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AFFORDABLE CARE ACT IMPLEMENTATION: EXAMINING HOW TO ACHIEVE A SUCCESSFUL ROLLOUT OF THE SMALL BUSINESS EXCHANGES

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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AFFORDABLE CARE ACT IMPLEMENTATION: EXAMINING HOW TO ACHIEVE A SUCCESSFUL ROLLOUT OF THE SMALL BUSINESS EXCHANGES

WEDNESDAY, NOVEMBER 20, 2013

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS
AND ENTREPRENEURSHIP,
Washington, DC.

The committee met, pursuant to notice, at 10:00 a.m., in Room 428–A, Russell Senate Office Building, Hon. Mary L. Landrieu (Chair of the Committee) presiding.

Present: Senators Landrieu, Shaheen, Heinrich, Booker, Risch, Vitter, Scott, Fischer, Enzi, and Ron Johnson of Wisconsin.

OPENING STATEMENT OF HON. MARY L. LANDRIEU, CHAIR, AND A U.S. SENATOR FROM LOUISIANA

Chair LANDRIEU. Good morning, everyone, and if we could take our seats and welcome to this important hearing this morning.

The purpose of today's hearing is to explore the success stories of the rollout of the Affordable Care Act in states throughout the country where teamwork and cooperation has proven to be exceedingly effective.

We will also hear from a federal panel that will talk about the federal rollout and some of the challenges that have presented themselves. Normally, we have the federal panel first and the state panel second. But at the discretion of the Chair, I reversed it but required the federal leaders to be here to hear from the state exchanges and from individual business owners about how the situation could be improved.

I would like to begin by quoting, I think it was Mark Twain who said, "A lie can get halfway around the world before truth gets out of bed in the morning and puts its boots on."

So, this morning we are going to try to give truth a chance.

Thank you for joining us for this hearing. The Affordable Care Act passed, as we all know, in March of 2010 and was signed into law by the President three days later. That was over three and a half years ago.

Last year, the Supreme Court upheld one of the essential components of this law, including the no free rider provision, requiring full participation through private and public health insurance marketplaces.

The goals of the Affordable Care Act at the time we passed the law were implemented for creating a workforce that was healthy because only a healthy workforce can be a strong workforce and America needs the strongest workforce we can get so we can continue to have the strongest economy in the world.

Those were the goals three and a half years ago. That is the hope and promise today.

There were four specific goals of the Affordable Care Act. One, to slow skyrocketing health care costs and reduce what America spends on health care as a share of our GDP. It was rising from 15 percent to 16.5 and headed very soon to 19. That trend has been reversed.

To use the power, not of the government but of the private sector competition, the proven power of private sector competition to rein in costs and improve quality care and coverage.

To provide the first opportunity in the history of our country, whether union or nonunion, middle, high, or low income wage earner, whether self-employed, small or large business to access affordable quality health care.

And one of the most exciting and under appreciated features of the Affordable Care Act and one that this Committee has focused a great deal of work is that it provided for the first time a key to Americans to unlock them from job-lock which prevents individuals in every state, including my own, from starting a new business because the risk associated with leaving full and good employment with full and good health care coverage causes them to stay sometimes in companies where they themselves might even do a better job starting their own providing disruptive technology or good services.

I am proud to hand many of our entrepreneurs that key and intend to do so.

According to the Robert Wood Johnson Foundation, nearly 1.5 million Americans, including 25,000 Louisianians, will become self-employed thanks to this bill, allowing them to fulfill their dream of becoming entrepreneurs, to pursue their dreams, to create the product or the system or service that they have dreamed about and have health insurance which was not possible before the Affordable Care Act.

Fourth, to provide coverage to millions of low income and working-class families that work 40, 50, and 60 hours a week and worked for decades and yet could not afford health care in the United States of America.

The way that this bill has been crafted, they will, if the governors would expand Medicaid, to be able to choose their hospitals, doctors, and have health care. Unfortunately, many of our governors are standing in the way.

This is the hope and vision that we fought for. It is still worth fighting for now.

The focus of today's hearing will be specifically, though, on coverage options and access to our small businesses or businesses regardless of size, and I want to be clear. This is about the self-employed, about the growing percentage of our population that call themselves contractors because of the way our economy is struc-

tured to be very flexible and independent, small businesses below 50 and small businesses above.

Now, we all know the rollout of the federal marketplace for individuals as not worked as well as we had hoped. We know that there are many challenges. We will hear about those today.

But thank goodness there are bright examples throughout the United States where the ACA's vision is working and we are going to hear from those states today.

