed and the "no change" percentage could change. According to IRS officials, cases resulting in "no change" tend to be the first cases closed because they close more quickly than cases requiring a change. However, IRS is not using change rate information from prior tax credits to determine if examinations for the credit have a "high" no-change rate, which could be one indicator to help decide how many examination resources to apply to the credit. IRS officials said they do not plan to use data from examinations of other tax provisions to benchmark measures—such as the no-change rate or length of time an examination is open—because results would not be comparable.

A summary of examination results specific to the credit could also inform decisions about using additional compliance tools such as soft notices.[49] In the past, IRS has used soft notices to correct errors and collect funds

[49]A soft notice is a letter generated to taxpayers that IRS has identified possible errors on the taxpayer's form. The goal is to increase compliance at minimal costs by educating taxpayers for future compliance without doing an examination and minimizing the taxpayers' need to respond to the notice.

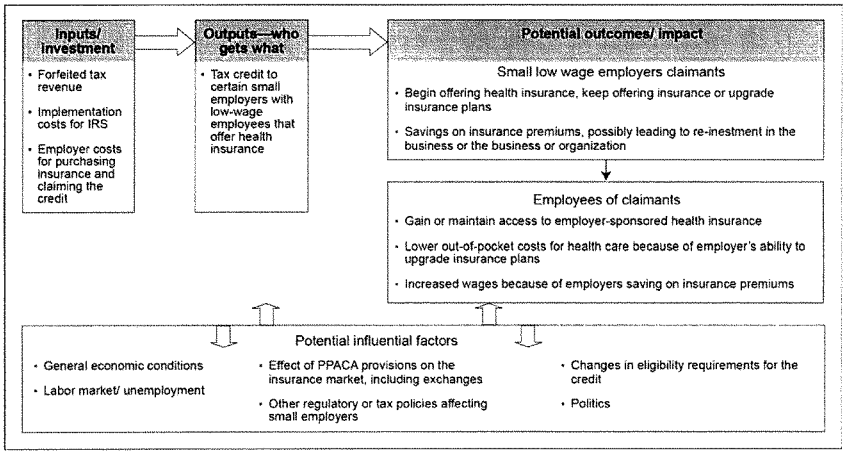
without initiating an examination.[50] A senior IRS official who is implementing the credit said IRS has not ruled out using soft notices, but examination results would need to identify an issue that would justify their use. He said soft notices are not effective for all taxpayers or situations. He said IRS would consider using soft notices if officials found a series of returns with mistakes from the same tax preparer or promoter of tax schemes. Furthermore, soft notices may necessitate follow-up, which would negate some of the advantages of the notices. If IRS analysis showed that examinations were not a cost-effective way to pursue certain errors made in claiming a credit, a soft notice may offer another approach to improving compliance with lower costs to IRS and less burden on claimants.

Data to Evaluate Many Questions about the Effects of the Credit Are Not Available

There are a variety of research questions that could be of interest to policymakers about the effects of the credit that cannot be evaluated with data currently available. Figure 5 shows how the credit may influence employer behavior and, ultimately, employees.

[50]For example, see GAO, *Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance*, GAO-07-1110 (Washington, D.C.: Aug. 10, 2007), and *Tax Gap: IRS Could Do More to Promote Compliance by Third Parties with Miscellaneous Income Reporting Requirements*, GAO-09-238 (Washington, D.C.: Jan. 28, 2009).

Figure 5: Model of Potential Outcomes and Influential Factors for the Small Employer Health Insurance Tax Credit



Sources: GAO analysis and University of Wisconsin Extension Program Development and Evaluation model.

Note: Basic model structure is based on University of Wisconsin Extension Program Development and Evaluation model, as shown in GAO-12-208G. Content and relationships among variables are based on GAO analysis of interviews with subject matter specialists, and literature review.

To answer research questions about the credits potential outcomes shown in figure 5, the following are examples of data that might be needed:

- number of small, low-wage employers offering health insurance, before and after the credit was available;
- number of employees at small, low-wage employers, who have or could obtain health insurance through their employers; and
- amount of annual health insurance premium costs for small, low-wage employers before and after the credit.

None of these data are readily available or free of limitations, which complicates an evaluation. For example, the available data on employer-sponsored health insurance do not align with the credit's eligibility criteria, according to our interviews with subject matter specialists and our review

of the data (see app. VI for a summary of the data sources), nor could we identify a data source that tracks when, and why, employers begin offering insurance. As a result of the limitations with all three types of data, it would be difficult to precisely measure changes in health insurance availability, offering, and costs because of the credit, without collecting additional data. Isolating influential factors—such as those shown in figure 5—that may contribute to the effects of the credit would also be a challenge in an evaluation.[51]

IRS officials said they will not collect data on credit claimants, outside of those collected on Form 8941. IRS's position on data collection for all provisions of the tax code is that it only collects data it needs to ensure compliance with the tax laws.[52]

Collecting additional data needed for policy evaluation would have costs, and the magnitude of those costs would depend on the type and amount of data needed, which depends on the research questions being asked. An additional consideration in thinking about the benefits and costs of additional data collection for policy evaluation purposes is the time limits on claiming the credit. The current version of the credit runs through the end of 2014.[53] Policymakers' conclusions about the questions to be answered by any evaluations of the credit's effects would determine the type of data that would need to be collected.

Conclusions

The Small Employer Health Insurance Tax Credit was intended to offer an incentive for small, low-wage employers to provide health insurance. However, utilization of the credit has been lower than expected, with the available evidence suggesting that the design of the credit is a large part of the reason why. While the credit could be redesigned, such changes

[51]For details on methods for identifying causation, including experiments and quasi-experiments, using comparison groups, see GAO, *Designing Evaluations: 2012 Revision*, GAO-12-208G (Washington, D.C.: January 2012). These designs are not feasible for the credit because it was implemented simultaneously across the country.

[52]See GAO, *Government Performance and Accountability: Tax Expenditures Represent a Substantial Federal Commitment and Need to Be Reexamined*, GAO-05-690 (Washington, D.C.: Sept. 23, 2005).

[53]Starting in 2014, eligible small employers can claim the credit for the 2 consecutive years beginning when the employer first offers employee health insurance from a state exchange.

come with trade-offs. Changing the credit to expand eligibility or make it more generous would increase the revenue loss to the federal government.

In administering the credit to ensure compliance, IRS employed a number of practices that were shown effective for other tax provisions or are consistent with IRS strategic objectives. Nevertheless, we identified several opportunities for IRS to either improve compliance or perhaps reduce the resources it is devoting to ensuring compliance. Without additional guidance for examiners on employers with non-U.S. addresses, there is a risk of improper credit claims being allowed. Without more systematic attention to early examination results, IRS could lock itself into devoting more scarce resources than needed to examinations.

Recommendations for Executive Action

To help ensure thoroughness and consistency of examinations on the credit, we recommend that the Commissioner of Internal Revenue take the following two actions:

1. Revise the SB/SE and TEGE examination instructions to include instructions for examiners on how to confirm eligibility for the credit for small employers with non-U.S. addresses.

2. Revise the TEGE examination guidance to include more detailed instructions for examiners on how to confirm that claimants properly calculated eligible health insurance premiums paid for purposes of the credit. The SB/SE examination instructions could serve as a model.

To help ensure that IRS uses its examination resources efficiently, we recommend that the Commissioner of Internal Revenue take the following two actions:

3. Document and analyze the results of examinations involving the credit to identify how much of those results are related to the credit versus other tax issues being examined, what errors are being made in claiming the credit, and when the examinations of the credit are worth the resource investment.

4. Related to the above analysis of examination results on the credit, identify the types of errors with the credit that could be addressed with alternative approaches, such as soft notices.

