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S. HRG. 114–258

THE AFFORDABLE CARE ACT AT FIVE YEARS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

MARCH 19, 2015



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

20–034—PDF WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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CONTENTS

OPENING STATEMENTS

	Page
Hatch, Hon. Orrin G., a U.S. Senator from Utah, chairman, Committee on Finance	1
Wyden, Hon. Ron, a U.S. Senator from Oregon	3

WITNESSES

Holtz-Eakin, Douglas, Ph.D., president, American Action Forum, Washington, DC	5
Wade, Holly, director of research and policy analysis, National Federation of Independent Business, Washington, DC	7
Blumenthal, David, M.D., M.P.P., president, The Commonwealth Fund, New York, NY	8

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Blumenthal, David, M.D., M.P.P.:	
Testimony	8
Prepared statement	37
Responses to questions from committee members	54
Hatch, Hon. Orrin G.:	
Opening statement	1
Prepared statement	57
Holtz-Eakin, Douglas, Ph.D.:	
Testimony	5
Prepared statement	58
Responses to questions from committee members	62
Wade, Holly:	
Testimony	7
Prepared statement with attachment	64
Wyden, Hon. Ron:	
Opening statement	3
Prepared statement	110

COMMUNICATION

Markell, Hon. Jack A.	113

THE AFFORDABLE CARE ACT AT FIVE YEARS

THURSDAY, MARCH 19, 2015

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:31 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Roberts, Cornyn, Thune, Burr, Portman, Coats, Heller, Scott, Wyden, Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, and Casey.

Also present: Republican Staff: Chris Campbell, Staff Director; Kimberly Brandt, Chief Healthcare and Investigative Counsel; Preston Rutledge, Tax Counsel; and Jill Wright, Detailee. Democratic Staff: Joshua Sheinkman, Staff Director; Jocelyn Moore, Deputy Staff Director; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Advisor; Juan Machado, Professional Staff Member; and Anne Dwyer, Professional Staff Member.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Good morning. Our hearing today will consider what has happened in the 5 years since March 23, 2010, when the so-called Affordable Care Act was signed into law. In my opinion, this anniversary presents a perfect opportunity to take a look back and evaluate whether promises that were made to gain support for the law have been kept. It is also a good time to look forward and consider the many unanswered questions that we still have about the impact and viability of the ACA.

At the time that the Affordable Care Act was enacted, there was great disagreement about whether it would effectively reduce costs or expand coverage. Five years later, the people of Utah, and others whom I hear from, are in total agreement about one thing with respect to this law: it just is not working. In fact, it is, by most objective accounts, an unmitigated disaster.

The President and his allies claim that the law is a success, usually by cherry-picking particular data points and ignoring the larger picture. Most often, they point to the number of individuals who have signed up for health insurance since the botched roll-out of the *HealthCare.gov* website, somehow arguing that people opting to buy insurance under the threat of the government penalty is cause for celebration. What they do not talk about are the still-skyrocketing health care costs that are hitting families across this

country, and they also ignore the widespread frustration and delay caused by this law, which many Americans are finding out about during this tax filing season.

Let us talk about that frustration. According to H&R Block, in the first 6 weeks of this tax filing season, 52 percent of customers who enrolled in insurance through the State or Federal exchanges had to repay a portion of the advanced premium tax credit that they received under Obamacare. That same report found that individuals, on average, are having to repay about $530, which is decreasing their tax refunds by roughly 17 percent.

Now, let us talk about delay. On February 20, 2015, the Obama administration announced that, due to an error in the health law, they sent out about 800,000 incorrect tax statements related to Form 1095–A, meaning that hundreds of thousands of Americans may be seeing delays in their tax refunds this year.

Now, these are just some of the problems hardworking taxpayers are facing as they try to deal with Obamacare during this tax season. While the ramifications to taxpayers are significant, the overall impact on America's budget is even greater. The total overall cost of Obamacare so far has numbered in the tens of billions of dollars, and we are barely through the first phases of implementation. Unfortunately, a significant portion of that money resulted in no benefit whatsoever to the taxpayers.

Specifically, an analysis done by my staff shows that in just five areas, over $5.7 billion went to projects which added no value to the taxpayers. That is $5.7 billion down the drain. Taxpayers have been left on the hook for funds that were doled out for Obamacare to States, corporations, and contractors, with little to no accountability.

The following five examples are some of the most egregious. One, failed State exchanges. According to the Congressional Research Service, $1.3 billion in taxpayer funds have been spent on State exchanges that failed and were never operational,

Two, Consumer Oriented and Operated Plans, or CO-OPs. The Centers for Medicare and Medicaid Services has loaned $2.4 billion to 24 CO-OPs, one of which failed before it enrolled anyone. Taxpayers are set to lose nearly half of this money from default or artificially low interest rates. CMS has no plans to recoup any of the funds, meaning a total cost to taxpayers of around $1 billion.

Three, the *HealthCare.gov* website. The Obama administration's website became a preexisting condition for many Americans who were forced to purchase insurance on the broken site or face a fine. Despite fixes to *HealthCare.gov*, the total cost of the failed enrollment system surpassed $2 billion.

Four, Serco. This contractor was awarded $1.2 billion to manage paper applications during the first enrollment period of the health care law; however, only a handful of the total applications received were paper applications, leaving Serco employees with little to do. The waste was so apparent that a whistleblower who worked at the company reached out to the *St. Louis Post Dispatch*, saying, "I feel guilty for working there as long as I did. It was like I was stealing money from people."

Five, marketplace navigators. The administration spent over $120 million on the navigator program for the 2014 and 2015 open

enrollment periods. The purpose of the navigators is to provide individuals with information about health insurance, including signing up for the health insurance marketplace. The Kaiser Family Foundation estimates 2015 marketplace enrollment at approximately 11 million individuals. The overall value of the navigator program is at best inconclusive, and at worst it represents more waste of taxpayer dollars.

Now, these five examples are just a handful of the countless misguided, poorly defined, and poorly implemented aspects of the Affordable Care Act. We mark the 5-year anniversary that passes today, but it is certainly no cause for celebration.

[The prepared statement of Chairman Hatch appears in the appendix.]

The CHAIRMAN. I do want to thank our witnesses for appearing today to help discuss the impacts of this law, and I look forward to what I am sure will be a spirited discussion.

I would now like to turn it over to my partner, Senator Wyden, for his opening remarks.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Chairman and colleagues, my first choice for this morning's hearing would be to get past the well-worn talking points and begin to find bipartisan ways to improve the Affordable Care Act. There is not a law in the history of legislation that cannot be improved.

What I have tried to do in my time in public service, particularly in health care, is to try to find bipartisan approaches, building on principles that both sides feel strongly about. That is simply, in my view, the best use of our time. Unfortunately, it looks like it is going to take a rear-guard action to keep from going back to the dark days when America's health care system basically worked just for the healthy and the wealthy. Just this week, we have seen proposals that would rip the law up by the roots.

Gone would be the guarantee of coverage that protects Americans who have preexisting conditions. Gone would be the tax credits that help working families to pay for health insurance. Back would be insurance company skullduggery that forces Americans to pay top dollar for rock-bottom coverage. Back would be locking out adopted children from their parents' insurance plans. Back would be the prospect of having insurance canceled the moment an American got sick. Back would be pregnancy being considered a preexisting condition.

There are not any legitimate alternative legislative proposals that address these issues. In the last 5 years, Congress has taken more than 50 votes to undermine or repeal the Affordable Care Act and not one on legislation that comprehensively replaces it.

The non-stop campaign that I have described to undercut the law is just bad news for Oregonians like Beth Stewart. She is a mother of three from La Grande, OR who had to pick out an insurance policy after a career change in 2003. The plan she chose had a $7,500 deductible. A few years later, Beth was diagnosed with Stage 4 thyroid cancer, and it had spread to her spine. On her road to recov-

ery, she twice hit her out-of-pocket limit. Her medical bills grew to the tens of thousands of dollars. She worked hard to pay them off, but every year her check-ups cost thousands of dollars more. Last year she was finally able to buy a new health insurance plan that has given her, in her words, a welcomed safety net. Her deductible is now a tenth of what it was before the Affordable Care Act. Her out-of-pocket maximum has been cut by nearly half. For this Oregonian, staying healthy while supporting a family is a lot less expensive.

Kim Schmith is a resident of Madras, OR in her late 40s. Kim won a battle against breast cancer 6 years ago. Her husband is going to go on Medicare this year, and Kim will have to pick out an insurance plan of her own. She wrote my office about how she was once worried that being a cancer survivor meant she would never be able to find insurance. Under Federal law before the Affordable Care Act, an insurance company could have taken just one look at Kim's medical history and stamped her application "denied." Now with this law, she has some peace of mind. She can find an affordable, high-quality health insurance plan. She does not have to panic or over-pay for bargain-basement coverage. As she wrote me, "I fought for my life. I should not have to fight for insurance." That, in my view, is something that Democrats and Republicans ought to agree on right at the outset.

As I mentioned in my first paragraph, there is not a law in history that cannot be improved on. But the pie-in-the-sky insistence that the Affordable Care Act is just going to be repealed and somehow everything is going to come out fine has no basis in reality. It is time to recognize the real-world consequences of this dysfunctional, old political battle. The debate is no longer about numbers on a page. More than 16 million Americans have gained health insurance coverage thanks to the Affordable Care Act. Their health is at stake in every single vote for repeal.

So again, I will tell my colleagues that I am willing to meet both sides at least halfway. That is what I have done on health policy really since my days when I was director of the Gray Panthers. We make progress by working in a bipartisan fashion rather than bringing back yesteryear when the health care system was for the healthy and wealthy.

Mr. Chairman, again, I just want to say I would very much like to work with you in a bipartisan way, and I look forward to hearing from our colleagues.

The CHAIRMAN. Well, thank you, Senator. I hope we can.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Our first witness is Dr. Douglas Holtz-Eakin, president of the American Action Forum. Dr. Holtz-Eakin was the Director of the Congressional Budget Office from 2003 to 2005, and, prior to that, he was the Chief Economist of the President's Council of Economic Advisors.

Dr. Holtz-Eakin, we are sure happy to have you here. It is a pleasure to have you join with us today. We look forward to your testimony.

Our next witness is Ms. Holly Wade, director of research and policy analysis for the National Foundation of Independent Business.

Ms. Wade produces the monthly small business economic trend survey with NFIB's chief economist. Previously, she worked for the National Conference of State Legislatures.

We certainly welcome you, Ms. Wade, and look forward to hearing from you today.

Finally, our last witness is Dr. David Blumenthal, president of The Commonwealth Fund. Dr. Blumenthal was formerly a professor of medicine at Harvard Medical School and chief health information and innovation officer at Partners Health Care System in Boston. He was previously a practicing primary care physician, so we are really happy to have you here, Dr. Blumenthal, and we appreciate you joining us today.

We will start with Dr. Holtz-Eakin first.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, Ph.D., PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Chairman Hatch, Ranking Member Wyden, members of the committee, thank you for the privilege of appearing today to discuss the Affordable Care Act. You have my written statement. Let me just make a few introductory comments, and I look forward to your questions.

The ACA is a sweeping law with vast impacts. It is hard to summarize them in a short fashion, as a result. But at the heart of it was a promise for affordable health insurance and high-quality health care, and I would argue that the ACA has failed to meet that promise and wasted valuable dollars in the process.

If you look at affordability, I think one of the least-discussed but most important aspects is the fact that the ACA was passed and implemented at a time when the U.S. economy was not delivering increases in incomes to middle-class America. There is nothing about the ACA, with its $500 billion in new taxes, its $1-trillion new entitlement spending program, and its vast regulatory burden, that is a pro-growth policy. It hurt the ability of Americans to meet all their needs, including the purchase of health insurance.

The ACA promised to reduce insurance premiums: $2,500 for the average family, estimates of $3,000 for employers. In contrast, we have seen premiums spike for many Americans; in my written testimony, we document that. We have also seen increases in their out-of-pocket cost, so the affordability that was promised simply was not delivered.

Embedded in the ACA are taxes which raise the cost of insurance—the Health Insurance Tax, the Medical Device Tax—all of which will be passed along to consumers in the form of higher premium costs, and regulations that raise the cost. The essential health benefits, a very unnecessarily rich package, and the community rating and other rating band issues, all serve to raise premium costs for many Americans.

Fundamentally, the ACA did not bend the so-called cost curve. If you look at the pieces of the ACA which were intended to do that, the Pioneer Accountable Care Organizations, the Medicare shared savings programs, these are all disappointments and did not deliver the promised reduction in the cost of quality care.

I also believe that the ACA has endangered some of the existing high-quality programs that the Federal Government provides.

There are sharp cuts in Medicare Advantage. Medicare Advantage is not a perfect program, but it is clearly the one thing that is not fee-for-service medicine. Everyone on both sides of the aisle has agreed that fee-for-service medicine is the problem in America, and the ACA has endangered the one program we have which is a bridge to the future and is not fee-for-service medicine.

It did the same thing with home health. The home health programs in Medicare apply to our most vulnerable seniors. They have been very effective at keeping those seniors out of hospitals, where they often end up being sicker than when they started—and at great expense. I believe the combination of the cuts to these things have really hurt the quality of the Medicare program and will be increasingly hurting it going forward, and I would urge the committee to reverse those cuts.

Lastly, there are a lot of wasted dollars in this. The chairman mentioned *HealthCare.gov*, well documented, a nearly billion-dollar expenditure for something that did not work. There are many failed State exchanges, I can attest from personal experience. I actually had the employees of the American Action Forum buy insurance this year through the Shop Exchange in DC. It was a horrific experience, and we should get our money back for that; it does not work.

There are big concerns about erroneous payments in the Affordable Care Act, which the chairman mentioned at the outset. We did some research. If you think about the structure of the subsidies, they are a refundable tax credit. The closest program we have to that in operation is the Earned Income Tax Credit, where the payment error rate is about 20 percent, 21 percent. If the same error rate applies to the ACA, we are going to have erroneous payments of about $150 billion over the next 10 years. It is an enormous waste of money, and I would argue the ACA is more complicated than the EITC. Much more information is required to be matched and submitted correctly. I think the error rate is quite likely to be much higher yet.

We have excessive subsidies due to the cost of the premiums themselves. This is a big burden on the taxpayer. The ACA relied far too heavily on using Medicaid expansions as the route for coverage instead of reforming Medicaid, which I would argue would be the right route forward. So, pouring more money into a program without reforms seemed like an unwise choice.

I do not think anyone should question the intent of the drafters of the ACA. There was an agreement at that time that spanned the ideological spectrum that America needed a health care reform that provided affordable insurance options to every American and high-quality care at a lower cost. That was indeed the goal, but this law did not deliver.

I look forward to answering your questions. Thank you.

The CHAIRMAN. Well, thank you, Dr. Holtz-Eakin.

[The prepared statement of Dr. Holtz-Eakin appears in the appendix.]

The CHAIRMAN. Ms. Wade, we will take your testimony at this time.

STATEMENT OF HOLLY WADE, DIRECTOR OF RESEARCH AND POLICY ANALYSIS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC

Ms. WADE. Good morning, Chairman Hatch, Ranking Member Wyden, and members of the Senate Finance Committee. Thank you for the opportunity to testify today on the Affordable Care Act at 5 years.

The NFIB Research Foundation recently published the second of a three-part health insurance longitudinal survey titled, "Small Business's Introduction to the Affordable Care Act, Part II." The objective of the three surveys is to measure the impact of the ACA on small business owners and the small group health insurance market. The following are a few highlights from our survey.

The cost of health insurance is the most critical issue facing small business owners. It is the main reason owners do not offer employer-sponsored health insurance and the main reason owners discontinue providing the benefit. For those offering, many owners annually confront the arduous task of adjusting profit expectations, insurance plans, cost sharing, and other mechanisms to help absorb often erratic changes in total premium costs.

Unfortunately, the ACA does little to alleviate these problems 5 years into its implementation and, in most cases, contributes to the ongoing frustration small employers face in offering health insurance. The survey found that the ACA exacerbates market turmoil, evidenced by the large numbers of policy cancellations, shifting renewal dates to obtain better rates, changes in employer cost sharing, and adoption of different, although not necessarily more desirable, health insurance plans.

Small business owners have also encountered repeated delays and confusion over major components of the law, including the SHOP exchange marketplaces, the Small Business Health Care Tax Credit, the employer mandate, and financial reimbursement options. All of the above are generating an uncertain and costly environment for many small business owners navigating the health insurance options for themselves and their employees.

Two of the ACA's hallmark small business provisions, the SHOP exchange marketplace and Small Business Health Care Tax Credit, were established to provide cost relief and to offer a transparent, competitive marketplace for employers purchasing in the small group market. Unfortunately, both have provided little relief for those offering, or an incentive to offer for those who do not. Currently, only a few States have fully operational SHOP exchange marketplaces, and for those States that do, they are finding little interest among small employers or their insurance agents. Small employers typically find no reason to visit the websites. Just 13 percent of small employers visited *HealthCare.gov* to look for individual insurance, 4 percent for business insurance, and 8 percent for both.

The Small Business Health Care Tax Credit is a targeted approach to help curb health insurance costs for offering small employers and was intended to provide an incentive for those that do not to start offering. However, the tax credit was largely ineffective on both fronts, as its design is exceedingly restrictive, complicated, and only offers temporary relief to a larger small business cost

problem. The tax credit now serves as a windfall for the few who qualify and take the time, or pay an accountant, to file for it.

While most small employers believe they are generally familiar with the health care law, many are still discovering new ways in which the laws impacts them. For instance, the law prohibits employers from reimbursing or otherwise providing financial support to employees in order to help them pay for individually purchased insurance plans. However, our survey found that about 18 percent of small employers offered this benefit last year and are now in violation of the law. NFIB continues to receive calls from owners, generally after having talked to their CPA or insurance agent, confused about the new rules prohibiting the practice and the substantial harsh penalties.

In conclusion, the ACA's potential benefits for small employers have not materialized 5 years into enactment. Instead, the small employer experience more often consists of increased levels of uncertainty and frustration related to changes in the small group health insurance market and rules associated with the employer mandate.

Thank you for the opportunity to summarize the findings of our survey. I look forward to answering any questions you may have.

The CHAIRMAN. Well, thank you.

[The prepared statement of Ms. Wade appears in the appendix.]

The CHAIRMAN. Dr. Blumenthal, we will take your testimony.

STATEMENT OF DAVID BLUMENTHAL, M.D., M.P.P., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. BLUMENTHAL. Thank you, Chairman Hatch, Senator Wyden, members of the committee, for this invitation to testify about the Affordable Care Act at 5 years. My name is David Blumenthal. I am president of The Commonwealth Fund, which is a nonpartisan health care philanthropy. As you noted, Senator, I was a practicing primary care physician for over 35 years.

The Commonwealth Fund and other sources demonstrate that the Affordable Care Act is helping to reduce the number of Americans who are uninsured and to improve access to health care. Currently, more than 25 million Americans are estimated to have health insurance under provisions of the Affordable Care Act; 11.7 million have selected a plan through the insurance marketplaces; an additional 10.8 million have enrolled in Medicaid or the Children's Health Insurance Program, or CHIP; and nearly 3 million more young adults are now covered under their parents' plans compared to 2010.

As a result, the number of uninsured has fallen. This week, the U.S. Department of Health and Human Services reported that 16.4 million previously uninsured people had gained coverage since the law passed in 2010. Similar gains in coverage have been documented in a number of government and private-sector surveys. Furthermore, the groups that historically have had the greatest difficulty getting access to insurance—young men and women and adults with low or moderate incomes—have experienced among the greatest gains in coverage.

To see how the newly insured are faring with their marketplace coverage, The Commonwealth Fund conducted a survey of these

adults in the second quarter of 2014. We found that three-quarters of the newly insured were satisfied with their insurance; a majority had already used their new plans to get health care, with most saying they could not have afforded or accessed this care previously. Most people who had tried to find a new doctor reported being able to do so with relative ease. Among all working-age adults, the percentage reporting not being able to get needed care because of the cost of care fell from 2012 to 2014, from 43 percent to 36 percent, a decline of 14 million people nationwide.

Overall, health plans sold in the insurance marketplaces created under the ACA appear to be relatively affordable. The majority of consumers with marketplace coverage have reported it being "very" or "somewhat easy" to pay their premiums. The Federal and State insurance marketplaces have also turned out to be quite stable and competitive. Nationwide, marketplace premiums did not increase at all, on average, from 2014 to 2015. This is unprecedented, in light of historical trends in the small group and private insurance market. The number of insurance carriers participating in the marketplaces also grew by 25 percent.

States have had considerable flexibility in implementing the Affordable Care Act's coverage reforms, and, as a result, the people in different States have experienced the law very differently. The most significant source of variation involves the decision to expand eligibility for Medicaid. Twenty-two States have not yet expanded Medicaid, though six of those are discussing ways to do so.

An unforeseen occurrence with implications for the Affordable Care Act has been the slow-down in the rate of health care spending growth in recent years. Partly in response, the Congressional Budget Office recently lowered its projections for the net Federal cost of the Affordable Care Act coverage provisions by an additional $142 billion over the period 2016 to 2026.

The 160 million people who have their coverage through an employer are also benefitting from new protections, like the ability to stay on a parent's health plan through age 25, or preventive care, which is now covered without cost sharing.

It is important to remember that the Affordable Care Act is not just about coverage, it is also about health system reform. The new Center for Medicare and Medicaid Innovation, for example, has launched an array of initiatives involving changes to health care payments and organization that together reach thousands of hospitals, tens of thousands of clinicians, and millions of patients across all 50 States. These reforms are incremental so far. I actually disagree with Dr. Holtz-Eakin about their track record to date. Most impressive to me is the fact that the number of hospital-acquired conditions has dramatically fallen from 2010 to 2013. As a clinician, I have seen people die from these. Seventeen thousand fewer lives have been lost as a result of these initiatives, and $12 billion has been saved.

At the 5-year mark, there is strong evidence that the Affordable Care Act has resulted in gains in coverage, affordability, and access to health care services. It may also have created the foundation for significant improvements in the way we deliver care and in the quality of care that we provide.

Taken together, a promising picture emerges. Five years, however, is a short time for a law of this comprehensiveness and impact, and additional studies and evaluations will undoubtedly be necessary to ascertain the full impact of the law over time.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Doctor.

[The prepared statement of Dr. Blumenthal appears in the appendix.]

The CHAIRMAN. Let me just ask this question to our panel about an aspect of the ACA that concerns me greatly, and that is the Consumer Oriented and Operated Plans, or CO-OPs, experiment.

Now, how does not setting premiums appropriately harm all consumers in a market? In some States, do traditional health insurers pay assessments that then fund paying the claims of the failed CO-OP, so really all consumers in a market are impacted, not just those in the failed CO-OP? Now, CO-OPs had a dismal track record in 2014; nearly all had negative cash flow in the first three quarters.

How likely is it that CO-OPs turn the corner and offer stable coverage and repay their loans, and is there a need for higher scrutiny and oversight of pricing and enrollment in CO-OPs to protect Americans from losing their plans and taxpayer dollars? Was it irresponsible of OPM to certify some of the CO-OPs to sell multi-State plan products?

Now, a recent S&P report found that net losses from the first three quarters of 2014 ranged from $2.9 million to $39.8 million, and the same report found the percentage of premiums that goes toward paying medical claims was "hopelessly high" for several CO-OPs.

With these alarming figures in mind, what steps should the States and the Federal Government take to protect consumers as we monitor the stability and viability of these CO-OPs? Now, that is a lot of questions, but we will start with you, Dr. Holtz-Eakin, and then move across the table.

Dr. HOLTZ-EAKIN. Well, as you said, Mr. Chairman, the track record to date is quite poor. The CO-OPs are not successful in pricing their products effectively, they are losing money, and in some cases have gone bankrupt. That clearly spills over to everyone in the marketplace, because other insurers will have to raise premiums to cover the cost of those losses, whether it is through the risk corridor program or through other State-based mechanisms.

To my eye, the CO-OPs have a bad set of incentives. It is generally bad incentive to operate with someone else's money, and these are funded by taxpayers and not by equity investors in these programs. They have restrictions on their business models—the inability to advertise, for example—pricing restrictions, and what they do with their earnings.

They appear unable to effectively compete, so it seems to me that the Congress faces a decision point where either they are modified to be able to compete effectively, or it would be unwise to allow them to use any more taxpayer dollars, because they are simply not going to be able to succeed. I think that is really the juncture at which we find ourselves.

The CHAIRMAN. All right.

Ms. Wade?

Ms. WADE. I will pass.

The CHAIRMAN. You will pass.

Doctor?

Dr. BLUMENTHAL. Mr. Chairman, the CO-OP is an experiment. Often CO-OPs are the only insurance programs in the markets in which they operate. Some have not done well; some have done better. The CO-OPs are modeled on a very, very popular and successful form of insurance, such as the Group Health Cooperative of Puget Sound, in which consumers have a very important role in governance. Some of these are among the most successful Medicare Advantage plans that are celebrated, justifiably, by advocates of Medicare Advantage.

When the health maintenance organizations that have now become Medicare Advantage plans were founded, many of them started with government loans. These are in difficult markets often; they are difficult to start. Not all of them will be successful. They are an experiment. I think we will have to judge how well that experiment plays out.

The CHAIRMAN. Well, thank you.

Ms. Wade, let me ask you a question. The provisions of Obamacare targeted at providing cost relief to small employers are ineffective and too complicated, in my view. My question for you is whether premium costs have continued to rise for small businesses and, if so, what actions they are taking to offset these increases in premiums.

Ms. WADE. Certainly. So the cost of health insurance is the most critical issue facing them in running their business, for providing insurance for themselves and also offering it to their employees. Increases have continued even though the rate has slowed, but all projections are that premium increases will start ramping up in the future.

So this problem is still not being confronted in a large way that helps benefit small business owners, and they take every measure possible to try to absorb these costs, the number-one being lower profits and lower earnings for themselves. That is their first line of attack. Outside of that, it is rearranging the benefits that they offer their employees in all different ways, whether it is cost sharing, or deductibles, or benefits designed for their insurance package. So, those are the many ways that they try to deal with the issue of increased cost.

The CHAIRMAN. My time is up.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Chairman, we heard again this morning, as has often been the case with critics of the Affordable Care Act, that in some way Medicare Advantage has been endangered by the Affordable Care Act. As someone who, like yourself, Mr. Chairman, is a very strong supporter of Medicare Advantage—Oregon has the second-highest percentage of Medicare Advantage in the country, and it is good Medicare Advantage—the proposition that the Affordable Care Act has in some way, I think the word was "endangered" Medicare Advantage, is just belied by the facts.

According to the Centers for Medicare and Medicaid Services, in September of 2014 they announced that between 2010 when the ACA was enacted and 2015, enrollment in MA is expected to increase 42 percent, and premiums will have decreased by 6 percent. So there are clearly, colleagues, a lot of opportunities for, once again, Democrats and Republicans to work together to build on what is a very promising feature of American health care.

Chairman Hatch and I have been particularly interested in Medicare Advantage over the years, and I just wanted to set the record straight on that particular point, given the fact that we have the statistics from the Centers for Medicare and Medicaid Services.

Let me go to you, Dr. Blumenthal, with respect to how the health care landscape would change if you just pulled the Affordable Care Act out root and branch, I guess would be the characterization that has been made.

What I feel is so important about the Affordable Care Act is that before it, we essentially had a system that worked best for the healthy and the wealthy. If you had a preexisting condition, for example, you were sick, the system was pretty much dysfunctional. You would go to bed at night knowing that you could be wiped out when you got up.

Essentially, in the old days, if you were healthy, you did not have a problem; if you were wealthy, you did not have a problem. But if you were not healthy or wealthy and you had a preexisting condition, you were already sick, you were in trouble. So that changed. I think that that is a huge, huge transformational feature of what has happened.

But in your view, what else are the major parts of the health care landscape that have changed? I will just throw one other one out. I think that there has been a lot of innovation as a result of the Affordable Care Act. Every day, I get a mailing from some exciting group that is offering a service, like here is how you compare various providers in your State and the like. But tell me what you think are the most positive features of the health care landscape now with this law.

Dr. BLUMENTHAL. Well, you have to come back to the point that the law was about getting people insured, that insurance is a public health intervention. Without insurance, people are less healthy, they die younger, they find cancers at a later date, their cancers are more likely to kill them. Insurance saves lives. I believe it is saving lives right now.

So the most important thing is that 16.4 million people who are newly insured as a result of the Affordable Care Act means people alive tomorrow who would not have been otherwise. It also means healthier children. Children are getting preventive services; they are not being excluded from the accessibility of insurance as they were before. They are getting oral and vision care which they were not getting before. These are investments in our future as a country.

Our health care system is being made more innovative. PricewaterhouseCoopers has estimated that 90 new small businesses have started as a result of the Affordable Care Act.

Senator WYDEN. These are essentially digital health companies, these 90 new businesses.

Dr. BLUMENTHAL. Some of them are digital, some are just oriented toward reducing health care costs, which is, of course, where we want innovation to occur in our health care system. The new Accountable Care Organizations that have been established under the law have, by CMS estimates compared to control populations, saved $700 million in the Medicare Shared Savings Program version, and about $200 million in the Pioneer version of the Accountable Care Organization.

Senator WYDEN. Let us do this, because my time is almost out. I would find it very helpful if you could get us a list of the most promising innovations that have taken place under the Affordable Care Act. I have been particularly attracted to some of the new models for oncology care, and I know you have had an interest in that area as well. So, if you could get back to us with what you think have been the most promising innovations since the law passed, that would be helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman and Mr. Ranking Member.

Well first, let me just start out and say that 16.4 million people who have insurance today who did not before, I would suggest, is a pretty big deal. I would suggest, for them and their families, they would consider that a pretty big deal. Three million young adults who have been able to stay on their parents' insurance, I know that has been a big deal in my family.

I have literally seen life-and-death issues come up where folks are now healthy and doing well because of that, and 10.8 million poor seniors, families, and children are able to be covered under Medicaid and CHIP. So I think that is a pretty big deal. I also think that the Kaiser Family Foundation saying that the average employer-based family coverage increased just 3 percent in 2014, which is tied for the lowest rate in the last 15 years—and we have heard even beyond that—is also pretty significant.

I want to talk about the structure for a moment on the small business side, because I am concerned about making sure things work for small business. As one of the folks who worked very hard to help author the small business tax credit, I would love to see that become much more robust and do more to be able to help small business.

But in Michigan, for years prior to the ACA, I heard over and over again, we as small businesses want to pool our companies together so that we can get the same rate as General Motors. Usually in Michigan it is General Motors or Ford. We want to be able to get the same rate. So they wanted to be able to pool their companies together to be able to get a better rate. Is that something that, Ms. Wade, you still hear from businesses?

Ms. WADE. Certainly. And they are open to all sorts of options in their ability to pool purchasing power and lower rates. The more options they have in offering health insurance to their employees, they find, the better. Currently being able to pool small employers together, say, in the SHOP exchange—the small group market has a number of cost increase limitations that they face in that market.

So unfortunately, where they are able to find some of these benefits, there are restrictions and limitations that limit their ability to afford health insurance——

Senator STABENOW. But you would agree that in order——

Ms. WADE. But that is certainly an option.

Senator STABENOW. Certainly, pooling competition—that is really what the exchanges are for. So what we ought to be doing is working together to make sure that those work well, because that is what creates leverage for small businesses. What creates leverage for consumers is to go into an exchange where the insurance companies are competing against each other to be able to lower rates, and that is what we have in the Affordable Care Act, the exchanges.

That is exactly what I have been hearing about from small businesses for years: why do we not do this? It actually was a Republican idea in the beginning, when we really had hoped this would get beyond partisanship, actually be something bipartisan rather than partisan. We thought this would be a major way to get that done by accepting a Republican idea of competition through exchanges. So I am very interested in seeing ways where we can make sure that that works, for businesses to be able to do that.

I also want to just mention one thing—as I am getting ready to go to the Budget Committee where we are debating the big picture and the budget for the future—that it is very interesting that in the House budget, as they look to restructure Medicare, they are proposing to eliminate exchanges and competition for businesses and consumers and create exchanges for Medicare.

This is the most interesting thing. It actually says in the budget, "This system would set up a carefully monitored exchange for Medicare plans." So they want to Obamacare Medicare. So this is a very interesting discussion.

I think what it points out is that we should just stop all the partisanship and actually deal with the fact that Democrats get sick, Republicans get sick, people who do not care about politics get sick. This is about how we can create and continue to have a system that lowers cost, increases quality, and makes sure that when somebody gets sick, they have the health care they have been paying for all their lives, and that they can turn around and make sure that they do not get dropped if, in fact, someone in the family gets sick.

So I just have to say for the record, Mr. Chairman, I find it very fascinating, as we go forward, that our House colleagues, who have voted over 50 times to repeal health care exchanges and the Affordable Care Act, are now proposing the same system for Medicare. It is going to be very interesting to see how that debate continues.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Roberts?

Senator ROBERTS. Well, thank you, Mr. Chairman. I want to assure my distinguished friend and colleague from Oregon, who was born in Wichita, KS but for some reason went to the land of Beavers and Ducks when he could have been supporting Shockers and Jayhawks and Wildcats—but I did not know that he was a Panther, a Gray Panther.

Senator WYDEN. It is true.

Senator ROBERTS. I certainly do not want to do anything to anger a Panther. That would be——

Senator WYDEN. Oh, a big mistake.

Senator ROBERTS [continuing]. Bad news and a big mistake. I hope that is not coming out of my time. I hope I am granted another 30 seconds, Mr. Chairman. [Laughter.]

These are not well-worn talking points. These are egregious complaints by my constituents, and they deserve an answer. I would remind everybody the President told them this law would reduce premiums for the typical family by $2,500. Jim from Overland Park, KS now tells me his 2015 premium went up 21 percent. William from Olathe, his monthly premium more than doubled if he wanted to keep his same plan, but as he says, "The devil was in the details, as the deductible increased and virtually none of our doctors was in the new network."

Now April 15th is approaching. The confusion and frustration is bubbling up again as folks prepare their taxes. Here is an example. An independent contractor told our office that, due to an unexpected contract he received, his estimated income was off for last year. As a result, all of the previous tax credit he received over the course of the year is now taxable income. Instead of foregoing coverage and paying a $700 penalty, he now owes the IRS $6,700. He tells me he has since dropped his coverage. Those are not well-worn talking points, those are real problems that constituents are facing, regardless of whether it is my State or any other.

Dr. Holtz-Eakin, the administration announced this week—and this was underscored by Dr. Blumenthal and by folks on the panel—there are 16.4 million people who have gained coverage since enactment of the law, but another survey that took into account insurance losses during some of those years had a much lower estimate of 9.7 million.

How might the administration's figures be off? Can you help us drill down on the number? Are some of these folks technically new enrollees only because their employers dropped coverage and they moved to the exchange? Too many individuals were previously insured, but, because of the rate increases, they are choosing to simply pay the penalty this year and forego coverage.

So who has dropped out of coverage? Who came in, with regards to what you see?

Dr. HOLTZ-EAKIN. There are lots of possibilities. The first and foremost would be people who had policies which they could no longer keep because of the law, so they lost that coverage and then went into the exchanges to get new coverage. That is one possibility.

The second is, as you mentioned, some people will simply forego coverage because there is no effective enforcement of the individual mandate, and they will pay a penalty if indeed they are found and asked to pay a penalty. I am skeptical of the ability to do that in the 2015 filing season.

Employers have incentives to drop coverage. The financial math is that for basically any employee up to 300 percent of the Federal poverty line, it is in the financial interest of both the employer and the employee for that employee to get coverage in the exchanges.

They can get coverage that is just as good or better than what the employer was providing, and they can get a raise in the process, and the employer can make a little money in the process. The bad news is, that all ends up on the taxpayers' dime. So, those incentives will begin to play out as time goes on. There are a variety of ways in which the sort of simple number of how many people buy a policy misleads on the net increase in coverage.

Senator ROBERTS. I appreciate that.

Mr. Chairman, my main concern here, regardless of the exact number of new folks with coverage, is whether these individuals actually have access to care. Are their deductibles so high as to prohibit them from actually seeking the care that they need? Are there enough doctors in the networks, in particular in rural areas, for them to be seen? The answer to that is "no." We have some real problems here. It is a bipartisan problem, and we need bipartisan answers to those problems.

I appreciate your comments about home health care. We used to have 424 outlets with regards to home health care providers in the big region before we went to the bid basis. CMS sent out bids. It was almost impossible for people to bid, but I will get past that. We delayed that.