Specifically, we are going to hear from representatives leading the implementation of the SHOP marketplaces now open at the state level to understand both the challenges and the successes experienced by those states who accepted the responsibility to build their own exchanges, who accepted the challenge of the Federal Government to say we cannot always do things right. Here, we will give you the option to do it.

Some of our governors were brave enough to do so; others were not.

Usually, this Committee hears from federal officials, as I said, but I have asked them specifically to be in the room because they need to hear the best practices about what is going on around the country so they can get a better understanding of what we are trying to do. We will also be hearing from representatives of federal agencies, et cetera.

Now, let me go into a few more things and the time that I take will be given equally to the minority.

Before we begin, I would like to take a moment to put today's discussion into context. As we were debating the Health Reform Act in 2009 and I was here and robustly engaged in that debate and helped to design the system that we have now which was a compromised system between a government-run, single-payer system and a medical savings account system with no floor or no safety net, we designed this.

It was particularly for 96 percent of all businesses that employ fewer than 50 people who were struggling to remain competitive and we were focused on helping them.

Small businesses were paying an average of 18 percent more than big business for health insurance that was not the same quality and they saw their health care costs increase faster than the prices of products and services they were selling. The record says four times faster than the rate of inflation between 2001 and 2009.

After the number of employers offering coverage remained relatively flat in the 1990s, average annual family premiums for workers at small businesses increased by 123 percent, from 5700 in 1999 to 12,700 in 2009.

So, in the rate of increase was going up substantially before the Affordable Care Act which is one of the reasons it was passed to try to taper down those rates and get them lower.

The percentage of small firms offering coverage started falling from 65 percent to 59 percent, and it was spiraling downward. It is no wonder that since 1986 one concern for every small business every year has been access to affordable care and this is not from a liberal think tank. This is the finding of the National Federation of Independent Business. They have testified before our Committee on many occasions.

This made reform, in my mind, imperative and the small business health care marketplace an important tool towards increasing choice and competition, reducing costs for small business and providing coverage to their employees that serve as the backbone of this American economy and a model for the world.

A SHOP is an online marketplace where small businesses with 50 or fewer employees can purchase health insurance for their employees voluntarily because under the Affordable Care Act they are not required, the businesses are not required, employees can. Functioning SHOP marketplaces will give small business owners the tools they need to be smart consumers as they choose affordable options for their businesses without damaging their bottom line and leveling the playing field with large businesses through improved access to affordable health benefit options for their employees.

Many are like family. I cannot tell you how many small business owners have come up to me over the course of the last several years and said, Senator, I would love to offer my people insurance but I cannot find it anywhere; and because my best friend to help me start this businesses wife has cancer, we are now completely priced out.

How am I going to keep my business because I feel badly because I do not want to ask him to leave? If he would leave, I could get insurance for my businesses.

That is a choice I do not think Americans should be making and I do not want anyone in Louisiana to make that choice or have to make that choice.

At the end of this month, small businesses with 50 or fewer full-time equivalents will be eligible, but not required, to purchase and provide coverage to their employees. Beginning in 2006 (sic), all SHOPs will be open to employees with up to 100 individuals.

Pooling these eligible, or FTEs, pooling these eligible small businesses and larger groups will spread risk, allowing insurers to stop charging higher premiums that accompany the greater uncertainty about the likely health care costs of small groups.

The new SHOP marketplaces will allow small businesses to compare plans easily which was never, hardly ever possible before, taking the administrative burden off employers and allowing them to get back to running their businesses which they do best, not filing paperwork to get health insurance.

It was a broken market. We intend to fix it.

According to a 2009 Business Roundtable Report, the administrative costs to small businesses through the exchanges would be reduced by as much as 22 percent.

I would like my staff to put up what is happening around the states, and I would like people's eyes to focus on what is happening in a good way and still challenging ways.

This is the United States of America. You will recognize it. Declared state-based exchanges are in red. Planning for partnership exchanges are in the gray area, and those states that defaulted to the Federal Government, and I want to underscore this because mine is one of them, states that had a chance to set up an exchange for their small businesses that were given every opportunity, and in the case of my State was also attached with a check

for $16 billion to help make it work, was rejected by my governor and by many governors.

And instead they defaulted, at their own choice, not my choice, at their own choice, not at President Obama's choice, to let the Federal Government set up their exchanges and then did nothing of virtually to help. It is no wonder some of them are not working.

But today we are going to have the opportunity to talk to those governors and those states, both Republican and Democrat, that did step up and lead, that did take what was offered to them and set up exchanges that could work for their small businesses.