Agency Comments and Our Evaluation

In an April 30, 2012, letter responding to a draft of this report (which is reprinted in app. VII), the IRS Deputy Commissioner for Services and Enforcement provided comments on our findings and recommendations as well as information on additional agency efforts related to implementing the Small Employer Health Insurance Tax Credit in PPACA. IRS generally agreed with all four of our recommendations. Regarding our recommendation on examination instructions related to small employers with non-U.S. addresses, IRS stated that SB/SE will provide additional guidance in its instructions and that TEGE has added guidance to its instructions. On May 1, 2012, IRS provided a copy of the TEGE instructions, which we are reviewing. On our recommendation on revising TEGE's examination guidance, IRS's letter said that on April 13, 2012, TEGE implemented more detailed instructions in its examination guidance related to confirming proper calculations of eligible health insurance premiums paid for purposes of the credit. These instructions were also included in the TEGE document provided on May 1, 2012.

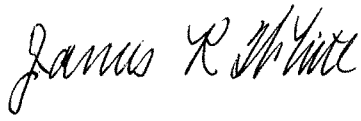
With regard to analyzing credit examination results to identify compliance issues specific to the credit, IRS said it regularly analyzes audit results to determine whether resources are expended efficiently, though its information systems do not currently capture adjustments by issue, such as this tax credit. IRS agreed to leverage existing information systems and, as appropriate, to allocate resources to manually analyze examination results. IRS said this will include, as feasible, identifying the types and amounts of errors related to the credit. We reiterate the benefit of documenting and analyzing the results of examinations involving the credit. If it does not do so, IRS will not have information for determining whether examinations of the credit are worth the resource investment.

Regarding our fourth recommendation on using examination results to determine whether alternative compliance approaches, such as soft notices, could help address errors with the credit, IRS agreed to continue to review its compliance efforts to determine whether soft notices would be appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Chairmen and Ranking Members of other Senate and House committees and subcommittees that have appropriation, authorization, and oversight responsibilities for IRS. We will also send copies to the Commissioner of Internal Revenue, the Secretary of the Treasury, the Chairman of the IRS

Oversight Board, and the Director of the Office of Management and Budget. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions or about this report, please contact me at (202) 512-9110 or at whitej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VIII.



James R. White
Director, Tax Issues
Strategic Issues

Appendix I: Scope and Methodology

To assess the extent to which the Small Employer Health Insurance Tax Credit (referred to in this report as the credit) is being claimed, we obtained and analyzed Internal Revenue Service (IRS) data on the claims on Form 8941 for tax year 2010. We interviewed responsible IRS staff and examined background materials. IRS provided a report from the Form 8941 data and we reviewed the programming code that created that report. We corroborated the results of this IRS report with a Treasury Inspector General for Tax Administration (TIGTA) report published in November and found similarities.[1] The data were found to be sufficiently reliable for our purposes. We identified estimates of employers that were potentially eligible to claim the credit by reviewing reports and websites of government agencies, think tanks, and interest groups. When possible, we interviewed officials from the government agencies and business groups that developed estimates.

To identify any factors limiting credit claims, we interviewed groups representing employers, tax preparers and insurance brokers and to assess how these factors could be addressed, we analyzed our interview results as well as relevant documents. Specifically, we spoke with representatives of the National Federation of Independent Businesses, the National Council of Nonprofits, the Small Business Majority, the U.S. Chamber of Commerce, the American Institute of Certified Public Accountants, America's Health Insurance Plans, the National Society of Accountants, the National Association of Enrolled Agents, and the National Association of Health Underwriters. We worked with some of these groups to assemble discussion groups with tax preparers, health insurance brokers, and employers to discuss potential factors and ways to address them. Discussion groups were, for the most part, telephone conferences. We also spoke with insurance and tax preparation companies, specifically, BlueCross Blue Shield of Kansas City, Independent Health of New York, H&R Block's Tax Institute, and Jackson Hewitt Tax Service. We used qualitative analysis software to do a content analysis of the interviews and discussion group comments.

To provide additional support for discussion group and interview findings we reviewed documents and, where possible, we identified data from IRS, the 2010 Medical Expenditure Panel Survey, or the 2011 Kaiser

[1]TIGTA, *Affordable Care Act: Efforts to Implement the Small Business Health Care Tax Credit Were Mostly Successful, but Some Improvements Are Needed*, 2011-40-103 (Washington, D.C.: Sept. 19, 2011).

Family Foundation Health Benefits Survey. At IRS, we interviewed officials from the Small Business/Self-Employed Division (SB/SE), including officials in the Communications and Liaison Office; the Tax Exempt and Government Entities Division (TEGE); the Research and Analysis for Tax Administration division, and the Taxpayer Advocacy Service.

To assess how fully IRS is ensuring that the tax credit is correctly claimed by eligible employers, we reviewed IRS's compliance plan and filters and instructions for IRS staff conducting examinations, and compared these documents with compliance practices used for prior tax provisions and found in IRS strategic objectives.[2] We also highlighted any gaps between filters and examination instructions and the credit's eligibility rules. We reviewed the filter results for tax year 2010 claims and interviewed SB/SE and TEGE officials about compliance efforts.

To assess what would be needed to evaluate the effects of credit, we conducted a literature review and interviewed representatives of the forenamed groups and subject matter specialists from government, academia, research foundations and think tanks. We selected the specialists based primarily on our literature review and spoke with individuals at the University of Massachusetts, Boston; Massachusetts Institute of Technology; the Commonwealth Fund; the Urban Institute; the Kaiser Family Foundation; the American Enterprise Institute; the Employee Benefit Research Institute; the RAND Corporation; the Small Business Administration Office of Advocacy; and the Office of Tax Policy at the Department of the Treasury. We reviewed available data in commonly cited surveys with questions on employer health insurance, and identified how the questions and variables match to the eligibility criteria for the credit.

We conducted this performance audit from July 2011 through May 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

[2]For example, see GAO, *Tax Refunds: Enhanced Prerefund Compliance Checks Could Yield Significant Benefits*, GAO-11-691T (Washington, D.C.: May 25, 2011).

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: State Average Premiums for Small Group Markets for 2010 and 2011

The Small Employer Health Insurance Tax Credit is based on a percentage of the lesser of (1) the premiums paid by the eligible small employer for employees during the taxable year and (2) the amount of premiums the employer would have paid if each employee were enrolled in a plan with a premium equal to the average premium for the small group market in the state (or in an area in the state) in which the employer is offering health insurance. The Secretary of Health and Human Services determines whether separate average premiums will apply for areas within a state and also determines the average premium for a state or substate area. Table 2 shows the average premiums for the small group market in each state for tax years 2010 and 2011.

Table 2: State Average Premiums for Small Group Markets for 2010 and 2011

	2010		2011	
	Employee only (single plan)	Family plan	Employee only (single plan)	Family plan
Alabama	$4,441	$11,275	$4,778	$12,084
Alaska	6,204	13,723	6,729	14,701
Arizona	4,495	10,239	4,614	11,063
Arkansas	4,329	9,677	4,378	9,849
California	4,628	10,957	4,790	11,493
Colorado	4,972	11,437	5,007	12,258
Connecticut	5,419	13,484	5,640	14,096
Delaware	5,602	12,513	5,902	13,411
District of Columbia	5,355	12,823	5,721	14,024
Florida	5,161	12,453	5,218	12,550
Georgia	4,612	10,598	5,085	11,440
Hawaii	4,228	10,508	4,622	11,529
Idaho	4,215	9,365	4,379	10,066
Illinois	5,198	12,309	5,565	13,176
Indiana	4,775	11,222	5,262	12,097
Iowa	4,652	10,503	4,694	11,051
Kansas	4,603	11,462	4,693	11,909
Kentucky	4,287	10,434	4,456	10,560
Louisiana	4,829	11,074	5,143	11,911
Maine	5,215	11,887	5,261	12,255
Maryland	4,837	11,939	5,073	12,530
Massachusetts	5,700	14,138	5,900	15,262
Michigan	5,098	12,364	5,195	12,539