Then there were 20 bids that were accepted. They are in Kansas City, they are in Wichita, they are in Topeka. They are not in Sabetha, KS, or Holton, or whatever it was in the outlying areas in Kansas in the northeastern part. I have asked repeatedly: there were 424, 20 bids; what happened to the other 404 in regards to home health care providers and durable medical equipment, et cetera, et cetera? Exactly what you touched on: nobody knows and nobody cares, and that is a problem.

Thank you.

The CHAIRMAN. Next, Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much. I appreciate the hearing that you and the ranking member have put together.

I wanted to focus, first and foremost, on children. We appreciate all the testimony that has been provided by our witnesses. One of the great bipartisan breakthroughs in the Congress—both the chairman and ranking member were and have been great supporters of the Children's Health Insurance Program. Of course, Medicaid plays a significant role as well in children's health insurance.

But all the while, we had these programs that provided health care for children, and yet we had what I think was an abomination, where you had children whose parents had health coverage for them for years and they were paying their premiums, and yet, if the child had a preexisting condition, he or she might not be protected.

That abomination, that insult, is all but gone from our system, but I would argue we should never, ever, ever allow that to come back. Anyone proposing changes to the ACA, repealing the ACA, altering it in any way, should make sure that that is a central plank, because that was a moral failing, in my judgment.

So now we have the ACA in place, and coverage has been expanded greatly. Dr. Blumenthal, I wanted to ask you about, first

of all, the impact on something as fundamental as dental care for children. We know that, according to one source, 15,000 children are diagnosed with cancer each year, and their parents should not have to worry about becoming uninsured because of any kind of arbitrary limits on coverage. So with the ACA ban on lifetime limits, that was the right thing to do. We also know that when parents are insured, their children are more likely to be insured.

So, with all of that and more that we could say, what would be the impact on children if the ACA did not exist, or maybe the better question is, if the ACA were repealed?

Dr. BLUMENTHAL. Thank you, Senator, for that question. Well, as you have pointed out, oral care is now a preventive benefit under the Affordable Care Act. Children cannot be excluded from coverage because of preexisting conditions. That is, if a child has cancer, they cannot be forbidden or denied coverage because they have cancer.

The expansion of coverage to parents has an enormous benefit for children, because families that are in bankruptcy because of the expenses of a parent obviously affect the welfare of a child. We know from our surveys that the numbers of families who are struggling with medical debt has declined since the Affordable Care Act was passed, for the first time since we have been tracking that number for over 15 years.

The expansion of coverage for preventive services generally affects children, so that is another benefit for them. Nine hundred thousand children were in households that selected coverage, family coverage, in 2014 to 2015 through the exchanges and the Affordable Care Act, so these are all ways in which the law has positively affected children.

Senator CASEY. Doctor, I also wanted to ask about the uninsured rate for young adults. I am looking at page 7 of your testimony. You state there, "The uninsured rate for young adults ages 19 to 34 has declined sharply." Can you tell us about that? That is part of, I know, the survey result. But this would be for the 19- to 34-year-olds.

Dr. BLUMENTHAL. Yes. The exact proportion of young adults with and without insurance, I would have to get back to you on. There is no question, though, that the combination of availability of coverage under parents' plans, the individual mandate, and the expansion of Medicaid have dramatically reduced the numbers of young adults in the United States who lack insurance.

One of the under-recognized facts around the Affordable Care Act is that many young adults are eligible for Medicaid because they have low incomes. It is actually the expansion of Medicaid, as much as the availability of insurance through parents' policies, that accounts for the reduction in the numbers of uninsured young Americans.

Senator CASEY. The one point that you made—I know we are low on time, and I will come back to it later—looking towards the end of your prepared testimony, about the health insurance marketplaces, one of your headlines is "Health Insurance Marketplaces Have Been Both Stable and Competitive." Can you walk through that? I know I am out of time, but I will not ask another question.

Dr. BLUMENTHAL. Sure. Very simply, the rate of increase in individual insurance policy premiums in the marketplaces was zero over the last year. That is absolutely without precedent in the history of the individual insurance market.

More plans are entering the market to sell insurance in those markets. The ease with which people were able to find insurance in the marketplaces this year was quite remarkable. Despite the failings in the first year of its launch, there were very few glitches in this past year. So we have competition, more plans, reduced premiums, and more people insured. I just do not see what is wrong with that picture.

Senator CASEY. Thanks very much.

The CHAIRMAN. Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman. Thank you for having this hearing.

Unfortunately, I think people are becoming desensitized to the rhetoric upon which Obamacare was sold to the American people. I think as you go back and reconstruct it, virtually all of the promises that were made ended up not being true.

If you are looking to try to expand health coverage availability to hardworking American families, the last thing that strikes me you want to do is to increase the price by $3,500, which is what happened under Obamacare because of the mandates. Premiums in the individual market have gone up 49 percent; so, rather than make health care more affordable and more accessible, we have made it less affordable.

Indeed, Obamacare was sold, as I recall it, in part also based on a concept of universal coverage, that everybody would be covered by insurance—and indeed, approximately 35 million people still remain uncovered—then the administration touts the Medicaid expansion. I have to tell you that the studies I have seen on outcomes for Medicaid are really no better. The medical outcomes are no better than for people who do not have insurance at all. Indeed, as the States have seen with the increasing costs of Medicaid to the States, they have crowded out, in many instances, their ability to fund other important State functions like education, law enforcement, and the like.

So at this point, we are left with the States asking the Federal Government's permission for waivers so they can conduct some innovative experiments in how to provide lower-cost, better-access coverage under Medicaid. But it strikes me as fundamentally wrong that the States have to ask the Federal Government how they can spend their money.

But, Dr. Holtz-Eakin, can you tell me—I still remember that Senator Schumer from New York, after the election, gave a speech at the National Press Club. He said he felt like this focus on the Affordable Care Act was really a mistake and that our Democratic friends paid for that at the polls on November 4th, and that really what they should have focused on is middle-income families. But would you speak to what the Affordable Care Act has done to median household income? Because it strikes me that it has made things worse, not better.

Dr. HOLTZ-EAKIN. I would concur with Senator Schumer. I mean, put the politics aside—that is his business. The Affordable Care

Act is damaging for economic growth, and it was enacted at a time when we had very poor growth in the United States to begin with.

Even since we started to create jobs, we have not seen those jobs carry increases in real wages and the kinds of incomes that Americans have expected, so the size of the pie just was not getting bigger, and this did nothing to help that. It, in fact, hurt it. And on top of that, in my view, it increased the cost of health insurance, one of the key things you want to use your income to cover. So it really had a double whammy on the average American family.

Senator CORNYN. I know the Independent Payment Advisory Board has been a feature that has caused bipartisan concern, and that of course was this idea that Congress would be taken out of the equation when it comes to actually determining what Medicare would cover.

While the threshold has not been triggered yet for the invocation of that authority, I am hopeful that we will be able to repeal that either in conjunction with congressional response to *King v. Burwell* or in some other context.

But I might ask you, Ms. Wade. The idea that Obamacare did something that only Obamacare could do, which is cover preexisting conditions and cover young adults under their family coverage—the only way you could do that is by passing the 2,700-page bill—is specious, it strikes me. But also, the fees on insurers are sort of hidden taxes that are indeed passed on down to consumers, and indeed this new health insurance tax is going to rise to more than $14 billion by 2018.

Could you speak to how that tax affects consumers and small businesses?

Ms. WADE. Absolutely. So the NFIB Research Foundation has looked into the health insurance tax, and we have estimated that the tax itself will reduce private-sector employment by between 152,000 to 286,000 employees, and 57 percent of those will be in the small businesses. It will also reduce U.S. real output by 2023 by between $20 billion to $33 billion.

One of the major issues for small businesses regarding the health insurance tax is that it affects the fully insured market, which is the market where most small businesses purchase their health insurance. So they are the ones absorbing these costs, and, whether it is the health insurance tax or other fees that affect the fully insured or their marketplace, they are the ones absorbing these costs, and they are unduly hit by increases, and they are the ones least able to afford increased premium costs. That is their number-one issue in health insurance.

Senator CORNYN. Mr. Chairman, if you would permit me, just a quick anecdote. I remember, after the employer mandate was passed, having a conversation at lunch with a friend of mine in San Antonio, TX who runs an architecture firm. When he realized that the employer mandate would kick in at a certain employment threshold—I believe it is 50—he said what he would end up doing is basically laying off his employees over that cap and then outsourcing the drawings that they depend on in their firm to other firms not even in the United States. So this has had a pernicious effect in so many different respects.

I appreciate your indulgence. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman. I appreciate you and Senator Wyden having this hearing. Thanks to our panel for joining us today.

The promises made during the lead-up to and passage of Obamacare were that premiums were going to go down by $2,500. Since 2009, premiums for the average family have increased by nearly $3,500, but we have supporters of the law who would argue that these premiums actually are not going up, that they are the same—that they were going to be the same as people's cell phone bills after this passed.

The other thing that gets lost in all this, in addition to the hike in the premiums, is that the deductibles are pretty staggering. According to HealthPocket, in 2015 the deductible for an average family with a Silver plan is $6,010. A family with a Bronze plan faces a $10,545 deductible. So you have the premium issue.

Even if the argument is made—and it is, often, by some of our colleagues who have supported the law—that premiums have not gone up all that dramatically, when you promise a $2,500 reduction and you see a $3,500 increase, that seems to me to be a pretty big increase.

But I am curious, Dr. Holtz-Eakin. Would you define a health plan with these types of deductibles as affordable to a middle-income family in this country?

Dr. HOLTZ-EAKIN. No. Clearly this has been a concern. As I mentioned in my opening remarks and in the testimony, the out-of-pocket costs have been rising, whether it is the deductibles, the copays, all the things that individuals are exposed to.

In the end, as insurers try to provide products and compete, they are forced to do some things to try to control these things. Passing these costs on to individuals is one; another is restricting the networks so that, once you pay that out-of-pocket cost, you are still not seeing the provider of your choice. So, it has hit both aspects: the affordability and the access to care.

Senator THUNE. And this whole issue of restricting networks seems to be the other thing—that you have fewer and fewer choices. You are collapsing your choices, you are paying more for less, basically. But just in your experience, the folks who have had their networks restricted or have fewer options available to them, do you see, in the insurance industry generally, just a lot of plans, a lot of companies, that have done this, that have gone and just said, look, we cannot continue to offer any kind of an affordable rate unless we have this dramatically smaller-sized network? Is that something that is kind of pervasive throughout the industry?

Dr. HOLTZ-EAKIN. Yes. We have seen this in Medicaid, we have seen it in the exchange plans. We saw it in Medicare Advantage, where not only have roughly a quarter of the MA plans disappeared since the cuts began, we have seen announcements of layoffs of doctors and others from the large MA providers. So, this is something that is going on in the medical landscape.

Senator THUNE. Ms. Wade, I have a similar story. In South Dakota, we had a small business that contacted us and said that they were trying to provide coverage to their employees and that in 2014

their maximum out-of-pocket costs doubled. Their out-of-pocket cost per employee now is well over $10,000 a year for family coverage.

So my assumption is, and your experience bears on this issue as well, but I think you mentioned that, after 5 years, benefits for small businesses have yet to materialize, and instead they are left with more uncertainty.

How impactful—I would use the word devastating, I guess—has this flawed law been on the sustainability of America's small businesses and their ability to hire more people? I mean, we talk about the impact on jobs. You would be someone who could speak specifically to your experience when it comes to the impact of the law on job creation.

Ms. WADE. Sure. So increased costs in compensation, which includes wages and benefits, affect what the employer is able to provide based on their profits and how they are doing in sales and revenues. So in the last 6 years through the recession, they have certainly struggled in keeping their doors open, first of all, but then also in retaining their most talented employees and things like that.

But it is all based on the profitability of their company. That is the bottom line for them. What they can provide after that is based on the structure of their employees, their workforce, and also whether they see predictable increases in revenues going forward.

So the uncertainty part of all this and the erratic changes in premium costs affect them in their willingness and ability to bet on a long-term benefit for their employees, whom they certainly do not take lightly, and it is very costly going forward. So, there is a lot of hesitation still about the benefit.

Senator THUNE. So, higher premiums, higher deductibles, fewer doctors and providers, and fewer jobs. That is, I think, the story 5 years later.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Senator Grassley?

Senator GRASSLEY. Yes. I only have one issue to discuss, and I want to do that with Ms. Wade. In your testimony, you point out that small businesses have been caught off guard by a little-known provision in Obamacare that essentially makes it illegal for people you represent to pay for their employees' health premiums on an individual market. Small businesses who fail to recognize this could face as much as a $100-per-day per-employee penalty simply because they want to help their employee obtain health insurance. This, of course, does not meet the common sense test.

In order to correct this, I have been working with Congressman Boustany from the House on a legislative proposal to permit small businesses to continue to reimburse their employees for health insurance premiums on a pre-tax basis. The reason I feel it is so important for Congress to address this issue is because of the stories I have heard from small business owners in my own State.

So, two questions at the same time, but they are very much related. I would like to have you elaborate on what small businesses from across the country are telling you about the damaging impact of the rule on their businesses and employees, and could you also speak to the transition relief that the Treasury announced in Feb-

ruary and why addressing this issue legislatively remains important to small businesses?

Ms. WADE. Absolutely. Thank you for the question. It is a fairly large population of small business owners that are offering this benefit. About 14 percent of those not offering provide financial support for their employees to purchase individual insurance, and also about 4 percent of those offering. Equally important are the 21 percent that we have found that are offering that are interested in maybe looking at this as a way to help support some or all of their employees in purchasing health insurance.

So it is affecting a great number of small employers. The main reason they are finding out about this is talking to their insurance agent or their CPA when it comes time for renewal, or if they are shopping for a new plan. We have received a number of calls where their CPA and their insurance agent are telling conflicting stories, whether this is permissible or not permissible. So then they call us, asking if we can help clarify.

So there is a lot of confusion, and one of our worries is that if they are not talking to their CPA or their health insurance agent or they are not finding out some other way, there is no way for them to know that this is a prohibitive benefit for their employees, and they will be stuck with the penalties this coming year.

The delay was helpful to a point, but not helpful in that this next year we are still going to have a number of employers that are providing this benefit that do not know that they are not supposed to otherwise. Then also there is the challenge of taking away a benefit in the middle of the year. If their renewal date or their benefit restructuring plans are at the end of the year, they are stuck having to deal with this from now until, I believe, June or July, whenever the penalties kick in.

So it is a large population of employers that are in this mix of providing this benefit, wanting to provide this benefit, and the frustration of not knowing that this is not allowed anymore.

Senator GRASSLEY. So a legislative alternative is necessary?

Ms. WADE. We believe so, yes.

Senator GRASSLEY. Yes. Thank you, Mr. Chairman. Thank you, Ms. Wade.

The CHAIRMAN. Thank you.

Senator Coats?

Senator COATS. Thank you, Mr. Chairman. This is an interesting hearing here that we are having.

I just wanted to mention to my colleague Senator Wyden, who I think legitimately gave some examples of people who have benefitted from the program, that I have hundreds, if not thousands, of letters in my office—and I have just a few of them here—from people who have been disadvantaged under this program, who have had their premiums increased up to 90 percent from what they were before, their deductibles doubled to unaffordable levels.

They fall in that so-called gap of the working middle class. Many have been decimated by this program, dropped from their employer-covered plans, stunned by affordable plans they had been paying for for 10, 15, 20 years suddenly being dropped because the plan did not meet the mandated requirements of the ACA. So there are two sides to this story. I know my colleague also indicated he

is open and ready for a discussion on reforms for those things that do not work.

As our first witness mentioned, there are a lot of things that are not working well in this plan. Simply to tout some of the things that do work, which we celebrate, has to be put in the context of things that have just thrown a lot of people into a situation where they are desperate in terms of getting the kind of insurance for their family that they can afford. So that is one thing.

The question I want to put to our witnesses is this. Indiana has received permission to put together a plan that is much more consumer-oriented, much more feasible in terms of our State, which does not have a State exchange. The statement that Doug Holtz-Eakin made—yes, many people have flooded into Medicaid, but the reforms have not been put into Medicaid, and that is a burden, a continued burden now, on the Federal Government as well as the State government.

But Indiana passed something called Healthy Indiana Plan 2.0. Indiana Plan 1.0 was initiated by our former Governor, Mitch Daniels, and 2.0 by our current Governor, which is an extension of that plan. It incorporates a number of reforms in Medicaid. It preserves incentives, but it has disincentives also. It is carrots and sticks for people to put in place personal responsibility.

Advance-driven health care has been based primarily on a health savings account type of plan and requires personal responsibility. It aligns with the commercial health insurance market. It is going to bring several hundred thousand, if not half a million, people into the system. It is a model that I think a number of States that have not signed up for the exchanges can take a look at.

I would just ask Dr. Holtz-Eakin if he is aware of that, and perhaps Dr. Blumenthal also, or any of our panelists, if they have had a chance to look at that. And is this a reform that potentially can address some of these issues that are not being addressed currently under the ACA?

Dr. HOLTZ-EAKIN. I am aware of it. We have seen, under Healthy Indiana 1.0, tremendous success, in my view. I thought that was an extremely successful public policy. I think 2.0 is very promising, and we will watch it as it evolves to see if it continues to have the characteristics of getting people access to care and controlling costs, which 1.0 seems to have done very, very well. So I think the use of the waiver to reform the Medicaid program is exactly the right thing to do, and this is a promising innovation.

Dr. BLUMENTHAL. Senator, I do not know the precise details of the latest Indiana plan. I would point out that it illustrates the flexibility that States have, often overlooked under the Affordable Care Act, to tailor programs to their own situations.

I also would point out that there is a great deal of change going on within the Medicaid program under the auspices of the Affordable Care Act, some of it sponsored by the Center for Medicare and Medicaid Innovation. In the State of New York, which is my place of employment, the State has totally revamped its Medicaid delivery system under the flexibility that has been created by the Affordable Care Act.

So I think it is fair to say that the Affordable Care Act does open opportunities for Medicaid reform at the delivery system level, which is where everything needs to take place.

Senator COATS. Well, my time has expired. Mr. Chairman, let me just say that, regarding flexibility, it took the State a year and a half to get the Federal Government to respond to allow them to add these changes and reforms to Medicaid, so flexibility is a word that may not directly apply here.

But hopefully the plan will now be looked at and will be successful, as Dr. Holtz-Eakin had said about the first iteration, and the second iteration greatly expands that. Hopefully it can be a model for other States and they will get the flexibility to be able to follow that.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator.

Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

Dr. Holtz-Eakin, as we continue to discuss this 5th anniversary—and certainly from my perspective, it has been a failure for the last several years as an opportunity to provide affordable health care. Frankly, having the government run a sixth of the economy and take over the responsibilities of providing affordable and accessible health care has been a complete failure, from my perspective.

Many of my constituents, who are some of the sickest Americans, find themselves unable to afford the out-of-pocket expenses. Whether it is the maximum out-of-pocket, your deductibles, co-pays on medicine, the fact of the matter is that the ability to afford seeing a doctor, even if you have a card that says you have access, is becoming harder and harder for so many of my constituents.

It seems to me that Obamacare plans often leave individuals with sticker shock and less access. I would appreciate your comments and your thoughts on what should be next as we look at ways to provide real access to health care. Mine would be, of course, to look at a private-sector model that would work, as opposed to continuing down a path that seems to lead to limited access, higher cost, higher deductibles, higher out-of-pocket expenses—now for the next 3 years, 8.5-percent increases in premiums.

Dr. HOLTZ-EAKIN. This is a real concern. We saw for years this manifest itself in the Medicaid program, where access to providers was quite limited. We are now seeing the exchange plans often replicate the Medicaid limited network problems as a way to sort of keep the premiums down, shifting to higher out-of-pocket costs. All of these things are a deep concern.

In the end, they are rooted in the sort of regulatory inflexibility for the kinds of insurance plans that could be offered—the rating bands and other restrictions on the pricing of those plans. So the way forward is to allow the private sector to innovate in the insurance options, to bring back insurance that provides the benefits that individuals value, not a one-size-fits-all benefit package but one that tailors products to different points in the life cycle when people have different insurance needs. Those things are missing from the design in the Affordable Care Act.

Senator SCOTT. Yes, sir.

Also, when you look at the recent studies that show that a majority of individuals below 400 percent of the Federal poverty level do not have sufficient assets to pay the extremely high deductibles offered in Obamacare, a very similar question arises. It seems that we are celebrating, or some are celebrating, the 5th anniversary without truly appreciating the lack of access, specifically in rural areas of my State where you have fewer health care providers. And by most estimates, by the year, I think it is 2025, another 100,000 doctors will be out of the health care system because of the cost.

I take into consideration the fact that we siphoned off about $716 billion from Medicare. It seems to me, those seniors who are also very sick, who also live in rural areas, will have even greater challenges, more hurdles to overcome, as we look for an affordable, hopefully, replacement at some point in the future for Obamacare.

Dr. HOLTZ-EAKIN. As I mentioned earlier, I am concerned about the future, about some key components of the Medicare program where the cuts, I think, will impinge on access to care. Home health is one. Medicare Advantage, I am also concerned about. Despite its current condition, the future does indeed look dangerous to me.

There is a generic problem with access to care, and we need to provide more flexible options to get people access to that care. That will be true regardless of whether it is an exchange plan or a Medicaid plan. That is how it is going.

The last thing I will just point out that the low-income face uniquely is, there is this phenomenon of people transitioning from Medicaid eligibility into exchange eligibility. There is a high probability that a low-income family will do that in any given year, and in fact a remarkably high probability that they might even go back.

That means every time you cross that line, you are changing your insurance product, which means you are changing your providers, and your care is being disrupted. That has been a concern since the beginning with the Affordable Care Act.

Senator SCOTT. Thank you. I think my last comment will be more of a comment than a question. We have heard in recent days that the cost of the ACA is going down to an estimate of about $1.2 trillion, with somewhere between 27 and 34 million Americans still uninsured in the next 10 years. My thought is that we ought not celebrate the reduction of a cost, because fewer people are actually using it. Thank you.

Senator WYDEN [presiding]. Senator Heller is next.

Senator HELLER. Thank you very much. I also appreciate the chairman and the ranking member bringing this issue in front of us. I want to thank the witnesses. Thank you very much for taking time, for being with us, and for making sure that we get answers to our questions.

I want to talk, Doctor, a little bit about Medicaid expansion, mostly because you brought that up in your earlier testimony. But we have seen in the State of Nevada, actually, a doubling in the Medicaid population. Here is the problem: we may have doubled our Medicaid population, but we do not have a corresponding increase in the number of Medicaid providers. I have serious concerns about that. Hospitals are stressed.

It is not just the State of Nevada. Obviously out west and across this country, we are seeing some really stressed-out hospitals, and they are asking, what is the difference? If you expand Medicaid but you do not expand providers, you are going to end up in the hospitals anyway, in the emergency rooms.

What has changed? What has changed from 5 years ago?

Dr. HOLTZ-EAKIN. The fundamental strategy in the Affordable Care Act, with which I politely disagree, was to expand coverage first and worry about providers, delivery system reform, and those things second. The expansion of coverage gives people access to the financial wherewithal to look for providers, but they are just not there.

This concern was voiced from the very beginning of the debate over what became the ACA, and it is now playing out in many parts of the country. There are not the providers to deal with the increasing number of Medicaid- and exchange-covered individuals.

Senator HELLER. Yes. We are seeing that from our medical hospitals, that a number of our graduating students cannot find internships, cannot find temporary jobs at other hospitals. They have to wait another year before they are accepted in these hospitals for the work that they do in their training. It is becoming very, very difficult.

I want to talk a moment about the tax season that is upon us now. Many Americans who have already dealt with confusion regarding their health plans and potential increased costs are now discovering a variety of surprises, as you are well-aware of, in the filing of their taxes. There are new forms to fill out. Their refunds are much lower than they expected.

The administration has also admitted that 800,000 incorrect 1095–A forms were sent out. There could be more from States that have set up their own exchanges. The 50,000 people who have already filed do not have to amend their returns, but the 750,000 who have not may end up owing additional taxes and further delaying their returns.

I think this is adding insult to injury. It is often discussed how the regulatory burdens of this law affected businesses, but what kind of impact from these do you foresee for individual taxpayers this year, and what do you see in the future?

Dr. HOLTZ-EAKIN. The difficulties that individuals will face this year, in the tax filing season, are hardly a surprise. This was utterly predicted and, indeed, in testimony I gave to the House Ways and Means Committee, it basically said, this is coming, get ready. I can share this with anyone who wants it. This is the design of the subsidy verification system. This is what it takes to get the subsidy right.

There is no way this is going to happen in a world where the employer mandate is not being enforced, so the information that comes with it is not going to be available. This is a dream, not a way to check on actual subsidies. This year we will see lots and lots and lots of problems. I think the larger concern is, I do not think this can ever be implemented successfully.

As I mentioned earlier, the Earned Income Tax Credit, which is simpler by far, has an error rate of 21 percent. I do not see how this ever comes even close to 21 percent, because it is just too com-

plicated. Every year then, those who are in the subsidy system are going to find themselves in a tax nightmare.

Senator HELLER. Yes.

Mr. Chairman, thank you. No further questions.

Senator WYDEN. Senator Carper is next.

Senator CARPER. Thanks so much.

To each of you, welcome. It is nice to see you, Doug. It is a good thing we do not have to pay for every time you testify. We would be running up the national deficit even more than it is. It is way nice to see you.

Dr. Blumenthal, it is nice to know that one of the Blumenthal boys turned out well. [Laughter.] For those of you who do not know, he has a brother who serves here with Senator Casey, Senator Wyden, Senator Heller, and I, and actually does a great job. I wish we could get him to swim more, wish he was in better shape. Actually, he is a great swimmer.

We have around here, on Wednesday morning, a prayer breakfast, and on Thursday we have a Bible study group for about six or seven of us who need the most help. We meet with the Senate chaplain. Oftentimes the Senate chaplain reminds us of the moral obligation that we have to the least of these in our society, and he will sometimes remind us of Matthew 25 and the words you probably have all heard before: "When I was hungry, did you feed me? When I was naked, did you clothe me? When I was thirsty, did you give me to drink? When I was sick and in prison, did you come to visit me?"

It does not say anything like, "When I did not have any health care coverage, when I could not get any health care coverage, when I could not afford any kind of health care coverage, did you do anything about it?" But I think the message is the same. We have a moral obligation to the least of these in our society, not just to people who are homeless or people who do not have anything to eat, but really people who do not have access to decent health care.

For years we talked about trying to meet that moral obligation, and failed miserably. I was a fairly new member on this committee. Senator Wyden was a grizzled veteran, but I was a fairly new member when an effort was begun, under the leadership of Max Baucus—who is as good as anybody I have ever known at reaching across the aisle—a negotiation with three Democrats and three Republicans that lasted for months to try to find common ground, and failed.

I am not a very partisan guy, as my colleagues will tell you, but I think they failed, not for the best of reasons. We ended up as Democrats drawing up and pretty much writing the bill ourselves. To our shame, we stole two good Republican ideas and included them in the bill.

One of those was the idea that we should create these large purchasing pools in order to try to bring down and make more affordable the cost of health care, and the other was—some guy up in Massachusetts, I think he had been Governor, had an idea about an individual mandate in order to make sure we did not end up with insurance pools with just the lame, the halt, and the blind, but we actually had some young, healthy people in there. So we

stuck those two Republican ideas in, and actually they are two of the main pillars of our bill.

When I listened to the comments of some of my colleagues here on the floor, over in the House, people just seem to forget that we had, and we still have, a huge problem in our country. We have a moral obligation to meet the challenge, and we have a fiscal obligation to try to do it, to meet that moral responsibility in a fiscally responsible way.

That is a long run-up to my question, but here is my question: I hope we are not going to just throw the baby out with the bath water here. I hope we will find a way to make this baby a lot healthier, and you have given us some ideas today.

Let me just ask this and start with you, Dr. Blumenthal. Where do you think the three of you agree on some logical steps where we sort of get this venom out of our system, some logical steps that we can take to improve access further and maybe actually make some progress on the cost side?

Dr. BLUMENTHAL. Well, Senator——

Senator CARPER. Where do you think you all agree? A couple of good ones.

Dr. BLUMENTHAL. Well, we have not had a chance to put our heads together. If you all took 3 or 4 months and were not able to come to agreement, I am not sure that we would take a lot longer or shorter.

Senator CARPER. I am not so sure that all six were trying. [Laughter.]

Dr. BLUMENTHAL. But I would be glad to caucus with my colleagues here and see if we could come up with something. I would not have the temerity to suggest what it was ahead of time. I have some ideas about ways in which the law could be made better, but I am not at all sure that they would be ways that my colleagues here would agree with.

I would say in general that I personally agree that the law was created with some haste with an unusual process and did not have the chance to get the kind of vetting that laws ought to get. That was unfortunate. It can certainly be improved. The Commonwealth Fund welcomes any opportunity to work on ways to improve it. It does need to be improved.

The health system of our country is as large as most independent nations. The GDP of our health care system, were it an isolated country, would be the fifth largest in the world. To expect that any single piece of legislation will fix all of its problems in 5 years or 10 years is unrealistic. The Medicare program was not the Medicare program we know now. When it was passed it needed lots of improvement over time. It got it. It is now incredibly popular and, despite its problems, remains popular.

Senator CARPER. Excuse me. My time has expired. The chairman has been very patient with me. I am going to ask you just to hold it right there. I am going to ask you, for the record, to give me an idea or two you think the three of you might actually agree on going forward. But thanks so much. Sorry to have to interrupt you.

Ms. Wade, same question. Where do you think the three of you might agree on some common-sense changes, some practical, reasonable improvements?

Ms. WADE. Improvements for small employers with the law would be lifting the taxes, fees, and paperwork burdens, all the increased cost components for them providing insurance for themselves, but also offering it for their employees, and also not locking more employers into the employer-sponsored system through the employer mandate.

Business owners, businesses, are varied, with different workforce compositions, profits, and things like that. Forcing more of them into this structure of offering health insurance certainly restricts their ability to grow and improve their business.

But also, in the small group insurance market where they purchase insurance, for those under 50 employees, lifting some of the costs and restrictions on that pool makes sense, because now there is even a further divide between those that purchase in the small group market and those that purchase in the large group market. The small group market is just becoming more restrictive and costly for small employers to purchase insurance.

Senator CARPER. All right. Thank you.

Could we get maybe 60 seconds from Doug? Doug, please.

Dr. HOLTZ-EAKIN. Thank you, Senator. First of all, I want to echo what you said about our moral obligations. My concern has always been that, in meeting those, we are not meeting a comparable test for the next generation and are leaving behind too large a fiscal burden for them in an economy not performing as well. Meeting the first obligation while not failing on the second is really the goal here.

The second thing I would say is, on the exchanges, we needed, and still need, better competition in insurance markets. No one should be confused about the quality of the competition in insurance markets circa 2009–2010. I think that would be on the list of things we can continue to do better on.

Senator CARPER. All right.

Dr. HOLTZ-EAKIN. I do not think we are there yet. The third thing I would mention would be Medicare. Medicare needs reforms on behalf of its beneficiaries who are often not receiving the care that they deserve, and again to meet the fiscal sustainability issue. And Medicare reform, in my view, is the first step in delivery system reform.

I would encourage the committee to focus on Medicare reform going forward. One of the unfortunate side effects of the ACA is, because it used Medicare as a pay-for and it used Medicaid as an expansion, it froze real progress in those two entitlement programs that need reforms, because touching them meant touching the ACA, and we know how that has played out.

The last thing I would say is, on the nuts and bolts, this committee could do a lot of improvement. Take the health insurance tax. I understand the need for revenue, but that tax is a disgrace. It makes no sense from a tax policy point of view to say, we are going to take $8 billion, rising to $14 billion, from an industry regardless of the economic circumstances in which they find themselves, and in the process of doing so discriminate between those who are liable for the corporation income tax, those who are not liable for the corporation tax, and those who happen to have a product line that focuses on seniors and low-income people. That

violates all the rules of good tax policy that say you should not drive the market with the tax decisions. That tax is horrible. So, get the money if you must, but get it in a way that makes sense.

Senator CARPER. Thank you all.

Thanks, Mr. Chairman. Thanks for your patience.

Senator WYDEN. Thank you very much.

At this point, Chairman Hatch has many obligations, so I think, by unanimous consent, I would like to put his closing statement in the record.

I am going to ask one additional question, and then I know Senator Casey has one additional question. I think it is our understanding from Chairman Hatch's folks and our folks that we will let Senator Casey wrap up after one additional question from me.

Dr. Blumenthal, a question with respect to what has happened in States that have had the Medicaid expansion and the States that have not. This is for you, Dr. Blumenthal. We know that when patients come to the hospital emergency room, there is a Federal law that hospitals must treat them whether or not they are able to pay. We also know that paying for their care has to come from somewhere. There are no free goods and services anywhere in the American economy.

Now, it is my understanding that, in 2014, States that expanded Medicaid saved an estimated $5.7 billion. I am curious and genuinely do not know the answer. Is it your sense that, in those States, there may be less cost shifting going on with hospitals and other providers?

Dr. BLUMENTHAL. Senator, while I cannot give you a number, I am quite sure that that is the case. I know that safety-net institutions, those that see disproportionate numbers of previously uninsured and Medicaid patients, are doing better and are feeling the positive effects.

I know that uncompensated care is going down in States that have expanded Medicaid. That puts less pressure on those institutions to raise their private insurance fees and makes it possible for them to see those less well-endowed, less well-protected patients.

So Medicaid expansions, as has been well documented, are worth tens of billions of dollars to the economies of States that expand, and also tens of billions of dollars to the health systems, including to community health centers and Federally Qualified Health Centers.

Senator WYDEN. How about the States that have not expanded Medicaid?

Dr. BLUMENTHAL. We know that they have had the least reductions, the lowest reductions, in rates of uninsurance. So Medicaid has been an important part of the reductions in uninsurance and a benefit for their young, poor, and ethnic minorities.

Senator WYDEN. All right. I am going to have to leave. I just want to say in wrapping up, before I turn it over to Senator Casey, from my vantage point I have worked with all three of you and have appreciated the candor, the scholarship. Obviously we have some differences of opinion. But I continue to believe there is an opportunity for some bipartisanship here and some reforms that can bring people together.

We are going to spend $2.9 trillion, apparently, this year on health care in our country. Structurally there is no challenge. I have outlined, a number of colleagues have outlined, what I think are benefits. I have tried to highlight some of the examples where I think there is common ground, like Medicare Advantage. Chairman Hatch is not here, but he has been a very outspoken proponent of that, as have I.

So there are opportunities for us to build on, and I think that is what Senator Carper was driving at. I think we build by going forward, as I say, not going back to the days, for example, when insurers could clobber the people with a preexisting condition.

So I very much look forward to working with all three of you. We have relied on your input and ideas in the past, and we are going to continue to do it.

Senator Casey, you may proceed and close the hearing for the Finance Committee.

Senator CASEY [presiding]. I want to thank the ranking member, and, as he leaves, I will have one question. But just for the record, there are a lot of arguments, predictions and arguments, made about the impact of the ACA on the economy. Some of the numbers, I think, belie that. In the 5 years since enactment, 12 million jobs created in that period, 60 consecutive months of private-sector job growth. The unemployment rate went from 10 percent to 5.5. So, I think those arguments—and of course the coverage now is 16.4 million people.

Dr. Blumenthal, I just have one question I meant to get in before. On page 15 of your testimony—a lot of your work in The Commonwealth Fund is on surveys. I think they are relevant here. This is simply an analysis of public policy. Part of what we are trying to do is ascertain the feeling or the attitude that people have about the ACA.

You talk on page 15—and you have a footnote with it—about how 61 percent of adults with marketplace coverage report that it has been "very" or "somewhat easy" to pay their premiums. So if you could just comment on that and how you arrived at that.

Dr. BLUMENTHAL. Well, we asked them, and that is what they told us.

Senator CASEY. And that is a 2014 survey?

Dr. BLUMENTHAL. That is right. So the data that we quote in our testimony is data derived either from our surveys or from surveys done by other credible organizations like the National Center for Health Statistics, the Urban Institute, or Gallup.

Senator CASEY. Thanks very much.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator. We appreciate it.