Each state has the flexibility to decide how they want to operate their health insurance marketplaces. As you can see on this map, there are four different categories that each of the 50 states and the District of Columbia fit into.

Some states have what they call federally-facilitated exchanges which means that they are not choosing to set up their own market and leaving it to the Federal Government. Unfortunately, that would be mine. I wish I had been given that choice but unfortunately that was one mistake in the bill, leaving it up to governors, maybe not a mistake but in some cases it was it seems.

Other states are operating partnership exchanges where the Federal Government operates the marketplace in conjunction with the state. Some states chose a partnership with the Federal Government. We will see how that is working.

And another group of states have split exchanges where the Federal Government runs the individual marketplace and the state runs the SHOP marketplace.

The final category is made up of states that run both, their own individual and small business marketplaces. These states cover approximately one third of the population of the United States.

This is a big country, and it goes way beyond the Beltway of Washington D.C. You are going to hear today about one third of the population that is either working really, really well or it is working to some degree and with some changes could work better and a few places where they are having some serious challenges. But you are going to hear from people that are at least trying.

Kentucky and the District of Columbia are included in this category. We will be hearing from representatives of these exchanges during our first panel this morning. In total, there are 18 states plus the District of Columbia running their own SHOP exchanges.

And for the record, since this is so important, I want to put these states in the record. California, Colorado, Connecticut, the District of Columbia—not a state yet, maybe one day—Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington State.

In all parts of our country, some with Republican governors, some with Democratic governors, some with Republican legislators, some with Democratic legislators, but all with people who need leadership to help them find health care that they can afford.

Nearly 40 percent of all the Nation's small employers are in these states. That is who we are focused on today.

We all know that the rollout of the individual insurance exchange website has been disappointing to say the least, but today's

hearing is focused on implementing the rollout of the SHOP exchanges which is the focus of our Committee where we had a lot of input into how this bill was designed to emphasize the need for a better rollout, not just for individuals but for small businesses.

Today, as I said, we are joined by states who accepted this challenge and responsibility to create state-based exchanges and did it well, as well as those who are having difficulty.

For those states that have made the decision to operate their own SHOP marketplaces, we are already seeing evidence. I am not going to repeat everything that is in the testimony but I will say that for Kentucky, I was completely happy to see and I spoke to Governor Beshear, Kentucky did what I thought we should do and I have a bill to correct this, to use their licensed health agents to sell the policies which is a brilliant idea. We did not do that unfortunately.

And so, they hit the ground running because their agents were already licensed and understood the market well and were able to sell. We will hear more about that. That is Kentucky, and you will hear more about Kentucky.

In D.C., between October 1 and 13, they had more than 84,000 visitors to their website. What I loved about the testimony from D.C., and you will hear more about it, is that instead of the Chamber of Commerce dragging its feet, he says, the D.C. Chamber of Commerce, the Greater Washington Area Hispanic Chamber, and the Restaurant Association partnered to build this exchange and put their muscle and their brainpower behind it, and it is probably one of the most successful in the country. Nearly 700 employer accounts have been created using their site.

Finally, in New Mexico, and our senator is here, has seen similar success as well. They accepted the leadership challenge, and today 1,143 small businesses with 3,192 employees have been registered, required information with the New Mexico exchange.

If they all fully enroll with the average number of dependents, that would be a potential total of 8,000 members, and it has just been opened for a very short period. We will hear more about that.

Making the ACA work the way it was intended is what I intend to try to do. There are others that have different goals. Ensuring that these marketplaces work the way they were intended when we passed the Act is vital to helping the businesses in our country and families that depend on these businesses to get the help that they need to stay healthy.

And most importantly for me as a mother, not just to stay healthy physically but to be mentally free of the worry that any day your business is one day away from bankruptcy or your family is one accident away from bankruptcy.

There is no price that you can put, in my view, on peace of mind. I do not know any economist in the world that could price it but I could tell you as a mother that it is very costly.

The SHOP marketplaces need to work so that small-business owners can easily and efficiently compare the different plans available for themselves which they were never able to do, and their employees can pick the plan that makes the most sense.

Now, opponents of the law, and there are many, are fixated, fixated on the problems of the law as opposed to the promise that it holds. I believe this is wrong.

These problems, while challenging, are fixable. We have fixed many things in the United States, big things, bold things, and great things. This is something we can fix.

And regardless of how we voted for the ACA, whether we liked it or not, it is the law of the land; and in my view, it deserves to be fixed, not repealed. We have the responsibility to make the Affordable Care Act work, not because of politics but because of the people.