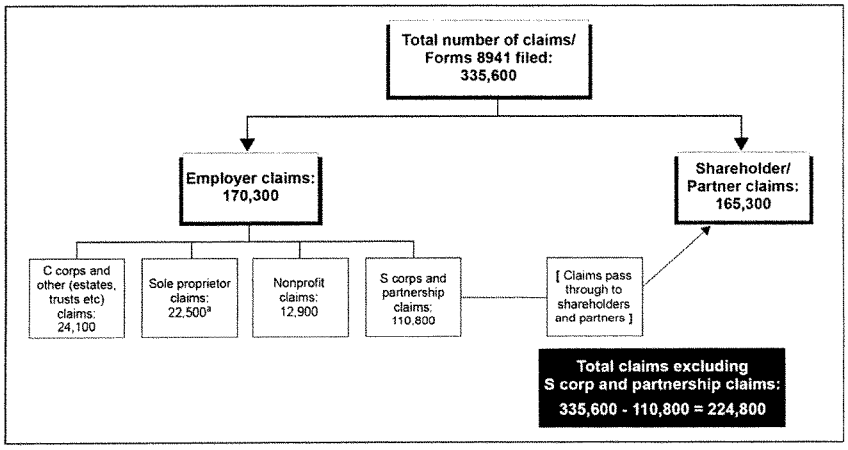
	2010		2011	
	Employee only (single plan)	Family plan	Employee only (single plan)	Family plan
Minnesota	4,704	11,938	5,048	12,790
Mississippi	4,533	10,501	4,787	10,860
Missouri	4,663	10,681	4,843	11,379
Montana	4,772	10,212	4,923	10,789
Nebraska	4,715	11,169	5,130	12,057
Nevada	4,553	10,297	4,781	10,836
New Hampshire	5,519	13,624	5,858	14,523
New Jersey	5,607	13,521	5,868	14,093
New Mexico	4,754	11,404	5,146	12,328
New York	5,442	12,867	5,589	13,631
North Carolina	4,920	11,583	5,136	11,949
North Dakota	4,469	10,506	4,545	11,328
Ohio	4,667	11,293	4,706	11,627
Oklahoma	4,838	11,002	4,922	11,200
Oregon	4,681	10,890	4,881	11,536
Pennsylvania	5,039	12,471	5,186	12,671
Rhode Island	5,887	13,786	5,956	14,553
South Carolina	4,899	11,780	5,036	11,780
South Dakota	4,497	11,483	4,733	11,589
Tennessee	4,611	10,369	4,744	11,035
Texas	5,140	11,972	5,172	12,432
Utah	4,238	10,935	4,532	11,346
Vermont	5,244	11,748	5,426	12,505
Virginia	4,890	11,338	5,060	12,213
Washington	4,543	10,725	4,776	11,151
West Virginia	4,986	11,611	5,356	12,724
Wisconsin	5,222	12,819	5,284	13,911
Wyoming	5,266	12,163	5,430	12,867

Source: Department of Health and Human Services and IRS information.

Appendix III: Adjustments in Counting Total Small Employer Claims and Total Credit Amount Claims for Tax Year 2010

Internal Revenue Service (IRS) data for tax year 2010 show 335,600 total claims filed. This total must be adjusted to avoid counting the 110,800 S corporation and partnership claims that were passed through to 165,300 respective shareholders and partners who then filed their claims separately. Excluding the 165,300 shareholder and partner claims filed leaves 170,300 small employer claims filed. To capture the number of credit amounts claimed and avoid the amounts that were claimed by the S corporations and partnerships as well as their respective shareholders and partners, we excluded the 110,800 S corporation and partnership claims to arrive at 224,800 credit amounts claimed. (See fig. 6.)

Figure 6: Number of Credit Claims by Taxpayer Type, Tax Year 2010

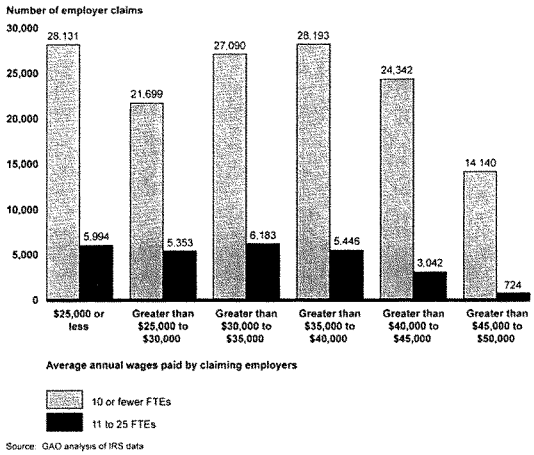


Source: GAO analysis of IRS data

Note: Numbers rounded to the nearest hundred.

[a]Also included in this group are single member owners of disregarded limited liability corporations.

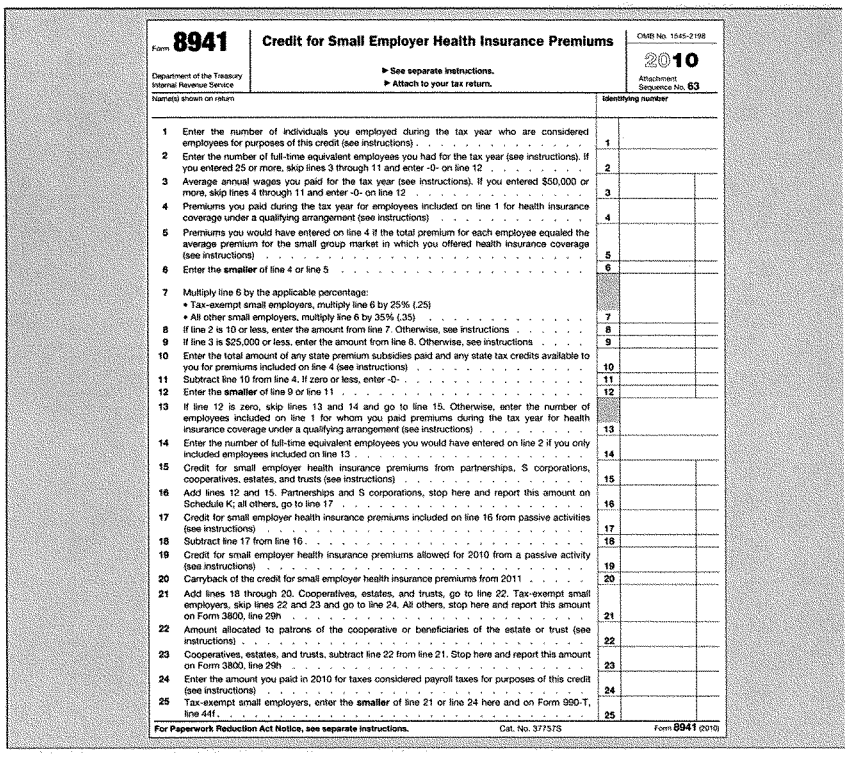
Appendix IV: Credit Claims by Employer Size and Wages Paid, Tax Year 2010



Source: GAO analysis of IRS data

Appendix V: Form 8941 and Worksheets for Claiming the Small Employer Health Insurance Tax Credit

This appendix contains the noninteractive Form 8941 and worksheets, shown in figure 4 in the letter.



Form **8941** — **Credit for Small Employer Health Insurance Premiums**

Department of the Treasury
Internal Revenue Service

▶ See separate instructions.
▶ Attach to your tax return.

OMB No. 1545-2198

2010

Attachment Sequence No. 63

Name(s) shown on return | Identifying number

1	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions)	1	
2	Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12	2	
3	Average annual wages you paid for the tax year (see instructions). If you entered $50,000 or more, skip lines 4 through 11 and enter -0- on line 12	3	
4	Premiums you paid during the tax year for employees included on line 1 for health insurance coverage under a qualifying arrangement (see instructions)	4	
5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions)	5	
6	Enter the **smaller** of line 4 or line 5	6	
7	Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 25% (.25) • All other small employers, multiply line 6 by 35% (.35)	7	
8	If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions	8	
9	If line 3 is $25,000 or less, enter the amount from line 8. Otherwise, see instructions	9	
10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	10	
11	Subtract line 10 from line 4. If zero or less, enter -0-	11	
12	Enter the **smaller** of line 9 or line 11	12	
13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1 for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (see instructions)	13	
14	Enter the number of full-time equivalent employees you would have entered on line 2 if you only included employees included on line 13	14	
15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	15	
16	Add lines 12 and 15. Partnerships and S corporations, stop here and report this amount on Schedule K; all others, go to line 17	16	
17	Credit for small employer health insurance premiums included on line 16 from passive activities (see instructions)	17	
18	Subtract line 17 from line 16	18	
19	Credit for small employer health insurance premiums allowed for 2010 from a passive activity (see instructions)	19	
20	Carryback of the credit for small employer health insurance premiums from 2011	20	
21	Add lines 18 through 20. Cooperatives, estates, and trusts, go to line 22. Tax-exempt small employers, skip lines 22 and 23 and go to line 24. All others, stop here and report this amount on Form 3800, line 29h	21	
22	Amount allocated to patrons of the cooperative or beneficiaries of the estate or trust (see instructions)	22	
23	Cooperatives, estates, and trusts, subtract line 22 from line 21. Stop here and report this amount on Form 3800, line 29h	23	
24	Enter the amount you paid in 2010 for taxes considered payroll taxes for purposes of this credit (see instructions)	24	
25	Tax-exempt small employers, enter the **smaller** of line 21 or line 24 here and on Form 990-T, line 44f	25	

For Paperwork Reduction Act Notice, see separate instructions. Cat. No. 37757S Form **8941** (2010)

Source: IRS.