Let me just ask one more question of Dr. Holtz-Eakin. You recently put out an analysis on the House SGR bill that is currently being drafted. I am especially interested in the inclusion of the two structural entitlement reform proposals, means-testing and Medigap reform, that are being included in the bill. Tell us what the long-term impact of these policies will be on Medicare solvency.

Dr. HOLTZ-EAKIN. So my analysis was prompted by the fact that the reports were that the proposed legislation would not pay for $140 billion of the cost of the SGR repeal. I, at first blush, found

that unappealing. We have serious fiscal problems, and everything should be paid for.

But there are these structural reforms, and so I just asked the question, well, if we extend the analysis from 10 years to the second 10 years, what are the potential savings from structural reforms in Medicare and would that compensate for the $140 billion that was not paid for up front?

The answer is, there are substantial savings—$230 billion—more than enough to compensate, with interest, for not paying the $140 billion. As usual, providing people good price signals with both premiums and with deductibles gives you changes in behavior, and that is at the heart of those analyses.

The CHAIRMAN. Well, I am glad to have that.

I want to address something that Ranking Member Wyden mentioned earlier on Medicare Advantage. Obamacare did cut hundreds of millions of dollars from the Medicare Advantage program. CMS actuaries warned at the time that cuts could cause up to 7 million of the nearly 16 million seniors in Medicare Advantage to lose their plans by 2017. Many of those cuts have been masked by administrative actions that have not yet gone into effect, including new taxes on health insurance plans.

I remain concerned about the future of the popular Medicare Advantage program as the Obamacare cuts continue to be implemented. So I look forward to continued work with the ranking member to protect Medicare choices for our seniors, and I want to especially express my gratitude to the three of you for appearing here today and helping us to understand this better.

I think, Doctor, I personally believe, that we can do much better than the Affordable Care Act. A lot of it has not triggered yet, and a lot of the cost. I think it is going to be an awful mess as the future goes on. Your goal, and mine too, is to make sure we take care of everybody in this country and do a good job in doing so. The problem is, the Affordable Care Act has been seriously flawed from the beginning. I have criticized it over the years.

As someone who has passed probably more health care bills than anybody in the Congress, I have to say that I am very concerned about it. Yes, there are some good things about it, but there are an awful lot of bad things.

Let me just thank you witnesses for being here today. I also want to thank all of the Senators who participated. This has been a fairly robust discussion, and I appreciate everyone's participation.

Senator Menendez, do you want to ask some more questions?

Senator MENENDEZ. I do, Mr. Chairman.

The CHAIRMAN. Then we will turn to you. I was going to shut this place down here.

Senator MENENDEZ. I have been here three times, Mr. Chairman. Unfortunately, it did not work out in the order, but I appreciate your forbearance.

The CHAIRMAN. Glad to do it.

Senator MENENDEZ. Let me say that I guess that one can look at a painting and see it in many different ways. However, I think the facts, as they relate to the Affordable Care Act, are beyond the beauty in the eye of the beholder.

For me, I see it extending coverage to more than 60 million Americans, many Hispanic Americans who have seen among the largest increase in insurance coverage when they were one of the largest groups that was uninsured. It now guarantees that nearly 130 million Americans can no longer be denied coverage because of a preexisting condition, which, prior to the Affordable Care Act, meant insurance companies could deny coverage to a woman who had a C-section or a child with allergies.

It sharply reduced the cost of prescription medications under Part D, saving seniors $11.5 billion while keeping premiums flat. It has improved the quality of coverage, so that when an unfortunate diagnosis occurs, families will know that their insurance has the coverage they need and that they cannot be dropped from coverage entirely because they need care. So I look at some of the statements that have been made, and I guess, again, there is a different way to look at it. I hear the question of, well, higher deductibles.

Dr. Blumenthal, is it not true that there are no annual or lifetime limits and new annual out-of-pocket limits? As I understand it, beginning in 2014, the law banned annual limits on coverage in new health care plans, extending the protection to millions. As well as that, additionally, most insurers must place a hard limit on enrollees' annual out-of-pocket spending for essential health benefits, providing protection against catastrophic costs.

Dr. BLUMENTHAL. You are correct, Senator. There are now limits on the deniability of coverage, with guaranteed renewability, and you can no longer set lifetime limits on benefits.

Senator MENENDEZ. Now, the next thing I have heard consistently is "more limited benefits," which I really find difficult to understand. As I understand it, the Affordable Care Act ultimately—health care plans cover proven preventative services, which has resulted in more than 76 million Americans gaining coverage of preventative benefits with no cost sharing or deductible. Is that a fair statement?

Dr. BLUMENTHAL. That is correct.

Senator MENENDEZ. And then I hear "fewer doctors." Under the health care law, for the first time insurers are required to cover a range of doctors, specialists, and community providers and meet minimum network adequacy standards. It seems to me that that gives consumers the opportunity, the tools, and the information to shop for a plan that meets their needs, and it ensures families do not face higher cost sharing if they have to go to an out-of-network emergency room. Is that a fair statement?

Dr. BLUMENTHAL. That is correct.

Senator MENENDEZ. Now, let me talk about what the plan has not caused, which I heard when we were passing the Affordable Care Act. It has not caused an economic catastrophe. In fact, in the last 5 years, the U.S. has seen the longest stretch in job growth ever, adding 12 million jobs, cutting the unemployment rate in half.

It has not led to the creation of what some have called a part-time economy, since more than 90 percent of that record-breaking job creation has been full-time jobs. It has not led to massive increases in health spending or premiums, but rather it slowed the

growth in health costs to the lowest level in half a century, resulted in below-predicted premiums for private-market insurance plans, and led to historically low increases in employer-sponsored health premiums.

It has not—I repeat, not, and this is particularly important as we go into the budget debates we are going to have, Mr. Chairman—added to the deficit. In fact, the Congressional Budget Office has, on every occasion, stated that the Affordable Care Act reduces the budget deficit in both the near and long term.

So, while my friends on the other side of the aisle might not want to recognize this fact, the budget proposal they released just yesterday admits it, because it explicitly prohibits raising a budget point of order against adding to the country's long-term deficit that would be caused by repealing the Affordable Care Act. To top things off, their budget continues to count the billions of dollars in revenue generated by the Affordable Care Act in the budget's baseline, despite having repealed the ACA and all of the policies that generate the revenue it contains.

So, you cannot have it both ways. You cannot have all the benefits under the law and account for all the revenue under the law and then say it should just be repealed. That does not work, and that is not even realistic. I think the American public gets that.

Thank you, Mr. Chairman, for the opportunity.

The CHAIRMAN. Thank you.

Well, we have come to the end of this particular hearing. I would just like to ask one more question. Dr. Holtz-Eakin, you have heard Senator Menendez. Do you have any differences of opinion with what he just said about how we are actually saving money?

Dr. HOLTZ-EAKIN. I would disagree, politely, with the reading of the economic history and the performance of the U.S. economy over the past 5 years. It is true that the labor market has generated jobs, but it has not generated income. The vast majority of Americans had a job, but they are not getting a raise, and I think that is due, in part, to the $40 billion a year in regulatory burdens placed on small businesses and others, the tax increases. I do not believe that this adds up budgetarily.

It was passed with the use of a lot of front-loading of revenues, back-loading of spending. That bill will come due, and it will be placed unfairly on the next generation in a way that I have never approved of. So, in a variety of ways, I disagree with the reading of the record on the economy and the budget. The Affordable Care Act has had a big impact.

The CHAIRMAN. Do you expect them to ever get the total spending under control if we cannot find some way of changing Obamacare?

Dr. HOLTZ-EAKIN. I do not. Many advocates for the Affordable Care Act trace the recent slow-down in the pace of national health expenditure to the Affordable Care Act, and I do not think that is a fair reading of the record.

Two things about that. Number one, it started before the ACA was passed. It is not related to the ACA. The second, there is a lot of talk about how medical inflation is lower than it has ever been. But the reality is, we are in a low-inflation environment. The overall inflation rate is something like 1.3 percent.

If you look at medical inflation relative to overall inflation, there is nothing special about the post-ACA period. What we have really seen is people not utilizing as much, and that is probably because of the recession. It may not even be desirable health policy if people are not utilizing things they should be, and I have a far less sanguine reading of that record than many.

The CHAIRMAN. Some have said that Obamacare is going to go up in price 8 percent for each of the next 3 years. Do you agree with that?

Dr. HOLTZ-EAKIN. I do not know the exact figure off the top of my head, but that is consistent with the projections we have seen in the past.

The CHAIRMAN. Well, it does not sound to me like it is saving money if it is going to do that. My contention is, we can do much better than this and give people better opportunities for health care than what they get under Obamacare. It is always a very difficult issue.

I have worked on health care matters every year since I have been in the Senate, but I have to say that I think, if we cannot reform Obamacare or replace it with something better, we are going to wind up with a terrible, costly mess on our hands that is going to eat up everything else in the budget. Am I that far off-base?

Dr. HOLTZ-EAKIN. Well, it might be Obamacare and Medicare, sir, but both are a problem.

The CHAIRMAN. Well, yes. I am concerned about it. I want the American people to have the best health care we can give them, but I also want to have us live within our means too, which is a crucial aspect of all of our lives, it seems to me.

I have appreciated each of you three here today and have appreciated my colleagues taking this much interest in this. So with that, we are going to keep the record open, and any questions for the record should be submitted by no later than Thursday, March 26th. We will just adjourn this hearing for now.

Thank you so much for being here.

[Whereupon, at 11:27 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF DAVID BLUMENTHAL, M.D., M.P.P., PRESIDENT, THE COMMONWEALTH FUND

The author gratefully acknowledges the contributions of David Squires, Sara Collins, Rachel Nuzum, Sophie Beutel, Melinda Abrams, Jordan Kiszla, and Chris Hollander to this testimony.

The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

EXECUTIVE SUMMARY

Thank you, Chairman Hatch, Senator Wyden, and members of the Committee, for this invitation to testify on the Affordable Care Act at 5 years. Research from The Commonwealth Fund and other sources demonstrate that the Affordable Care Act is helping to reduce the number of Americans who are uninsured and improving access to health care.

Currently, more than 25 million people are estimated to have health insurance under the provisions of the ACA. About 11.7 million have selected a plan through the insurance marketplaces—8.8 million through the federal website *HealthCare.gov* and 2.8 million through state-based marketplaces. An additional 10.8 million have enrolled in Medicaid or the Children's Health Insurance Program, or CHIP. Finally, nearly 3 million more young adults are covered under their parent's plan compared to 2010.

As a result, the number of uninsured adults has fallen. This week, the U.S. Department of Health and Human Services reported that 16.4 million previously uninsured people had gained coverage since the law passed in 2010. Similar gains in coverage have been documented in a number of government and private-sector surveys. Furthermore, groups that historically have been most likely to lack insurance—young men and women, and adults with low or moderate incomes—have experienced among the greatest gains in coverage. These gains have occurred across racial and ethnic groups.

To see how the newly insured are faring with their marketplace or Medicaid coverage, The Commonwealth Fund conducted a survey of these adults in the second quarter of 2014. We found that three-quarters of the newly insured were satisfied with their insurance. A majority had already used their new plans to get health care, with most saying they could not have afforded or accessed this care previously. Most people who had tried to find a new doctor reported being able to do so with relative ease; they also were able to get appointments within timeframes similar to those reported by the general population of adults in prior surveys.

Other indicators demonstrate that improvements in insurance coverage have helped remove cost barriers to care. Among all working-age adults, the percentage reporting not being able to get needed care because of the cost fell between 2012 and 2014, from 43 percent to 36 percent—a decline of 14 million people. Similarly, better insurance coverage has meant fewer Americans experiencing financial difficulties related to health care. The number of adults who had problems paying their medical bills, or were paying off medical debt, declined from 75 million to 64 million between 2012 and 2014. This is the first time these numbers have declined since The Commonwealth Fund began asking these questions, with the changes likely re-

flecting improvements in coverage and in the economy. However, rates for these problems remain high, particularly for low-income adults.

Overall, health plans sold in the insurance marketplaces created under the ACA appear to be relatively affordable. A majority of consumers with marketplace coverage has reported it being very or somewhat easy to pay their premiums. This has especially been true for those with low incomes who are benefitting from the ACA's insurance subsidies.

The federal and state insurance marketplaces have also turned out to be quite stable and competitive. Nationwide, marketplace premiums did not increase at all, on average, from 2014 to 2015. This is unprecedented in light of historical trends in the individual and employer-based health insurance markets. The number of insurance carriers participating in the marketplaces also grew by 25 percent. However, these trends varied substantially by state: 14 states saw average premiums decline, while 10 states and the District of Columbia saw double-digit increases.

States have had considerable flexibility in implementing the ACA's coverage reforms. As a result, consumers, insurers, and providers are experiencing the reforms somewhat differently from state to state. The most significant source of variation involves the decision to expand eligibility for Medicaid. So far, 22 states and the District of Columbia have expanded Medicaid under the law's provisions, and six states have received approval to expand Medicaid eligibility in a somewhat different fashion. Twenty-two states have not yet expanded Medicaid, though six of those are discussing ways to do so.

The impact of these decisions is clear. As several surveys have shown, uninsured rates are falling to the lowest levels in those states that have expanded Medicaid eligibility. Because state flexibility in whether to expand Medicaid stems from the 2012 Supreme Court decision, it was unforeseen by the drafters of the ACA.

Another unforeseen occurrence with implications for the ACA has been the slowdown in the rate of health care spending growth in recent years. This slowdown has been observed across the board, in public programs as well as private insurance. Partly in response, the Congressional Budget Office recently lowered its projections for the net federal costs of the ACA's coverage provisions by an additional $142 billion over the period 2016 to 2026. The CBO's most recent report also notes that, between 2015 and 2019, these federal costs will be 29 percent lower than the agency originally projected in 2010. While a number of factors have contributed to these downward revisions, slower cost growth has been one important contributor.

The 160 million people who have their coverage through an employer are also benefitting from new protections, like the ability to stay on a parent's health plan through age 25, and preventive care coverage without cost-sharing. Even with these changes, premium growth in employer-based health plans has slowed in the majority of states since 2010, when the provisions went into effect.

The CBO projects the law will have only minor effects on the labor force, driven almost entirely by workers' voluntary choices. For example, people who had been locked into their jobs because of the need for health insurance may now choose to retire early, stay home to care for children or elderly parents, or earn a college degree.

Finally, it's important to remember that the ACA aimed to do more than strengthen access to, and the affordability of, health insurance and health care; it also sought to improve how care is organized, delivered, and paid for.

There is widespread agreement that the U.S. health care delivery system is inefficient and fragmented, leaving patients, providers, and payers dissatisfied with the value of care provided and received. The ACA includes several reforms to improve health system performance.

The new Center for Medicare and Medicaid Innovation, for example, has launched an array of initiatives involving changes to health care payment and organization that together reach thousands of hospitals, tens of thousands of clinicians, and millions of patients across all 50 states. These reforms, incremental so far, are quickly gathering momentum. A number of the initiatives have the potential to dramatically improve the value of health services received by patients throughout the United States.

Earlier this year, Secretary Burwell announced a goal to have at least 50 percent of traditional Medicare payments linked to some form of alternative payment method by 2018. A private-sector consortium comprising leading health systems, payers,

and purchasers has set similar goals. The alignment of public- and private-sector activity around such goals sends a strong signal to providers and payers alike that the momentum around delivery and payment reform will only be accelerating. The ACA's delivery system reforms have helped to catalyze this new public-private alliance.

At the 5-year mark, there is strong evidence that the Affordable Care Act has resulted in gains in coverage, affordability, and access to health care services. It may also have created the foundation for significant changes to the way we deliver and pay for care. Taken together, a promising picture emerges. Five years, however, is a short time in the life of legislation as ambitious and sweeping as the ACA. Additional studies and evaluations will be necessary to paint a fuller picture of the law's impact on Americans and their health care system.

THE COMMONWEALTH FUND

Thank you, Chairman Hatch, Senator Wyden, and the members of the Committee, for inviting me to testify. I am David Blumenthal, president of The Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

I am honored to testify before the Committee about the Affordable Care Act at five years. Research from The Commonwealth Fund and other sources demonstrates that the ACA is helping to reduce the number of Americans who are uninsured and improving access to health care. Further, the ACA is reforming the way care is delivered and paid for in our country. Taken together, the ACA is the most sweeping overhaul ever of our nation's health system. And while it's too early to assess the impact of many provisions and programs, a review of progress to date suggests a number of positive trends.

THE AFFORDABLE CARE ACT HAS REDUCED THE NUMBER OF UNINSURED ADULTS

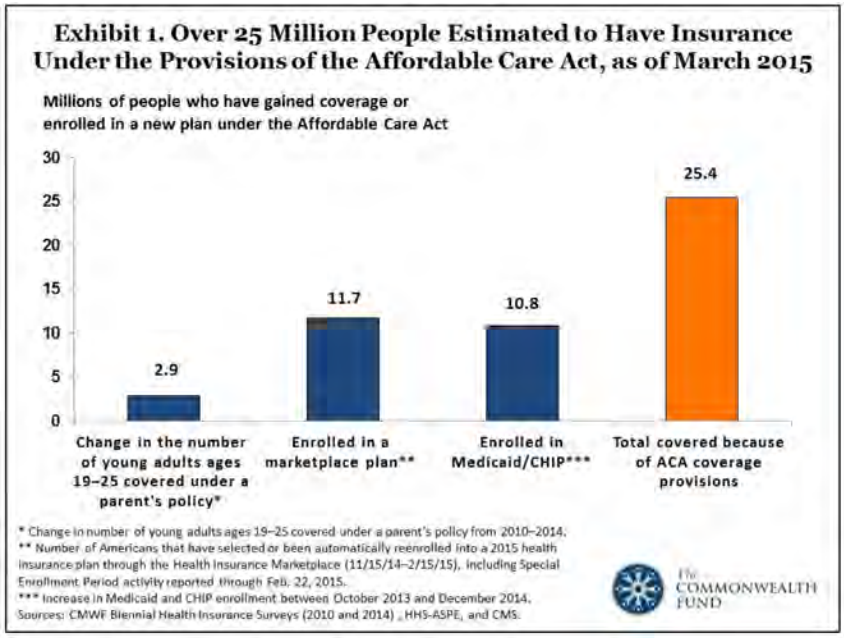
More than 25 million people are estimated to have health insurance under the provisions of the ACA (Exhibit 1). During the most recent enrollment period, about 11.7 million have selected, or were automatically reenrolled in, a health plan through the insurance marketplaces, and special enrollment periods are still open in several states.[1] About 8.8 million people selected a plan through the federal website *HealthCare.gov*—an increase of more than 3 million over last year—and more than 2.8 million selected a plan through the state-based marketplaces. An additional 10.8 million have enrolled in Medicaid or the Children's Health Insurance Program, or CHIP, since October 2013.[2] Finally, we estimate nearly 3 million more young adults are covered under their parents' health plan compared to 2010.[3]

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[1] *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report,* Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, March 10, 2015: *http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf.*

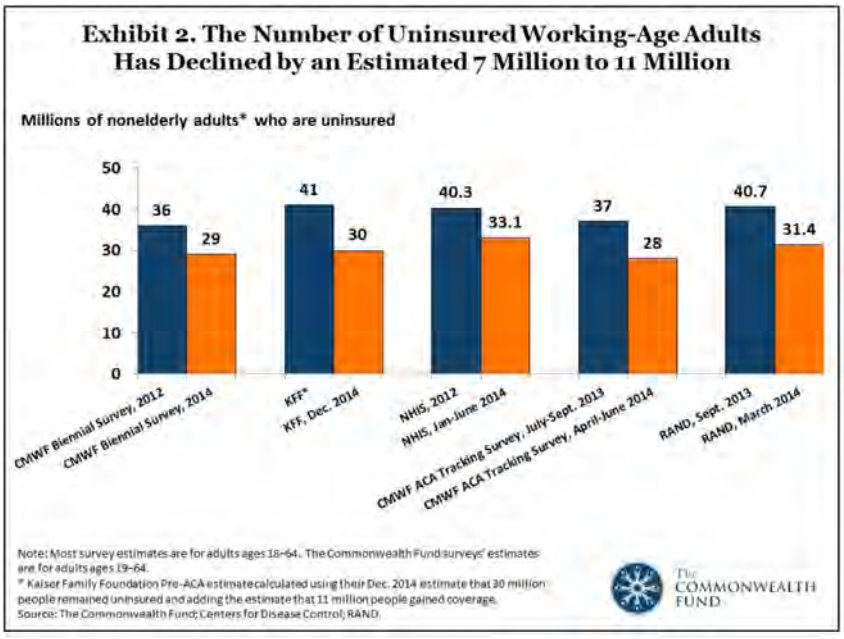
[2] V. Wachino, "Nearly 10.8 Million Additional Individuals Enrolled in Medicaid as of December 2014," Department of Health and Human Services, Feb. 23, 2015: *http://www.hhs.gov/healthcare/facts/blog/2015/02/medicaid-chip-enrollment-december.html.*

[3] Commonwealth Fund Biennial Health Insurance Survey, 2014.



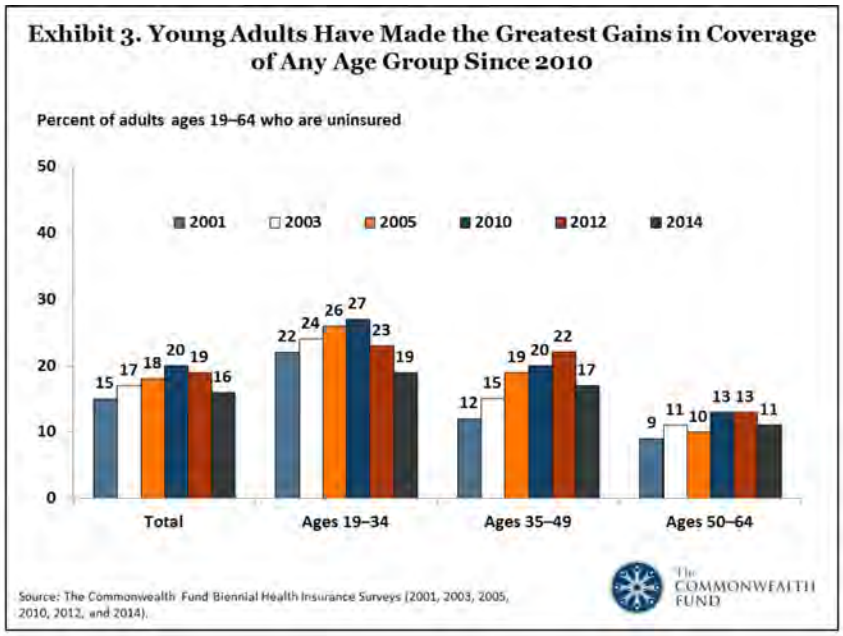
As a result, the number of uninsured adults has fallen. This week, the U.S. Department of Health and Human Services reported that 16.4 million previously uninsured people had gained coverage since the ACA was passed in 2010. Government and private surveys by The Commonwealth Fund, the Kaiser Family Foundation, the RAND Corporation, the Urban Institute and the Centers for Disease Control and Prevention have documented declines in the uninsured population of 7 million to 11 million adults over the past year. These declines are unprecedented (Exhibit 2).[4]

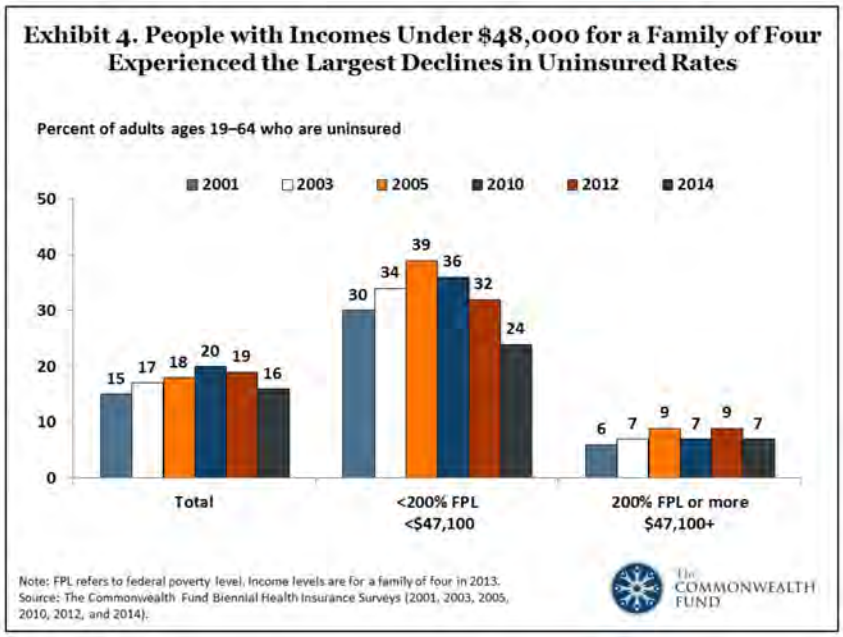
[4] M.E. Martinez, R.A. Cohen, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2014," Centers for Disease Control and Prevention, Dec. 2014; S.R. Collins, P.W. Rasmussen, M.M. Doty, and S. Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect,* The Commonwealth Fund, Jan. 2015; S.R. Collins, P.W. Rasmussen, and M.M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period,* The Commonwealth Fund, July 2014; R. Garfield and K. Young, *Adults Who Remained Uninsured at the End of 2014,* The Henry J. Kaiser Family Foundation, Jan. 2015; K.G. Carman and C. Eibner, "Changes in Health Insurance Enrollment Since 2013: Evidence from the RAND Health Reform Opinion Study," *RAND Health Quarterly,* 2014 4(3).



Groups that historically have been most at risk for lacking insurance have experienced some of the greatest gains in coverage. For example, the uninsured rate for young adults ages 19 to 34 has declined sharply, falling from 27 percent in 2010 to 19 percent in 2014 (Exhibit 3).[5] There have also been striking declines among low-income adults. The uninsured rate for people with incomes below 200 percent of the federal poverty level dropped from 36 percent in 2010 to 24 percent in 2014 (Exhibit 4). Uninsured rates for low-income and young adults are the lowest observed since 2001.

[5] S.R. Collins et al., *Rise in Coverage and Affordability,* The Commonwealth Fund, Jan. 2015.

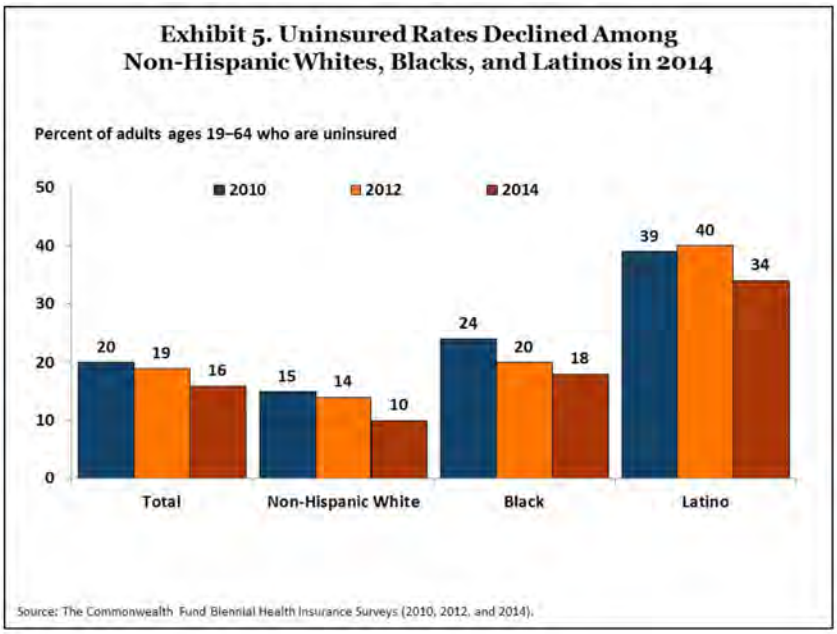




Coverage gains have also occurred across racial and ethnic groups. Between 2010 and 2014, the uninsured rate, fell from 15 percent to 10 percent for non-Hispanic

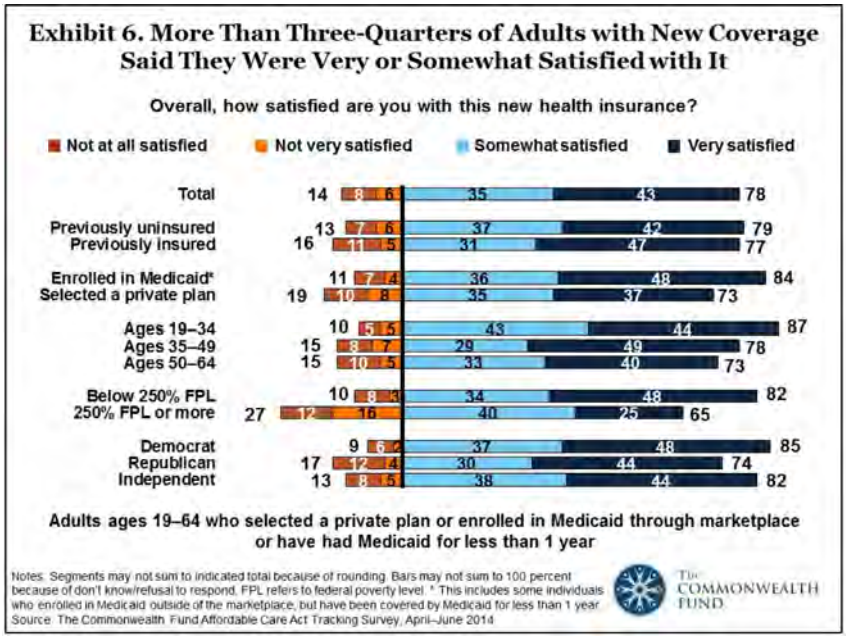
whites; from 24 percent to 18 percent for African Americans; and from 39 percent to 34 percent for Latinos (Exhibit 5).[6]

Despite these declines, African Americans and Latinos continue to be much more likely than non-Hispanic whites to be uninsured.

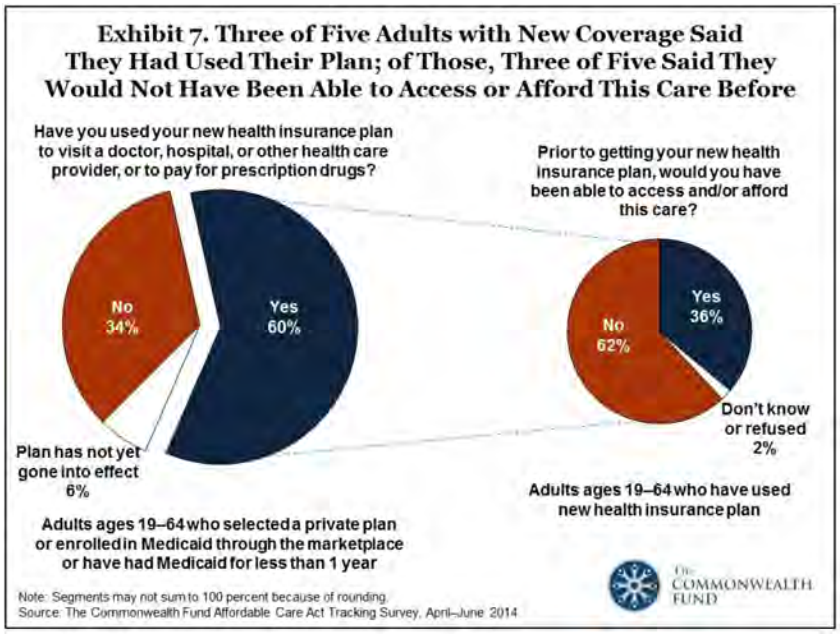


To see how the newly insured are faring with their marketplace or Medicaid coverage, The Commonwealth Fund surveyed these adults in the second quarter of 2014.[7] We found that three-quarters of the newly insured were satisfied with their insurance (Exhibit 6). People who had been insured prior to gaining their new coverage and those who had been uninsured were equally satisfied. Compared to people who selected a marketplace plan, larger shares of those who newly enrolled in Medicaid were satisfied with their new coverage.

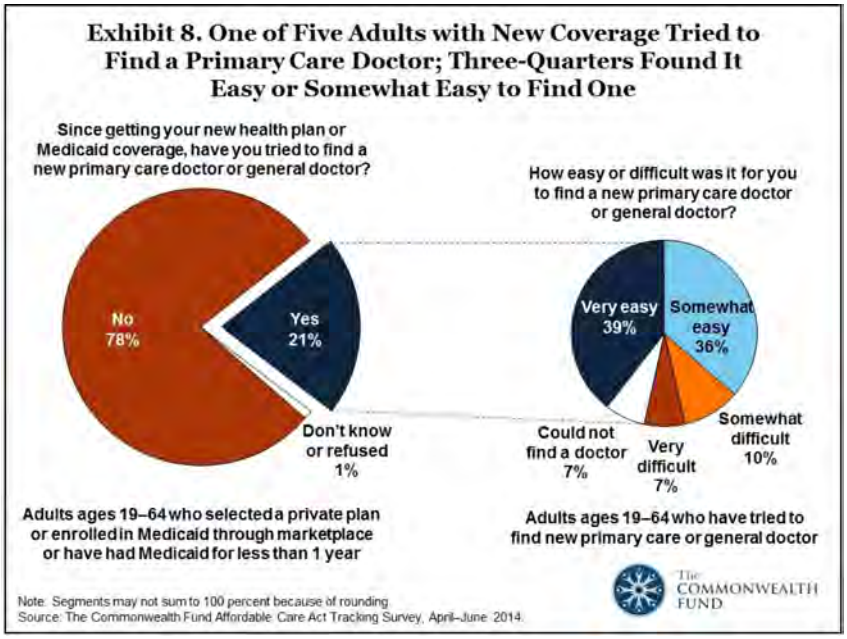
[6] S.R. Collins et al., *Rise in Coverage and Affordability,* The Commonwealth Fund, Jan. 2015.
[7] S.R. Collins et al., *Gaining Ground,* The Commonwealth Fund, July 2014.



At the time of the Commonwealth Fund survey, a majority of the newly insured had already used their plans to go to a doctor or a hospital or to pay for a prescription drug (Exhibit 7). Sixty-two percent of these adults said that they could not have afforded or accessed this care previously. Rates were particularly high for those who had previously been uninsured (75%). But nearly half of those who previously had insurance (44%) said that they, too, would not have able to get this care before enrolling in their new plan.



Of those survey respondents who had tried to find a new primary care physician or general doctor with their new insurance, three-fourths reported that doing so had been very or somewhat easy (Exhibit 8). Two-thirds of respondents who said they found a new primary care doctor were able to get an appointment within two weeks. Wait times were longer for some—for example, 15 percent waited longer than one month—but average wait times were consistent with those reported in prior Commonwealth Fund surveys of the general population, including both insured and uninsured Americans.



IMPROVEMENTS IN INSURANCE COVERAGE ARE REMOVING COST BARRIERS TO CARE AND REDUCING PROBLEMS WITH MEDICAL BILLS

Other indicators demonstrate that improvements in insurance coverage have helped remove cost barriers to care. Among all working-age adults surveyed, the percentage who reported not getting needed care because of the cost fell between 2012 and 2014, from 43 percent to 36 percent, a decline of approximately 14 million people (Exhibit 9).[8] This is the first year that this indicator has fallen since The Commonwealth Fund began tracking it in 2003.

[8] S.R. Collins, et al., *Rise in Coverage and Affordability,* The Commonwealth Fund, Jan. 2015.

Exhibit 9. The Number of Adults Reporting Not Getting Needed Care Because of Cost Declined in 2014

Percent of adults ages 19–64

	2003	2005	2010	2012	2014
In the past 12 months:					
Had a medical problem, did not visit doctor or clinic	22% 38 million	24% 41 million	26% 49 million	29% 53 million	23% 42 million
Did not fill a prescription	23% 39 million	25% 43 million	26% 48 million	27% 50 million	19% 35 million
Skipped recommended test, treatment, or follow-up	19% 32 million	20% 34 million	25% 47 million	27% 49 million	19% 35 million
Did not get needed specialist care	13% 22 million	17% 30 million	18% 34 million	20% 37 million	13% 23 million
Any of the above access problems	37% 63 million	37% 64 million	41% 75 million	43% 80 million	36% 66 million

Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, and 2014).

The decline in cost-related access problems likely reflects the ACA's expansions of coverage as well as the law's improvements in coverage, such as the inclusion of preventive care services without cost-sharing. The decline may also reflect some improvement in the economy. Still, these rates remain quite high, particularly among those with low incomes. Forty-five percent of adults with incomes below 200 percent of poverty reported problems getting care because of the cost, including one-third of those with insurance.