This is not about President Obama. It is about the people of the United States of America. It is about the millions of small business owners who want desperately to provide quality, affordable health care to their employees who dreamed about building a business, who love the people that they work with, and they were never able to find something that they could afford or count on.

And if they did, they had to compromise below their standards because I know Americans pretty well and they are very generous people. And it is about people like Kiwi Armstrong from Baton Rouge, and independent construction worker. He works on big projects in both oil and gas onshore and off. We have a lot of those people.

Because of the nature of his employment, he works on several different projects throughout the course of his year and he is not a member of a labor union. In 2012, he got nine different W–2s. He works hard every day.

But the shifting nature of his employment means he cannot get coverage through his employers. When he tried to get Blue Cross Blue Shield through his last steady job, they denied him because of type II diabetes.

Because of the Affordable Care Act, he can get coverage on the health insurance marketplace. It will be there when he needs it, and give him flexibility to work any project he wants without worrying about whether it will provide coverage or not.

This is why we are having this hearing today. We are having this hearing to make sure we are doing everything possible to make sure that this Act works for small business owners and their employees.

My goal for this hearing is it will not be occasion for grandstanding but rather an opportunity to focus on the work before which is fixing what is broken.

And to do that, we have to be honest with each other and open to hear testimony about what is working, what is not working; and when we find something that is not working, how it can be fixed.

Some of our witnesses today are also small business owners that have yet to realize the benefits that their colleagues in states where these exchanges are working. Some of these businesses are in states where the governor has basically said, no, we are sorry, we do not want to help you. I am sorry that you all are in those states but that is the situation.

I am going to add one thing for the record and turn it over to my Ranking Member. There was a study that came out yesterday that I want to put into the record, a tax study, I have it here.

This study came out this week. The Supreme Court's ACA decision and its hidden surprise for employers. This report is about Medicaid expansion, and the key finding is, states that do not expand Medicaid leave employers exposed to higher shared responsibility of payments under the Affordable Care Act. The associated cost to employers could total $876 million to $1.3 billion each year in the 22 states that have opposed or leaning against or remain undecided. By way of example, the decision in Texas to forgo Medicaid expansion may increase federal tax penalties on Texas employers by $299 to $448.

Now, this is from a completely nonpartisan Jackson Hewitt, I think they prepared tax returns. I do not think they are a stakeholder group to anyone.

So, because of the decision that Governor Perry made, his decision, not President Obama's, is going to cost his businesses more.

Now, I am going to turn this over to Senator Risch. He can have as much time as I did which I think is probably about 20 minutes, 25 minutes, and then we will go to, your statements will be submitted to the record and then we are going to go directly to our testimony. I thank all of my colleagues for coming this morning.

OPENING STATEMENT OF HON. JAMES E. RISCH, RANKING MEMBER, AND A U.S. SENATOR FROM IDAHO

Senator RISCH. Well, thank you very much, Madam Chairman.

First of all, I commend you for holding this hearing, but probably not for the reasons that you think. Certainly, when you throw hundreds of billions of dollars against the wall, something is going to stick; and to try to use the handful of things that actually have worked in this 3,000 pages of legislation and nobody knows how many pages of regulations and say, okay, well, it is working because this small part is, really is to ignore the overall problem.

Again, I commend you for your courage in holding this hearing; and more importantly, Madam Chairman, I commend you for your statement that you helped to design this system that we have today.

I suspect that as we go forward trying to find people who will admit to having had some part in this is going to be like trying to find somebody that admitted voting for Richard Nixon.

This has been a catastrophic failure across America. And you talked about the truth and you know, the American people, they do not understand all the niceties and all the complexities of health care and health care insurance and what have you.

But they know when they have been lied to, and the polling is incredibly strong, indicating that they believe that they have been lied to. And once the American people believe they have been intentionally lied to, it really causes difficulties in trying to solve problems. This does not bode well as we go forward.

You provided your list of successes and one of them was Idaho. When I was Governor, I appointed the gentleman who now sits as the Director of the Department of Health and Welfare. My successor kept him on and he is a really good guy. He came out of the insurance industry.

I am not exactly sure if you were boasting that Idaho is one place where Obamacare is working. But I can tell you that it is a dis-

aster in Idaho. Perhaps it is not in Louisiana, but it is a disaster in Idaho.

I know that you brought in some people from Kentucky to talk about some of the good things. I believe that Kentucky is working better than other places, although that is not a very high bar.

I have got a couple of letters I want to put into the record from insurers who are working in this area in Kentucky, and I am just going to read parts of them as an indication of what is actually happening in Kentucky.