Worksheet 1. Information Needed To Complete Line 1 and Worksheets 2 and 3

If you need more rows, use a separate sheet and include the additional amounts in the totals below.

(a) Individuals Considered Employees	(b) Employee Hours of Service	(c) Employee Wages Paid
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
Totals:		

Worksheet 2. Full-Time Equivalent Employees (FTEs)

1. Enter the total employee hours of service from Worksheet 1, column (b) . . . . . 1. _____
2. Hours of service per FTE 2. 2,080
3. **Full-time equivalent employees.** Divide line 1 by line 2. If the result is not a whole number (0, 1, 2, etc.), generally round the result down to the next lowest whole number. However, if the result is less than one, enter 1. Report this amount on Form 8941, line 2 . . . . . 3. _____

Worksheet 3. Average Annual Wages

1. Enter the total employee wages paid from Worksheet 1, column (c) . . . . . 1. _____
2. Enter FTEs from Worksheet 2, line 3 . . . 2. _____
3. **Average annual wages.** Divide line 1 by line 2. If the result is not a multiple of $1,000 ($1,000, $2,000, $3,000, etc.), round the result down to the next lowest multiple of $1,000. Report this amount on Form 8941, line 3 . . . . . 3. _____

Source: IRS

Worksheet 4. Information Needed To Complete Lines 4 and 5 and Worksheet 7

If you need more rows, use a separate sheet and include the additional amounts in the totals below.

(a) Enrolled Individuals Considered Employees	(b) Employer Premiums Paid	(c) Employer State Average Premiums	(d) Enrolled Employee Hours of Service
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
Totals:			

Worksheet 5. FTE Limitation

1. Enter the amount from Form 8941, line 7 . . 1. _____
2. Enter the amount from Form 8941, line 2 . . . . . 2. _____
3. Subtract 10 from line 2 . . . . . 3. _____
4. Divide line 3 by 15. Enter the result as a decimal (rounded to at least 3 places) . . . . . 4. _____
5. Multiply line 1 by line 4 . . . . . 5. _____
6. Subtract line 5 from line 1. Report this amount on Form 8941, line 8 . . . . . 6. _____

Worksheet 6. Average Annual Wage Limitation

1. Enter the amount from Form 8941, line 8 . . . 1. _____
2. Enter the amount from Form 8941, line 7 . . . . . 2. _____
3. Enter the amount from Form 8941, line 3 . . . . . 3. _____
4. Subtract $25,000 from line 3 . . . . 4. _____
5. Divide line 4 by $25,000. Enter the result as a decimal (rounded to at least 3 places) . . . . . 5. _____
6. Multiply line 2 by line 5 . . . . . 6. _____
7. Subtract line 6 from line 1. Report this amount on Form 8941, line 9 . . . . . 7. _____

Worksheet 7. FTEs Enrolled in Coverage

1. Enter the total enrolled employee hours of service from Worksheet 4, column (d) . . 1. _____
2. Hours of service per FTE 2. 2,080
3. Divide line 1 by line 2. If the result is not a whole number (0, 1, 2, etc.), generally round the result down to the next lowest whole number. However, if the result is less than one, enter 1. Report this amount on Form 8941, line 14 . . . . . 3. _____

Source: IRS.

Appendix VI: Publically Available Data on Small Employer Health Insurance

Through our literature review and interviews, we identified several commonly cited non-Internal Revenue Service data sources on employer health insurance. Each source has different variables related to the key eligibility requirements for the Small Employer Health Insurance Tax Credit. Table 3 summarizes each source, its basic methodology, and whether its data matches with these requirements for the credit. The table only considers data that are readily accessible in public-use data sets.

Table 3: Publically Available Data on Small Employer Health Insurance

	Employer Health Benefits Survey	Medical Expenditure Panel Survey (Insurance Component)	National Compensation Survey
Sources and methodology			
Organizations responsible for the survey	Kaiser Family Foundation and Health Research and Educational Trust	Department of Health and Human Services, Agency for Healthcare Research and Quality	Bureau of Labor Statistics
Frequency and contact method	Annual, conducted by phone	Annual, generally conducted by phone or mail	Annual, conducted by personal visits, mail, telephone, and e-mail
Unit of analysis, sample size and source	Employers—2,088 from Dun and Bradstreet and the Census of Governments	Employers[a]—38,409 private sector establishments from U.S. Census Bureau's Business Register	Employers;[b] 15,566 private industry establishments from state unemployment insurance reports
Response rate and most recent data, as of April 2012	Forth-seven percent in 2011	Eighty-three percent for private establishments in 2010	Fifty-six percent for private industry in 2011
Key eligibility requirement for the credit, and whether the source contains data			
Employer is a for-profit or tax-exempt entity	Yes	Yes	Yes[c]
Employer offers health insurance and pays at least 50 percent of premiums	Yes	Yes	Yes
Employer has fewer than 25 full-time equivalents (FTE)	No—number of employees	No—number of employees	No—number of employees, from 1 to 49, and number of full- and part-time employees
Average annual wages are less than $50,000 per FTE	No—percentage of full-time employees who make $23,000 or less per year	No—percentage of employees who earned wages in one of three categories[d]	No—wages are presented in five percentiles[e]

Source: GAO analysis of data sources.

[a]The Medical Expenditure Panel Survey's Insurance Component sample is drawn at the establishment level; an establishment is a particular workplace or location.

[b]The National Compensation Survey sample is drawn at the establishment level; an establishment is a single economic unit that engages in one, or primarily one, type of economic activity. It is usually a single physical location.

[c]Statistical models used by the National Compensation Survey are able to control for profit/non-profit status.

[d]The annual wage categories are about (1) $23,920 or less, (2)$23,920 to $54,080, and (3) $54,080 or more.

[e]Wage data are presented in percentile categories in the published data. The annual wage categories, for private industry workers, are about: (1) 10th percentile makes $17,160 or less, (2) 25th percentile makes $22,235 or less, (3) 50th percentile makes $33,009 or less, (4) 75th percentile makes $51,605 or less, and (5) the 90th percentile makes $78,811 or less.

Appendix VII: Comments from the Internal Revenue Service

DEPUTY COMMISSIONER

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

April 30, 2012

Mr. James R. White
Director, Tax Issues
Strategic Issues Team
United States Government Accountability Office
Washington, DC 20548

Dear Mr. White:

Thank you for the opportunity to review your draft report entitled, "Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity (GAO-12-549, Job Code 450922). As your report notes, the IRS conducted significant outreach to ensure that eligible small businesses are aware of the credit, and have the information that they need to claim it.

With respect to your specific recommendations, the IRS agrees that more detailed instructions to examiners and more detailed data about examination results would be helpful improvements to our program. The enclosed response addresses each recommendation separately.

If you have questions, please contact me, or a member of your staff may contact Faris Fink, Commissioner, Small Business/Self-Employed Division at (202) 622-0600.