Exhibit 10. The Number of Adults Reporting Medical Bill Problems Declined in 2014

Percent of adults ages 19–64

	2005	2010	2012	2014
In the past 12 months:				
Had problems paying or unable to pay medical bills	23% 39 million	29% 53 million	30% 55 million	23% 43 million
Contacted by a collection agency about medical bills*	21% 36 million	23% 42 million	22% 41 million	20% 37 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 30 million	18% 32 million	15% 27 million
Contacted by a collection agency because of billing mistake	7% 11 million	5% 9 million	4% 7 million	4% 8 million
Had to change way of life to pay bills	14% 24 million	17% 31 million	16% 29 million	14% 26 million
Any of three bill problems (does not include billing mistake)	28% 48 million	34% 62 million	34% 63 million	29% 53 million
Medical bills being paid off over time	21% 37 million	24% 44 million	26% 48 million	22% 40 million
Any of three bill problems or medical debt	34 % 58 million	40% 73 million	41% 75 million	35% 64 million

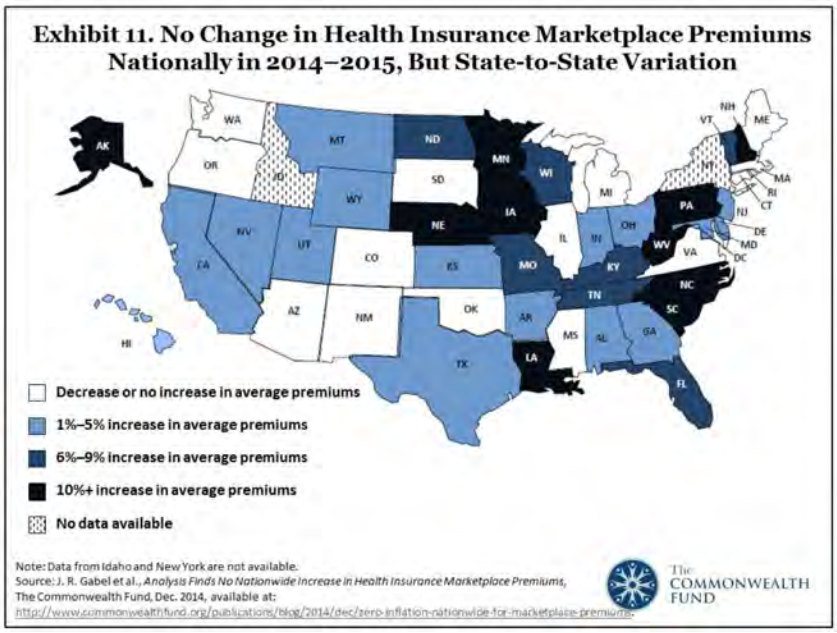
* Subtotals may not sum to total: respondents who answered "don't know" or refused are included in the distribution but not reported.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, and 2014).

Better insurance coverage and an improving economy have also meant fewer Americans are reporting health care-related financial difficulties. The number of adults saying they had problems paying their medical bills in the past year declined from 75 million people in 2012 to 64 million in 2014 (Exhibit 10).[9] This included 8 million fewer people paying off bills over time, and 5 million fewer people being contacted by a collection agency for unpaid medical bills. As with cost-related access problems, though, rates of financial problems remain high, particularly for adults with low incomes.

HEALTH INSURANCE MARKETPLACES HAVE BEEN STABLE AND COMPETITIVE

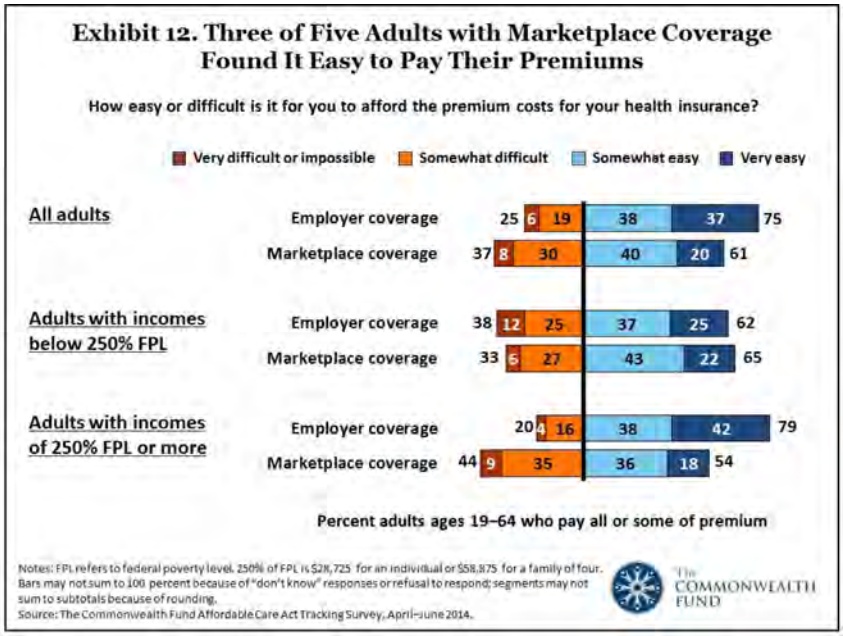
The health insurance marketplaces created under the ACA have turned out to be quite stable and competitive. Nationwide, marketplace premiums did not increase at all, on average, from 2014 to 2015. This is unprecedented in light of recent trends in the individual and employer-based health insurance markets (Exhibit 11).[10] Furthermore, the number of carriers participating in the marketplaces increased by 25 percent. Trends in both premiums and participating carriers, however, varied substantially by state: 14 states saw average premiums decline, while 10 states and the District of Columbia saw double-digit increases. This heterogeneity reflects local market conditions and differences between urban, suburban, and rural areas.

[9] Ibid.
[10] J.R. Gabel, H. Whitmore, S. Stromberg, et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," The Commonwealth Fund Blog, Dec. 2014: *http://www.commonwealthfund.org/publications/blog/2014/dec/zero-inflation-nationwide-for-marketplace-premiums.*



Overall, health plans sold in the marketplaces also appears to be relatively affordable for consumers. A majority of adults (61%) with marketplace coverage reported it has been very or somewhat easy to pay their premiums (Exhibit 12).[11] This is especially true for those with incomes below 250 percent of the poverty level, of whom two-thirds reported that paying their premiums was somewhat or very easy. These adults benefit from the ACA's insurance subsidies, including reduced cost-sharing to protect from high out-of-pocket expenses.

[11] P.W. Rasmussen, S.R. Collins, M.M. Doty, and S. Beutel, *Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces? Results from the Commonwealth Fund Affordable Care Act Tracking Survey,* The Commonwealth Fund, Sept. 2014.

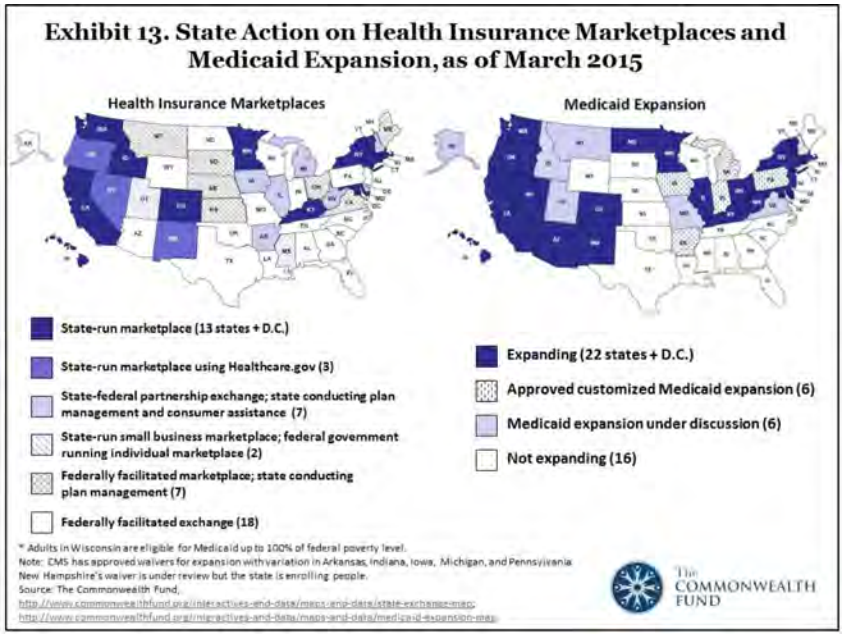


In contrast, having trouble paying insurance premiums was somewhat more common among people with higher incomes, who receive smaller subsidies or none at all: 44 percent of adults with incomes that put them at or above 250 percent of the poverty level said it was somewhat difficult, very difficult, or impossible.

THE AFFORDABLE CARE ACT HAS UNFOLDED DIFFERENTLY IN EACH STATE

States have had considerable flexibility to implement the ACA's insurance coverage reforms. This flexibility stems from the statute itself, from how federal regulations have been implemented, and from decisions made by the Supreme Court. As a result, consumers, insurers, and providers are experiencing the reforms somewhat differently from state to state.

Significant differences have arisen regarding states' management of their insurance marketplaces (Exhibit 13). Sixteen states and the District of Columbia opted to run their own marketplaces, although this year three of these states—Oregon, New Mexico, and Nevada—are using *HealthCare.gov*. Thirty-four states are using the federal marketplace, but there is a great deal of variation in their involvement in operations. For example, seven states using the federal marketplace take responsibility for plan management, and seven more are undertake both plan management and consumer assistance.



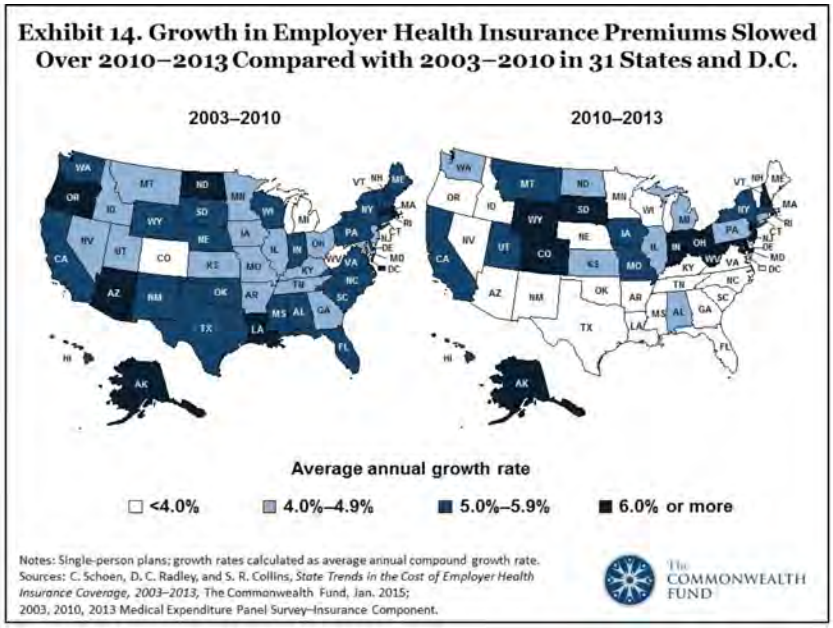
The most significant source of variation in how states have been affected by the ACA concerns their decision to expand eligibility for Medicaid. So far, 22 states and the District of Columbia have expanded Medicaid under the law's provisions, and six states have received approval from the Department of Health and Human Services to expand Medicaid eligibility under Section 1115 waiver authority (Exhibit 13). Twenty-two states have not yet expanded Medicaid, though six of those are discussing ways to do so. The impact of these decisions is clear: several surveys have shown uninsured rates falling to the lowest levels in those states that have expanded Medicaid eligibility.

HEALTH CARE SPENDING GROWTH HAS SLOWED, REDUCING FEDERAL COSTS OF ACA COVERAGE PROVISIONS

One unforeseen event with implications for the ACA has been the slowdown in the rate of health care spending growth in recent years. This slowdown has been observed across the board, both in public programs and in private insurance. Real (inflation-adjusted) Medicare spending per beneficiary has actually fallen,[12] and 31 states and the District of Columbia have experienced slower growth in employer-sponsored insurance premiums from 2010 to 2013 compared to the 7 prior years (Exhibit 14).[13]

[12] M. Sanger-Katz, "Per Capita Medicare Spending Is Actually Falling," *New York Times,* Sept. 3, 2014: *http://www.nytimes.com/2014/09/04/upshot/per-capita-medicare-spending-is-actually-falling.html.*

[13] C. Schoen, D.C. Radley, and S.R. Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003–2013,* The Commonwealth Fund, Jan. 2015.



Partly in response to this slowdown in spending growth, the Congressional Budget Office recently lowered its projections of net federal costs for the ACA's coverage provisions over the period 2016 to 2026 by $142 billion.[14] The CBO's most recent report also notes that between 2015 and 2019, these federal costs will be 29 percent lower than the agency originally projected in 2010. A number of factors have contributed to these downward revisions, including changes in law, changes in the CBO's economic projections, and the Supreme Court's decision regarding Medicaid. However, slower spending growth has been sufficiently broad and persistent to convince the CBO to lower its projections of federal costs for health care.

THE LAW IS BENEFITTING PEOPLE IN EMPLOYER-BASED PLANS AND FREEING PEOPLE FROM "JOB LOCK"

The 160 million people with health coverage through an employer are also benefitting from new protections, like the ability to stay on a parent's health plan through age 25, and preventive-care coverage without cost-sharing. And despite these changes, premium growth in employer-based plans slowed in the majority of states since 2010, when these provisions went into effect.

The CBO projects only minor effects on the labor force from the law. The agency estimates the ACA will reduce hours worked by 1.5 percent to 2 percent over the period 2014 to 2017. This translates into a decline in full-time-equivalent workers of 2 million in 2017, rising to 2.5 million in 2024. The CBO believes this reduction will occur almost entirely because workers will chose to work less as a result of the law's new coverage options.[15] For example, workers who have been locked into their jobs because of the need for health insurance may now chose to retire early, stay home or work part-time to care for children or elderly parents, or earn a college degree.

[14] *Updated Budget Projections: 2015 to 2025,* Congressional Budget Office, March 2015: *http://www.cbo.gov/publication/49973.*

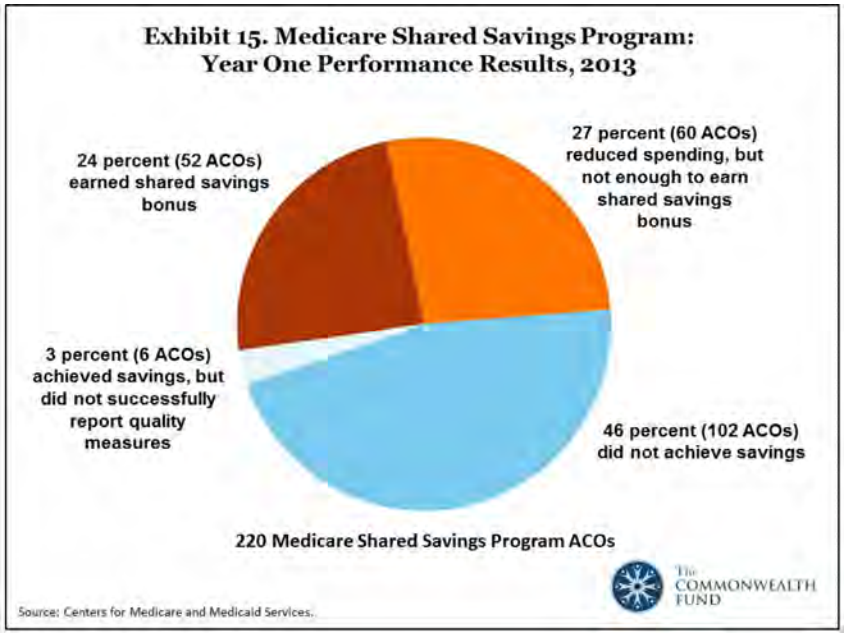
[15] Congressional Budget Office, *The Budget and Economic Outlook, Appendix C: Labor Market Effects of the Affordable Care Act,* February 2014:
http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf.

Finally, it's important to remember that the ACA aimed to do more than strengthen access to, and the affordability of, health insurance and health care. It also sought to improve how care is organized, delivered, and paid for.

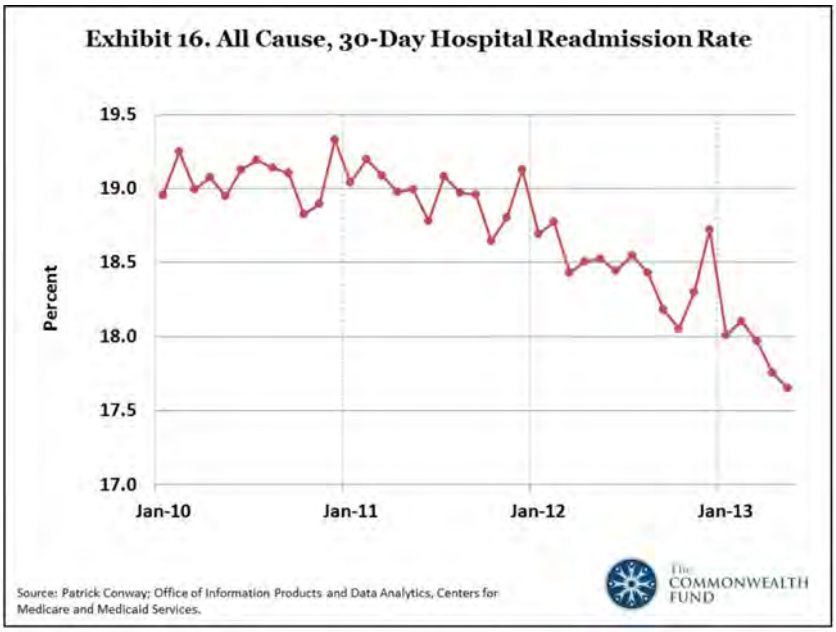
There is widespread agreement that the U.S. health care delivery system is inefficient and fragmented, leaving patients, providers, and payers dissatisfied with the value of care provided and received. The ACA includes several reforms to improve health system performance.

The new Center for Medicare and Medicaid Innovation (CMMI), for example, has launched an array of initiatives involving changes in the way care is paid for and organized that together reach thousands of hospitals, tens of thousands of clinicians, and millions of patients across all 50 states. While the general direction of CMMI activities is promising, it is for the most part too early in the evolution of these nascent initiatives to assess them rigorously. It is reasonable to infer, however, that the reforms are contributing to the gathering momentum across the country around payment and delivery system reform.

One ACA payment initiative currently being tested is the Medicare Shared Savings Program. Established as a way of encouraging providers to form accountable care organizations, or ACOs, the Shared Savings Program provides an opportunity for provider groups that are serving as an ACO and take responsibility for the quality and cost outcomes for a specified patient population to split the savings with the federal government if they meet quality and spending targets. Currently there are more than 400 Shared Savings ACOs, and together they serve 13 percent of the Medicare population. Although provider participation has exceeded expectations, first-year results were mixed, with only 24 percent earning shared-savings bonuses (Exhibit 15).



Another payment change relates to how Medicare reimburses hospitals for higher-than-expected numbers of readmissions. Since the program began at the end of 2012, there have been approximately 150,000 fewer Medicare readmissions each year. In large part because of the financial penalties associated with the ACA's policy change, 30-day hospital readmission rates have declined from 19 percent to 17.5 percent (Exhibit 16).



Earlier this year, Secretary Burwell announced a goal to have at least 50 percent of traditional Medicare payments linked to some form of alternative, value-based payment method by 2018. A private-sector consortium comprising leading health systems, payers, and purchasers has set similar goals. The alignment of public- and private-sector activity around such goals sends a strong signal to providers and payers alike that the momentum around delivery and payment reform will only be accelerating. The ACA's initiatives seem to have played an important part in catalyzing this public-private alignment, which is crucial to improving health care for all Americans.

CONCLUSION

At the 5-year mark, there is strong evidence that the Affordable Care Act has resulted in gains in health insurance coverage, the affordability of coverage and care, and access to health services. The law may also have laid the foundation for significant improvements in the way we deliver and pay for care. Taken together, a promising picture emerges. Five years, however, is a short time in the life of legislation as ambitious and sweeping as the ACA. Additional studies and evaluations will be needed to paint a fuller picture of its impact on Americans and their health care system.

QUESTIONS SUBMITTED FOR THE RECORD TO DR. DAVID BLUMENTHAL

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

ECONOMIC BENEFITS OF MEDICAID EXPANSION

Question. Dr. Blumenthal, can you speak to the impact of Medicaid expansion on state economies? How does Medicaid help create jobs in expansion states?

Answer. A number of studies have shown Medicaid expansion to have a significant positive economic impact for states.[1] These benefits accrue not only to newly

[1] For a round-up of several of these studies, see: Economic Impact of the Medicaid Expansion, Office of the Assistant Secretary for Health Planning and Evaluation, Department of Health and Human Services, March 2015: *http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_MedicaidExpansion.pdf.*

insured individuals, but also to health care providers, to state governments, and to the state's economy as a whole.

Most directly, because the federal government covers the vast majority of the costs—100% until 2016, decreasing to 90% by 2020—Medicaid expansion results in a net influx of federal dollars. These funds are substantial—a Commonwealth Fund study found California would receive $10 billion, Ohio $7.8 billion, and New York $8.6 billion in 2022.[2] The 24 states that had not expanded Medicaid as of July 2014 will forego $88 billion in federal funding between 2014–2016.[3] These funds directly boost state domestic product and create jobs. This has been borne out by experience, as health care sector jobs grew faster in 2014 in expanding states than in non-expanding states.[4] Health care providers in states expanding Medicaid also saw their uncompensated care costs fall $2.6 billion more than in the non-expanding states.[5]

Furthermore, Medicaid expansion is a good deal for state taxpayers. This is because states' costs for expanding are more than offset by savings in other state health programs and increased tax revenue. In Ohio, for example, Medicaid expansion is estimated to boost the state budget by $1.4 billion between 2014 and 2022.[6] A similar study of Kentucky estimated the boost to be $919 million between 2014 and 2021.[7]

Finally, it is important to recognize the economic benefits that redound to individuals and society from insurance coverage. Insured adults are more likely to be working and productive.[8] They are less likely to have unpaid medical bills or declare bankruptcy.[9] And they are more likely to receive preventive services that reduce the need for more costly treatment down the road.[10] Medicaid is also the country's third largest poverty-reducing program.[11] For these reasons, expanding Medicaid has clear short- and long-term benefits for states' economies.

PRESCRIPTION DRUG ACCESS AND AFFORDABILITY

Question. Dr. Blumenthal, when assessing financial burden, how do shifts in cost-sharing impact low-income individuals or those with chronic health conditions or rare diseases that must be managed through prescription drugs? What more must be done to ensure access to affordable prescription drugs?

Answer. By increasing the number of Americans with health insurance, restricting insurers' ability to deny coverage based on pre-existing conditions, and limiting annual out-of-pocket costs for insured patients, the ACA has made tremendous strides in improving access to pharmaceuticals. Between 2012 and 2014, the percentage of working-age adults who reported not filling a prescription because of the

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[2] S. Glied and S. Ma, How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion, The Commonwealth Fund, December 2013.

[3] The Council of Economic Advisors, Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid, Washington, D.C.: The Council of Economic Advisors, July 2014.

[4] J. Furman, The Economic Benefits of the Affordable Care Act, Presented to the Center for American Progress, April 2015: *https://www.whitehouse.gov/sites/default/files/docs/20150402_aca_economic_impacts_fifth_anniversary_cap_0.pdf.*

[5] Impact of Insurance Expansion on Hospital Uncompensated Care Costs, Office of the Assistant Secretary for Health Planning and Evaluation, Department of Health and Human Services, March 2015: *http://aspe.hhs.gov/health/reports/2015/MedicaidExpansion/ib_UncompensatedCare.pdf.*

[6] C. Candisky, "Study backs expanding Medicaid in Ohio," *The Columbus Dispatch,* January 16, 2013.

[7] Commonwealth of Kentucky: Medicaid Expansion Report, 2014: Updated February 2015, Deloitte: *http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.*

[8] A. Dizioli and R. Pinheiro, Health Insurance as a Productive Factor, June 2012. Available at SSRN: *http://ssrn.com/abstract=2096415.*

[9] S.R. Collins, P.W. Rasmussen, M.M. Doty, and S. Beutel, The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect, The Commonwealth Fund, January 2015; D.U. Himmelstein, D. Thorne, E. Warren et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," American Journal of Medicine, Aug. 2009 122(8):741–46.

[10] S.R. Collins, et al., The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect.

[11] B. Sommers and D. Oellerich, "The Poverty-Reducing Effect of Medicaid," *Journal of Health Economics,* September 2015 32(5):816–832.

cost fell from 27% to 19%—a decline of 15 million people.[12] This was the lowest rate since the Commonwealth Fund began tracking this statistic in 2003.

However, among those who remained uninsured in 2014, cost-barriers to prescription drugs are all-too common. Thirty-two percent of uninsured, working-age adults did not fill a prescription due to its cost; and, among those with chronic conditions, 35 percent skipped doses or did not fill a prescription for a drug for their condition.[13] These findings speak to the importance of further reducing the number of Americans without health insurance, particularly by expanding Medicaid. Ensuring that insurance plans offer adequate financial protection will also remain important, as many patients who are "underinsured" also report cost-barriers to pharmaceuticals.

Drug coverage and affordability poses a particular problem in the present moment because, after a decade-long slowdown, spending on pharmaceuticals is now growing by more than 10% annually.[14, 15] This growth is largely being driven by high-priced specialty drugs. The poster drug for this trend is Sovaldi—a highly effective treatment for hepatitis C, priced at $84,000 for a standard course. The high prices that specialty drugs like Sovaldi can command threaten the budgets of public and private payers: Sovaldi's release coincided with a greater than 1,500% increase in Medicare spending on treatments for hepatitis C.[16] Furthermore, not all specialty drugs can boast the effectiveness of Sovaldi to justify their high prices.

In the years ahead, policymakers will likely need to take steps to ensure specialty pharmaceuticals are affordable for those who need them, so that we can all benefit from the breakthroughs coming down the pharmaceutical pipeline. This may require re-examining the extend and duration of current patent protections; encouraging competition from generics, including for biologics; funding comparative effectiveness research so that society can assess drugs' added value; and demanding larger rebates or negotiating power for the Medicare program.

Question. Dr. Blumenthal, can you please speak to the consequences of being uninsured as a child and what risks it poses for later on in life?

Answer. Being insured has been shown to significantly improve children's health as well as their long-term outcomes. A number of recent studies have looked at the impacts of expanding Medicaid and S–CHIP for children in the 1980s–1990s, and these have found:

- Childhood Medicaid eligibility increases rates of high school and college completion,[17] leads to higher lifetime earnings,[18] and promotes greater intergenerational mobility.[19]
- The government recoups most of the cost of childhood Medicaid coverage through higher tax revenue and lower EITC payments down the road.[20]
- Childhood Medicaid eligibility leads to fewer hospitalizations and emergency room visits among blacks once they become adults, especially among those living in low-income neighborhoods.[21]

Given the crucial role that health insurance plays in improving children's lives, it was promising to see the passage of H.R. 2, the Medicare Access and CHIP Reauthorization Act. This bill assures that the 10 million children and pregnant women who rely on CHIP will remain insured. However, the bill only authorized CHIP for

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[12] S.R. Collins, et al., The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect.

[13] The Commonwealth Fund Biennial Health Insurance Survey (2014).

[14] D. Blumenthal and D. Squires, Drugs and Dollars, The Commonwealth Fund Blog, July 2014.

[15] Insights From Monthly National Health Spending Data Through February 2015, Altarum Institute, Health Sector Economic Indicators, April 2015.

[16] C. Ornstein, "New hepatitis C drugs are costing Medicare billions," *The Washington Post,* March 29, 2015.

[17] S. Cohodes, D. Grossman, S. Kleiner, and M.F. Lovenheim, "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions," NBER Working Paper No. 20178, May 2014.

[18] D.W. Brown, A.E. Kowalski, and I.Z. Lurie, "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts," NBER Working Paper No. 20835, January 2015.

[19] R.L. O'Brien and C.L. Robertson, Medicaid and Intergenerational Economic Mobility, Institute for Research on Poverty, Discussion Paper No. 1428–15, April 2015.

[20] D.W. Brown, et al, "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts."

[21] L.R. Wherry, S. Miller, R. Kaestner, and B.D. Meyer, "Childhood Medicaid Coverage and Later Life Health Care Utilization," NBER Working Paper No. 20929, February 2015.

an additional two years. Furthermore, policymakers will need to make careful decisions in the coming years regarding the interplay between CHIP and the ACA's Marketplace. One important step would be to fix the "Family Glitch," which locks out millions of low- and middle-income children and spouses from receiving Marketplace subsidies. Until these and other steps are taken, CHIP will continue to serve as a crucial safety net for America's children.

Finally, while CHIP and other programs have sharply reduced the uninsured rate among children in recent decades, 7 percent are still without insurance.[22] The majority of these are likely eligible for Medicaid or CHIP but have not yet enrolled. Several states—including Massachusetts, Hawaii, and Vermont—have considerably lower uninsured rates among children, demonstrating that progress is indeed possible given sufficient political attention and will.[23]

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a committee hearing examining Obamacare's broken promises and wasted taxpayer dollars, 5 years after the law's enactment:

The committee will come to order.

Good morning. Our hearing today will consider what has happened in the 5 years since March 23, 2010, when the so-called Affordable Care Act was signed into law.

In my opinion, this anniversary presents a perfect opportunity to take a look back and evaluate whether the promises that were made to gain support for the law have been kept. It's also a good time to look forward and consider the many unanswered questions that we still have about the impact and viability of the ACA.

At the time that the Affordable Care Act was enacted, there was great disagreement about whether it would effectively reduce costs or expand coverage. Five years later, the people of Utah and others that I hear from are in total agreement about one thing with respect to this law: It just isn't working. In fact, it is, by most objective accounts, an unmitigated disaster.

The President and his allies claim that the law is a success, usually by cherry-picking particular data points and ignoring the larger picture. Most often, they point to the number of individuals who have signed up for health insurance since the botched rollout of the *HealthCare.gov* website, somehow arguing that people opting to buy insurance under the threat of a government penalty is cause for celebration.

What they don't talk about are the still skyrocketing health care costs that are hitting families across this country. And, they also ignore the widespread frustration and delay caused by this law, which many Americans are finding out about during this tax filling season.

Let's talk about that frustration.

According to H&R Block, in the first 6 weeks of this tax filing season, 52 percent of customers who enrolled in insurance through the state or federal exchanges had to repay a portion of the Advance Premium Tax Credit that they received under Obamacare. That same report found that individuals, on average, are having to repay about $530, which is decreasing their tax refunds by roughly 17 percent.

Now, let's talk about delay.

On February 20, 2015, the Obama Administration announced that, due to an error in the health law, they sent out about 800,000 incorrect tax statements relating to Form 1095–A, meaning that hundreds of thousands of Americans may be seeing delays in their tax refunds this year.

These are just some of the problems hardworking taxpayers are facing as they try to deal with Obamacare during this tax season.

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[22] G.M. Kenney et al., A First Look at Children's Health Insurance Coverage Under the ACA in 2014, Urban Institute, September 2014.

[23] D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Aiming Higher: Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fund, May 2014.

While the ramifications to taxpayers are significant, the overall impact on America's budget is even greater. The total overall cost of Obamacare so far has numbered in the tens of billions, and we're barely through the first phases of implementation.

Unfortunately a significant portion of that money resulted in no benefit whatsoever to the taxpayers. Specifically, an analysis done by my staff shows that in just five areas, over $5.7 billion went to projects which added NO value to the taxpayers.

That is $5.7 billion dollars down the drain. Taxpayers have been left on the hook for funds that were doled out for Obamacare to states, corporations, and contractors with little to no accountability.

The following five examples are some of the most egregious:

1. Failed State Exchanges: According to the Congressional Research Service, $1.3 billion in taxpayer funds have been spent on state exchanges that failed and were never operational.
2. Consumer Oriented and Operated Plans (Co-ops): The Centers for Medicare and Medicaid Services has loaned $2.4 billion to 24 co-ops, one of which failed before it enrolled anyone. Taxpayers are set to lose nearly half of this money from default or artificially low interest rates. CMS has no plans to recoup any of the funds, meaning a total cost to taxpayers of around $1 billion.
3. *HealthCare.gov* Website: The Obama Administration's website became a pre-existing condition for many Americans who were forced to purchase insurance on the broken site or face a fine. Despite fixes to *HealthCare.gov,* the total cost of the failed enrollment system surpassed $2 billion.
4. Serco: This contractor was awarded $1.2 billion to manage paper applications during the first enrollment period of the health care law. However, only a handful of the total applications received were paper applications, leaving Serco employees with little to do. The waste was so apparent that a whistleblower who worked at the company reached out to the St. Louis Post-Dispatch, saying: "I feel guilty for working there as long as I did. It was like I was stealing money from people."
5. Marketplace Navigators: The Administration has spent over $120 million on the Navigator program for the 2014 and 2015 open enrollment periods. The purpose of the Navigators is to provide individuals with information about health insurance, including signing up for the Health Insurance Marketplace. The Kaiser Family Foundation estimates 2015 marketplace enrollment at approximately 11 million individuals. The overall value of the Navigator program is, at best, inconclusive, and, at worst, it represents more wasted taxpayer dollars.

These five examples are just a handful of the countless misguided, poorly defined, and poorly implemented aspects of the Affordable Care Act. We mark the 5-year anniversary of its passage today, but it's certainly no cause for celebration.

I want to thank our witnesses for appearing today to help discuss the impacts of this law, and I look forward to what I am sure will be a spirited discussion.

I'd now like to turn it over to Senator Wyden for his opening remarks.

PREPARED STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D.,
PRESIDENT,* AMERICAN ACTION FORUM

Chairman Hatch, Ranking Member Wyden, and members of the committee thank you for the privilege of appearing to discuss the Patient Protection and Affordable Care Act ("ACA") on the 5th anniversary of its enactment. This milestone is the perfect time to more closely examine the law, the promises that were made to gain support for its passage, and, most importantly, how many of those promises have been kept.

The main promise that we heard repeated over and over again was that the ACA would provide universal access to affordable coverage of high-quality health care. In

*The views expressed here are my own and not those of the American Action Forum, the Partnership for the Future of Medicare or the Center for Health and Economy. I thank Brittany La Couture for her assistance.

these remarks I will discuss (1) coverage, (2) affordability, (3) quality, and (4) access to care under the ACA.

The ACA has been riddled with wasted money and broken promises. It has proven to be poor growth policy, red-ink budget policy, flawed insurance policy, and poor health care policy. Instead of growth, it has contributed to a mediocre recovery. Instead of fiscal responsibility, it has exacerbated the red ink that plagues the government. Instead of universal coverage for the uninsured, the retention of valued policies and lower premiums, it has produced spotty, uneven coverage expansions, the forcible loss of valued polices and higher premiums for all. And instead of bending the cost curve and raising quality, it has delivered limited access to doctors and the loss of preferred providers.

BACKGROUND

The ACA was first passed in the Senate in 2009 on a partisan vote on Christmas Eve, and subsequently through the House in a similarly partisan fashion. The American public was, and remains, deeply divided over the law. Prior to passage and after enactment, President Obama and the ACA's supporters made numerous and oft-repeated promises about all the ways in which the ACA would improve Americans' lives by allowing for universal coverage while simultaneously lowering the cost and increasing the quality of care. Instead, the law has produced $43.8 billion in regulatory burden, 163.5 million annual paperwork hours.[1] Five years later it is clear that the law cannot deliver on those promises.

UNIVERSAL COVERAGE

One of the main selling points of the ACA was that all Americans, including 46.3 million uninsured individuals, would be guaranteed access to insurance coverage either through their employer or current provider, the private market health insurance exchanges created under the law, or Medicaid and CHIP. Yet 5 years later, over 35 million Americans are still uninsured.[2]

Prior to passage of the ACA, most Americans had insurance plans that they liked, typically through an employer-sponsored plan. President Obama assured them on at least 37 separate occasions that "if you like your health care plan, you can keep it."[3] As the law went into effect in 2014, however, 4.7 million Americans lost their insurance coverage.[4] Many were able to re-enroll in new plans, but often with higher premiums and new provider networks.