This is from Houchens Insurance Group from Bowling Green, Kentucky. This is written by their Executive Vice President.

He says, "We are writing to you to explain what we are seeing here in Kentucky and throughout other parts of the country that Houchens Industries, Incorporated, and the Houchens Insurance Group serves regarding our clients' implementation of the Affordable Care Act."

"While Houchens, with over 18,000 employees, is not a small company, our insurance group, HIG, serves over 1000 small businesses with their insurance needs throughout Kentucky and the United States. The remainder of this letter lays out what we are seeing. For an agency to represent its' customers responsibly, we need to be able to share all options available. At this point, Kentucky's Healthcare Connection, Kynect, presents us with more challenges than solutions. To date we have not enrolled any groups in the Small Business Health Options Program, SHOP, primarily because of the confusion the system has created. Business owners are anxious and frustrated as to what they have to do in order to get pricing. Creating an account within Kynect and then assigning an agent takes a considerable amount of time and is not something they should have to do while managing their business."

He then goes on to list many more of the problems with Kentucky's system.

The other letter comes from The Benefits Firm, another company in Kentucky. And again, their Senior Vice President writes, "Kentucky has been viewed by other states and people in Washington, D.C., as a state that most things have gone correctly with the Health Insurance Market place. While it is true that Kynect has been operating properly, especially compared to the Federally Facilitated Marketplace, there are still many unresolved problems. In particular, I would like to address the SHOP exchange. Logistically and technologically, we are not having the same success with the SHOP exchange as we are with individuals in Kynect in Kentucky. This week, I have reached out to numerous employee benefit brokers in Kentucky, none of which have finished a SHOP exchange application. While I do believe that the technical hindrance is part of the problem, it is not the primary obstacle to the success of the SHOP exchange. I firmly believe there are flaws to this system that the current law cannot overcome. Numerous businesses that I have worked with decided that with PPACA there are advantages to their business through Kynect. However, the advantage to their business is to drop their employer-sponsored health plan and allow each of the individuals and families to enroll in Kynect."

And then he goes on and explains why that is a very good financial decision for small businesses.

So, there is no doubt you are going to find some things that happened here that are good. But, like I say, when you throw these kinds of hundreds of billions of dollars at something, you are bound to find that.

Lastly, I would like to focus on what has been something that has really undermined the confidence of the people of America in this. When the President stood up as many times as he did, and particularly Democrat senators stood up as many times as they did, looked in the camera and said, if you liked your health care plan, you can keep it, those of us who listened to that the first time said that that is impossible. Where the government was going to lay out all of these new requirements in the new health care plans, no plan would exist.

So, I do not know how the President of the United States could stand up and say that, and then repeat it over and over and over again, when his people had to tell him that the policies no longer existed. Somebody should have said, "Mr. President, stop saying that. You are going to get hit over the head with this." And of course now, the chickens have come home to roost.

And that is where we are. You know, we tried to change this. My good colleague, Senator Enzi, introduced Senate Joint Resolution Number 39, and we had a vote on the Senate floor on September 21, 2010.

And that resolution which, if passed, would have become the law of the United States said, if you like your plan, you can keep it. But we were not able to pass that were we, Senator Enzi? There was a straight partyline vote with all Republicans voting for Senator Enzi's bill saying just like the President had promised and every Democrat voting against that promise.

It is really unfortunate that it has come to that. Well, here we are again trying to apply lipstick to this pig; and no matter how many times it is said, the American people are not buying it.

The numbers are deteriorating every day as far as the confidence of the American people—not only in what has happened here, but particularly in going forward—what we are going to do about this catastrophe.

And that is a problem that I think you and your colleagues are going to have a very, very difficult time wrestling with. But the good news is we are Americans and we are free.

We are going to have an election next November and the Americans again are going to have a say in this. And everybody is going to be able to stand up and say, look, I did this, I helped design this system, I had my hands involved in this. So, put me back there and see if I cannot do a little bit better next time, and the American people are going to decide whether or not that is enough.

And that is exactly as it should be in America. And, as with all other issues we have had in America, even though this is what someone would call a man-made disaster, we will get through this. We are Americans. We know how to fix these problems and we will do it.

With that, I yield back, Madam Chair.

Chair LANDRIEU. Thank you very much, Senator.

Let us begin on the panel with our first panelist, and then I am going to call on Senator Heinrich to introduce the gentleman from his State.