Sincerely,

Steven T. Miller
Deputy Commissioner for Services and Enforcement

Enclosure

Enclosure

GAO Recommendations and IRS Responses to GAO Draft Report
Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity
GAO-12-549

Recommendation: Revise the SB/SE and TEGE examination instructions to include instructions for examiners on how to confirm eligibility for the credit for small employers with a non-U.S. address.

Comments: We agree with this recommendation. Although a foreign address does not necessarily reflect ineligibility for the credit, we agree that when a foreign address is listed, the examiner should take special care to ensure that the requirements for the credit are satisfied. SB/SE instructions and a current job aide explain that eligibility for the credit requires that health care premiums are paid to a U.S. regulated insurance carrier and that the credit is applied to a U.S. federal tax liability. SB/SE will supplement existing guidance to highlight this area and provide additional information for auditing this issue. TEGE has also developed and implemented additional examination instructions for examiners on how to confirm eligibility for the credit for small employers with a non-U.S. address. These additional instructions for examiners are based upon published guidance.

Recommendation: Revise the TEGE examination guidance to include more detailed instructions for examiners on how to confirm that claimants properly calculated eligible health insurance premiums paid, for purposes of the credit. The SB/SE examination instructions could serve as a model.

Comments: We agree with this recommendation. TEGE has revised its written examination guidance to include more detailed instructions for examiners on how to confirm that claimants properly calculated eligible health insurance premiums paid, for purposes of the credit. These revisions were based upon SB/SE examination instructions and were implemented on April 13, 2012.

Recommendation: Document and analyze the results of examinations involving the credit to identify how much of those results are related to the credit versus other tax issues being examined, what errors are being made in claiming the credit, and when the examinations of the credit are worth the resource investment.

Comments: We agree with this recommendation. We regularly analyze audit results to determine whether resources are being expended efficiently. Currently, our information systems do not capture adjustments by issue. However, we will leverage existing information systems and, as appropriate, allocate resources to manually analyze examination results to optimize our compliance efforts. This will include, as feasible,

identifying what errors taxpayers are making in claiming the credit and how much of the examination results relate to the tax credit as opposed to other tax issues.

Recommendation: Related to the above analysis of examination results on the credit, identify the types of errors with the credit that could be addressed with alternative approaches, such as soft notices.

Comments: As noted above, the Service continuously strives to improve its compliance efforts. It uses all tools at its disposal—including soft notices—to promote compliance with the least burden to the taxpayer and the Service. We will continue to review our compliance efforts to determine whether the use of soft notices would be appropriate.

Appendix VIII: GAO Contact and Staff Acknowledgments

GAO Contact	James R. White, (202) 512-9110 or whitej@gao.gov
Staff Acknowledgments	In addition to the contact named above, Thomas Short, Assistant Director; Susan Baker; Amy Bowser; Ellen Grady; George Guttman; Donna Miller, Ruben Montes de Oca, Edward Nannenhorn; Robert Gebhart; Crystal Robinson; Cynthia Saunders; and Lindsay Swenson made key contributions to this report.

Massachusetts Health Reform Spending, 2006-2011: An Update on the "Budget Buster" Myth

We would like to recognize Alan G. Raymond as the principal author of this report.

Funding for this report was provided by the Blue Cross Blue Shield of Massachusetts Foundation.

MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011: AN UPDATE ON THE "BUDGET BUSTER" MYTH

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MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011: AN UPDATE ON THE "BUDGET BUSTER" MYTH

Overview

Six years after Massachusetts enacted its groundbreaking health reform law, Chapter 58 of the Acts of 2006, more than 98 percent of the state's residents have health insurance, access to needed care has improved, and the percentage of employers offering coverage to their workers has climbed despite the national recession.

The gains of health reform have been achieved without placing an unexpected or unmanageable burden on the state's budget. Annual spending for programs affected by Chapter 58 grew from $1.041 billion in fiscal 2006 to $1.947 billion in fiscal 2011, an increase of approximately $906 million (Table 1). The state's share of this spending increase is $453 million, or 50 percent of the total. While critics periodically claim that health reform has been a "budget buster," additional state spending attributable to the health reform law accounted for only 1.4 percent of the Commonwealth's $32 billion budget in fiscal 2011.

Over the five full fiscal years since the law was implemented, the incremental additional state cost per year has averaged $91 million, an amount that is well within projections made prior to the law's enactment.[1] These figures are consistent with the findings in the Taxpayers Foundation's 2009 report, *Massachusetts Health Reform: The Myth of Uncontrolled Costs.*

Table 1: Spending on Health Care Reform (Fiscal 2006-2011, in millions)

Program	2006	2007	2008	2009	2010	2011	Total Change 2006-2011	State Share of Change
Commonwealth Care and Commonwealth Care Bridge	$0	$133	$628	$805	$749	$835	$835	$442
MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases	$0	$224	$355	$569	$399	$391	$391	$196
Health Safety Net Trust Fund	$656	$665	$416	$417	$420	$420	$(236)	$(118)
Supplemental Payments to Medicaid MCOs	$385	$0	$0	$0	$0	$0	$(385)	$(193)
Supplemental Payments to Safety Net Hospitals	$0	$287	$287	$287	$307	$301	$301	$125
Total	**$1,041**	**$1,309**	**$1,686**	**$2,078**	**$1,875**	**$1,947**	**$906**	**$453**

[1] Four months before enactment of the law, the Massachusetts Taxpayers Foundation recommended that the state earmark an additional $100 million per year for implementation of health reform (*Health Care Reform: Expanding Access Without Sacrificing Jobs.* December 2005).

Key Provisions of the Law

Based on the concept of "shared responsibility" among government payers, employers, and individuals, the programs and incentives in the 2006 Massachusetts health reform law have worked in concert to expand access to affordable coverage while encouraging enrollment in employer-sponsored and individual health insurance plans.[2]

As Table 1 indicates, the calculation of spending for health reform does not start at zero in 2006 because the state's investment in expanded coverage for low-income adults and children had, in fact, begun almost a decade earlier. In 1997, Massachusetts was granted a federal Section 1115 "research and demonstration" waiver that gave the state greater flexibility to develop health insurance programs for low-income adults and children, with roughly half of the dollars for subsidized coverage coming from federal matching funds.[3] This led to the creation of MassHealth, a public insurance program that includes both Medicaid and the Children's Health Insurance Program (CHIP). Even earlier, the state had set up an Uncompensated Care Pool to pay hospitals and community health centers for certain types of medical services provided to low-income residents who were uninsured or underinsured.

In 2005, federal and state officials agreed on the terms of a renewed Section 1115 MassHealth waiver that provided the financial underpinnings for health reform, based on the premise that state and federal money that was funding uncompensated care should be redirected to provide subsidized health insurance coverage for low-income uninsured residents. To accomplish this, the health reform law created a new public health insurance program called Commonwealth Care for low-income adults who do not have access to employer-sponsored health insurance or Medicaid. The law also expanded and restored certain categories of MassHealth coverage for adults and children and transformed the Uncompensated Care Pool into the Health Safety Net Trust Fund, with new eligibility and payment rules.

The health reform law also created a quasi-public agency – the Commonwealth Health Insurance Connector Authority – to oversee the Commonwealth Care program and act as an "insurance exchange" through which individuals and small businesses may purchase unsubsidized, private health insurance plans that meet state standards for adequacy of coverage and overall value.

The most debated provision of the law, nationally if not in Massachusetts, is the individual mandate – a requirement that all Massachusetts residents 18 and older obtain health insurance if affordable coverage is available to them, or be subject to a state income tax penalty. And while lawmakers rejected creating an equivalent employer mandate, employers with 11 or more full-time equivalent employees are required to pay a "fair share assessment" to the state if they do not make a "fair and reasonable contribution" to their employees' coverage. The amount of the assessment, $295 per employee, is based on the estimated cost of uncompensated care for employees who work for employers that do not meet the fair and reasonable contribution standard.

[2] An annotated text of Chapter 58 of the Acts of 2006 is available at bluecrossfoundation.org.

[3] Section 1115(a) of the Social Security Law allows states to obtain "research and demonstration" waivers from the federal government to experiment with new ways of structuring and running their Medicaid programs. These waivers are time limited, usually for 3 to 5 years, and renewable if the U.S. Department of Health and Human Services and the state can reach agreement on terms and conditions.