Another feature Americans were promised was an easy to use online health insurance portal. About one-third of the states established their own health care exchanges and websites with varying degrees of failure during the first year. Some states were forced to completely rebuild their exchanges, others bought software developed by more successful states, and two states gave up completely and relinquished their exchange to the Department of Health and Human Services (HHS).[5]

Speaking about the federal website operated by HHS, President Obama promised, "Now, ultimately, this website, *HealthCare.gov,* will be the easiest way to shop for and buy these new plans, because you can see all these plans right next to each other and compare prices and see what kind of coverage it provides."[6] This statement also turned out to be patently false—software glitches, incompatibility between Medicaid and exchange software, and miscommunication between the exchange and insurers left millions of Americans frustrated, confused, and without insurance coverage at the end of the first open enrollment period. This disaster of a website cost the American taxpayer nearly $840 million.[7] The second year open enrollment was slightly smoother, but has been extended to allow people to make changes once they realize how the ACA affected their tax liability in 2014.[8] The fact

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[1] *http://americanactionforum.org/week-in-regulation/30-billion-in-regulatory-costs.*
[2] *http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.*
[3] *http://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/.*
[4] *http://finance.yahoo.com/news/policy-notifications-current-status-state-204701399.html.*
[5] *http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.*
[6] *http://insider.foxnews.com/2013/10/30/transcript-president-obamas-health-care-law-speech-boston.*
[7] *http://www.nationaljournal.com/health-care/obamacare-website-has-cost-840-million-20140730.*
[8] *http://content.govdelivery.com/accounts/USCMSHIM/bulletins/f80de2;*

Continued

that 5 years after the law was passed people still do not understand what it means for them is a striking indictment.

Low-income Americans who cannot afford to purchase individual market insurance plans were promised free access through Medicaid. However, the Medicaid program that the ACA actually created is not as targeted or complete as supporters promised it would be. In 2012, the U.S. Supreme Court ruled that the ACA's Medicaid expansion was unconstitutional and that states cannot be forced to participate. As a result, Medicaid eligibility varies by state and in some places leaves low-income Americans with less support than higher-income individuals.[9] The enhanced payment structure of the ACA Medicaid expansion causes counter-intuitive incentives for states to try to enroll these newly eligible individuals—those with more resources—rather than focusing on helping the neediest among us.

As a result of new coverage restrictions in the employer market, eligibility limitations in the individual market, and chaotic Medicaid eligibility standards, adults below the poverty line and children are falling through the cracks. Perverse incentives created by the ACA have caused phenomena like the *Family Glitch,* leaving millions of individuals and families unable to enroll in affordable health insurance.[10]

AFFORDABILITY

During passage and implementation of the ACA, Americans heard many promises about "bending the cost curve" and "helping middle-class families" by reducing the cost of insurance thousands of dollars a year.[11] But as it has played out, the ACA has not reduced the cost of health insurance for the federal government, states, businesses, or American families.

Before the ACA reached his desk, President Obama promised, "I will not sign a plan that adds one dime to our deficits—either now or in the future."[12] The ACA, however, was riddled with budget gimmicks that hid the fact that it did not add up over the long term.

The Secretary of HHS promised that "[t]he state doesn't pay" for the ACA's Medicaid expansion, but that is simply untrue.[13] States are currently being held hostage by maintenance-of-effort provisions that force state Medicaid agencies to continue paying for temporary programs that have long since expired. Next year, most states will begin paying for a portion of Medicaid expansion to new populations. They will also become responsible for funding and maintaining their own exchanges if they do not use the federal platform.

In 2009, employers were told "cost savings could be as much as $3,000 less per employer. [. . .]"[14] It is unclear whether and how much employers have saved as a result of the law, but many employers generated savings by offering less generous plans with more restrictive networks. Some employers also dropped dependent coverage to lessen the burden of providing ACA-compliant coverage for their employees' families. For some, these efforts still barely covered the new administrative costs of the law.

There is also evidence that when the employer mandate is actually enforced (it is one of a number of provisions the administration has unilaterally decided to delay), many employers will face tax penalties as well. Employers will have to pay a $2,000 penalty per employee not offered coverage above the first thirty, and an even greater penalty will be assessed for offering non-compliant coverage.[15]

The president promised the ACA would "cut the cost of a typical family's health insurance premium by up to $2,500 a year."[16] In 2014, average individual market premiums increased by 50 percent, and they went up another 4 percent in 2015

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http://americanactionforum.org/videos/policy-in-60-seconds-the-aca-and-your-tax-bill.

[9] *http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.*

[10] *http://americanactionforum.org/research/the-family-glitch.*

[11] *http://www.nationalreview.com/corner/359352/obamacare-bends-cost-curve-upward-avik-roy.*

[12] *https://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.*

[13] *http://talkingpointsmemo.com/dc/hagan-obamacare-burwell-hearing.*

[14] *https://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-fairfax-virginia.*

[15] *http://americanactionforum.org/research/primer-employer-mandate.*

[16] *http://www.huffingtonpost.com/2008/12/04/obamas-long-list-of-promi_n_148598.html.*

with the greatest changes seen in low-cost plans.[17] These increases are attributable, among other things, to market uncertainty caused by the law, guaranteed issue and community rating requirements, and the mandatory inclusion of "essential health benefits."

There are plenty of other ways premiums could increase besides the actual cost of the plan going up.[18] A new job, a raise, marriage, moving or being auto-enrolled in an exchange plan are all ways that the mere structure of the ACA could effectively increase the cost of private market insurance. Some of the greatest premium increases, though, hit individuals and families who did not purchase the benchmark silver plan—if the benchmark decreased, so did subsidies, and an individual or family's share of the premium for any other plan proportionately increased. This is what happened to enrollees in non-benchmark plans in 361 of 461 rating areas where 2015 data was available, and for individuals and families in 234 of these rating areas, switching plans to the new benchmark would mean leaving their current insurance carrier and provider network, causing discontinuity of care.[19]

Americans' out-of-pocket expenses are also increasing. In 2014 the average deductible for a bronze plan was $5,081—42 percent higher than in comparable group market plans.[20] Insurers are using large increases in deductibles to offset slower premium growth caused by competition in the exchanges. Before the ACA, average annual deductible growth was about 5 percent, but it spiked to 10 percent as the ACA was implemented, though it is now beginning to settle.

Just as the cost of insurance has increased under the ACA, the cost of not having comprehensive insurance has increased. Individuals who choose not to be insured or purchase only catastrophic coverage are now subject to an individual mandate penalty that will increase annually as a percentage of the individual's income.[21] There is hardly anything less "affordable" than paying for something you don't have.

QUALITY

One of the first promises made by President Obama in his rush to get health reform passed was "I will protect Medicare."[22] Yet the ACA makes substantial cuts to the Medicare program and uses Medicare money to fund the law's subsidies for non-seniors, while simultaneously being used on paper to delay the Medicare trust fund's insolvency.

Cuts to Medicare mean seniors will have less access to the doctors and care they need, yet the law does next to nothing to improve the quality or efficiency of the Medicare program.[23] Voters were also told that "the law prohibits IPAB [the Independent Payment and Advisory Board] from rationing health care." Since that statement was made some supporters of the law have acknowledged that some rationing in Medicare is inevitable, while then-Secretary Sebelius suggested that CMS will avoid this limitation through its ability to define "rationing."[24]

"The final bill [. . . will] make sure that people are getting the care they need and the checkups they need and the screenings they need before they get sick—which will save all of us money and reduce pressures on emergency rooms."[25] We were told that the Medicaid expansion would work by using preventive care to increase overall health and decrease utilization of emergency rooms. Yet there is evidence from studies done in Oregon and the RAND Health Insurance Survey that show that Medicaid coverage does not increase overall health or reduce emergency

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[17] *http://www.washingtonpost.com/blogs/monkey-cage/wp/2014/11/17/obamacares-premiums-are-going-up-at-the-same-rate-as-everyone-elses/.*

[18] *http://americanactionforum.org/insights/seven-ways-your-exchange-premium-can-increase.*

[19] *http://americanactionforum.org/weekly-checkup/an-analysis-of-benchmark-premiums-in-year-2-of-the-affordable-care-act-exch.*

[20] *http://www.thefiscaltimes.com/Articles/2014/02/03/Obamacare-Sticker-Shock-Found-Deductibles-Not-Premiums.*

[21] *http://americanactionforum.org/weekly-checkup/state-by-state-estimates-of-individual-mandate-payments.*

[22] *https://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care.*

[23] *http://americanactionforum.org/insights/accountable-care-organizations-what-the-demonstration-projects-tell-us.*

[24] *http://www.dpc.senate.gov/docs/fs-112-2-193.pdf.*

[25] *https://www.whitehouse.gov/the-press-office/remarks-president-after-meeting-with-senate-democrats.*

room use.[26] In fact, Medicaid coverage arguably leads to the worst health outcomes because reimbursement rates for providers are so low that it makes non-emergency room care virtually inaccessible. Yet the expansion of Medicaid will cost American taxpayers around $33.5 billion between 2014 and 2020, $12 billion of which will be paid by the states for administrative costs.[27]

ACCESS TO CARE

Medicare and Medicaid enrollees are not the only ones whose access to quality health care has been impeded by the ACA. Individuals and families in individual and group market plans have seen networks constrict to keep premiums low.

"If you like your doctor, you will be able to keep your doctor" is another promise that has not been kept. The ACA restricts insurance plans' ability to control costs in a number of ways, leaving narrow provider networks as one of the few cost control mechanisms still available to insurers. As a result insurers are creating narrow networks where only a few providers are covered, and those providers are sent high volumes of patients at lower reimbursement rates.[28] While having the choice of narrow network plan options is not a bad thing for consumers, the ACA incentivizes this type of plan structure to the exclusion of more robust provider options. Other studies indicate that many providers and hospitals have decided not to participate in one or more ACA exchange plans because of the extremely low reimbursement rates. Many sole practitioners and small physician groups have similarly indicated an intention to switch to cash-only practices or even enter early retirement to avoid the burdensome new mandates and financial obligations imposed on them by the ACA, further limiting patients' choice of providers and driving up wait times in the offices where enrollees are being accepted.

As a result of these incentives, individuals may find that while they have insurance coverage and access to doctors and hospitals, they may have access to an in-network hospital but not have coverage for the doctors inside it. Likewise, individuals may have access to an in-network doctor, but none of the hospitals in which he or she operates.[29] This is hardly access to care.

CONCLUSION

The past 5 years have revealed how the promises made by President Obama and the ACA's supporters, however well-intentioned, do not match the reality of the law. The number and scope of broken promises around the ACA show that the current law is not what Americans wanted and is not the kind of reform American health care needed. With this clearer understanding of the past, perhaps we can make the most of lessons learned and start moving towards more effective reforms in the future.

QUESTIONS SUBMITTED FOR THE RECORD TO DR. DOUGLAS HOLTZ-EAKIN

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

ECONOMIC BENEFITS OF MEDICAID EXPANSION

Question. Medicaid expansion has meant more than just providing insurance coverage to the uninsured. For hospitals and health care providers, it means treating people in the appropriate and least costly setting. Dr. Holtz-Eakin's testimony focused on how the Medicaid expansion has created "counter-intuitive incentives for states to try and enroll newly eligible individuals . . . rather than focusing on helping the neediest." However, both non-expansion states and expansion states, like Ohio, have experienced a "woodworking effect" in the number of non-expansion Medicaid-eligible individuals who have signed up for insurance.

Dr. Holtz-Eakin, can you speak to the Medicaid "woodworking effect" that we've seen in states—both expansion and non-expansion states—across the country? How

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[26] *http://qje.oxfordjournals.org/content/127/3/1057.full; http://www.rand.org/health/projects/hie.html; http://americanactionforum.org/insights/more-insurance-shouldnt-lead-to-more-emergency-room-visits-but-it-might.*

[27] *http://www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States.*

[28] *http://americanactionforum.org/insights/health-care-providers-are-opting-out-of-obamacare-exchang-plans.*

[29] *http://www.huffingtonpost.com/2014/04/10/obamacare-patients-without-doctors_n_5044270.html.*

many individuals have gained coverage through this effect, and why is this concerning to states (particularly their budgets) that have chosen not to expand Medicaid?

Answer. The woodwork effect is an expensive phenomenon whereby publicity and outreach by the federal and some state governments to increase enrollment for one population of Medicaid eligible individuals that are funded entirely by the federal treasury has caused a 2.8 percent increase in enrollment in the previously eligible population, for which the FMAP has not been increased. This places a significant financial burden on state treasuries that are now responsible for paying for health services for at least an additional 550,300 individuals.[1, 2] Naturally, state officials are concerned that they may be unable to fund these new enrollees, particularly in light of the stringent Maintenance of Effort and Minimal Essential Coverage provisions being enforced under the ACA.

The concern, for many, arises not from unwillingness to help needy individuals, but in part from the inability of state leaders to adjust to changing circumstances and help their own citizens in the best way available because of restrictions imposed by the law.

MEDICAID PAYMENT PARITY AND ACCESS TO CARE

Question. In his testimony, Dr. Holtz-Eakin stated that the ACA has impeded access to quality care for Medicaid and Medicare beneficiaries. The testimony went so far as to claim that Medicaid coverage "makes non-emergency room care virtually inaccessible."

In fact, there are many provisions in the ACA that have improved access to health services for beneficiaries. For instance, one of these provisions increased reimbursement rates for certain Medicaid providers and services to the Medicare rates for 2013 and 2014. A study published in the *New England Journal of Medicine* examined this provision and found an association between increased Medicaid reimbursements and the availability of primary care appointments for Medicaid enrollees.

This is an example of something in the ACA that ensures access to care and has helped individuals get to the doctor's office for critical primary care and preventive services. I understand how important it is to remove barriers to accessing quality care, which is one of the reasons I introduced *The Ensuring Access to Primary Care for Women and Children Act.* This bill would extend an expired provision of the ACA that guaranteed primary care reimbursement parity between doctors treating Medicaid and Medicare patients. It would also expand this payment parity to other health care providers who treat women and children, including ob-gyns, nurse practitioners, and physician assistants.

Dr. Holtz-Eakin, can you discuss the increase in primary care appointment availability for Medicaid beneficiaries, as reported in the recent article published in the New England Journal of Medicine—*Appointment Availability after Increases in Medicaid Payments for Primary Care*—and elaborate on how the Medicaid primary care payment enhancement provision from the ACA has helped increase access to care for the Medicaid population in non-emergency room settings?

If the ACA is not doing enough to get individuals to the doctor, what do you suggest we do to help more Americans to gain access to the health sector?

Answer. While access to Medicaid coverage does little to give enrollees better access to health care services, Medicaid primary care payment enhancements may very well have contributed to increased access to providers. Unfortunately, this provision was fiscally unsustainable, which is why it was allowed to expire last year. The *New England Journal of Medicine* article cited in the question supports the thesis that expanding Medicaid does not provide better care or even access to care in and of itself.

The expiration of the program examined by the article demonstrates that simply increasing payment rates is likewise considered an inefficient way to provide low income Americans with consistent access to care. While the payment enhancement may have contributed to increases in access to care, the effect was moderate. There was an average 57 percent increase in reimbursement with only a 7.7 percent aver-

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[1] *http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-non-expansion-states-experience-up-to-10-enrollme.*

[2] This number is likely larger, as the analysis was unable to include states where data was incomplete or where there was inconsistent treatment of CHIP enrollees.

age increase in access, and results by state were similar regardless of the amount of the increase.[3] For example, at the extremes, Montana increased its Medicaid reimbursement by 7 percent (the lowest) and saw a 6.8 percent increase in access, and New Jersey increased reimbursement by 109 percent (the highest increase) and saw a 10.9 percent increase in access; yet Oregon had a 39 percent reimbursement increase, and a 2.8 percent decrease in access. This uneven result may imply that factors beyond the payment bump also contribute to accessibility.

Rather than continuing to debate precise levels of reimbursements, we should begin thinking outside the box and consider allowing the market to provide dynamic solutions: for instance, loosening scope of practice laws, or looking to states with § 1115 waivers for indications of how to more effectively manage the Medicaid program.

PREPARED STATEMENT OF HOLLY WADE, DIRECTOR OF RESEARCH AND POLICY ANALYSIS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

Good morning, Chairman Hatch, Ranking Member Wyden, and members of the Senate Finance Committee. Thank you for the opportunity to testify today on "The Affordable Care Act at Five Years."

The NFIB Research Foundation recently published the second of a three-part health insurance longitudinal survey titled, "Small Business's Introduction to the Affordable Care Act, Part II."[1] The objective of the three surveys is to measure the impact of the Affordable Care Act (ACA) on small business owners and the small group health insurance market. The following are a few highlights from the survey.

The cost of health insurance is the most critical issue facing small business owners. It is the main reason owners do not offer employer-sponsored health insurance and the main reason owners discontinue providing the benefit. And for those offering, many owners annually confront the arduous task of adjusting profit expectations, insurance plans, cost-sharing and other mechanisms to help absorb often erratic changes in total premium costs.

Unfortunately, the ACA does little to alleviate these problems five years into its implementation, and in most cases contributes to the ongoing frustrations small employers face in offering health insurance.

The survey found that the ACA exacerbates market turmoil evidenced by large numbers of policy cancellations, shifting renewal dates to obtain better rates, changes in employer cost-sharing, and adoption of different, though not necessarily more desirable, health insurance plans.

Small business owners have also encountered repeated delays and confusion over major components of the law including the SHOP exchange marketplaces, the small business health insurance tax credit, the employer mandate and financial reimbursement options.

All of the above are generating an uncertain and costly environment for many small business owners navigating health insurance options for themselves and their employees.

Two of the ACA's hallmark small business provisions, the SHOP exchange marketplaces and small business health insurance tax credit were established to provide cost relief and to offer a transparent, competitive marketplace for employers purchasing in the small group market. Unfortunately, both have provided little relief for those offering, or an incentive to offer, for those who do not.

Currently, only a few states have fully operational SHOP exchange marketplaces and for those states that do, they are finding little interest among small employers or their insurance agents. Small employers typically find no reason to visit the websites. Just 13 percent of small employers visited the *HealthCare.gov* website to look for individual insurance, 4 percent for business insurance and 8 percent for both.

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[3] The numbers reported in the study appear slightly biased, as the study reported only on the 4 states with the highest increases in payments, and the bottom 6 states with the lowest increases in payments, skewing the average increase downward and potentially skewing the average increase in access upward.

[1] *http://www.nfib.com/assets/nfib-aca-study-2014.pdf.*

The small business health insurance tax credit is a targeted approach to help curb health insurance costs for offering small employers and was intended to provide an incentive for those that do not, to start offering. However, the tax credit was largely ineffective on both fronts as its design is exceedingly restrictive, complicated, and only offers temporary relief to a larger small business cost problem. The tax credit now serves as a windfall for the few who qualify and take the time, or pay an accountant, to file for it.

While most small employers believe they are generally familiar with the healthcare law, many are still discovering new ways in which law impacts them. For instance, the law prohibits employers from reimbursing or otherwise providing financial support to employees in order to help them pay for individually purchased insurance plans. However, our survey found that about 18 percent of small employers offered this benefit last year and are now in violation of the law. NFIB continues to receive calls from owners, generally after having talked to their CPA or insurance agent, confused about the new rules prohibiting the practice and the subsequent harsh penalties.

In conclusion, the ACA's potential benefits for small employers have not materialized five years into enactment. Instead, the small employer experience more often consists of increased levels of uncertainty and frustration related to changes in the small group health insurance market and rules associated with the employer mandate.

Thank you for the opportunity to summarize the findings of our survey. I look forward to answering any questions you might have.

ATTACHMENT

NFIB Research Foundation

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SMALL BUSINESS'S INTRODUCTION TO THE AFFORDABLE CARE ACT, PART II

December 2014

The **NFIB Research Foundation** is a small business-oriented research and information organization affiliated with the **National Federation of Independent Business,** the nation's largest small and independent business advocacy organization. Located in Washington, DC, the Foundation's primary purpose is to explore the policy-related problems small business owners encounter. Its periodic reports include *Small Business Economic Trends, Small Business Problems and Priorities,* and the *National Small Business Poll.* The Foundation also publishes ad hoc reports on issues of concern to small business owners.

EXECUTIVE SUMMARY

- Self-assessed familiarity with the Affordable Care Act (ACA) continues to grow among small employers. Seventy-eight (78) percent now claim familiarity with the ACA, 12 percentage points more than in mid-2013. Those employing 50–100 people have greater familiarity, 40 percent "very" familiar and 56 percent "somewhat" familiar, than those employing fewer people.
- Industry sources, particularly health insurance industry sources, have become an increasingly important place for small employers to obtain information about the ACA. Still, the general news media is the single most important source for more small employers than is any other followed by the health insurance industry and the healthcare industry (providers, hospitals, etc.). Small employers currently offering health insurance are much more likely to rely on industry sources while those who do not offer lean heavily on the general news media.

- Twenty-five (25) percent of small employers visited *HealthCare.gov* in the last 12 months, 13 percent to search for personal insurance, 4 percent for business insurance and 8 percent for both. Just 4 percent consider government as their most important information source on ACA.
- A majority of small employers are satisfied with the information they have obtained about the ACA by a 61–38 percent margin, a 5 percentage point tick upward from the prior year. Some sources yield more satisfactory information than others. Those most satisfied cite a business advisor, such as a lawyer or accountant, a trade/business association, and an insurance carrier (in that order) as their most important information source.
- Fifteen (15) percent of small employers did not carry health insurance on themselves in mid-2013. The Affordable Care Act requires everyone (with limited exemptions), including small-business owners, to be covered, effective January 1, 2014 (delayed), or pay a penalty. The number of uncovered small employers dropped to 8 percent in mid-2014.
- Forty-three (43) percent of the small employer population carrying personal health insurance obtain their coverage under their firm's employer-sponsored health insurance plan, 39 percent under an individual insurance market plan, and 19 percent under a spouse's plan.
- Nine percent of all small employers report that their personal health insurance had been terminated or cancelled (for any reason other than non-payment) in the prior 12 months. Terminations, therefore, affect about one-half million small employers on a personal level. Most appear able to find insurance coverage elsewhere, but the new policies come with a comparatively hefty price increase.
- Non-offering small employers are receiving little employee pressure to offer health insurance despite employees now being required to have coverage or to pay a fine. Just 4 percent received a request from five percent or more of employees (usually no more than one person) in the last six months to institute an employer-sponsored health insurance plan, the same number as last year at this time.
- Fourteen (14) percent of small employers not offering health insurance reimbursed or otherwise provided employees financial support to help them pay for health insurance that they purchased on their own, about the same number as in the prior year. However, 21 percent of those offering, but not currently providing financial incentives have considered, 9 percent seriously, helping employees pay for purchasing their insurance on the open market in lieu of the business offering it. Financial incentives to help employees purchase health insurance as a substitute for an employer sponsored plan is an employer option substantially more likely to be pursued than it is as a means to help employees newly acquire insurance on their own.
- Small employers perceive little change in insurance carrier competition for their health insurance business over the last two years. If anything, they perceive less (net 12 percentage points less) competition for it. The perceived competitive situation among health insurers does not differ between offering and not offering small employers.
- Forty (40) percent of small employers report offering employer-sponsored health insurance, down 6 percentage points from the prior year. Firm size is closely associated with offer rates. Small employers with 50 or more employees increased their offer frequency while those with 20 or fewer employees saw theirs decline.
- Few small employers now self-insure and there is no stampede to do so. Even among those with 20 or more employees, the group most likely to be able to purchase re-insurance, just 10 percent of the offering population pursue this course. Another one in ten projects switching from fully-insured to self-insured in the coming year. However, equivalent projections last year yielded no net increases in self-insured small businesses.
- Change among individual firms is much greater than net change across the small business population. Eleven (11) percent changed offer status within the last year, more dropping their employer-sponsored health insurance than adding it. Those percentages represent an 4 percentage point escalation (both adds and drops) in offers status change over the last 12 months.

- About 12 percent of offering small employers adjusted their insurance renewal date in order to avert higher premium costs and/or loss of a plan due to ACA rules that were effective January 1, 2014.
- Eighty-nine (89) percent of small employers offer just one type of health insurance plan. That falls to 70 percent among firms with 50–100 employees. The most common type of plan used is a conventional PPO (40%), an increase of 8 percentage points over the last year. The use of HMOs as the most used type in small businesses fell 7 percentage points in a year to 19 percent. However, small employer choices among primary types of health insurance blur as plan types lose their distinctiveness and morph into one another.
- A recurrent theme in this report is a recent emphasis on employee-only (individual) coverage over the past year and a de-emphasis on family and employee plus-one coverages. The evidence for these changes appear in the relative frequency of offers, employee take-up, employer premium contribution, premium costs, and even the decline in employers who obtain their personal coverage from a spouse's plan. The employee appears increasingly the focus of coverage and family members less so.
- The size of the employer cost-share fell notably for family and employee plus-one coverage over the past year while rising modestly for employee-only coverage. The number contributing 75 percent or more of premium fell 7 percentage points for family and 4 percentage points for employee plus-one coverage. Meanwhile, contributions of that size for employee-only coverage increased 4 percentage points.
- Employer-sponsored health insurance premium costs per employee continue to climb for small employers, though at a reduced rate. Sixty-two (62) percent claim per employee premium costs were higher in mid-2014 than in mid-2013 compared to 64 percent the prior year. Another 31 percent experienced no change (29 percent the prior year) and 8 percent premium decreases (6 percent the prior year). *Per employee* premium costs rose more for family than for employee plus-one coverage, but declined for employee-only coverage. These data do not account for benefit changes, either desired by the small-employer plan sponsors or forced on them by the ACA.
- Employee participation in employer-sponsored health plans appears to be rising. Sixty (60) percent of offering firms have 75 percent or more participation among full-time, non-seasonal employees compared to just 54 percent one year ago. Greater employee participation (more people) in addition to premium increases caused the *per firm* cost of health insurance to rise substantially.
- Small employers faced with health insurance premium increases took an average of 2.4 business actions to offset (pay for) them, the number increasing as the size of the premium increase rose. The most frequently taken actions were swallowing the increase (lower profits), delayed, postponed or reduced business investment, and raising productivity. Forty-five (45) percent resorted to measures that affected employee pay checks.
- Between 35 and 40 percent of small employers reduced benefits in their employer-sponsored health insurance; somewhat less than 10 percent increased them. That net frequency of benefit cuts was offset by ACA compelled benefit increases, increases that small employers may not have known about, let alone approved. The result likely approximates intent rather than actual outcomes of which no one can be certain.
- Small employers who added health insurance as an employee benefit within the prior 12 months report that sustained business profitability allows them to now offer. Market competition for employees is a second important reason for their action.
- Small employers who dropped health insurance as an employee benefit within the prior 12 months most often report the cost of insurance was an important reason for doing so. A notable number from that group dropping their insurance also indicated that employees were better off purchasing it on their own.
- About 90 percent of small employers in mid-2013 accurately forecast on a longitudinal basis whether they would carry employer-sponsored health insurance in the following 12 months. Thirty-eight (38) percent in mid-2014 expected to sponsor an employee health insurance plan in mid-2015 and 60 percent did not. Expectations dropped 10 percentage points in the last year.

- This is the second of three surveys conducted for the NFIB Research Foundation by Mason-Dixon Polling & Research on the introduction of small business to the Affordable Care Act. Nine hundred (900) small employers participated in this year's edition, 288 having also participated the year before. The survey sample was selected using a random stratified pattern with the approximately four equal strata representing small employers having 2–9 employees, 10–19 employees, 20–49 employees, and 50–100 employees.

SMALL BUSINESS'S INTRODUCTION TO THE AFFORDABLE CARE ACT, PART II

William J. Dennis, Jr., NFIB Research Foundation

The Affordable Care Act (ACA) began its administrative public life with a troubled and glitch-filled Web site roll-out one year ago. The Web site, *HealthCare.gov,* the heart of the Act's administrative apparatus to enroll subsidized applicants, functioned very poorly when it functioned at all. Small business was not generally impacted by that debacle, except to the extent that some small employers and self-employed business owners approached the exchange marketplaces to purchase health insurance (subsidized and not) and met the same success that others did. However, small business had its own set of issues.

The bulk of small business issues were indirect, stemming from requirements that limited the policies that health insurers could sell to small employers. One visible result was market turmoil evidenced by large numbers of policy cancellations, shifting renewal dates to obtain better rates, changes in employer cost-sharing, and adoption of different, though not necessarily more desirable, health insurance plans. In addition, obvious policy U-turns and failure to implement publicized aspects of the ACA created confusion among small employers and their advisors. SHOP (Small Business Health Options Program) exchange marketplaces, a parallel to the shopping function of the individual exchange marketplaces, intended to help small-business owners transparently and competitively purchase their health insurance, did not get off the ground. Relatively few states launched a SHOP for 2014; only 12,000 employers and 76,000 individuals purchased insurance through a SHOP; and 18 states have already delayed additional offering arrangements again to 2016.[1] Since only small employers purchasing their insurance through SHOP are eligible for the small business health insurance tax credit, the credit's already limited eligibility fell to a trickle. Confusion even reigned over established policies. Could small business keep its existing, noncompliant insurance? The answer was not always clear. Some could; some could not; and, some could, but only for a limited time. The employer mandate was administratively delayed and then modified, good news for larger small employers. But then those most affected offered anyway and the delay may simply align the employer mandate deadline with the minimum essential health benefits package and community rating requirements to which they remain subject beginning in 2016. Perhaps the most consequential result of the mandate's delay was the effective elimination, at least temporarily, of the highly complex and largely unknown aggregation rules.

The following pages document the turmoil caused by the ACA and many of the changes occurring within the last twelve months. Some of those changes result in noticeable net shifts in population totals. For example, the employer cost-share for family and employee plus-one plans fell notably. Small employers, as a group, are simply contributing less for them. However, a key to appreciating the turmoil and other challenges small employers face is individual firm change even when the population totals do not. For example, the net percent of all small employers changing offer status moved somewhat lower from the prior year. That reduction conceals the fact that one in ten changed offer status over the last 12 months. Adding and/or dropping employer-sponsored health insurance is a significant change to a business with repercussions throughout the firm. Thus, even when matters seem publicly calm, they often are not within individual firms.

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[1] Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors (2014). United States Government Accountability Office Report to the Chairman, Committee on Small Business, House of Representatives. GAO–15–15. November; Harrison, JD (2014). July 14. *http://www.washingtonpost.com/business/on-small-business/why-we-still-dont-know-how-many-small-businesses-signed-up-through-obamacare/2014/07/10/773d0cb6-0859-11e4-a0dd-f2b22a257353_story.html.*

While one assumes that much of the turmoil created for small business by the ACA will ebb as the compliant/non-compliant policy issue resolves itself, that is not necessarily true. The status of SHOP exchange marketplaces and the employer mandate implementation remain unsettled. Perhaps more important is the consequences of the 2016 consolidation of the fewer than 50 employee and 50–99 employee groups into a single small group market. It is not known how, if at all, combining the two will affect the rates of different size firms. Healthcare cost pressures will continue to force insurance rates higher requiring small employers to make more painful choices between employee wages and benefits, between higher deductibles and cost-shares, between lower earnings and greater contributions to their employer-sponsored health insurance. The Cadillac tax provision of ACA (2018) is likely to affect a limited number of small employers initially, and the remainder of those offering long after large employers have adapted to it. The impact of subsidies to individual and families through the exchange marketplaces is likely to alter the offer pattern of small employers long before large. And then, there is always the possibility of further administrative change—even legislative change—for good or ill.

Familiarity with the Affordable Care Act

It has been four years since the Affordable Care Act (ACA) became law. Millions of words have been written about the Act and likely more have been spoken of it during that time. Much has been polemical, obfuscating the Act's content and impact. Yet, in mid-2014 just 24 percent of all small employers claim to be "very" familiar with the ACA (Q#68). Fifty-four (54) percent say that they are "somewhat" familiar with it. The remainder describe themselves either as "not too" familiar (15%) or "not at all" familiar with the Act (7%).

Small employers with 50 to 100 employees, those presumably most affected by the new law, claim greater familiarity with the Affordable Care Act than do those with fewer employees. Forty (40) percent of that group assert that they are "very" familiar with it and another 56 percent maintain that they are "somewhat" familiar with that law. Self-assessed familiarity among small employers declines gradually with the number of employees in the business. However, a noticeable gap occurs between owners employing fewer than ten people and those employing ten or more. The proportion claiming familiarity ("very" and "somewhat") among those with fewer than ten employees is 76 percent while 24 percent do not claim familiarity ("not too" and "not at all") compared to 88 percent and 12 percent respectively among those with ten or more employees. The gap is most noticeable in the "very familiar" response, 21 percent among the former group and 37 among the latter.

Familiarity is not related to health insurance offers. Offering small-business owners are no more likely to claim familiarity than those not offering. However, familiarity is modestly associated with recent premium cost increases. Small employers incurring premium increases in the last year are 9 percentage points more likely to claim familiarity than those either incurring premium decreases or premium stability (84 percent to 75 percent).

ACA exchange marketplaces for individuals can be divided into three groups: state-run, partnership, and federally-run.[2] (SHOP exchange marketplaces for small businesses cannot be similarly grouped because few states effectively operate one and because the federal government has postponed its participation in their operation.) As a general rule, states with state-run exchange marketplaces have embraced Obamacare more enthusiastically than have partnership states and partnership states more enthusiastically than federal-run states. It is reasonable to speculate that more enthusiasm results in more information available about ACA and hence greater small business familiarity with the Act. Some relationship does exist. Small employers in state-run states most frequently claim familiarity (84%) followed by partnership states (77%) and federally-run states (76%). But as will be shown shortly, few small employers use government as their primary source of information about the Act. Few small employers not relying on government for information does not negate the possibility that the relevant agencies provide more information to the general news media, etc., which in turn transmit it to business owners.

Small employers in the Central region and to a lesser extent the Mid-western region report familiarity with ACA less often than do those in the Northeast, South-

[2] State-based Exchange Marketplaces—CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, AND WA. Partnership Marketplaces—AR, DE, IL, IA, MI, NH, AND WV. Federally-facilitated Exchange Marketplaces: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, AND WY.

east, and Pacific regions. The latter three report familiarity ranging from 81 to 83 percent.

Self-assessed familiarity with the Affordable Care Act rose between mid-2013 and mid-2014. The proportion claiming familiarity ("very" and "somewhat") rose 12 percentage points while those not claiming familiarity ("not too" and "not at all") declined the equivalent amount. That increase is somewhat larger than the one experienced in the two year interval, mid-2011 to mid-2013, when the familiarity of small employers with fewer than 50 employees rose from 58 to 66 percent.[3]

The change in familiarity appears broadly based. For example, 96 percent of employers with 50 to 100 employees claim familiarity with the Act compared to 89 percent in the year prior. At the other end of the size scale, 76 percent with 2 to 9 employees claim familiarity compared to 65 percent twelve months earlier.

Information Sources

More small employers cite the general news media (34%) as their most important source of information about ACA than any other (Q#69). The insurance industry ranks second (22%) followed by the healthcare industry (13%). Small employers identified every other source in less than 10 percent of cases. Trade associations or business groups prove the prime source for 9 percent; a business advisor, such as an accountant or lawyer, account for another 8 percent; government, 4 percent; other sources and no answer, 2 percent. Seven percent do not have a single most important source.

The most important sources small employers use to obtain information about ACA changed somewhat over the past year. The most notable change was an 8 percentage point reduction in reliance on general news media and a 9 percentage point increase in the number identifying the health insurance industry. Five percentage points more identified the healthcare industry (providers, hospitals, etc.) this year than last. Primary reliance on other sources remained relatively stable. For example, 4 percent cited government in mid-2013 and 4 percent cited it in mid-2014 despite the flurry of information surrounding the opening of the exchange marketplaces (much of it negative, encouraging small employers to look elsewhere); 10 percent cited business advisors in mid-2013 and 8 percent in mid-2014; trade associations/business groups declined from 12 percent to 9 percent. Seven percent claimed to have received no useful information this year compared to 1 percent last, a discouraging commentary on the country's ability to transfer useful information about a major government initiative.

The smallest employers continue to be the size group most reliant on the general news media (42%) for information about the ACA. They are also the group most likely to think that they have not received any useful information about it (8%). Owners of the largest businesses are the most reliant on the health insurance industry (38%).