But let me start with Mr. William Nold, Deputy Executive Director of the Office of Kentucky Health Benefit Exchange. Then we have Mr. David Allen, President and CEO of David Allen Enterprises. I am sorry. We are going to go in the order of Mr. Nold, go ahead. I will come back and introduce everyone else.

Go ahead. Thank you.

STATEMENT OF WILLIAM NOLD, DEPUTY EXECUTIVE DIRECTOR, OFFICE OF THE KENTUCKY HEALTH BENEFIT EXCHANGE, FRANKFORT, KY

Mr. NOLD. Chairman Landrieu, Ranking Member Risch, and members of the Committee, we really appreciate the opportunity——

Chair LANDRIEU. You are going to have to speak into your mic. Just lean into it. Thank you.

Mr. NOLD. We appreciate the opportunity to come over here to D.C. this morning and to share Kentucky's experience with our exchange which we call, as Senator Risch said, we call it kynect. It is a combined exchange in the sense that both our SHOP and our individual, for administrative purposes, operates under one name.

My name is William Nold, and as the Senator said, I am the Deputy Executive Director of the Office of the Kentucky Health Benefit Exchange. It is a long title and we have got a lot of responsibilities. I have submitted a written statement and also some other documents that I assume will be made part of the record.

Chair LANDRIEU. We do. That will be part of the record and you have four minutes and 10 seconds.

Mr. NOLD. Yes, ma'am. My next note was time is limited. But I think a little time should be spent to talk about the landscape in Kentucky as it has existed for a number of years.

Our population is about 4.4 million. 640,000 of those individuals are uninsured. Of grave concern to our governor, however, is the health status of our State.

We are 44th in overall health status, 50th in smoking, 40th in obesity, 41st in diabetes, 50th in cancer deaths, 49th in heart disease, 43rd in cholesterol counts, 48th in heart attacks.

You know, we began our implementation of this law immediately after it was passed. But as you know, many of the provisions in the law were related to insurance matters early on and the exchange seemed like it was far off, year 2010, and the exchanges really do not have to be operational until 2014.

But we began immediately to try to bring consensus among all the stakeholders in Kentucky about what we were wanting to do with this exchange when the time came. Everyone in our State wanted us to do a state-based exchange, everyone.

I think Deb Moessner, who is the President of Anthem in Kentucky, probably said it best. She said, "If I am going to be regulated, I want to be regulated across the Kentucky River, not the Potomac River."

And that kind of said it all, I think. Although a lot of the stakeholders were opposed to this law, they realized that, you know, at

least until the Supreme Court would make its decision that we were stuck with it. And it is a good thing that we are stuck with it. That is the way we found it anyway.

So, of course, we continued to meet with Governor Beshear along the way, making decisions about what we were going to do, and so he wanted to wait until after the Supreme Court had ruled to really dig into this and get moving on it and that is what he did.

And so, we presented all the pros and cons to our governor about what we should do or what we should not do, and he kind of stopped us. He said look, he said, and he is a lawyer, he had read the bill.

He said this bill provides a unique opportunity for Kentucky to improve these health statistics. I want you to do everything that you can do to use this bill, not let this bill use me, but to use this bill to improve our health. And that has been the charge that we have accepted and have gone with ever since.

You know, my time is getting short here. I do want to share with you, you know, we went live on October 1, down for a few hours, not down, slowed up for a few hours. Got that all straightened out and we have been running ever since and helping people get enrolled, not only in our SHOP but also in the individual market.

So, I guess the message from our governor is that he was very strong in his opinion that the best way we could improve the health of our State was to go the state-based exchange route. And then also what we have done is that we have gotten agents involved. Right now, 94 percent of the small insurance policies in our State, small employer insurance policies, are offered through agents.

Chair LANDRIEU. Try to wrap up please.

Mr. NOLD. Yes, ma'am.

Well, to summarize, and again this is in particular with regard to the SHOP, since we went live on October 1, we have had 193 small businesses that have started applications to be eligible for an employer coverage.

[The prepared statement of Mr. Nold follows:]

UNITED STATES SENATE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

TESTIMONY OF WILLIAM NOLD, DEPUTY EXECUTIVE DIRECTOR

OFFICE OF THE KENTUCKY HEALTH BENEFIT EXCHANGE

November 20, 2013

Thank you, Chairwoman Landrieu, Ranking Member Risch and members of the Committee for inviting me to testify this morning about Kentucky's success in the operation of our state-based health benefit exchange, and especially about the very positive response we have received from the small business community.

First, please allow me to introduce myself to the committee.