What Has Massachusetts Health Reform Accomplished?

The positive impact of health reform on access to coverage and needed care has been documented through numerous studies and reports.* The most recent data show that:

- Health insurance coverage is nearly universal in Massachusetts. Fewer than two percent of residents lack health insurance, compared with a nationwide average of more than 16 percent uninsured.
- Expanded coverage has been accompanied by improved access to needed care, especially among middle and low-income residents, racial and ethnic minorities, and people with chronic diseases.
- Seventy-seven percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2010, up seven percentage points since 2005. This compares with 69 percent of employers offering health coverage to their workers nationwide.
- Surveys consistently find that about two-thirds of residents support Massachusetts health reform, the same as when the law passed in 2006.
- The affordability of health care, which was not directly addressed by the health reform law, remains a concern for many residents. More than a quarter of adults reported that their health care spending in 2010 had caused financial problems, including the need to cut back on health care services and other spending or to reduce savings.

**The Blue Cross Blue Shield of Massachusetts Foundation is a sponsor of the Massachusetts Health Reform Survey, which has been conducted annually by the Urban Institute since fall 2006. Results of this research and a five-year progress report on health reform are among the comprehensive resources available at bluecrossfoundation.org.*

Increases in State Spending

Commonwealth Care

As an entirely new program, Commonwealth Care accounts for the largest increase in state spending for health reform—approximately $442 million of the increase between fiscal 2006 and fiscal 2011 (Table 1). The program uses a combination of state funds and the federal matching dollars available through the state's MassHealth waiver to provide income-based premium subsidies for adult residents earning up to 300 percent of the federal poverty level (Appendix B). As a condition of eligibility, the applicant cannot have access to employer-sponsored health insurance or Medicaid coverage. The state enrolls Commonwealth Care members in private health plans that are selected through an annual procurement process conducted by the Health Connector. Approximately half of all Commonwealth Care members pay a partial premium and half pay no premium.

Most of the enrollment and spending growth in Commonwealth Care occurred during the first two years after the program's launch in mid-2006 thanks to a comprehensive outreach, education, and enrollment effort by state agencies, community organizations, and providers that serve low-income residents.

Enrollment in the program has leveled off, although the numbers for the next fiscal year will increase because of a court-ordered change in eligibility rules for documented immigrants. At the outset of health reform, policymakers decided to include low-income, documented immigrants in Commonwealth Care even though the federal government does not provide matching funds for this population. However, when the state was faced with a severe revenue shortfall in mid-2009 as a result

of the national recession, the governor and Legislature agreed to stop new enrollment of documented immigrants in Commonwealth Care and developed a scaled-back coverage plan called Commonwealth Care Bridge for those already enrolled. Advocates mounted a court challenge, and in January 2012 the Massachusetts Supreme Judicial Court ruled that the cutbacks were an unconstitutional denial of equal protection. As a result, the state is restoring full Commonwealth Care coverage to an estimated 40,000 eligible immigrants – approximately 13,000 will be transferred from Commonwealth Care Bridge, with the remainder coming from a waiting list. In fiscal 2014, federal matching funds for coverage of documented immigrants are due to become available under the provisions of the Patient Protection and Affordable Care Act.

MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases

Although MassHealth (Medicaid and CHIP) spending has grown significantly since 2006, an estimated three quarters of the increase in enrollment has been in categories that predated the 2006 law and would have occurred in the absence of reform.[4] Table 1 shows that the five-year increase in the state's share of MassHealth spending that can be attributed directly to provisions in the health reform law was $196 million.

When health reform was enacted, about one million residents were receiving MassHealth coverage, but cutbacks during a prior state budget crisis had resulted in a loss of coverage for certain categories of low-income residents that had once been eligible for membership. The reform law restored eligibility and reopened enrollment for several of these categories, which include people living with HIV/AIDS, adults and children with disabilities, and the long-term unemployed. In addition, the law raised the family income ceiling for CHIP eligibility from 200 percent of the federal poverty level (FPL) to 300 percent. This allowed the state to take full advantage of federal matching dollars and close the remaining gaps in coverage for low-income uninsured residents.

In addition to these eligibility changes, the health reform law included a three-year increase in MassHealth provider reimbursement rates. Without some relief from historically low MassHealth payments, physicians and hospitals would have faced a growing financial burden as MassHealth membership rose. Business groups, concerned that continued government underpayment would result in greater cost shifting to the private sector in the form of higher premiums, supported the increases as well. The health reform law increased MassHealth provider payment rates by approximately $90 million per year for fiscal years 2007, 2008, and 2009, but the recession led to state budget cuts that have effectively eliminated the increases. As a result, the shortfall in MassHealth payments to providers has returned to pre-reform levels.

Supplemental Payments to Safety Net Hospitals

The health reform law included special provisions to assist the two Massachusetts hospitals that had traditionally provided the highest level of free care to uninsured patients, Boston Medical Center and Cambridge Health Alliance. As Table 1 indicates, the hospitals received $287 million in annual supplemental payments for three years, starting in fiscal year 2007, to help them through the transition to providing more insured care to their low-income patients and to support their continued role as safety net providers for a disproportionate share of people who remain uninsured or under-insured. The two hospitals faced the prospect of significant financial losses after the health reform law's three-year authorization of supplemental payments expired, but the state was able to secure an amendment to the MassHealth waiver that allowed supplemental payments to continue in fiscal 2010 and 2011.

[4] Massachusetts Medicaid Policy Institute. *Growth in MassHealth Enrollment Since Reform*. May 2011.

Decreases in State Spending

Uncompensated Care Pool/Health Safety Net Trust Fund

A major premise behind the Section 1115 MassHealth waiver renewal that preceded enactment of health reform was that the added costs of expanding public health insurance coverage would be largely offset by reductions in spending for uncompensated care that would occur as previously uninsured residents enrolled in Commonwealth Care or other coverage. As Table 1 illustrates, annual state spending for uncompensated care dropped by $118 million over the first five years of reform.

Annual Health Safety Net (HSN) spending fell by one-third from fiscal 2006 to fiscal 2008, reflecting a more than 50 percent decline in the number of inpatient discharges and outpatient visits for which HSN payments were made during that period. Since fiscal 2008, the use of the HSN has trended back up as a result of the economic downturn, but it is still well below pre-reform levels (Appendix C). Another factor contributing to the increased use of the HSN was the 2009 change in Commonwealth Care coverage for documented immigrants described earlier. The combined effects of a freeze on new enrollment and the scaled-back benefits in the Commonwealth Care Bridge program meant that an increasing number of low-income documented immigrants were uninsured or underinsured, and therefore eligible for the HSN.

The Health Safety Net is funded through a combination of assessments on acute care hospitals and surcharges on payments made by insurers and self-insured employers for hospital and ambulatory surgery services, and state and federal funds available through the MassHealth waiver. The private sector contributions are fixed at $320 million annually. The state's contribution is subject to appropriation, and, as Table 1 indicates, combined state and federal spending did not increase from fiscal 2010 to fiscal 2011 despite an increase in HSN use during that period. When the amount owed to providers for safety net care exceeds the amount of HSN funds available, the shortfall is distributed among hospitals using a formula that is intended to cushion the impact for the hospitals that care for most of the state's uninsured and underinsured residents. The shortfall is estimated at $134 million in fiscal 2012 and at least that amount in fiscal 2013.

Supplemental Payments to Medicaid Managed Care Organizations

The 1997 MassHealth waiver that triggered the first round of expanded public coverage for low-income adults and children led to the creation of Medicaid managed care organizations (MCOs) operated by the state's two largest safety net hospitals, Boston Medical Center (at the time called Boston City Hospital) and Cambridge Health Alliance (formerly Cambridge City Hospital). The waiver authorized additional financial support in the form of supplemental payments to the MCOs because they were expected to enroll a disproportionate number of people with complex medical and social needs, while at the same time accepting payments for members that would be less than the hospitals had received for providing uncompensated care. The MCO supplemental payments, which totaled $385 million in fiscal 2006, were eliminated as part of the waiver renewal that preceded the health reform law, but Massachusetts was allowed to retain the federal dollars to help fund expanded insurance coverage for low-income, previously uninsured individuals.[5] Table 1 shows that the net effect on state spending for health reform was a reduction of approximately $193 million.