The major difference in information sources about the ACA falls along the divide between those who offer employer-sponsored health insurance and those who do not. Fifty-eight (58) percent of small employers offering report their most important information source as the insurance industry (40%) or a healthcare provider (18%). Just 21 percent of those not offering name one of those two industry sources. In contrast, 18 percent of offering small employers cite the general news media compared to 45 percent among small employers not offering. These results logically follow from the greater exposure that offering small business owners have to industry sources.

Just less than one in four (24%) rely principally on a single source for most their information. Those who did identify a second source as important were distributed much as were the most important source. The noticeable difference is that the insurance industry and healthcare industries switched places. Twenty (20) percent identified the general news media; 12 percent a provider; 11 percent a carrier; 11 percent a trade association/business groups; 10 percent a business advisor; 7 percent "other"; and, 6 percent government (Q#70).

Four combinations of sources (first and second choices) prove most common among those citing more than a single source. The most frequent (14%) is the general news media and insurance carriers, followed by a provider(s) (health-care industry) and

[3] Dennis, WJ, Jr. (2013). Small Business's Introduction to the Affordable Car Act, Part I. NFIB Research Foundation: Washington, DC.
http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/nfib-aca-study-2013.pdf.

the media (10%), trade/business associations and the media (8%), and trade associations/business groups and insurance carriers (6%).

HealthCare.gov

HealthCare.gov is the government Web site that the public can visit both to gather information about the ACA as well as to sign up for its benefits (during open enrollment). While plagued by a disconcertingly problematic roll-out, the site remains the single most visible place to learn about the Act's exchange marketplaces and the insurance available to individuals. It is also the place where small employers were supposed to take advantage of the SHOP provisions of ACA, a prospect now restricted to a small number of businesses operating in a few states and businesses that enrolled directly through an insurer or an insurance agent/broker.

Small employers typically find no reason to visit *HealthCare.gov*. Sixty-five (65) percent report that they did not visit the site in the last year and another 10 percent say that they did so out of simple curiosity (Q#72). Still, one in four (25%) did visit *HeathCare.gov* for its intended purposes. The largest share visiting the site did so to inquire about the purchase of personal insurance (13%). Four percent visited the site about business insurance and another 8 percent visited to inquire about both business and personal coverage. Those percentages translate into a non-mutually exclusive 21 percent visiting *HealthCare.gov* for personal reasons and 12 percent for business reasons. Given that just 4 percent named government as their most important information source about ACA, *HealthCare.gov* apparently did not provide a great deal that small employers found helpful.

As a general rule, small employers looking for business insurance on *HealthCare.gov* currently offer (66%–34%) and those looking for personal insurance do not (32%–68%). Those looking for both business and personal are more evenly divided (56%–44%). Seventy-seven (77) percent visiting for any insurance purpose expect to offer next year as do 98 percent of those visiting out of curiosity. Virtually no one (0 of 70 cases) who does not expect to offer next year visited the site for either business or personal insurance. *HealthCare.gov* therefore appears to be a shopping tool for small employers already offering rather than a persuasive tool for those who do not. Once an affirmative offer decision has been made, small employers search for the best deal, often on the public Web site. If that decision is negative, they do not bother to search it. The unknown is whether the poor (or lack of a) SHOP roll-out will discourage small employers from using the tool in the future or whether greater site visibility will encourage them to try again.

The number who visited *HealthCare.gov* is likely somewhat higher than reported doing so. Nearly half of those who claim to have purchased their personal health insurance through government also said that they had not visited *HealthCare.gov* (N=33). It is possible that some accessed the exchange marketplace using a different address, particularly in states with state-run exchange marketplaces. Or, it is possible that some simply did not recognize the site's name/address. Still, the inconsistency demonstrates the confusion many small-business owners have dealing with the ACA, its specific provisions, and its terminology.

Information Satisfaction

More small employers are satisfied than not with the information they have received to date about the Affordable Care Act. But, they are far from completely happy. Nineteen (19) percent say that they are "very" satisfied (Q#71). Another 42 percent say that they are "somewhat" satisfied, yielding a total of 61 percent on the satisfied side of the ledger. Thirty-eight (38) percent fall on the other side with 16 percent "not at all" satisfied with the information that they have received.

With a single exception, little association appeared between information satisfaction and either size-of-business or offer status. The exception appeared among the group having the most employees, 50–100. It is noticeably more satisfied with the information received (78%) than are the other three size group individually or combined (59%). It is likely that ACA requirements made them get satisfactory answers to more questions and their size provided them the resources to do so. Offer status showed no relationship to information satisfaction.

Satisfaction is slightly higher in mid-2014 than it was in mid-2013. A net 5 percent more are now satisfied than last year and the same number not. The largest change came among those "not at all" satisfied, which fell 6 percentage points between mid-2013 and mid-2014.

Some most important information sources yield greater satisfaction than others (Exhibit 1). Small employers who rely on business advisors and trade association/

business groups, for example, are usually more satisfied than those relying on other sources. Sixty-six (66) percent primarily sourcing business advisors are satisfied with the information they have received and 24 percent are "very" satisfied with them. Sixty-five (65) percent primarily sourcing trade association/business groups are satisfied with the information they have received and 28 percent are "very" satisfied with them. Insurance carriers also produce a 66 percent satisfaction level, but only 15 percent of affected small employers give them the highest mark. The general news media and the healthcare industry produce least satisfaction, particular the healthcare industry. As many relying on it for ACA information are as dissatisfied with the information received as are satisfied. Just 8 percent relying on the industry are "very" satisfied.

Exhibit 1

INFORMATION SATISFACTION BY MOST IMPORTANT INFORMATION SOURCE

Satisfaction	Most Important Information Source					
	Health Insurance Industry	Health Care Providers	Business Advisors	Trade/Business Groups	General News Media	Total †
Very	15%	8%	24%	28%	21%	19%
Somewhat	51	42	42	37	38	41
Not too	23	33	17	18	21	22
Not at all	12	17	17	17	21	18
(DK/Ref)	*	*	*	*	*	*
Percent	100%	100%	100%	100%	100%	100%
N	277	157	89	111	143	818

† *Includes sources with too few cases to report—Government (N = 36) and Other (N = 5).*

The frequency of citations as the single most important source does not indicate overall satisfaction. The general new media, one of the two most common sources, receives relatively low satisfaction marks while insurance carriers, the other most important source receives, moderate satisfaction marks. Just 9 percent identify a trade association or a business group as their most important source and another 8 percent identify a business advisor, such as an accountant or lawyer. Yet, small employers are likely to be more satisfiedwith these two ACA information sources than those more frequently relied upon.

Every source has a significant number of small employers relying on them who are "not at all" satisfied with the information received from it. The health insurance industry has the fewest who are "not at all" satisfied with its efforts (12%) while the general news media has the most (21%). The other three listed sources each have 17 percent who are "not at all" satisfied. One in six suggests all sources could do a better job producing relevant information about the ACA for small employers.

Personal Insurance

Fifteen (15) percent of small employers did not carry health insurance on themselves in mid-2013. The Affordable Care Act requires everyone (with limited exemptions), including small-business owners, to be covered, effective January 1, 2014, or pay a penalty. By mid-2014, the number of uncovered small employers dropped to 8 percent, almost half the number uncovered one year prior (Q#5).

Nine of ten (90%) small employers have personal health insurance (2% did not respond). A plurality (39%) have individual coverage (43% of the covered population). Another 34 percent obtain (38% of the covered population) their coverage from their firm's health plan. Nineteen (19) percent obtain their insurance through a spouse's plan (21% of the covered population). The key difference in the distribution of sources for personal coverage from last year is the greater importance of individual plans. It would appear that a substantial share of those moving from an uninsured to an insured status buy an individual plan rather than sponsoring an employee plan and joining it or obtaining a plan through a spouse. The number with individual plans rose 9 percentage points while the number with business plans fell 4 percentage points and the number covered by a spouse's plan was unchanged.

Particular interest falls on the 39 percent purchasing individual market health insurance plans because that market has been volatile, suffering severe disruptions,

typically due to the government imposition of mandated minimum essential health benefit requirements. Small employers searching for non-employer-sponsored (individual) health insurance can purchase this non-group insurance directly in the private market or through a government-sponsored individual exchange marketplace. Seventy-two (72) percent who purchased individual market insurance (28 percent of covered small employers) claim they bought it directly through the market and 19 percent bought it through an exchange marketplace (Q#6). The remaining 9 percent are not certain. That relatively high uncertainty is understandable given the consumer-opaque relationships between the exchange marketplace and the non-exchange individual market.

The individual exchange marketplace is the location where people sign up for ACA subsidies when purchasing their health insurance. While almost one in five (18%) of the 39 percent who purchased an individual policy through the exchange marketplace (7 percent of the covered small employer population), too few cases are available (N=33) to estimate the proportion who obtained a subsidy (Q#7). However, the limited cases available suggest that a substantial portion of small employers who went through the individual exchange marketplace did receive one.

Complaints are common from people holding individual health insurance policies that their plans have been terminated despite assertions from the President that people could keep their insurance if they liked it. Nine percent of all small employers claim that their personal health insurance was terminated or cancelled (for any reason other than non-payment) in the prior 12 months (Q#8). One in ten translates into about one-half million small-business owners who lost insurance in this manner. The data do not show the source of insurance among those who lost policies (at least temporarily) due to their plan's termination.

Virtually all who lost their personal insurance in this manner were able to replace it, but typically at a higher cost. Over 70 percent replaced their terminated policies with more expensive ones; 28 percent were able to find a cheaper product (Q#9). Though the number of cases is small (N=78), actual price changes appear substantial. Only 14 percent experienced price changes between plus 10 percent and minus 10 percent.[4] Both the median increase (between 25 and 30 percent) and the average increase proved considerably higher than the median and average decrease. Factors, such as benefits, deductibles, etc., are not included thereby yielding a change in cost, but not necessarily in policy value. Given that many of the terminated plans were also likely to have been plans with relatively modest benefits, the steep price increases reported are not implausible. Additional benefits will raise the cost regardless of whether the purchaser wanted them or not.

Virtually all of those who are currently without personal coverage did not have a plan cancelled in the last 12 months (N=42). That implies members of the current uncovered small-employer group have probably been uncovered for more than a single year.

Two Incentives

The ACA created or changed numerous incentives affecting health insurance buying decisions; some were intended, some not. The author isolates two that may have significant effects on small business, but which will likely take some time before their impacts are known fully. One has received considerable public attention; the other has not. The under-publicized incentive appears first.

Increased Employee Demand for Insurance

With Americans required to have health insurance by January 1, 2014 (with limited exceptions), non-offering small employers are likely to face increased pressure from uninsured employees to offer a health insurance plan. This is particularly true of employees who cannot receive a subsidy from an individual exchange marketplace, or who do not understand that they will be eligible to receive one. The situation creates two questions: how much pressure can and/or will employees exert on non-offering small employers to offer a health insurance benefit? After all, an employer-sponsored health insurance plan could lower employee out-of-pocket expenses for many, though not all, simply because the employer typically shares the cost. The second question is: how will non-offering small employers respond to employee requests? Only the first can addressed directly, in large part because there are so few cases of reported requests.

[4] If less than plus or minus 10 percent is classified as no change, 60 percent experienced a price increase, 18 percent no change, and 23 percent experienced a price decrease.

Four percent of non-offering employers report that in the last six months more than five percent of their employees or representatives of more than five percent of their employee asked that the business institute an employer-sponsored health insurance plan (Q#10). The current level represents no increase from the prior year. Noteworthy is that the time frame used to gauge the change covers the period in which for the first time individuals must purchase health insurance or pay a penalty. Employee interest in obtaining an employer-sponsored plan logically would spike at this time (and perhaps in the next twelve months).

Five percent of employees, the threshold for answering affirmatively about employees requesting health insurance, likely mean no more than a single employee in a small business. In a 40 employee firm, the threshold means requests from just two employees, or one employee speaking on behalf of himself and one other. Since that is an insignificant portion of the workforce, the data capture a minimal expression of interest.

No increase in employee requests for health insurance from a small base during a period when a strong expression of interest might be expected, combined with a modest definition of employee request (usually a single person), indicates that uncovered employees are putting little pressure on non-offering employers to make health insurance part of the employee benefit package. That situation could change as more uncovered and formerly uncovered employees look for a place to lay-off their health insurance costs or experience non-coverage penalties. Change could also occur as a result of a stronger economy and employees having a more advantageous bargaining position. But, the fact that demand remains modest questions whether pressure on small, non-offering employers will ever rise substantially. That leads to a search for the reason why. Topping the list of candidates is composition of the workforce and its attachment to a specific workplace (turnover). Increased participation among full-time, non-seasonal employees in offering small businesses, a topic discussed subsequently, supports these possibilities.

Reimbursement/Financial Incentives

Incentives exist within the ACA for employers, particularly small employers with relatively low paid employees, to dump their employer-sponsored health insurance, reimburse or otherwise adjust employee wages upward to compensate for the lost insurance, and let employees purchase their health insurance, often with subsidies, in the government exchange marketplaces. Over time the incentive to adopt this course is likely to become stronger. Still, inertia, uncertainty over the quality and cost of insurance in the individual exchange marketplaces, fear of adverse employee reaction when confronted with the change, etc., gives many small employers pause.

In the months between mid-2012 and mid-2013, 14 percent of small employers not offering health insurance reimbursed or otherwise provided employees financial support to help them pay for health insurance that employees purchased on their own. That figure is the same one year later. However, 18 percent of the entire population (offering and not) afforded incentives (Q#11).

A larger percentage (25% compared to 14%) of those offering insurance claim to offer financial incentives for employees to help them purchase health insurance on their own than do those who do not offer. Discrimination rules generally do not allow separating employees for purposes of providing tax subsidized employee benefits. However, these small employers may be using financial incentives to help full-time employees with family coverage when not offered by the firm or, to help part-time employees, that typically are not covered, or even to purchase associated types of services, such as dental or vision insurance. Those not offering family coverage (but offering insurance) are about three times as likely to provide such financial incentives as those offering family coverage. A substantial number of small employers may therefore being using the financial incentive to help employees with their familiar obligations. The part-time hypothesis has less have merit. Less than 20 percent of offering firms with part-time employees have a reimbursement policy. Since the survey collected no data on health benefits beyond insurance, it is not possible to determine whether these financial incentive from offering firms are intended for such purchases. Other sources indicate, however, that many small employers give such benefits.[5] The result leaves a sizeable number of offering firms providing unexplained reimbursement or financial incentives to purchase health insurance or uncovered healthcare outside the business.

[5] Kaiser Family Foundation (2014). 2014 Employer Health Benefits Survey. Section 2, p. 50. September 10. *http://kff.org/private-insurance/report/2014-employer-health-benefits-survey/*.

Employees earning wages/salaries are directly related to financial incentives or reimbursement to purchase health insurance. If a firm's average wages are $12.50/hour or less (annual salary equivalent of $25,000), 15 percent receive this additional benefit; if averages wages are $27.50/hour or more (annual salary equivalent of $55,000), 44 percent do. The middle wage group receives the benefit in 26 percent of cases.

One would think that non-offering firms would be the ones giving employees incentives to purchase health insurance outside the firm. Fourteen (14) percent do. However, providing financial incentives to purchase insurance outside the firm *in lieu of* the firm offering health insurance is even more popular among those who currently offer, at least conceptually, than those who do not. Twenty-one (21) percent of offering small employers who do not already provide some additional financial incentive to purchase insurance have considered one in lieu of offering, 9 percent "seriously" (Q#13). Small employers not offering health insurance and not already providing some incentive are less attracted to financial incentives to help employees make the purchase. Just 2 percent in that group have "seriously" considered the move and another 8 percent have considered it. The result is that financial incentives to purchase health insurance or reimbursement for having purchased insurance is an employer option substantially more likely to be pursued as a means to drop an existing benefit than it is as a means to help add a non-existent one.

If those small employers who have considered providing a financial incentive and do not now offer one were to proceed, the most likely way (41%) they would implement the change is to offer a flat amount per employee (Q#14). The flat-amount method is the most equitable, most transparent, easiest to administer, and provides minimal incentives for over-insuring. It is also one that higher paid employees and those with dependents would be least likely to favor. The second most likely method is a percent of the employee's health insurance premium (23%). Percent of premium would be more popular with employees expending more on insurance. The remaining methods had negligible numbers with the employee's length of service (5%) and a percent of the employee's wages or salary (2%) trailing. Twenty-nine (29) percent have not thought about the switch seriously enough to consider a method to implement it. The depth of consideration this latter group has given to a switch is likely superficial.

The downside of such financial incentives is their tax status. The Internal Revenue Service (IRS) issued sub-regulatory guidance prohibiting employers from reimbursing employees with tax-preferred contributions in order to purchase health insurance. Penalties for violating this prohibition can be severe. In the past, many small employers, in lieu of offering expensive employer-sponsored health insurance, were able to provide employees with tax-free contributions to reimburse healthcare costs. The reimbursement was commonly provided in the form of stand-alone Health Reimbursement Accounts [HRAs] or Section 125 plans. Now, any reimbursement must be subject to payroll taxes for the employer and the employee and individual income taxes for the employee, significantly reducing the value of the contribution, particularly for better paid employees.

Health Insurance Offers

Forty (40) percent of small employers with 2–100 employees offer employer-sponsored health insurance; 61 percent do not (Q#15). That number is six percentage points fewer than one year ago. The decline was associated with small employers having fewer than 20 employees.

Employee size-of-firm continues to be highly associated with offers. Ninety-six (96) percent of small-business owners employing 50–100 people offer employer-sponsored health insurance and 81 percent in 20–49 employee group offer as well. One year ago, 92 percent of the largest offered as did 80 percent of the second largest. The number owning the largest small businesses, those originally covered by the employer mandate, raised their propensity to offer four percentage points, while small employers with 20–49 employees did not change theirs. The two size groups with less than 20 employees presented a very different look. Two-thirds (66%) in the 10–19 employee group offered in mid-2014 in contrast to 74 percent the year before for a drop of 8 percentage points. Employers with the smallest businesses are least likely to offer. Twenty-eight (28) percent did among those employing 2–9 people compared to 34 percent twelve months year earlier, meaning a fall of 6 percentage points. Just one in five (20%) of the numerous 2–4 employee group sponsored a plan in mid-2014.

Because owners of larger, small firms offering insurance increased in number while the owners of smaller, small firms offering decreased in number, the net total of employees offered employer-sponsored health coverage did not change as dramatically as the net total offering firms. It is even possible that the number of employees offered coverage in small businesses did not change. The data available here cannot answer that question.

Average wages paid in small businesses are not associated with employee size-of-firm. However, higher average wages paid in a small business are highly associated with health insurance offers. If a firm's average wages are $20.00/hour or less (annual salary equivalent of $40,000), there is a 33 percent chance the firm offers employer-sponsored health insurance; if averages wages are more than $20.00/hour or more, there is an 86 percent chance the firm offers.

Small employers offer health insurance in the Northeast region more frequently than in other regions. Those sponsoring employee insurance plans are about 20 percentage points fewer in the four remaining regions. The remaining four, the Midwest Southeast, Central, and the Pacific, trail in that order. The 2–9 employee group generates the gap. Forty-seven (47) percent of the smallest employers offer in the Northeast compared to the low to mid-20s elsewhere.

Eighty-three (83) percent offer health insurance to full-time employees only (70 percent have full-time employees exclusively), the same percent as the prior year (Q#20). Fifteen (15) percent theoretically offer it to both full- and part-time people, four percentage points more than 12 months earlier. However, 19 percent with part-time employees actually do. The smallest businesses appear modestly more likely to offer health insurance to part-time people, 16 percent among those with fewer than 20 employees and 11 percent among those with 20 employees or more. The reason for this unexpected relationship may be due to the inclusion of family members working part-time in the smallest firms.

Renewal

January 1, 2014, was more or less a magic date for the Affordable Care Act. Everyone required to do so was to have signed up for an insurance plan by that date (eventually postponed three months). Newly issued and renewed health insurance plans were required to comply with all of the new ACA requirements. Renewal of employer-sponsored health insurance prior to January 1 could thereby provide many small employers at least some temporary financial advantages.

If renewal/purchase were random, one would expect about 25 percent of small employers to renew their health insurance each quarter. That did not occur. Renewals bulged in the last quarter of the year, just prior to the deadline. Thirty-six (36) percent of offering small employers purchased their health insurance in the fourth quarter of 2013 (Q#18). Similar percentages purchased in each of the other three quarters—16 percent in the third quarter, 2013; 19 percent in the first quarter, 2014; and 22 percent in the second quarter, 2014. Seven percent could not recall their quarter of purchase. Over one in eight (11%, 14% adjusted for "don't know" responses) who purchased therefore renewed earlier than expected.

Sixty-eight (68) percent of small employers renewing in the fourth quarter report doing so because it was the normal renewal time (Q#19). The remainder renewed in the fourth quarter apparently to beat the January 1 dead-line. Eighteen (18) percent renewed at that time to keep their existing policy for at least another year. Fourteen (14) percent renewed at the time because their premiums would be cheaper than if they waited until the new year with the new requirements imposed on insurers. The latter two reasons are likely not mutually-exclusive.

The ability to retain one's existing, noncompliant health plan (and save costs) continues to be a moving target, like many aspects of ACA implementation. So, it is possible some small employers will be able to take advantage of existing, noncompliant, and more affordable policies either directly or by making it administratively unfeasible for insurers to offer them. If given the opportunity small employers are likely to continue to do as they did at the end of 2013. How long that will continue is another matter. Many states will not permit further extensions on plans that do not meet minimum benefits requirements.[6] It is therefore possible that another, smaller round of "beat the deadline" will factor into many small employer insurance purchase decisions in the next few months.

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[6] AHIP Coverage (2014). October 2. *http://www.ahipcoverage.com/2013/11/20/map-of-the-day-state-decisions-on-administrations-policy-on-coverage-extensions/*.

Competition

The rationale for Small Business Health Options Program (SHOP) exchange marketplace is to increase competition and transparency in the health insurance market for small employers. One can argue that the small group market is already highly competitive,[7] but many small employers would not have agreed, let alone concur that the existing small group market is transparent. SHOP was effectively been put "on ice" (postponed for at least a year) in 2014 and questions have arisen even among ACA supporters about its utility.[8] Still, with competition such a crucial element in controlling costs, it is important to understand that small-business owners are not impressed with what has transpired in the small group market over the last two years.

Thirteen (13) percent of small employers think that competition for their firm's health insurance has risen over the last two years (4% "much more" and 9% "slightly more") (Q#73). In contrast, almost twice as many (25%) think competition has decreased (15% "much less" and 10% "slightly less"). A plurality (38%) see no change and another 16 percent do not think the question is relevant to their situation. Eight percent did not respond. The overwhelming majority of the latter two responses come from small employers who do not offer and are likely out of the market. Regardless, the ACA has failed to this point, at least to the extent that it was intended, to increase competition in the small group market.

The perceived competitive situation among health insurers does not differ between offering and not offering firms. Once eliminating the response "not relevant to my business" the distributions are similar. Small employers purchasing insurance perceive no more or less change in competition for their health insurance business than do those who do not offer.

A change in competition is not the same as the level of competition. It is possible that small employers enjoy a high, but declining level of competition for their health insurance. While that is not likely, it is also beside the point. The issue is change, and small employers perceive competitive change as negative.

Self-Insurance

The potential for large numbers of small employers with relatively healthy labor forces self-insuring still concerns many, particularly supporters of Obamacare who prefer community rating to experience rating and do not want it threatened. Their fear is that by self-insuring, the best risks will opt-out of the small group market thereby increasing risk within the remaining pool and forcing premiums higher for pool members. Yet, their concern, at least in the short-term, appears more theoretical than practical. The number of self-insured remains small and stable, and interest in switching from a fully-insured product to self-insurance appears more wishful than practical.

The small group market currently consists of those with fewer than 50 employees. The market will be redefined in 2016 to include groups with fewer than 100 employees. That change makes the two size groups (fewer than 50 employees and 50–99 employees) noteworthy in a discussion of self-insurance. However, state insurance regulation effectively sets a minimum lower bound on group size for self-insurance through its requirements for re-insurance. Those rules vary from state to state. Reinsurers also impose minimum size requirements to avoid adverse selection. These lower bounds tend to cluster around 20 employees, making 20 employees an arbitrary, but reasonable minimum for discussion of self-insurance.

The 50 to 100 employee size group is more likely to self-insure than is the 20 to 49 employee size group, 9 percent compared to 8 percent, totaling 8 percent for the two groups combined in mid-2014 (Q#23).[9] One year prior, 14 percent of the larger

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[7] See, Karaca-Mandic, P, JM Abraham, K Simon, and R Feldman (2013). Going into the Affordable Care Act. Working Paper 19719. National Bureau of Economic Research: Cambridge, MA., December.

[8] Ezekiel Emanuel, one of the architects of the ACA, and a continuing advocate, thinks that ". . . few small businesses will join the SHOP exchanges set up for them. . . ." See, Mandelbaum, R (2014). March 26. *http://boss.blogs.nytimes.com/2014/03/26/why-employers-will-stop-offering-health-insurance/?_r=0.*

[9] A few owners employing fewer than 20 people, even some employing fewer than 10 people, report that they, too, self-insure. But those reports are not likely accurate. Firms with fewer than 20 employees let alone fewer than 10 typically cannot buy reinsurance either because state regulators prohibit it and/or insurers refuse to it. Without reinsurance, firms self-insuring with such a thin capital base borders on the edge of financial irresponsibility.

group and 6 percent of the smaller group reported self-insuring, a rounded total of 8 percent for the two groups combined. The result is no net change occurred in the number self-insuring during the period.

These data do not account for businesses entering (formed) and exiting (dissolved). Nor do they account for a small employer moving directly from non-coverage to self-insurance or from self-insurance to non-coverage. The chances either dynamic has an appreciable impact on the totals is doubtful. Only a small fraction of total starts begin with more than 10, let alone more than 20 employees, the practical threshold for self-insurance.[10] Further, just 3 of 48 cases(unweighted) for which there are data in mid-2013 and mid-2014 were a non-offering firm last year and a self-insured firm this year. Still, a rough one-half million businesses enter and exit every year, about one-tenth of the population. Average exit size is somewhat larger than average entry size. The self-insured estimate for the static population is there- fore not likely to be influenced significantly by annual population dynamics. But if they do influence the number, it is likely to be downward.

Small employer projections point to little change in the number of self-insured small businesses in the immediate future. Fifteen (15) percent in the 50 and over employee group say that it is "highly" likely or "somewhat" likely that they will switch and self-insure in the next 12 months. Seven percent say the same among the smaller group for a combined total of 10 percent (Q#24). Those projections are one percentage point lower, effectively, no different, than last year's.

Two hundred and eighty-eight (288) cases, about 30 percent of sample, responded to the survey in both mid-2013 and mid-2014. That allows examination within the group of expressed intentions (last year) and subsequent follow-through (this year). Unfortunately, just eight cases qualify. But of the eight cases indicating that it was likely they would switch from fully-insured in 2013 to self-insured in 2014, just one actually changed.

No stampede to self-insurance appears eminent. However, premium increases will continue to place pressure on small employers with young and healthy workforces to self-insure. A more immediate issue may be the pending consolidation of the larger (50–99 employees) and smaller (< 50 employees) groups into an expanded small group market in 2016. What type of incentives will the consolidation generate to either encourage or discourage self-insurance? Given prior relative stability, the probable answer is that incentives for individual firms will not change enough to make a noticeable difference in self-insurance totals. But that outcome is not a certainty.

Type of Plan

The principal type of health insurance plan small employers offer changed notably over the last 12 months and the reason is not obvious. The number subscribing to HMO plans declined 7 percentage points to a 19 percent market share while those subscribing to regular PPO plans increased by 8 percentage points, leaving regular PPOs with 40 percent of the market (Q#21). High-deductible PPOs have a 27 percent share, climbing 2 percentage points in the last 12 months. POS (point of service) plans control 5 percent, no change from the prior year. Thirteen (13) percent of small employers are not able to identify which plan type they have, a single point higher than in the previous measuring period. There is good reason for the large number who are uncertain about their plan type as will be discussed subsequently.

Except for POS plans which are more common as firm size increases, the principal type of health insurance plan was not associated with employee size-of-firm.

Eleven (11) percent of offering small employers sponsor more than a single type of plan (Q#22), down 4 percentage points from the prior year. Among small businesses with 50 or more employees, the percentage rises to 30 percent. A change in the relative use of plans within firms offering more than one plan could impact the percentages identifying a plan type as the one used by most employees. Still, with only one in eight offering multiple plan types, the change in emphasis within firms offering more than one is at best a modest, partial explanation for the shift.

The real question is whether these plan type categories are even relevant any longer. As PPO deductibles become higher, what is the difference between a high-deductible PPO and a PPO? As PPO networks shrink and the size of medical practices expand, what is the difference between a PPO and an HMO? Traditionally,

[10] Seventy-six (76) percent of starts with employees have 1–4 and another 13 percent have 5–9. Bureau of the Census Business Dynamic Statistics, Firm Characteristics Data Tables. *http://www.census.gov/ces/dataproducts/bds/data_firm.html.*

HMOs were the low cost alternative, and the one often selected by budget-conscious consumers. High deductible PPOs began to change the relative cost difference while regular PPOs gravitated toward their high-deductible brethren. With all plan types now morphing into variants of one another, it is not obvious that the current terminology meaningfully categorizes health insurance plans generally, let alone from a small employer (health insurance consumer) perspective.

Examine type of plan by per employee premium cost, for example. The median cost of an employee-only or a family HMO and high-deductible PPO plan are similar, though the median conventional PPO plan does cost somewhat more. However, 64 percent whose employees principally subscribe to historically cheap HMOs report that their per employee premiums rose in the last year. Sixty-two (62) percent with most employees in high deductible PPOs experienced increases and 64 percent in conventional PPOs did. In terms of cost and cost change, blending of types is apparent.

Coverage Type

One can address coverage in two ways: the first assesses whether a small employer offers a plan; the second assesses whether any employee(s) takes (subscribes to) it. The conceptual difference is that the offer of a plan is hypothetical until an employee is covered by it. An offer in this context means that the employer has it in the package should the demand arise. Take-up simply means that one or more employees use the type of plan offered.[11] The objectivity of take-up makes it the better measure for most purposes, and will be the principal one employed in the following paragraphs.

Exhibit 2 presents a summary of offers and take-up for family, employee-only (individual), and employee plus-one health insurance offerings for the years ending mid-2013 and mid-2014. Two points stand-out on the exhibit.

Exhibit 2

HEALTH INSURANCE AVAILABILITY AND EMPLOYEE TAKE-UP BY HEALTH INSURANCE PLAN TYPE AND YEAR

Plan Type	2012/2013		2013/2014	
	Availability	Take-Up	Availability	Take-Up
Family:				
Yes	79%	63%	73%	59%
No	21	36	27	40
(DK)	1	1	*	1
Total	100%	100%	100%	100%
N	664	584	620	532
Employee-Only:				
Yes	75%	70%	76%	71%
No	21	29	18	28
(DK)	5	1	6	1
Total	100%	100%	100%	100%
N	664	539	620	518
Employee Plus-One:				
Yes	40%	26%	42%	30%
No	55	73	55	69
(DK)	6	1	3	1
Total	100%	100%	100%	100%
N	664	329	620	335

First, a substantial numerical gap exists between small businesses that offer each type and small businesses that have at least one employee subscribing to it. For example, 73 percent of small employers claim to offer a family coverage, but just 59

[11] The take-up measure is calculated by subtracting the percentage reporting no employees taking the insurance type from the percentage reporting that they offer it.

percent have employees who subscribe it. Those differences between availability and take-up suggest that many small employers can be flexible and respond favorably should a new employee's needs be different than those chosen by current employees. Yet, a somewhat greater number of small employers would require an employee with different health insurance demands either to adjust his or her demands or request his employer to adjust the firm's offerings (100% minus availability).

Second, 73 percent offered family coverage (Q#26) and 76 percent offered employee-only coverage in mid-2014 (Q#30). Substantially fewer (42%) offer employee plus-one plans (Q#34). Both availability and take-up increased for plus-one plans over the last year, did not change for employee-only plans, but declined for family plans. Plus-one plans are relatively new to the small business market and may substitute for family plans in some cases. But on balance, those offering employer health insurance appear to be offering their employees plans in the same proportion that they did in the prior year and employees are taking them up with the same frequency.

The principal year-over-year difference in the plans offered appears to be the employer contribution to family and employee plus-one coverage; they declined notably (Exhibit 3). Yet, employer contributions did not change for employee-only plans. At least three reasons are likely associated with change in employer contributions: premium cost of family and employee plus-one coverage increased (measured by 25th, 50th, and 75th percentiles) while employee-only plans declined (see, Health Insurance Costs). Second, employee-only premiums cost less in absolute terms than family or employee plus-one premiums. Third, contributing less to multi-person plans can reduce costs substantially without affecting employee coverage as will be shown subsequently. Reducing employer contributions on family and employee plus-one coverage reduces employer insurance costs, maintains coverage for people working in the firm and does not intrude on insurer-imposed minimum employee participation requirements while still giving employees the option to carry multi-person coverage, albeit at a higher cost.

Exhibit 3

EMPLOYER CONTRIBUTION FOR FAMILY, EMPLOYEE-ONLY, AND EMPLOYEE PLUS-ONE PLANS BY YEAR

	2012/2013			2013/2014		
	Family	Employee-Only	Employee Plus-One	Family	Employee-Only	Employee Plus-One
100 Percent—All	27%	40%	20%	28%	42%	16%
75–99 Percent	19	23	34	11	25	33
50–74 Percent	29	27	20	27	27	17
1–49 Percent	11	6	9	19	4	20
0 Percent—Nothing	8	2	13	11	1	11
(DK)	6	2	5	5	1	3
Total	100%	100%	100%	100%	100%	100%
N	512	517	265	474	494	277

Family Coverage

A noticeable difference in family plans from the prior year is the size of the employer contribution. While more than one in four (28%) small employers continued to pay the entire premium (Q#27), the number who contributed between 75 and 99 percent declined 8 percentage points from one year earlier. The decline increased to 10 percentage points including those contributing 50 percent or more (48% compared to 38%).

Eighty-one (81) percent of small businesses that offer family coverage have at least some employees who subscribe to it. However, a relatively small and declining share of employees within those firms subscribe to the product. Sixty-one (61) percent with any family coverage subscribers have fewer than half using family coverage (Q#29), 8 percentage points more than in the prior year (Exhibit 4).

Exhibit 4

EMPLOYEE PARTICIPATION IN HEALTH INSURANCE PLAN BY TYPE OF COVERAGE AND YEAR

	2012/2013			2013/2014		
	Family	Employee-Only	Employee Plus-one	Family	Employee-Only	Employee Plus-One
Percent of Offering Firms:						
With Full-Time Employees Participating	79%	75%	40%	73%	77%	42%
N	664	664	664	620	620	620
Portion of Full-Time Employees Participating:						
All	14%	30%	6%	11%	28%	2%
Most	19	24	9	14	34	5
Half	12	12	4	13	13	12
Some	53	33	77	61	24	79
(DK/Refuse)	2	1	4	1	1	4
Total	100%	100%	100%	100%	100%	100%
N	523	525	227	474	494	277

Employee-Only Coverage

The employer cost share for employee-only coverage edged higher from the prior year. More than two of five small employers (42%) pay the entire health insurance premium for an employee only plan (Q#31), about the same number as one year ago. The number contributing 75–99 percent of the premium was also similar at the two points in time. The year-to-year change for the two groups amounted to a 4 percentage point increase as the proportion contributing 50–74 percent remained constant. Of the three types of coverage, employee-only proved the type for which small employees increased support.

Employee-only is the workhorse of small business employer-sponsored health insurance. Ninety-three (93) percent of small businesses that offer employee-only coverage have employees who subscribe to it. Twenty-eight (28) percent report that all of their employees use employee-only coverage with another 34 percent reporting most of them do (Q#33). The 62 percent with all or most of their employees using employee-only coverage represents a substantial increase, 8 percentage points, from the prior year. Part of the reason for the increase is employee choice and part of the reason is the amount the employer offers (or contributes to).

Employee Plus-One

Employee plus-one plans are a cross between employee-only and family coverages, a kind of mini-family plan. Small employers are choosing to treat them as such for purposes of employee cost share, that is, more favorably than family plans and less favorably than employee-only plans. Just 16 percent of small employers pay the entire premium of employees using it and another 34 percent contribute between 75 and 99 percent (Q#35). One year ago the equivalent numbers were 20 percent and 34 percent, a 2 point difference. However, contributions of between 50 and 74 percent were also 3 points less representing a 5 percentage point decline.