My name is Bill Nold and I am the Deputy Executive Director of the Office of the Kentucky Health Benefit Exchange. We call our exchange "kynect". I am pleased to appear before you today to provide some background and answer any questions members of the committee have about Kentucky's decision to fully participate in the Affordable Care Act by operating a state-based exchange, participating in the expansion of Medicaid and proceeding with the Small Business Health Options Program, or SHOP, for Kentucky's small employer groups.

I would like to begin with a brief timeline of some of the major milestones along the way of Kentucky's implementation of the Affordable Care Act.

On July 17, 2012, Kentucky Governor Steve Beshear issued an executive order directing our office to take the necessary steps to be approved as a state-based exchange. He did so with the vocal support of several interest groups representing employers, health care advocates, and citizens. These include the Kentucky Hospital Association, the Kentucky Chamber of Commerce, Kentucky Voices for Health, and Anthem Blue Cross Blue Shield, all of which expressed their strong preference that the Commonwealth, not the federal government, operate the exchange for our state. The Office operates under the Cabinet for Health and Family Services.

On September 18, 2012, Governor Beshear appointed 19 members to the Health Benefit Exchange Advisory Board. The board, which includes representatives with relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy related to the small group and individual markets and the uninsured, provided valuable

input into the policies and procedures of the exchange. Subcommittees were also established including one to deal with SHOP issues.

On May 9, 2013, Governor Beshear announced his decision to expand Medicaid to Kentuckians whose income does not exceed 138 percent of the Federal Poverty Level, providing access to healthcare for many low-income, working Kentuckians who do not qualify for Medicaid under the current threshold, but would not be eligible for subsidies available through the Affordable Care Act.

According to the 2010 Census, Kentucky's population is a little more than 4.4 million. Of those more than 4 million Kentuckians, approximately 640,000 currently are uninsured.

By expanding Medicaid eligibility, an estimated 308,000 Kentuckians will now qualify for health care coverage. The remaining 332,000 uninsured Kentuckians are now eligible to purchase insurance through Kentucky's exchange, which we call kynect. Of those 332,000, approximately 85 percent will qualify for some level of premium assistance to help offset the cost of their health insurance plan.

Gov. Beshear cited Kentucky's dismal rankings in multiple health outcomes as one of the reasons he chose to participate in the expansion, giving lower-income Kentucky families access to reliable, quality health care.

In 2012, Kentucky's overall health ranking was 44th. Kentucky is at the bottom of many national health rankings, including 50th in smoking, 40th in obesity, 41st in diabetes, 50th in cancer deaths, 49th in heart disease, 43rd in high cholesterol, 44th in annual dental visits and 48th in heart attacks.

The poor physical health of our citizens has contributed to Kentucky perpetually being a fiscally poor state. Providing Kentuckians with access to affordable health care coverage will help us tackle these abysmal health statistics.

Multiple state and national reports show that when someone has or gains health coverage, there are measurable improvements in health status, including a decrease in delayed care and reduction of mortality rate. And with improved health, our education levels and job opportunities will also improve. When larger groups gain health coverage, the workforce improves.

Kentucky small business owners know how important the health of their workforce is to the success of their business. Their employees truly are the lifeblood of their businesses. And the numbers show that Kentucky small businesses are eager to offer health insurance to their workers.

The Office submitted its Blueprint application to HHS in November 2012 and in January 2013 Kentucky was conditionally approved to operate its own exchange. Since that time, our exchange has been working closely with HHS, CCIIO and our state officer to comply with all of the conditions necessary for approval. Kentucky is offering an

individual exchange and a SHOP exchange. The two exchanges have been combined for administrative purposes as permitted by the ACA. Small employers may offer a full range of plans available from all participating issuers or plans from a single issuer.

In June 2013, Kentucky issued its final administrative regulation describing its Small Business Health Options Program. I have included this regulation along with other documents describing Kentucky's SHOP program and ask that they be included in the record.

In Kentucky, Anthem, Bluegrass Family Health, Kentucky Health Cooperative and UnitedHealthcare of Kentucky are offering plans in the small group market. With the exception of Bluegrass Family Health, which is offering only regional coverage, these insurers are offering plans in all 120 counties. Between these carriers, employers have 24 plan options from which to choose. Additionally, we anticipate that Humana, the only remaining insurer in the individual and small group market in Kentucky, will participate in SHOP beginning in 2015.

By using kynect, employers can choose the level of coverage they wish to provide to their employees. All health plans are classified in one of four metal levels; bronze, silver, gold and platinum. As the metal level increases in value, so does the percentage of medical expenses that the plan will cover.