[5] Stephanie Anthony, J.D., M.P.H., Robert W. Seifert, M.P.A., Jean C. Sullivan, J.D. Center for Health Law and Economics, University of Massachusetts Medical School. *The MassHealth Waiver: 2009-2011 ... and Beyond.* February 2009.

Conclusion

Summarizing the net effect of the increases and reductions in state spending that can be attributed to the 2006 health reform law, this analysis shows that incremental state spending attributable to the law was approximately $453 million, or 1.4 percent of the state's $32 billion budget in fiscal 2011. The average annual increase in state spending for health reform between fiscal 2006, prior to implementation of the law, and fiscal 2011, which ended on June 30, 2011, was just under $91 million.

The 2006 health reform law was designed to expand access to affordable coverage, not to address the cost of care. It did, however, help trigger a series of legislative, regulatory, and private sector initiatives directed at controlling the state's historically high costs, and there is early evidence that a transformation is underway, centered around provider payment reform. A majority of the state's primary care physicians are now participating in health plan contracts based on some form of "global payment," which rewards the quality and efficiency of care rather than quantity, and several long-term contracts between health plans and hospital systems have been renegotiated at lower rates of payment. Payment reform has, in turn, been an added catalyst for hospital systems and physician groups to invest in better coordination of care and in improving outcomes for their sickest patients. In addition, Massachusetts has seen the rapid proliferation of health insurance products that allow employers and consumers to save money by using lower-cost providers or by choosing limited provider networks.

It would be premature to claim that the state's historically high health care costs have been tamed, but there are encouraging signs of progress. For example, in the latest round of proposed premiums for the merged health insurance market for small businesses and non-group individuals, health plans sought average increases of just two to three percent, compared with increases of 15 to 20 percent two years ago. Although the trend of slower premium growth is currently a nationwide phenomenon and may be, in part, a function of the economic recession, Massachusetts is experiencing a notably slower rate of growth than the national average. In fact, recent data show that family premiums for private, employer-sponsored coverage in Massachusetts fell by an average of nearly one percent from 2009 to 2010, while the country as a whole saw a six percent increase. As a result, the state's ranking for family premiums fell from the highest in the country in 2009 to ninth place in 2010. Similarly, individual premiums for Massachusetts workers rose by just 2.8 percent in 2010 versus 5.8 percent for the nation as a whole.[6]

Governor Deval Patrick and the leaders of the Massachusetts House and Senate have said they expect to approve some form of cost containment legislation in 2012 that would accelerate reform of provider payment and health care delivery and set the stage for sustainable reductions in the underlying trend. If passed, it would build on a 2008 law that created a process to examine the causes of the state's high health care costs, and a 2010 law aimed primarily at giving small businesses more options for managing their health insurance bills. While the state's private sector stakeholders hold divergent views on some of the issues under consideration, the broad coalition of providers, health plans, business groups, and consumer advocates that formed during the first round of health reform has remained engaged and united around the shared goals of expanding access to coverage, improving quality and outcomes of care, and reducing the growth of health care spending.

[6] C. Schoen, A. Fryer, S. Collins, and D. Radley, *Realizing Health Reform's Potential*, The Commonwealth Fund, November 2011, and MTF analysis of data from the Agency for Healthcare Research and Quality.

Appendix A

Methodology

Estimates of government spending attributable to the 2006 Massachusetts health reform law are based on a Massachusetts Taxpayers Foundation analysis of data provided by the Commonwealth's Executive Office for Administration and Finance.

The state share of health reform spending was calculated using a conservative assumption that federal support was 50 percent, even though the actual federal match was temporarily increased during FY2009, 2010, and 2011 by the American Recovery and Reinvestment Act, thereby reducing the state share during those years. MTF's estimates account for the fact that the state has paid the full cost of Commonwealth Care, and subsequently Commonwealth Care Bridge coverage, for eligible documented immigrants (see page 4). The Supplemental Payments to Safety Net Hospitals category includes special federal payments that did not require a state share because they were funded through Intergovernmental Transfers (see page 4).

The Foundation's analysis does not include adjustments for the rate of health care inflation from 2006 to 2011, which was significantly higher than the overall rate of inflation. As a result, the effect of health reform on state spending is most likely less than the data indicate. It should also be noted that, starting in fiscal 2009, the economic recession became a factor in driving health reform spending as more residents became eligible for MassHealth and Commonwealth Care.

Appendix B

Federal Poverty Level Guidelines

Gross Annual Income Limit: Effective March 1, 2012 – February 28, 2013

Family Size	100% of FPL	300% of FPL
1	$11,170	$33,510
2	$15,130	$45,390
3	$19,090	$57,270

Source: U.S. Department of Health and Human Services

Appendix C

Health Safety Net Use
Since Health Reform (in thousands)

	2006*	2007	2008	2009	2010
Hospitals	1,613	1,184	715	703	800
Community Health Centers	446	342	262	287	312
Total HSN Use**	2,059	1,526	977	990	1,112

** Prior to health reform, the HSN was called the Uncompensated Care Pool (UCP).*
*** Health Safety Net use includes hospital inpatient discharges, hospital outpatient visits, and community health center outpatient visits. Health Safety Net use fell dramatically during the first two years of reform, then started an upward trend that continued into HSN fiscal 2011.*

Source: Division of Health Care Finance and Policy: Health Safety Net/Uncompensated Care Pool annual reports

Statement of Congressman Gerald E. Connolly
Committee on Oversight and Government Reform
July 10, 2012

Once again the Republican majority on the Committee on Oversight and Government Reform has convened a hearing to score political points under the guise of conducting legitimate oversight and thoughtful reform. Coming one day before House Republicans hold their 31st vote to repeal the Patient Protection and Affordable Care Act, it appears this hearing will function as a de facto press conference for unsubstantiated accusations to be lobbed against these important reforms.

Lest anyone be mistaken that today's proceedings are an honest, fact-based examination of the Affordable Care Act's impact on businesses and the economy, I would simply note that Republicans have already revealed the fix is in. In holding 31 duplicative votes to repeal all or part of the Affordable Care Act, while simultaneously admitting that they actually agree with the majority of its popular provisions, such as protecting Americans with preexisting health conditions, or allowing young adults to stay on their parent's health insurance plan until they are 26, Republicans have revealed that this debate is nothing but crass politics.

Just last week, when asked in an interview, "why not then, if you like some of the provisions in the Affordable Care Act, why not work with them (Democratic Members of Congress), rather than repeal the whole thing?" the Speaker of the House flat out rejected working in a civil, bipartisan, and productive manner to improve healthcare for all Americans, preferring to dig in his heels and hold steady in his extremist and erroneous position that the Affordable Care Act must be "ripped out by its roots," because it is the "government taking over the entire health insurance industry." I would respectfully remind the Speaker and my colleagues that the latter statement is grossly inaccurate and received the dubious honor of being named Politifact's 2010 Lie of the Year.

So I ask my colleagues on the other side of the aisle, what is the majority trying to accomplish with this political hearing? Can Republicans on this Committee truly claim they are interested in reforming health care to more efficiently serve the American people, when they waste taxpayer dollars on "examining" the impact of legislation they already have deemed to be so terrible, it must be "ripped out by its roots"? If that is the case, then where are your proposed alternatives?

We need to move on and address the real challenges facing our economy, such as unemployment, or the pending expiration of numerous individual and business tax cuts. Certainly a majority of Americans believe it's time to move on to the true pressing challenges facing our Nation, according to a recent Kaiser Family Foundation poll.