Seventy-one (71) percent of small businesses that make available plus-one insurance have employees who subscribe. Employee-plus coverage is the least common coverage small businesses offer. Not only is it offered least frequently, it is subscribed to less frequently when available. Seventy-nine (79) say that just "some" of their employees, meaning less than half, use the product, similar to the prior year's number. However, the percent of small firms experiencing substantial subscription fell by half over the same time.

Change in Coverage Distribution

The percentage of employees choosing one type of health insurance coverage compared to another has remained relatively stable over the last year or two. Eighty-eight (88) percent of offering small employers report that the distribution has not changed while 9 percent report that it has (Q#39). Three percent do not know. Of those who indicate that the distribution has changed, 54 percent identify the shift as toward employee-only coverage (Q#40). Another 13 percent identify a shift to family coverage and 12 percent employee to plus-one coverage. Just over one in five (21%) who report a change do not know its direction.

Nine percent of offering small employers in mid-2013 also reported changes in their workforce coverage distribution. But differing from mid-2014 when the changes heavily tilted toward employee-only and away from family plans, the change one year ago showed no direction. Forty-six (46) percent who experienced a distribution change witnessed a move towards family plans and 41 percent witnessed a move to employee-only plans.

The reasons for the change in employee choices appear many and varied, but cost is never far away. Twenty-six (26) percent of affected small employers say the primary reason for type of coverage change is the change in employee costs (Q#41). Higher costs are incentives for employees to make different choices. A greater employee cost share for a family plan may encourage an employee with a working spouse, for example, to drop the family plan for an employee-only plan and have the spouse enroll in an employee-only plan in his or her place of employment. Twenty-eight (28) percent attribute the change to employees just making different choices. Fourteen (14) percent point to a changing composition of the workforce. However, 16 percent say the reason is more employees participating in the plan. Eight percent say the reason for change in the coverage distribution within their firms is fewer employees participating in the plan. In effect, 38 percent think the reason is associated directly or indirectly to changing employee profiles.

Employee Participation

The ACA's individual mandate requires virtually all Americans to carry health insurance or pay a penalty. The effective date of this requirement was January 1, 2014. The result is that one would expect uninsured people working in non-offering firms to approach their employer about offering an employer-sponsored health insurance plan while uninsured people working in an offering firms would simply sign up for coverage. The former group of employees as reported earlier (see, Increased Employee Demand for Insurance) did not respond as expected. They did not often ask their employer for insurance. But the latter group did respond as expected. They often signed up.

More employees are participating in their employer's plan this year than last, though the data are not always consistent. Sixty-two (62) percent of offering small employers have 75 percent or more of their full-time, non-seasonal employees participating their firm's plan; 40 percent have everyone (Q#25). The equivalent figures in mid-2013 were 52 percent with 75 percent or more full-time, non-seasonal participation and 32 percent with complete participation. These data would appear to be contradicted by the number of small employers reporting more and less participation. Just 5 percent say that participation increased from the prior year, 10 percent say it was less, and 86 percent report no change (Q#56). The latter measure is driven by the 2–9 employee size firms. Just 4 percent of that group report greater participation and 23 percent report less. The skew is even greater in the 2–4 employee size group. Owners of larger firms meanwhile report greater participation.

Health Insurance Costs

The cost of health insurance has been the principal concern of small-business owners during healthcare debates over the last 25 years or so. High cost led to lesser demand for health insurance over the last 10 to 15 years which exacerbated the coverage (uninsured) problem. The ACA and its supporters chose coverage rather than cost as its central focus. Presumably, the cost problem would be addressed later. And so, small business is still left with a cost problem that shows more signs of getting worse than of getting better.

The cost of healthcare and hence health insurance is rising more slowly today than it has in a long time. But it is still rising, and rising faster than the rate of inflation. Ominously, CMS actuaries [12] expect healthcare costs to accelerate and outstrip the cost-of-living and GDP growth, implying increases at unsustainable rates. They are not alone. Outside experts do as well.[13]

The data collected for this report generally find insurance costs lower than do other sources, but rising faster. These data are not always consistent, particularly

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[12] Centers for Medicare & Medicaid Services (2014). National Health Expenditure Projections 2012–2022. *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf.*

[13] Chandra, A, J Holmes, and J Skinner (2013). Is This Time Different? The Slowdown in Healthcare Spending. NBER Working Paper 19700. National Bureau of Economic Research: Cambridge, MA., December; Roehrig, C (2013). U.S. Health Spending as a Share of GDP—Where Are We Headed? Altarum Institute Health Policy Forum, July 16. *http://altarum.org/health-policy-blog/u-s-health-spending-as-a-share-of-gdp-where-are-we-headed.*

with respect to size (in contrast to direction) of the cost changes. The author gives greater credence to reports that require less precise estimates, recognizing that all information supplied has value. This unfortunate lack of consistency in insurance cost reports suggests considerable market turmoil, not just in terms of actual outlays for premiums, but in terms of new and eliminated policies, and the benefits purchased in each. In fact, a substantial share of the rate discrepancy may lie with cost increases associated with additional, unwanted benefits that the ACA requires.

Premium Increases

Sixty-two (62) percent of offering small employers report that the per employee premiums for their current health plan rose between mid-2013 and mid-2014 (Q#44). On the other side of the ledger, 8 percent now experience lower per employee premiums. Twenty-nine (29) percent report no change and 1 percent are not sure. On top of the 6+:1 ratio of premium increases to premium decreases, the size of change proved larger on the increased side than on the decreased. The median premium increase ran in the 13–14 percent range, while the median decrease was just over 10 percent (Q#45). The result is an average per employee premium growth well above any measure of real wealth increase.

The frequency of per employee premium cost increases was less in the mid-2014 data than in the mid-2013, but marginally so. The number reporting increases fell 2 percentage points (from 64 percent to 62 percent) while the number reporting decreases rose 2 (from 6 percent to 8 percent). However, the prior year's median increase was some- what lower.

Monthly Per Employee Premiums by Coverage

The course of premium cost diverged over the year by type of coverage. Employee-only coverage costs actually fell while family and plus-one coverage costs rose. This assessment is based on comparisons of premiums at the 25th, 50th, 75th percentiles for the years ending in mid-2013 and mid-2014. The comparison is not exact. While these estimates include both the employee and employer shares, they do not account for net benefit changes either chosen or ACA mandated.

Employee-only costs at the 25th percentile stood at an identical $380 per month for both years. But they differed at the 50th (median) and 75th percentiles. The median declined from $555 a month (Q#32) to $515 a month, the equivalent of a 7 percent drop. The decline at the 75th percentile was even greater, part of a pattern for both employee-only and family coverage that shows the largest premiums changing the most on a percentage basis and the smallest the least. Reported premium costs for employee-only coverage at the 75th percentile fell from $800 a month to $635 a month, a 19 percent decline.

The cost of family coverage took the opposite path. It rose from the period ending in mid-2013 to the one ending in mid-2014 at all three measuring points. The change at the 25th percentile was a 15 percent escalation, from $550 to $630 a month. The percent change at the median was 16 percent, from $810 to $940 a month (Q#28). Lastly, the percent change at the 75th percentile was an even larger, 19 percent. The increase was from $1,155 to $1,370 a month or $215.

The plus-one premium estimates fall between estimates for the other two types of coverage, but do on balance rise. The principal difference between plus-one costs and the other two coverages is that change decreases as premiums grow rather than the opposite. At the 25th percentile, costs increased from $450 a month to $575 a month or 28 percent. At the 50th percentile, costs increased from $790 a month to $850 a month or 11 percent. But at the 75th percentile, costs actually declined. They fell $15 a month, from $1,075 to $1,060, just 1 percent, but they went down nonetheless.

Premiums rose for two types of coverage, family and employee plus-one, and declined for the third, employee-only. Apparently, the more people covered by a policy type, the greater the percent increase. Family coverage increased most, employee plus-one coverage increased, and employee-only coverage declined. That pricing pattern can be explained on an absolute dollar basis, but it is much more difficult on a percentage basis. Even if the cost estimates collected for this report are less precise than desirable, they strongly suggest a pricing shift underway among smaller firms. The price structure is tied to the package of benefits, deductibles, and copays, data which are not available here, and that obfuscates much. Still, the question is why premium costs of various plan types are changing in different directions. The data offer no obvious answers. Nor do they provide obvious answers to the question why the smallest premiums do not have the largest percentage rise (they do for plus-one). After all, the least costly packages should be the ones most often sub-

ject to the minimum essential health benefits requirements. On the other hand, the ACA's modified community rating encourages cross-subsidization and cross-subsidies may provide part of the explanation.

The NFIB premium estimates appear substantially lower than those produced by the Kaiser Family Foundation[14] and the Medical Expenditure Panel Survey (MEPS).[15] Part of the explanation is that Kaiser and MEPS use averages rather than medians as NFIB does. Average health insurance prices tend to inflate as the distribution is skewed to the high side; percentiles do not skew. NFIB does not ask respondents to consult records to obtain precise premium figures. Rather it asks for best estimates. Given the small employer outcry over health insurance costs, the assumption might be that they would exaggerate the premiums they pay. However, should NFIB data underestimate small employer health insurance costs as is likely, small employers do not fully recognize the cost impacts that provision of this employee benefit has on them.

Monthly Firm Premiums

Median monthly premiums *per offering* firm rose between mid-2012/mid-2013 and mid-2013/mid-2014. They amounted to about $3,800 per month ($45,600 per annum) this year compared to about $3,420 the prior year ($41,040 per annum) (Exhibit 5). The premium at the 25th percentile was about $2,150 per month ($25,800 per annum) compared to about $1,850 per month the year before ($22,200 per annum). The premium at the 75th percentile was $8,030 per month ($96,360 per annum) compared to $8,070 per month ($96,840 per annum) the prior year. About 1 percent report spending more than $20,000 a month, about the same as last year. Thus, while spending is going up at the bottom, it has leveled, at least temporarily at the top. That pattern suggests owners of large offering firms can control their health insurance costs more readily than can owners of small offering firms.

The reported increases underscore three points: health insurance premiums paid by small employers and their employees continued to increase above the rate of inflation even in times when healthcare cost increases are at an ebb. Note on Exhibit 5 that the percent with monthly premiums of less than $2,000 per month declined 20 percent in the last year. More affordable policies are being phased out, usually due to ACA mandates, and that appears in the per firm premium cost. To continue offering, a small employer must pay more. Second, the number of employees signing up for employer-sponsored health insurance is increasing when offered. Those newly insured do not affect the per employee cost of insurance (other factors equal), but they do affect its per firm cost and per firm cost is the issue here. Third, reductions in the number of firms offering coverage come from among smaller, small businesses; increases come at other end of the scale. The implication for present purposes is that the average firm offering is larger and a larger offering firm by definition has more people covered.

Combination Coverage

Twenty-three (23) percent of offering firms have employees who use each of the three types of coverage discussed above. Twenty-nine (29) percent use two of the three types and 48 percent use only a single coverage type. Breaking down those offering two types of coverage, 20 percent use the employee-only and family coverage combination, 6 percent the family and employee plus-one coverage combination, and 4 percent employee-only and employee plus-one coverage combination. However, 31 percent subscribe to employee-only coverage exclusively, 16 percent to family coverage only, and 1 to percent employee plus-one coverage only. If the choice had been made to define coverage in terms of its availability rather than its take-up (see, Exhibit 2), the distribution would have been quite different. For example, 36 percent have all three available, but only 23 percent have employees using all three. Similarly, 33 percent make just one type of plan available, but 48 percent have employees using only one.

The number of coverage types offered varies sharply by employee size-of-business. Half (50%) of the largest (50–100 employees) firms have employees using each type. Just 14 percent in that group have employees who use just one type. The situation among the smallest (2–9 employees) is the opposite. Seventy-two (72) percent of that group have employees use just one type of coverage while 11 percent use all three. There are two likely causes for such coverage distribution. The first is simple probabilities. A larger workforce is more likely to have people in different situations than a smaller one, creating a broader set of employee demands/needs for health

[14] Kaiser Family Foundation (2014). op. cit., Section 1, pp. 14–33.
[15] *http://meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=7Z-1.*

insurance. The second reason is more closely tied to the business. The smallest firms can find it relatively expensive and administratively difficult to offer more than a single coverage type and the smallest firms tend to be the most price sensitive. A single coverage type, most prominently employee-only coverage, also allows the small employer to forgo the cost-share for a more expensive family and/or employee plus-one plan types while complying with insurer minimum participation requirements.

Monthly Firm Premiums

Median monthly premiums *per offering firm* rose significantly between mid-2012/mid-2013 and mid-2013/mid-2014. They amounted to about $5,000 ($60,000 per annum) this year compared to about $3,400 the prior year (Exhibit 5). The premium at the 25th percentile was about $2,600 per month ($31,200 per annum) compared to about $1,800 per month the year before ($21,600 per year). The premium in the 75th percentile was $10,000 ($120,000 per annum) compared to $7,500 ($90,000) the prior year.

These data indicate premium costs *per offering firm* rose almost one-third over the period, an increase that is not plausible. Yet, the substantial reported increase underscores three points: health insurance premiums paid by small employers and their employees continued to increase substantially above the rate of inflation even in times when health-care cost increases were at an ebb. Note on Exhibit 4 that the percent with monthly premiums of less than $2,000 was halved in the last year. More affordable policies are being phased out usually due to ACA mandates and that appears in the per firm premium cost. To continue offering, a small employer must pay more. Second, the number of employees signing up for employer-sponsored health insurance is increasing when offered. Those newly insured do not affect the per employee cost of insurance (other factors equal), but they do affect its per firm cost and per firm cost is the issue at stake. Third, reductions in firms offering coverage come from among smaller, small businesses; increases come at other end of the scale. The implication for present purposes is that the average firm offering is larger and a larger offering firm by definition has more people covered.

Paying for Premium Increases

Small employers experiencing employer-sponsored health insurance premium increases took an average of 2.4 actions to offset expense increases (Exhibit 6). The greater the average premium increase, the more actions small employers took in response. Those reporting a 20 plus percent increase, for example, say they took an average of 3.3 actions to offset their cost increases compared to 2.2 actions among those with increases of less than 10 percent.

The most frequent single action taken was absorbing the higher costs with lower profits/earnings. Sixty-seven (67) percent, two-thirds of those experiencing an increase, paid for at least part of that increase out-of-pocket (Q#49). That is a generous but unsustainable response. The next most frequent action (37%) was delayed, postponed, and/or reduced business investment (Q#50). The future of the business therefore was at least temporarily mortgaged to pay for higher premiums. The remainder of possible actions were taken less frequently.

Exhibit 5

TOTAL MONTHLY HEALTH INSURANCE PREMIUMS PER SMALL BUSINESS BY YEAR

Monthly Per Firm Premium (Employer and Employee Shares)	Year	
	Mid-2012/Mid-2013	Mid-2013/Mid-2014
<$1,000	12%	9%
$1,000–$1,999	13	11
$2,000–$2,999	15	17
$3,000–$3,999	11	11
$4,000–$4,999	5	7
$5,000–$7,499	10	12
$7,500–$9,999	5	5
$10,000–$12,499	4	5
$12,500–$14,999	1	3
$15,000–$19,499	5	3
$20,000–$24,999	2	2
$25,000–$49,999	3	5

Exhibit 5—Continued

TOTAL MONTHLY HEALTH INSURANCE PREMIUMS PER SMALL BUSINESS BY YEAR

Monthly Per Firm Premium (Employer and Employee Shares)	Year	
	Mid-2012/Mid-2013	Mid-2013/Mid-2014
$50,000+	1	1
(DK)	13	9
Total	100%	100%
N	664	620

Forty-five (45) percent of small employers faced with higher premium costs took one or more actions that directly affect employee wages and/or benefits. These actions became notably more frequent as average premium increases grew larger. Cuts in employees or employee hours were confined to a relatively small 2 percent if the premium increases were under 10 percent, but their frequency grew to 27 percent if premium increases rose to 20 percent or more (Q#47). The same pattern, though more extreme, appears with frozen or reduced wages and reduced non-health employee benefits. The former rose from 14 percent to 46 percent as the premium increase accelerated (Q#51) and the latter from 5 percent to 32 percent (Q#52). Small employers tended to take the three actions directly affecting employee compensation in concert. If they took one, there was a high likelihood that they would take one or more of the others as well. For example, if employee wages were frozen, there was a high likelihood that a job(s) or hours would also be lost.

A fourth action associated with the three employee compensation actions is delay, reduce, postpone, or reduce business investment. Thirty-seven (37) percent scrimped on capital investment/reinvestment, 73 percent when premiums increases reached 20 percent or higher. When premiums rise, small employers draw resources from their productive capacities, which ultimately have a long-term adverse effect on their businesses.

Increasing an employee's cost share is an indirect way to effectively reduce or freeze wages. One in four (25%) with rising premiums raised employee cost-shares (Q#48). These data correspond with the generally falling employer cost-share appearing on Exhibit 3. Increasing an employee's cost share is treated somewhat differently than other forms of employee compensation. It is not associated with action on any other form of compensation. Rather, when small employers do not raise the employee's cost-share, they tend to absorb the greater cost of employer-sponsored health insurance premiums, and vice versa.

Becoming more productive/efficient and/or raising prices are more attractive options than damaging productive capacity. However, they are not always possible. Thirty (30) percent said that they made their businesses more productive (Q#53). Greater productivity is a positive development. However, efficiency gains were more likely when cost increases were small. That atypical relationship between frequency of action taken and size of cost increase indicates that only small productivity gains were realized. Moreover, failure to take those efficiency actions previously begs the questions, why those steps had not been taken previously and what else is there to be done. Twenty-five (25) percent chose to raise selling prices (Q#46). About the same percentage raised prices regardless of their premium increase amount. The latter fact suggests small employers will take the price increase option when they can. But inflation is very low, customers are resistant to price increases, and competition is keen. Over the last several years, small employer plans to raise prices have significantly outstripped their ability to do so.[16] A fortunate 13 percent experiencing premium cost hikes in the last year were able to both raise prices and increase productivity to (help) offset them.

[16] Dunkelberg, WC and H Wade (series). Small Business Economic Trends. NFIB Research Foundation: Washington, DC.

Exhibit 6

ACTIONS TAKEN TO DEFRAY COSTS OF HEALTH INSURANCE PREMIUM INCREASES BY PERCENT TAKING THEM AND AVERAGE PREMIUM INCREASE

Cost Defraying Action	% Took Action	Average Premium Increase		
		<10%	10–19%	20+%
Raised Prices	25%	22%	29%	24%
Cut Employees/Reduced Hours	12	2	10	27
Increased Employee Cost-Share	25	17	32	25
Took Lower Profit	67	50	75	75
Delayed, Postponed, Reduced Business Investment	37	18	32	73
Froze or Reduced Wages	26	14	25	46
Reduced Non-Health Employee Benefits	14	5	10	32
Became More Productive/More Efficient	30	45	32	25
Ave. Number of Action Taken	2.4	2.2	2.5	3.3
N	366	146	141	66

Responses to health insurance increases that small employers reported in mid-2014 mirror those reported in mid-2013. Effectively, they took the same actions with about the same frequency in both years. That is reasonable. Economic conditions at both points in time were similar. Under those circumstances, one expects small employers as a group to react in much the same way. Some differences in emphasis did appear, however. More average actions were taken one year ago, 2.7 actions compared 2.4 actions, and the spread between actions taken when premiums rose less than 10 percent and 20 percent or more was somewhat smaller. The number able to defray costs with greater productivity also dropped from 48 percent to 30 percent. Perhaps much of the "low-hanging fruit" was picked previously.

The Benefit Side

Health insurance policies provide a series of benefits. The more benefits in the plan, the more costly the plan, other factors equal. But other factors are not equal. The ACA undermines the actuarial value of benefits in two ways: it requires one set of consumers to subsidize another set (community rating) and requires many customers to purchase benefits that they otherwise would not (essential health benefits), creating more demand for them than would otherwise be the case. Thus, the small-employer consumer may pay more for benefits than actuarially warranted.

Small employers on balance consciously offered fewer benefits in their health insurance package this year than last. Twenty-three (23) percent claim fewer benefits were offered in the mid-2013 to mid-2014 period than the year before (Q54). Seven percent claim their benefit package contained more benefits. A substantial majority (69%) indicate that there was no change. The current figures show a considerable decline from the prior year when 5 percent reported more benefits, 9 percent reported fewer and 75 percent reported the same benefits level. It would appear therefore that small employers increasingly are consciously reducing the benefits they can (not ACA deemed essential health benefits), almost certainly as a premium reduction mechanism.

The disguised issue influencing the actual benefit package rather than the perceived benefit package is the number of small employers who now have benefits that they involuntarily offer and/or have no idea they are offering because the ACA requires them. As a result, the numbers provided above almost certainly understate benefit package increases. Rather the numbers more likely represent the conscious efforts of small employers to adjust their benefit packages to cost necessities. The effect is to trade the benefits small employers want to offer their employees for the benefits the ACA says that they must offer them.

An indirect way to reduce benefits is to increase employees' cost-share for the benefit. Smaller employer premium contributions, higher deductibles and greater copays/co-insurance are examples. Exhibit 6 shows that 25 percent of those reporting premium cost increases also raised the employee cost-share. The question was posed only to those experiencing premium increases. The total therefore is likely even larger than suggested in Exhibit 3.

Thirty-five (35) percent state that they raised deductibles compared to 2 percent who lowered them (Q#55). The majority (61%) did not change them. However, 13

percent of all respondents, and 36 percent of small employers raising deductibles indicate that their plan benefits were unchanged. It is clearly possible that the higher deductibles, which are a form of decreased benefits, could have been offset by benefit increases elsewhere in the package. But that is not likely for many given the small number who report increasing benefits. Adding the reported 23 percent to the 13 percent means the total lowering benefits over the year rises to a minimum of between 35 and 40 percent of those offering. The remaining question is what portion of those reductions are off-set by additional benefit mandates forced on unsuspecting small employers by the ACA.

Small Business Health Insurance Dynamics

The proportion of small employers offering employer-sponsored health insurance typically changes modestly from year to year, perhaps by a percentage point or two. Yet, that picture of slow change conceals a more pervasive dynamic. A notable number add employer-sponsored health insurance as a benefit each year while another notable number drop it. Since adds and drops are similar in number, the net percent of small employers offering employer-sponsored health insurance changes modestly. The number of new firms that offer health insurance and the number of exiting firms that by definition drop it add to the disorder. Since the annual population turnover is about 10 percent or one-half million firms, the changes numerically have the potential to influence the frequency of offers. However, as noted earlier, that is not likely, at least in significant amounts (see, Self-Insurance).

Exhibit 7 presents the offer status of small businesses in mid-2013 and mid-2014 and changes between the two dates. Eighty-nine (89) percent of small employers experienced no change. If they offered health insurance in mid-2013, a high probability existed that they offered it in mid-2014 as well, and vice versa. Eleven percent who currently offer did not offer the prior year. Eleven percent who currently do not offer did offer the prior year. The same number, excluding entries and exits, added as dropped. No net change is the result counting by firm even though at least one-half million businesses changed offer status. While the N is small the number of both adds and drops appear centered among firms in the 2 to 9 employee size group, though drops appear somewhat less so.

Exhibit 7

CHANGE IN OFFER STATUS BETWEEN MID-2013 AND MID-2014

Offered Year Before (Mid-2013)	Offer This Year (Mid-2014)		
	Do Offer	Do Not Offer	Total
Did Offer	89%	11%	46%
Did Not Offer	11	89	54
D/K	*	*	*
Total	100%	100%	100%
N	620	280	900

Exhibit 7 raises another consistency question in the data. How can the percent of offering firms fall six percentage points, but the percent of changing offer status show 11 percent offering this year and not last, and vice versa. The answer is that the 11 percent changing to non-offer is on a larger base then the 11 percent changing to offer. In addition, and perhaps more important in this case, are the usual sampling errors.

Changes recorded over the past 12 months are somewhat more frequent than over the prior 12 months, about 4 percentage points higher among both adds and drops. The difference suggests increasing turbulence in small business health insurance markets. While change has been a hallmark of that market since passage of the ACA with its accompanying elimination of various insurance policies and institution of the minimum essential health benefit package, the past 12 months has seen more than its share. But without a longer time series it is not clear whether the data are capturing a particular high-point in the percentage of firms changing offer sta-

tus, or whether it is simply a measure of constant dynamism among smaller firms and their owners.[17]

Offer Dynamics—Longitudinal Cases

Two hundred and eighty-eight (288) cases, about 30 percent of each of the two samples, responded to the survey in both mid-2013 and mid-2014. The health insurance offer dynamics of this longitudinal population reinforce the results of the two larger populations, 70 percent of which represent cases in independent samples. Of those who said in mid-2013 that they planned to offer ("definitely" and "probably") in the coming year, 89 percent (177 out of 199 unweighted cases) offered in mid-2014. Of those who said they would not offer ("definitely" and "probably"), 90 percent (75 out of 83 unweighted cases) did not. The result is that these "carry-over" cases, where the survey recorded an individual small employer's plans and subsequently the same small employer's behavior, produced the equivalent outcomes for all intents and purposes as did the two independent samples. One can be reasonably confident, therefore, that a small employer's expectations to offer/not offer health insurance in the coming year will be quite accurate.

Because these longitudinal cases were not weighted, they were divided into two groups, those employing 19 people and fewer and those employing 20 or more. The division led to a curious result. Owners of businesses in the smaller employee-size group were more likely to accurately forecast that they would *not* offer (92% correct) than that they would (80% correct). Meanwhile, owners of businesses in the larger group performed in the opposite manner. Ninety-four (94) percent of those who said that they would offer insurance in the coming year did; 85 percent who said they would not offer, did not. The former population (19 people and fewer) tends not to offer while the latter (20 people and more) does. Small employers do follow-through on their plans for the most part, but they also seem influenced by the status of their peers, who effectively may also be their primary competitors, not only for customers, but for employees.

Adding Insurance

Every year perhaps one in ten small employers adds health insurance as an employee benefit. The reasons for their decision vary. The survey presented small employers who added health insurance in the prior 12 months a series of possible reasons for their decision and asked them to evaluate the importance of each. This approach differs from traditional surveys asking small employers why they offer health insurance to their employees because the current effort focuses exclusively on those who have just introduced the benefit. It does not include those who have offered it for years, and may have different motives for retaining insurance than for introducing it. The number of cases (N=69) from the mid-2013 to mid-2014 survey and the mid-2012 to mid-2013 survey made it necessary to combine eligible employer responses for two years (two surveys) in order to report results.

The reason cited most frequently (63%) as "very important" for introduction of health insurance is that profitability now allows them to offer the health insurance benefit (Q#57). Presumably these small-business owners had wanted to offer previously, but were constrained by the profitability of their firms. The introduction of employer-sponsored health insurance is a large payroll expense, even with a substantial employee cost-share. Ensuring adequate firm profitability prior to its introduction therefore seems prudent. Besides being "very" important for more than a majority, it is also "somewhat" important for another 23 percent. Just 11 percent did "not" think current firm profitability is an important factor in their decision. This latter group has likely been consistently profitable for some time.

The cost of health insurance is the reason typically associated with the failure to offer it as an employee benefit. The lack of profitability is simply the other side of the coin. If a firm is insufficiently profitable, and its prospects for sustained profitability remain problematic, introduction of a large, fixed cost is a dubious decision. A large fixed cost, in this case health insurance, undoubtedly affects profitability, but is only one of many factors.

The ACA requires employers with 50 or more full-time equivalent employees to offer employer-sponsored health insurance to full-time employees or pay a penalty.

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[17] A 2011 survey of employers with 50 or fewer employees showed that just 1 percent added health insurance in the prior 12 month and 4 percent dropped it. See, Dennis, WJ, Jr. (2011). Small Business and Health Insurance: One Year After Enactment of PPACA. July. *http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/NFIB-healthcare-study-201107.pdf.*

(The employer mandate has been postponed or modified twice). Ninety (90) to 95 percent of that group already provides the benefit. That leaves about 5,000 to 10,000 firms without insurance and legally required to add it. An unknown number of others with fewer than 50 employees may also be legally required to offer due to rules requiring multiple businesses to be combined into a single entity for legal purposes (aggregation rules). The total number affected is, therefore, relatively minor compared to the small business population. Yet, 53 percent say that the Affordable Care Act is a "very" important reason for them to introduce employer-sponsored health insurance (Q#58); 15 percent say that it is "somewhat" important; 27 percent say ACA is "not" an important reason. Another 5 percent are undecided.

Fifty-three (53) percent sounds excessive because the ACA will require relative few small businesses to offer. Recall, however, that the 53 percent responding affirmatively are just 53 percent of the roughly 5 percent who added health insurance in the last 12 months. That implies many small employers directly affected by the Act moved into compliance with what was at the time legally required. The sole group of small employers increasing their percentage offering employer sponsored health insurance was the 50 employee and over group, the one presumably most affected by the employer mandate (see, Health Insurance Offers).

The ability to compete for employees is another important reason for many small employers to add the health insurance benefit. Forty-two (42) percent cite the reason as "very" important; 38 percent call it "somewhat" important; 18 percent say that it is "not" important (Q#59). Good employees are difficult to attract and keep despite the number of unemployed and under-employed people. This is particularly true of higher skilled employees who have employment options. Smaller employers introduced the benefit because they thought they needed it to compete for employees. The labor market therefore exercised a strong influence over these employers' decisions to add health insurance.

A non-offering small employer may find himself without good options for personal health insurance. The problem may become particular pressing given the 9 percent who saw their personal insurance terminated in the last year. He (or she) may therefore introduce an employee plan to acquire coverage for the family with more satisfactory terms than would otherwise be the case. Purchase for personal needs would likely be a last resort (on the margin) except in the very smallest businesses because the employer would be only one participant among many. Still, family considerations prove a "very" important reason for adding an employee health policy in 35 percent of cases (Q#60). It is "somewhat" important in another 53 percent, but it is "not" important 12 percent of the time.

The explanations given by the small employer population for maintaining the health insurance benefit for long periods focus on the need to attract and keep good employees and a moral imperative. But those explanations are possible only so long as business profitability allows it. The reasons offered by small employers for instituting an insurance plan (in contrast to maintaining a plan) underscore the sustained profitability issue. Small employers newly introducing a plan can now do so because the firm has become sufficiently profitable Continuing health insurance premium increases chip-away at that profitability as do a variety of other factors. Yet, business profitability (adequate and continuous) is the floor for offering.

Dropping Insurance

A small employer may drop employer-sponsored health insurance for several reasons. Those who chose that course of action within the prior twelve months evaluated five potentially important reasons that may have stimulated them to do so. Due to the small number of cases (N=75), the author combined their responses for the past two years (surveys) as was done earlier for those adding insurance. These data are again unique because they interview the individual dropping insurance shortly after they have done so, rather than asking them to reflect over a lengthy period or asking those who do not offer insurance the reason(s) for their reticence.

The most important reason for dropping employer-sponsored health insurance is cost. Insurance simply became too expensive. Sixty-nine (69) percent claim cost was a "very" important reason that led them to drop employer-sponsored health insurance; 18 percent claim it was "somewhat" important; and 11 percent claim it was "not" important (Q#63). With the cost of health insurance rising for small firms overall, and rising dramatically for a subset, this small employer reaction is predictable. The surprise is that more have not dropped insurance due to its cost. Their failure to do so demonstrates small employer reluctance to drop an employee benefit already given. Despite the financial logic, it is poor employee relations. However, there are consequences. The most notable is the reticence, and the built-in inertia

accompanying it, that will likely slow the insurance drop rate even when employees would do better purchasing their own insurance through the individual exchange marketplaces.

Another frequently identified reason small employers drop employer-sponsored health insurance is that employees can do better on their own. Fifty-two (52) percent present this reason as "very" important compared to 22 percent presenting it as "somewhat" important, and another 26 percent as "not" important (Q#66). The "do better on their own" response is not necessarily wishful thinking. It is highly possible for low income employees to obtain subsidized health insurance through an individual exchange marketplace at a lower cost than the employee contribution to employer-sponsored insurance. That would be particularly true if the small employer supplements the employee's wages to help pay for subsidized coverage through an individual exchange marketplace. Since employees as a general rule must accept employer-provided insurance if it is affordable (less than 9.5 percent of the employee's income), dropping health insurance allows affected employees to benefit from the individual exchange marketplace. Some small employers appear to have discovered this strategy already. Yet, the number is currently modest, merely a few percentage points.

A corollary of insurance cost is business profitability. Forty-seven (47) percent say that business profitability has taken a turn for the worse and it is a "very" important reason that led to dropping employer-sponsored health insurance (Q#65). Thirty-three (33) percent say it is "somewhat" important, but 18 percent say that decreased profitability is "not" important.

Two other possible reasons for dropping health insurance polled poorly. Relatively few affected small employers thought either of them "very" or "somewhat" important reasons for their decision to drop. The first of the two is a decline in employee participation. Employees might decline to participate because of cost (their cost-share) or they are simply not interested. Even a small decline in participation can mean an insurance carrier will drop a small firm due to adverse selection. Small employers are keen to head-off such employee behavior and its possible consequences, particularly among the very smallest firmsas their continuing large percentage contribution of total premiums for employee-only coverage demonstrates. Earlier it was shown that participation is increasing on average (see, Employee Participation). That means participation problems may be easing. However, increases do not occur in every firm as the 28 percent who report the reason is "very" important for dropping insurance illustrate (Q#62). But this reason appears a relatively unimportant one in most instances.

Employees often prefer wages to benefits even though benefits are typically tax sheltered. The ACA with its individual mandate has changed that trade-off for previously uninsured people. Yet, if there is a perceived positive reception, a small employer might drop health insurance and substitute higher wages to attract or retain employees. Relatively few employers (19%) currently think the trade is a "very" important reason for their elimination of the health benefit (Q#64). Another 8 percent think it is "somewhat" important. However, the overwhelming majority (69%) do "not" think it is important. Four percent did not respond.

Profitability and health insurance costs are not surprisingly two important reasons causing small employers to drop their health insurance benefit. The "new" reason intruding on the prior stimulants for dropping insurance is that employees can do better on their own. This is a reason created by the ACA. Few small employers yet appear to drop insurance and justify it on those grounds. Still, employee reimbursement and/or financial incentives are more often associated with their consideration as a strategy to drop insurance than a strategy to help uninsured employees acquire it (see, Reimbursement/Financial Incentives). The association merits continued attention.

Expect to Offer Next Year

Just 58 percent of small employers are definite about their offer status 12 months from now. Twenty-one (21) percent definitely expect to offer next year and 37 percent definitely expect not to offer (Q#67). Forty (40) percent are probable (17% "probably" and 23% "probably not"). Most expect to retain the same offer status they now have. Just over one in 20 (6%) think they will change, 4 percentage points moving from offer to not offer and 2 percentage points moving from not offer to offer (Exhibit 8). No major net changes should therefore result in small employer offer status barring some earthshaking event in the interim.

Expectations are notably lower in mid-2014 than they were in mid-2013. Twelve months ago, 48 percent expected to sponsor a health insurance plan for employees, 48 percent did not, and 4 percent were not certain. Eventually 40 percent took out a plan while 61 percent did not. Thirty-eight (38) percent now think they will; 60 percent do not think they will; 2 percent are undecided. The mid-2014 offer expectations level is 10 percentage points lower than one year ago, and that level yielded a decline in offer rates of six percentage points. This year to year comparison provides a decidedly less favorable outlook than their reported plans.

Employee size-of-business has virtually no association with expectations to offer once current offer status has been controlled.

Exhibit 8

EXPECT TO OFFER NEXT YEAR BY CURRENT OFFER STATUS

Current Offer Status	Expected Offer Status Next Year					
	Definitely Yes	Probably Yes	Probably No	Definitely No	DK/Not Sure	Total
Yes	95%	92%	11%	3%	17%	40%
No	5	8	89	97	83	61
Total	21%	17%	23%	37%	2%	100%
N	358	237	122	166	17	900

Reasons Not to Offer

Researchers keep asking small employers who do not offer employee insurance why they do not do so and the answer is always the same: health insurance is too expensive. The data here simply pile on. Forty-nine (49) percent say that the single most important reason not to offer is the cost of health insurance (Q#16). That reason is followed in order by can't get enough employee participation (13%), too many employees are part-time or seasonal (composition of the labor force) (13%), employees can purchase insurance on their own (including in the new exchange marketplaces) (11%), revenue is too uncertain (10%), and the administrative hassles are too great (1%). Four percent did not provide an answer.

Small employers identifying a reason for not offering were asked if they had a second reason as well. Twenty-seven (27) percent said that they had no second reason (Q#17). A majority of that group isolated "too expensive" as their only choice. Nineteen (19) percent of owners who chose a second reason said the cost of insurance is a problem for them. That means 68 percent reported that cost is either the first or second major issue for them. Revenue too uncertain (18%) and employees can purchase on their own (15%) followed as did labor force composition (9%), low employee participation (6%), and administrative hassles (5%). The most frequent combinations of reasons joined too expensive and revenue too uncertain (16% of the total non-offering population), and too expensive and can't get enough employee participation (14% of the total population).

The response that "employees can purchase it on their own, including the new exchange marketplaces" is a questionnaire option intended to help determine the extent to which non-offering employers recognize that employees have an additional, new alternative from which to obtain their health insurance. Pressure (market and social) to offer is reduced to the extent small employers consider the exchange marketplaces a viable option. Twenty-six (26) percent of small employers cite "employees can do better on their own" as either the first or second most important reason for not offering. But, no evidence suggests that this group of respondents is any more or less knowledgeable about the exchange marketplace option than others. That raises the question of whether the reason involves the exchange marketplace or something else.

Profitability was not offered as an option, though it was a prominent reason for introduction of a plan. Yet, it effectively appears here as well. The combination of the revenue too uncertain and insurance too expensive is a product of the same profitability cause.

Conclusion

The world of employer-sponsored health insurance appears tranquil to the public and most policy-makers with only fitful episodes, such as Wal-Mart's elimination of

part-time employee coverage, occasionally intruding to remind them of the sweeping changes that the American healthcare financing system is undergoing. However, beneath the calm one in ten small employers in the last year changed offer status, one in ten had his or her personal health insurance terminated (for reasons other than non-payment), and one in 6 adjusted renewal dates to avoid, temporarily at least, ACA requirements. Another net one in two claims to pay higher insurance premiums, requiring adjustments in employer-sponsored health insurance, other forms of employee compensation, capital investment, and even their own take-home pay. Small employers shop for employer-sponsored health insurance in markets that they see as relatively less competitive with types of insurance evolving so rapidly that conventional PPOs may now have higher deductibles than conventional high deductible PPOs and conventional PPOs may limit networks to a size challenging HMO networks. Owners consciously cut benefits to reduce costs while ACA mandates add benefits, jacking costs through the back door and leaving a very different plan than the purchaser originally envisioned. The rules continue to change, usually affecting small businesses indirectly, through the insurance they can and cannot buy, and the price they must pay for it. The next scheduled potentially significant change will merge the fewer than 50 employee group and the 50–99 group into a single small group market. Later, the Cadillac tax kicks in, though it is not likely to affect many small firms for several years, perhaps excepting some professional services businesses. The current small-business health insurance headline therefore is the turmoil, the turmoil that a significant portion of individual firms are now experiencing.

No evidence in this report suggests that small-business owners as a group are moving abruptly in any direction, though the reduction in net offering firms and small employer expectations to offer next year give pause. There is no rush to self-insure or push employees, particularly lower paid employees, to the exchange marketplaces. But there are pressures building, many of which are temporarily dampened by the turmoil and constantly moving regulatory targets. Thus, change is more likely to come from a growing weight tipping and dragging small employers along rather than from any type of eruption. When and how that comes is more uncertain than the fact that small employers have major operating issues yet to confront when they do offer. One thing seems certain—non-offering small employers with minor exceptions are not about to reverse their stance.

The lead for much of the employer-sponsored health insurance world is the slowdown in the rate of premium increases. The slowdown is good news for small-business owners who for years have placed health insurance costs at or near the top on their list of business difficulties. Still, perspective is important. The slowdown is projected to be temporary; premiums are still at an unsustainably high level; and, small employers are not impressed as they continue to report increases above, and at variance, with the estimates officially produced. Cost remains the serious and largely unaddressed pressure impacting smaller firms.

If cost and, to a lesser extent, turmoil are the stimulants for action, what will be the small employer responses? Cost-sharing is already changing and has been for several years. Additional cost-sharing increases for employees may become tricky however, particularly for owners of the smallest and largest, small businesses. Insurer participation requirements often force small employers to pay a substantial share of the premium to keep employees in the group. The ACA's individual mandate could reduce that pressure because it encourages employees to carry health insurance, which in turn relieves pressure on small employer cost-sharing. Larger small firms may be caught by the minimum contribution requirement of the employer mandate should it ever be enforced. Benefits will continue to be pared, though there may be practical limits because of the plans insurers can legally offer. More controversial is the withdrawal of support for family and employee plus-one plan types to compensate for greater support of employee-only plan types and greater employee participation. The evidence presented here to support such a developing trend is not overwhelming, but certainly enough to merit attention. Withdrawal of benefits for part-time small-business employees does not appear to be taking place, in part because so few offer them in the first place and in part because those that do offer part-time health benefits tend to be more profitable firms and pay employees more than average. Many smaller employers meanwhile are considering dropping their insurance plans and substituting some type of financial reimbursement. Yet, this approach to the health insurance benefit remains more conversation than real. At the other end of the spectrum, few non-offering small employers are considering financial incentives or reimbursement to help employees purchase insurance on their own.

The Kaiser Foundation reports that between 1999 and 2014, a 15 year span including the introduction of ACA, the percentage of small businesses (defined as 3–199 employees) offering employer-sponsored health insurance declined from 65 percent to 54 percent, a 17 percent drop.[18] The changes in small employer-sponsored health insurance financing suggest further declines. How much, how soon seems to be the question.

NFIB Health Survey 2014—Frequency Distribution

1. Not including yourself, approximately how many total employees does your business have?

1. 2–9 (unweighted)	222
2. 10–19 (unweighted)	225
3. 20–49 (unweighted)	228
4. 50–100 (unweighted)	225
Total	900

2. Not including yourself, approximately how many part-time employees working less than 30 hours a week do you currently have working for you?

0. None	30%
1. 1–4	59
2. 5–9	8
3. 10–19	2
4. 20–49	1
5. 50 or more	*
Total	100%
N	900

3. Not including yourself, approximately how many full-time employees working 30 hours or more a week, do you currently have working for you?

1. 1–4	61
2. 5–9	18
3. 10–19	12
4. 20–49	8
5. 50 or more	2
Total	100%
N	900

4. Which best describes your full-time employees pay: In wages, salary, tips, commissions, etc., do half of your full-time employees earn more than:?

1. <$25,000 per year or $12.50 per hour	11%
2. $25,000 per year or $12.50 per hour	42
3. $40,000 per year or $20 per hour	23
4. $55,000 per year or $27.50 per hour	7
5. $70,000 per year or $35 per hour	7
6. (DK/Refuse)	10
Total	100%
N	864

[18] Kaiser Family Foundation (2014). *op. cit.,* Section 2, p. 42.

5. Do you personally have health insurance, and if so do you get it from your business's health plan, a spouse's health plan, or an individual health plan?

1. Have business plan	31%
2. Have spouse's plan	19
3. Have individual plan	39
4. Do not have health insurance	8
5. (DK/Refused)	2
Total	100%
N	900

6. Was your personal health insurance purchased through the government's new health insurance exchange or directly on the private market?

1. Government Exchange	19%
2. Private Market	72
3. (DK/Refused)	9
Total	100%
N	226

7. Did you receive a reduced rate when you purchased your personal health insurance through the government exchange?

1. Yes	—%
2. No	—
3. (DK/Refused)	—
Total	100%
N	33

8. In the last 12 months did you have your personal health plan terminated or cancelled for any reason other than non-payment?

1. Yes	9%
2. No	90
3. (DK/Refused)	1
Total	100%
N	900

9. Is the cost of your current personal health plan compared to your terminated or cancelled plan:

1. 35 percent or more higher	28%
2. 10 to 34 percent higher	37
3. Less than 10 percent higher	6
4. Less than 10 percent lower	8
5. 10 to 34 percent lower	20
6. 35 percent or more lower	1
Total	100%
N	78

10. In the last 6 months, have more than 5 percent of your employees, or representatives of more than 5 percent of your employees, asked that the business offer an employee health insurance plan?

1. Yes	4%
2. No	96
3. (DK/Refused)	1
Total	100%
N	280

11. Does your business offer any employee reimbursement or financial support to help pay for a health insurance plan that employees purchase on their own?

1. Yes	18%
2. No	81
3. (DK/Refused)	1
Total	100%
N	900

12. Is that financial support based primarily on:

1. A flat amount per employee	—
2. A percent of the employee's health insurance premium	—
3. A percent of the employee's salary or wages	—
4. The employee's length of service	—
5. Something else (specify)_____	—
6. (DK/Refused)	—
Total	100%
N	45

13. Have you seriously considered, considered, or not considered offering your employees a cash payment or a financial incentive to purchase health insurance on their own instead of directly offering the benefit?

1. Seriously Considered	4%
2. Considered	13
3. Not Considered	80
4. (DK/Refused)	3
Total	100%
N	721

14. Would that financial support be based primarily on:?

1. A flat amount per employee	41%
2. A percent of the employee's health insurance premium	23
3. A percent of the employee's salary or wages	2
4. The employee's length of service	5
5. OR, Haven't you thought that far yet	29
Total	100%
N	192

15. Does your business currently offer health insurance coverage to employees?

1. Yes	40%
2. No	61
3. (DK/Refused)	*
Total	100%
N	900

16. What is the most important reason that you don't you offer employee health insurance?

1. Too expensive	49%
2. Can't get enough employees to participate	13
3. Administrative hassle too great	1
4. Many employees are part-time, seasonal, or high turn-over	13
5. Revenue is too uncertain	10
6. Employees can purchase it on their own, including in the new exchanges	11
7. (Other/DK/Refused)	4
Total	100%
N	280

17. Is there a second most important reason?

1. Too expensive	19%
2. Can't get enough employees to participate	6
3. Administrative hassle too great	2
4. Many employees are part-time, seasonal, or high turn-over	9
5. Revenue is too uncertain	18
6. Employees can purchase it on their own, including in the new exchanges	15
7. No second reason	27
8. (Other/DK/Refused)	2
Total	100%
N	280

18. When did you last renew or take out your current health insurance policy? Was it in the:?

1. Third calendar quarter of 2013	16%
2. Fourth calendar quarter of 2013	36
3. First calendar quarter of 2014	19
4. Second calendar quarter of 2014	22
5. (DK/Refuse)	7
Total	100%
N	620

19. Why did you choose that time to purchase your health insurance? Was it because:?

1. It was the normal renewal time	68%
2. Could keep your current policy by renewing in 2013	18
3. Could get a cheaper rate than waiting until 2014	15
4. (Other)	*
5. (DK/Refuse)	*
Total	100%
N	331

20. Is health insurance offered only to full-time employees or to both full-time and part-time employees?

1. Full-time only	83%
2. Both full-time and part-time	15
3. Part-time only	1
4. (DK/Refused)	1
Total	100%
N	620

21. Under which one of the following types of health plans are most of your employees covered?

1. HMO	19%
2. High-deductible PPO	27
3. PPO	40
4. Point of Service	2
5. (DK/Refused)	13
Total	100%
N	620

22. Does your business also offer another type of health plan?

1. Yes	11%
2. No	89
3. (DK/Refused)	*
Total	100%
N	558

23. Which best describes the health plan that covers most of your employees? Is it a:

1. A **Fully Insured Plan** in which you contract with a health plan that assumes financial responsibility for the costs of enrollees' medical claims, OR	87%
2. A **Self-Funded Plan** in which you assume direct financial responsibility for the costs of enrollees' medical claims, but have ''stop-loss'' coverage from an insurer to protect you against very large claims	7
3. (Self-Funded with no stop-loss)	2
4. (DK/Refused)	7
Total	100%
N	620

24. Is it highly likely, somewhat likely, not too likely or not at all likely that you will switch to a self-funded employee health insurance the next time your policy comes up for renewal, or haven't you thought about renewal yet?

1. Highly likely	6%
2. Somewhat likely	7
3. Not too likely	22
4. Not at all likely	48
5. Haven't thought about renewal yet	16
6. (Not Sure/Refuse)	1
Total	100%
N	528

25. How many of your full-time, non-seasonal employees participate in your health plan?

1. <25 percent	2%
2. 25–49 percent	8
3. 50–74 percent	26
4. 75–89 percent	19
5. 90–99 percent	3
6. 100 percent	40
7. (DK/Refused)	2
Total	100%
N	620

26. There are typically three types of health coverage policies: FAMILY, INDIVIDUAL, that is EMPLOYEE-ONLY, and PLUS ONE, that is, EMPLOYEE and ONE OTHER PERSON. Does your business offer:

Family coverage?	
1. Yes	73%
2. No	27
3. (DK/Refused)	*
Total	100%
N	620

27. Approximately, what percentage of the premium does your business pay for a FAMILY health insurance policy?

1. All of it—100%	28%
2. 90–99 percent	2
3. 75–89 percent	9
4. 50–74 percent	27
5. 25–49 percent	14
6. 1–24 Percent	5
7. Nothing	11
8. (DK/Refused)	5
Total	100%
N	474

28. Including both employer and employee contributions, what is the average total MONTHLY cost per employee policy?

1. <$500	11%
2. $500–$599	8
3. $600–$699	8
4. $700–$799	5
5. $800–$899	8
6. $900–$999	8
7. $1,000–$1,099	4
8. $1,100–$1,199	5
9. $1,200–$1,299	7
10. $1,300–$1,399	4
11. $1,400–$1,499	2
12. $1,500–$1,749	7
13. $1,750–$1,999	8
14. $2,000+	3

28. Including both employer and employee contributions, what is the average total MONTHLY cost per employee policy?—Continued

15. (DK/Refused)	12
Total	100%
N	474

29. Do all, most, half, some or none of the employees participating in your health plan have family coverage?

1. All	11%
2. Most	14
3. Half	13
4. Some	61
5. None (see text)	0
6. (DK/Refused)	1
Total	100%
N	474

30. Does your business offer an INDIVIDUAL health insurance option?

1. Yes	77%
2. No	18
3. (DK/Refused)	6
Total	100%
N	620

31. Approximately, what percentage of the premium does your business pay for an INDIVIDUAL health insurance policy?

1. All of it—100%	42%
2. 90–99 percent	8
3. 75–89 percent	17
4. 50–74 percent	27
5. 25–49 percent	3
6. 1–24 percent	1
7. Nothing	1
8. (DK/Refused)	1
Total	100%
N	494

32. Including employer and employee contributions for INDIVIDUAL health care coverage, what is the average total MONTHLY cost per policy?

1. Less than $200	4%
2. $200–$299	5
3. $300–$399	18
4. $400–$499	18
5. $500–$599	21
6. $600–$699	13
7. $700–$799	7
8. $800–$899	1
9. $900–$999	2
10. $1,000+	5

32. Including employer and employee contributions for INDIVIDUAL health care coverage, what is the average total MONTHLY cost per policy?—Continued

11. (DK/Refused)	7
Total	100%
N	494

33. Do all, most, half, some or none of the employees participating in your health plan have individual coverage?

1. All	27%
2. Most	34
3. Half	13
4. Some	25
5. None (see text)	0
6. (DK/Refused)	1
Total	100%
N	494

34. Does your business offer a so-called "plus-one" health insurance option, that is, an option that covers the employee and one other person?

1. Yes	42%
2. No	55
3. (DK/Refused)	3
Total	100%
N	620

35. Approximately, what percentage of the premium does your business pay for a "plus-one" health insurance policy?

1. All of it—100 percent	16%
2. 90–99 percent	12
3. 75–89 percent	21
4. 50–74 percent	17
5. 25–49 percent	10
6. 1–24 percent	10
7. Nothing	11
8. (DK/Refused)	3
Total	100%
N	277

36. Including employer and employee contributions for "plus-one" health care coverage, what is the average total MONTHLY cost per policy?

1. Less than $300	2%
2. $300–$399	2
3. $400–$499	4
4. $500–$599	18
5. $600–$699	9
6. $700–$799	5
7. $800–$899	11
8. $900–$999	13
9. $1,000–$1,099	6

36. Including employer and employee contributions for "plus-one" health care coverage, what is the average total MONTHLY cost per policy?—Continued

10. $1,100–$1,199	3
11. $1,200–$1,299	9
12. $1,300–$1,399	3
13. $1,400–$1,499	1
14. $1,500+	6
15. (DK/Refused)	9
Total	100%
N	277

37. Do all, most, half, some or none of the employees participating in your health plan have plus-one coverage?

1. All	2%
2. Most	5
3. Half	12
4. Some	79
5. None (see text)	0
6. (DK/Refused)	2
Total	100%
N	335

38. What is your business's total monthly health care insurance premium cost, for all types of health insurance offered? (Employer and Employee shares)

1. < $1,000	9%
2. $1,000–$1,999	11
3. $2,000–$2,999	17
4. $3,000–$3,999	11
5. $4,000–$4,999	7
6. $5,000–$7,499	12
7. $7,500–$9,999	5
8. $10,000–$12,499	5
9. $12,500–$14,999	3
10. $15,000–$19,999	3
11. $20,000–$24,999	2
12. $25,000–$49,999	5
13. $50,000 or more	1
14. (DK/Refused)	9
Total	100%
N	485

39. Has the percentage of employees choosing INDIVIDUAL, FAMILY, or "PLUS ONE" options changed over the last year or two, or has the mix held reasonably steady?

1. Changed	8%
2. Steady	90
3. (DK/Refused)	3
Total	100%
N	620

40. Which type of policy option has increased its share of employee participation? (If asked, in ABSOLUTE NUMBERS)

1. Individual policies	54%
2. Family policies	13
3. Plus one policies	12
4. (DK/Refused)	21
Total	100%
N	620

41. What is the primary reason for this change?

1. Change in employee costs	26%
2. Changing composition of the workforce	14
3. More employees participating	16
4. Fewer employees participating	8
5. Employees just making different choices	26
6. (DK/Refused)	10
Total	100%
N	74

42. Was the change in employee cost primarily due to a change in the employee/employer cost share or a change in the total price of the plan, or both?

1. Cost-share	—%
2. Plan price	—
3. Both	—
4. (DK/Refused)	—
Total	100%
N	21

43. Did you offer employee health insurance to any of your employees LAST year at this time?

1. Yes	89%
2. No	11
3. (DK/Refused)	1
Total	100%
N	620

44. Is the PER EMPLOYEE cost of your current health plan more, less or about the same as last year's plan? (Plan cost, not employer's or employee's share)

1. More	62%
2. Less	8
3. Same	29
4. (DK/Refused)	1
Total	100%
N	582

45. Please estimate the PER EMPLOYEE percent change in cost of this year's plan compared to last year's plan. Was it:

	Increases/More	Decreases/Less	Net More/Less
1. Less than 5%	9%	—%	7%
2. 5–9%	27	—	29
3. 10–19%	36	—	36
4. 20–34%	11	—	9
5. 35–49%	3	—	3
6. 50% or more	10	—	11
7. (DK/Refused)	5	—	5
Total	100%	100%	100%
N	290	32	322

Did you do any of the following in order to pay for the increase?

	Yes	No	(DK/ Refuse)	Total	N
46. Raise prices?	25%	67%	8%	100%	290
47. Cut employees or reduce their hours?	12	86	3	100%	290
48. Increased employee cost-share?	25	73	3	100%	290
49. Take a lower profit or suffer a loss?	67	32	2	100%	290
50. Delay, postpone or reduce business investment?	37	60	3	100%	290
51. Freeze or reduce wages?	26	73	2	100%	290
52 Reduce non-health employee benefits?	14	83	3	100%	290
53. Became more productive, more efficient?	30	60	10	100%	290

54. Are the benefits in this year's plan more, less, or about the same, as they were in last year's plan?

1. More	7%
2. Less	23
3. Same	69
4. (DK/Refused)	1
Total	100%
N	582

55. Are the deductibles in this year's plan higher, lower, or about the same as they were in last year's plan?

1. Higher	35%
2. Lower	2
3. Same	60
4. (DK/Refused)	2
Total	100%
N	582

56. Did more, less, or about the same number of eligible full-time employees choose to participate in this year's health insurance plan as participated last year?

1. More	5%
2. Less	14
3. Same	86
4. (DK/Refused)	*
Total	100%
N	582

Please tell how important each of the following was in your decision to offer employee health insurance in the last year? (Newly Offering Employers ONLY—Combines Two Years of Data)

57. Profitability now allows me to offer it.

1. Very Important	63%
2. Somewhat Important	23
3. Not Important	11
4. (DK/Refused)	1
Total	100%
N	69

58. The new health care law will soon require me to add it.

1. Very Important	53%
2. Somewhat Important	15
3. Not Important	27
4. (DK/Refused)	5
Total	100%
N	69

59. Need to offer it to compete for good employees.

1. Very Important	42%
2. Somewhat Important	38
3. Not Important	18
4. (DK/Refused)	2
Total	100%
N	69

60. Needed to find a more affordable plan for you and family to participate in.

1. Very Important	35%
2. Somewhat Important	53
3. Not Important	12
4. (DK/Refused)	*
Total	100%
N	69

61. Did you offer employee health insurance to any of your employees LAST year at this time?

1. Yes	12%
2. No	88
3. (DK/Refused)	*
Total	100%
N	280

Please tell me how important each of the following reasons were that led you to drop employee health insurance in the last year?

62. The number of participants in my plan fell.

1. Very Important	29%
2. Somewhat Important	15
3. Not Important	56
4. (DK/Refused)	*
Total	100%
N	75

63. It became too expensive.

1. Very Important	69%
2. Somewhat Important	18
3. Not Important	11
4. (DK/Refused)	1
Total	100%
N	75

64. My employees preferred cash rather than insurance.

1. Very Important	19%
2. Somewhat Important	8
3. Not Important	69
4. (DK/Refused)	4
Total	100%
N	75

65. Business profitability took a turn for the worse.

1. Very Important	47%
2. Somewhat Important	33
3. Not Important	18
4. (DK/Refused)	2
Total	100%
N	75

66. My employees could do better on their own.

1. Very Important	52%
2. Somewhat Important	22
3. Not Important	26
4. (DK/Refused)	1
Total	100%
N	75

67. Do you expect to offer employee health insurance to any of your employees at this time NEXT year?

1. Definitely Yes	21%
2. Probably Yes	17
3. Probably No	23
4. Definitely No	37

67. Do you expect to offer employee health insurance to any of your employees at this time NEXT year?—Continued

5. (DK/Refused)	2
Total	100%
N	900

68. A new health care and financing law, sometimes known as the Affordable Care Act, health care reform, or Obamacare, is being implemented. How familiar are you with this law? Are you:

1. Very familiar	24%
2. Somewhat familiar	54
3. Not too familiar	15
4. Not at all familiar	7
5. (DK/Refused)	*
Total	100%
N	900

69. From what one source have you obtained the MOST useful information about your business's responsibilities and opportunities under the new health care law? Has it been:

1. Health insurance industry or insurer	22%
2. Health care industry or provider	13
3. Business advisor, like accountant or lawyer	8
4. Government	4
5. Trade associations or business groups	9
6. General news media	34
7. (Other)	*
8. Have not received any useful information	7
9. (DK/Refused)	2
Total	100%
N	866

70. Is there a second source that has been useful?

1. Health insurance industry or insurer	11%
2. Health care industry or provider	12
3. Business advisor, like accountant or lawyer	11
4. Government	6
5. Trade associations or business groups	11
6. General news media	21
7. (Other)	7
8. (None/DK/Refused)	24
Total	100%
N	818

71. How satisfied are you overall with the clarity and usefulness of the information received? Are you?

1. Very satisfied	19%
2. Somewhat satisfied	41
3. Not too satisfied	22
4. Not at all satisfied	18

71. How satisfied are you overall with the clarity and usefulness of the information received? Are you?—Continued

5. (DK/Refused)	*
Total	100%
N	818

72. In the last year, have you visited the ACA or Obamacare Web site, HealthCare.gov, to look for individual health insurance policies, for business insurance policies, for simple curiosity, or have you not visited it?

1. Individual	13%
2. Business	4
3. (Both, individual and business)	8
4. Curiosity	10
5. Not visited	65
6. (DK/Refuse)	1
Total	100%
N	900

73. Compared to two years ago, is there much more, slightly more, about the same, slightly less, or much less competition for your firm's health insurance business or potential health insurance business?

1. Much more competition	5%
2. Slightly more competition	9
3. No change in competition	38
4. Slightly less competition	10
5. Much less competition	15
6. Not relevant to your situation	16
7. (DK/Refuse)	8
Total	100%
N	900

Demographics

The following questions are for classification purposes only

D1. Over the next three to five years, do you want this business to:

1. Grow a lot	48%
2. Grow a little	35
3. Stay the same	11
4. Downsize a little	3
5. Downsize a lot	2
6. (DK/Refused)	2
Total	100%
N	900

D2. Compared to last year at this time, is this business currently:

1. Much more profitable	4%
2. Somewhat more profitable	23
3. About as profitable	42

D2. Compared to last year at this time, is this business currently:—Continued

4. Somewhat less profitable	21
5. Much less profitable	7
6. (DK/Refused)	3
Total	100%
N	900

D3. How old are you?

1. < 35 years old	4%
2. 35–44 years old	11
3. 45–54 years old	28
4. 55–64 years old	37
5. 65–74 years old	13
6. 75+ years old	2
7. (Refused)	5
Total	100%
N	900

D4. Region of the country.

1. Northeast	20%
2. Southeast	20
3. Mid-west	27
4. Central	22
5. Pacific	11
Total	100%
N	900

D5. Sex

1. Male	61%
2. Female	39
Total	100%
N	900

Methodology

The NFIB Research Foundation engaged Mason-Dixon Polling & Research in late 2012 to help it begin a projected three-year longitudinal survey of small business and the introduction of the Affordable Care Act. The purpose of this research was to follow small businesses as the new law took effect and measure the changes that they experienced over time. It likewise was intended to trace health insurance cost changes and small employer response to them. What the survey will not do was attempt to measure opinion about the Affordable Care Act. The answer to those questions appeared reasonably well-established and well-known and therefore required little additional attention.

The Foundation's research strategy for the project was to draw a nationally representative stratified random sample of small employers and then follow small-employer respondents to the first year's survey for an additional two years. A stratified random sample is necessary to conduct the project due to the distribution of the small employer population. Ninety (90) percent of all small employers have fewer than 20 employees and 60 percent have fewer than five. Although the Affordable Care Act affects all small employers, its major direct impacts was expected to

fall on larger, small firms, principally those approaching the 50 employee employer-mandate threshold and larger. It was, therefore, important that the survey contain enough cases to be able to say something about the larger, small business segment of the population. A sufficient number of cases from this group requires over-sampling them. Hence the Foundation targeted a sample size of 225 cases from each of the four employee size strata: 2–9 employees, 10–19 employees, 20–49 employees, and 50–100 employees. The choice to cap the definition at 100 employees rather than some other point is arbitrary, but probably not controversial. It is an intuitively satisfying dividing line; virtually all small business above the line offer health insurance; adding another stratum of say between 100–250 employees appears to offer little additional informational value; owners of increasingly large firms are increasingly difficult to interview; etc. In the end, Mason-Dixon initially interviewed 921 small employers from mid-June through July 2013, numerically distributed across the four strata from smallest to largest as follows: 231 cases, 224 cases, 238 cases; and 228 cases. Use of a random stratified sample means population totals can only be reached by weighting cases, smaller, small firms (under-sampled) being given a greater weight per case and vice versa. Thus, population totals for a 2–100 employee firm size population, or totals for a 20–100 employee firm size population are presented using weighted numbers.

A second round of interviewing occurred one year later, from mid-June through July, 2014. Efforts were made to reinterview all initial participants. Two hundred and twenty-eight (228) who participated in 2013 agreed to participate in the second year. They were distributed by firm size as follows: 74 cases, 66 cases, 83 cases, and 65 cases. Not a single case changed firm size classification. Recognizing that not all participating in 2013 would be willing to participate in 2014, on a parallel track Mason-Dixon also began interviewing a new stratified random sample in the same manner as in the prior year. Initial participants supplemented by the new ones yielded 223 cases (2–9 employees), 227 cases (10–19 employees), 224 cases (20–49 employees) and 226 cases (50–100 employees) for a total of 900 cases.

Participants in the mid-2013 survey were contacted twice during the next few months, once to advise them of the gift card incentive winners for random participants and once to provide a summary of survey results. They were then contacted for a third time by mail and telephone seeking their continued participation. The gift card incentive was repeated and they were given the choice of participating by telephone or e-mail.

New participants were recruited in the same manner as were those in the first year. The sampling frame for both rounds was the Dun & Bradstreet file, an imperfect frame, but one the best currently available from a non-government source. Mason-Dixon mailed potential members of the new sample an introductory letter outlining the project, asking for cooperation, and announcing gift card incentives for randomly drawn participants. Telephone calls followed the introductory letters and respondents were given the choice of answering by telephone or by e-mail.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

My first choice for this morning's hearing would be to get past the well-worn talking points and begin the effort to find bipartisan ways to improve the Affordable Care Act. That strikes me as the best use of our time. Unfortunately, it looks like it'll take a rear-guard action to keep from going back to the dark days when America's health care system worked only for the healthy and the wealthy.

Just this week, members of Congress are pushing budget proposals that would rip the law up by the roots. Gone would be the guarantee of coverage that protects Americans who have preexisting conditions. Gone would be tax credits that help hard-working families pay for health insurance. Back would be insurance company skullduggery that forces people to pay top dollar for rock-bottom coverage. Back would be excluding adopted children from their parents' insurance plans. Back would be insurance cancellations the moment people get sick. Again pregnancy could be considered a preexisting condition. And there's still no legitimate alternative legislation that addresses those issues. In the last five years, Congress has taken more than fifty votes to undermine or repeal the Affordable Care Act and not one vote on legislation that replaces it.

This nonstop campaign to undercut the law is bad news for Oregonians like Beth Stewart. Beth is a mother of three from La Grande, Oregon, who had to pick out

an insurance plan after a career change in 2003. The plan she chose had a 7,500 dollar deductible. A few years later, Beth was diagnosed with stage four thyroid cancer, and it had spread to her spine. On Beth's road to recovery, she twice hit her out-of-pocket limit. Her medical bills grew to the tens of thousands of dollars. Beth worked hard to pay them off, but every year her checkups cost thousands more. Last year, she was finally able to buy a new health insurance plan that's given her what she called a "welcome safety net." Her deductible is now a tenth of what it was before the ACA. Her out-of-pocket maximum has been cut by nearly half. For Beth, staying healthy while supporting a family is a lot less expensive.

Kim Schmith is a resident of Madras, Oregon, in her late forties. Kim won a battle against breast cancer six years ago. Her husband will go on Medicare this year, and Kim will have to pick out an insurance plan of her own. Kim wrote to my office about how she once worried that being a cancer survivor meant she'd never be able to find insurance. Under federal law before the Affordable Care Act, an insurance company could have taken one look at Kim's medical history and stamped her application "denied." But the law gives Kim peace of mind. She'll find an affordable, high-quality health insurance plan. She won't have to panic or overpay for bargain-basement coverage. As Kim wrote in her letter, ". . . I fought for my life, I should not have to fight for insurance." I couldn't agree more.

There's never been a law in history that couldn't be improved—including this one. But the pie-in-the-sky insistence that the Affordable Care Act will be repealed and everything will work out fine has no basis in reality.

It's time to recognize the real-world consequences of this dysfunctional, old political battle. This debate is no longer about numbers on a page. More than 16 million Americans have gained health insurance coverage thanks to the Affordable Care Act. Their health is at stake in every vote for repeal. So let's find a bipartisan path that makes progress, rather than bringing back the dark days when health care was reserved for the healthy and wealthy.

COMMUNICATION

LETTER SUBMITTED FOR THE RECORD BY GOVERNOR JACK A. MARKELL

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March 17, 2015

The Honorable Orrin G. Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Hatch,

The Affordable Care Act has brought security and peace of mind to thousands of Delawareans who no longer have to worry that an injury or serious illness could place them in significant debt. The ACA is making it possible for adults and children to be connected to quality health care—and the positive outcomes that we know our health care system can deliver.

More than 25,000 Delawareans have signed up for health insurance coverage since January 2014 via the Delaware Marketplace, established as a State Partnership Exchange. Subsidies available under the Affordable Care Act have helped more than eight in 10 of those Delaware residents afford their monthly premiums. Those getting financial help to enroll in 2015 plans received an average monthly advance premium tax credit of $264, reducing their premiums an average 65 percent, from $404 to $140.

In addition to those purchasing health insurance on the Marketplace, another nearly 10,000 newly eligible adults have found coverage under Delaware's expanded Medicaid program.

Recent national surveys show that Delaware is making progress in reducing the number of uninsured individuals in the state. The Kaiser Family Foundation recently reported that as of the end of the 2015 open enrollment period, 52% of Delawareans who are eligible for coverage through the Health Insurance Marketplace had enrolled, tying as the state with the third-highest enrollment rate in the country.

The impact of connecting our neighbors to the health care they need is profound. The Affordable Care Act has helped people like Felipe Hernandez, a 26-year-old machine operator from Wilmington, who is now able to get regular preventive checkups and prescriptions to manage his high blood pressure and high cholesterol. Hernandez says now that he is covered, he is less stressed and more hopeful about the future for him, his wife, Irene, and their 2-year-old daughter, saying "I'm not going to go broke because I get sick."

The Affordable Care Act has helped Stephanie Brown, 32, of Smyrna, who can now get the daily medications her 6-year-old son, Connor, needs to control his ADHD

and asthma. "This program has been a godsend for me, and Connor is a healthy, active 6-year-old boy because of it."

The Affordable Care Act has helped Janice Baker of Selbyville, who like so many others was denied coverage prior to the ACA because of pre-existing conditions. She was able to enroll on Delaware's Health Insurance Marketplace in 2013, with her coverage beginning Jan. 1, 2014.

Overall:

- At least 6,000 young adults in Delaware who would otherwise have been uninsured have gained coverage nationwide because of the ACA's provision that allows parents to add or keep children on their policy until they turn 26.
- The law's requirement that insurers cover those with pre-existing conditions—like asthma, serious and persistent mental illness, diabetes or cancer—has brought peace of mind and the promise of care to Delawareans.
- Women made up 55 percent of Delaware's Marketplace enrollees in 2014, and because of the Affordable Care Act, did not pay more for their health care coverage because of their gender.
- The health care law's expansion of mental health benefits, substance use disorder benefits and federal parity protections has benefited thousands of Delawareans.
- Health insurance companies now have to spend at least 80 percent of premiums on health care or improvements to care, rather than administrative costs or they have to provide their customers with a refund, helping to ensure affordability of rates. In 2014, that meant more than 5,800 Delawareans with private insurance coverage benefited from $734,000 in refunds from insurance companies, for an average refund of $174 per family.
- The law bans insurance companies from imposing lifetime dollar limits on health benefits—freeing patients with cancer, individuals with serious and persistent mental illness and individuals living with other chronic diseases from having to worry about going without treatment because of their lifetime limits.
- The ACA has also delivered new benefits in Medicare. In 2013, approximately 21,000 Delawareans on Medicare saved more than $46 million on prescription medications because the Affordable Care Act filled the "doughnut hole" coverage gap.
- The Affordable Care Act increases the funding available to community health centers nationwide. Health center grantees in Delaware have used these funds to offer a broader array of primary care services, extend hours of operations, hire more providers, renovate or build new clinical spaces, and help enroll uninsured Americans in the Health Insurance Marketplace.

We are always interested in ways upon which the ACA can be improved. Even as access to insurance has greatly expanded, our health care system continues to face challenges, particularly in reigning in rising costs.

Our state is taking steps to address this issue and the ACA in its current form is already providing some support. Delaware has received a $35 million federal grant to move toward high quality, well-coordinated patient-centered care that is financially sustainable. Our effort would:

- strengthen the primary care system so that patients experience well-coordinated team-based care that delivers better health outcomes;
- align incentives for providers and health insurers to focus on quality and affordability;
- support patients to engage in their own health; and
- support communities to work together to promote health and connect community resources to the health care system.

In Delaware, the Affordable Care Act has helped expand access to quality, affordable health care coverage for people across our state and has been a key component of our work and commitment to improve the health of all Delawareans and provide a sustainable health care system for future generations.

Sincerely,

Jack A. Markell