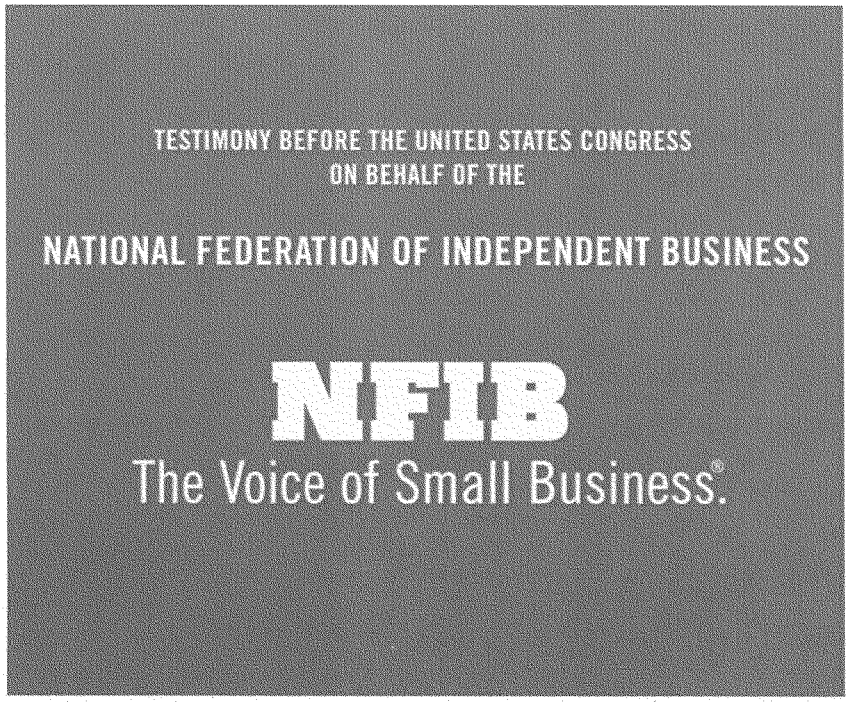
Lost in this political charade is the fact that the Affordable Care Act is actually working! Seniors who fall in the prescription drug donut hole are saving an average of $651 this year alone as a

result of new reforms. Almost 13 million Americans are eligible for rebates averaging $151 from their insurance companies thanks to new requirements that more of your premium dollars be spent on actual health care, rather than administrative costs. Premiums for Medicare Advantage are down 7 percent and enrollment is up 10 percent, while Medicare is on track to save $200 billion by 2016. Contrary to what critics of the Affordable Care Act forecast, both programs are on stronger footing today thanks to the health care reform law.

In response to business concerns about the impact on the bottom line of offering insurance coverage to employees, we have to look no further than Massachusetts – where former Governor Romney championed similar reforms – to see the economic impacts of the Affordable Care Act. If the dire predictions of Republicans were true, then one would expect that following the passage of the Massachusetts Health Care Reform law, the State's economy would have cratered and its businesses would have laid off workers. Unfortunately for my friends on the other side of the aisle, the Massachusetts case study clearly dispels their narrative and exposes their economic analysis as anything but factually based.

But don't take my word for it, as one of the witnesses for today's hearing notes in his prepared testimony, after Governor Romney signed the health reforms into law, including an individual mandate and health exchanges, "unemployment in Massachusetts has dropped from 8 percent in 2009 to 5.8 percent in May of this year," the State "ranks 8th in the nation in job creation this year, adding 37,800 new jobs through May," and "Since January 2007, Massachusetts ranks third in the nation in economic performance, as defined by our gross state product."

I do hope we will further discuss those impacts even if they do fall outside the scope of the majority's narrative. Thus far, House Republicans have conveniently ignored real world evidence and facts. This Congress, this Committee, has considerably more pressing business to attend to – whether it's addressing the expiration of individual and corporate tax rates, or promoting innovative technology policy to achieve better services and savings – and that is what we ought to be collaborating on, rather than conducting political theater in support of yet another repeal vote.



Statement for the Record for the

House Committee on Oversight and Government Reform

Examining the Impact of Obamacare on Job Creators and the Economy

July 10, 2012

National Federation of Independent Business (NFIB)
1201 F Street, NW Suite 200
Washington, DC 20004

The National Federation of Independent Business (NFIB) appreciates the opportunity to submit this statement for the record for the Committee on Oversight and Government Reform hearing entitled "Examining the Impact of Obamacare on Job Creators and the Economy." NFIB is the nation's leading small business advocacy organization representing over 350,000 small business owners across the country, and we appreciate the opportunity to provide our perspective.

NFIB has long supported healthcare reforms that lower the cost of providing health insurance to employees and increase health insurance flexibility for small business. Unfortunately, the Patient Protection and Affordable Care Act (PPACA or Obamacare) went the opposite direction. PPACA did little to address small business' number one concern – the skyrocketing cost of health insurance.

Increased mandates, taxes, and requirements will only drive up the cost of health insurance for individuals and small businesses. Beginning in 2014, small businesses with 50 or more full-time equivalent employees will be required to provide insurance or pay a penalty. This employer mandate provides a strong disincentive to grow above the 50 full-time equivalent employee threshold and provides a powerful incentive to shrink below the threshold in order to avoid the mandate, shift full-time employees to part-time hours, or drop coverage altogether. All of the potential scenarios are unappealing, especially during a time when unemployment remains stubbornly high.

The largest tax increases contained within PPACA will fall on small businesses, as well, making it more difficult to purchase health insurance. The small business health insurance tax – a $102 billion tax increase in the first ten years following inception that will continue to grow as premiums increase – falls exclusively on products sold in the full-insured market, where individuals and small businesses purchase their coverage. According to the Joint Committee on Taxation (JCT), "a very large portion of the insurance industry fee to be passed forward to purchasers of insurance in the form of higher premiums... We estimate that the premiums would be between 2.0 to 2.5 percent greater than they otherwise would be... Eliminating this fee could decrease the average family premium in 2016 by $350 to $400." The Congressional Budget Office (CBO) and Medicare Actuary have also qualified that the tax will be passed along to purchasers in the form of higher premiums. The NFIB Research Foundation estimates this tax will reduce private-sector employment by 125,000 to 249,000 jobs in 2021, with 59 percent of the losses coming from small business.

Other poorly designed taxes will disproportionately hit individuals and small businesses including the individual mandate tax, increased payroll and investment taxes, and limitations on flexible-spending arrangements (FSAs) and health savings accounts (HSAs). None of these tax increases make health insurance more affordable or flexible for individuals and small businesses.

New requirements have already increased premiums, but forthcoming requirements could exacerbate costs and are currently creating layers of uncertainty for small businesses. The Essential Health Benefits (EHB) package will provide new benefit mandates to only the individual and small group markets. EHB is a list of ten mandated benefit categories from the

statute, combined with additional mandated benefits that states wish to require. While the cost and comprehensiveness of this package is far from certain, it is certain that the cost will be higher than what many individuals and small businesses currently offer.

NFIB continues to support full repeal of PPACA, based on feedback and surveys from our membership. A recent NFIB Member Ballot demonstrates this with 93% of NFIB members believing that Congress should repeal the law. However, the pre-PPACA world was also unacceptable to small businesses. NFIB members continue to support reforms that will lower the cost of health insurance. Solutions begin with increasing free-market competition – historically the best path to lowering costs and ultimately increasing coverage.

Insurers should be encouraged through state and federal approaches to offer more creative insurance options in the small group and individual market. In turn, small business owners and employees need more flexibility to build plans that suit unique needs and budgets. Free-market competition should also eliminate the current arbitrary lines of state boundaries that small businesses face when trying to secure health insurance options. There is little justification why big businesses can purchase across state lines and small businesses cannot.

Similarly, making health insurance truly portable will improve competition and enhance individual control. Employees should be able to keep their plans when they change jobs, allowing them to own and control their policies in the same way they own and control their auto insurance, property insurance and life insurance.

Another option that should be part of any future reform effort is the idea of putting individuals in control of the kind of health insurance they want to purchase. This can be done even through the current employer system by providing a pre-tax account to an employee where the employer contributes an amount of pre-tax dollars towards the purchase of insurance, removing barriers of entry to providing health insurance. We also need to ensure fair tax treatment by extending tax parity to any purchaser in the health insurance marketplace, whether you are an individual, self-employed or an employer.

Thank you again for the opportunity to provide comments on this important matter. NFIB remains eager to work with members of the Committee on Oversight and Government Reform on reforms that truly lower the cost of providing health insurance to our nation's small business job creators.

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