We are thrilled with the response we have received from the small business community and we believe this is in no small part due to the active role our advisory board played in developing the policies and procedures for the SHOP program. Agents, insurers and health care providers all had input and the process was very collaborative and transparent.

We have also received a very positive response to the SHOP from our agent community. At this time, Kentucky has approximately 1,300 licensed agents that have been trained, certified, on-boarded and identity-proofed and are standing by to assist their employer clients in selecting health plans available on the exchange.

Since kynect, launched on October 1, 2013, consumer interest has been overwhelming. As of last Friday, over 450,000 visitors to our kynect website; almost 48,000 have enrolled in new health coverage with over 8,780 individuals enrolled in a qualified health plan.

In addition, with respect to the SHOP exchange, and as of November 15th a total of 913 small businesses have started applications to be eligible to offer employee coverage. Of those 913 businesses, 343 have completed applications and are eligible to offer coverage to employees and 97 of those small businesses are currently in the enrollment process. Approximately half of the small businesses that have selected health plans using the SHOP are offering their employees a full choice of plans.

These numbers have truly exceeded our expectations. Small businesses with 50 or fewer employees are not required to provide health insurance to their workers, but many Kentucky small businesses are turning to kynect to seek insurance anyway. Business owners know that a healthy workforce is a dependable workforce. Plus, small businesses with 25 or fewer employees may be eligible for tax credits by using kynect.

To qualify for tax credits through kynect, a business must employ 25 or fewer full-time employees; pay at least 50 percent of the premium for their employees and meet a group average annual wage of less than $50,000

kynect allows small business owners to easily compare a variety of health plans offered by private insurers. There is no designated open enrollment period for small businesses. Small employer groups can enroll whenever they choose. Employers can choose the level of coverage, the amount they wish to contribute toward their employees' coverage so long as it is at least 50% and any amount they may want to contribute toward family or dependent care.

Employers also have one monthly bill for employee coverage and they can continue to work with their current insurance agent. If they do not have an agent, kynect can help them find one.

Employer-sponsored health insurance coverage is valuable for a number of reasons. People who are insured are protected against uncertain and high medical expenses. They are more likely to get healthcare. Health insurance also improves health outcomes and lowers mortality.

Employees with health insurance are more likely to be productive workers. Offering health insurance can also help businesses attract and retain employees. It is a good business decision because of the favorable tax treatment to both the employer and the employee.

With almost half of all Americans receiving their health insurance from their employers, business owners play an important role. Many small businesses already offer health coverage to their employees and with SHOP, more soon will. It helps them recruit and retain employees who are healthier, happier and more productive. It is good business for the employers and the employees.

Thank you for allowing me the opportunity to appear before you today to testify about Kentucky's extremely positive experience with the implementation of the Affordable Care Act and its SHOP exchange.

Bio for Bill Nold

Bill is a lifelong resident of Louisville; he graduated from the University of Kentucky in 1968 with a BS degree in Mechanical Engineering. He graduated from the University of Louisville in 1974 with a JD Degree. In 2001, after 26 years of private practice, he became employed with the legal division of the Kentucky Department of Insurance as a staff attorney. In this position, his job duties primarily related to issues involving health insurance and worker's compensation insurance. In 2008, Bill became the director of the Health and Life Division within the Department of Insurance, where his job duties involved all aspects of health and life insurance regulation.

In September 2012 Bill was appointed as the Deputy Executive Director of the Kentucky Office of the Health Benefit Exchange. The Office has been working over the last year to establish a state-based exchange that meets the requirements of state law and the ACA.

Chair LANDRIEU. I am sorry. I am going to have to stop you there. We have so many people to testify, and I really appreciate and you have a wonderful statement. We have put it in the record. Thank you, Mr. Nold, but we are going to have to go to our second panelist.

Senator.

OPENING STATEMENT OF HON. MARTIN HEINRICH, A U.S. SENATOR FROM NEW MEXICO

Senator HEINRICH. Thank you, Chair Landrieu for holding this hearing on the rollout of the Affordable Care Act small business exchanges.

With attention squarely focused on implementation challenges at the national level, a deep understanding of how our small businesses are fairing in securing meaningful, affordable health insurance coverage for their employees is timely and essential to the economic well-being of Americans.

Just an introduction, okay. Well, I am delighted and honored to be here today to introduce one of our invited panelists, Dr. Martin Hickey. He will describe to you in detail the success of the New Mexico SHOP.

Dr. Hickey is not only a member New Mexico Health Insurance Exchange Board but he is also the CEO of the New Mexico Health Connections, a co-op, not-for-profit plan formed under the Affordable Care Act to provide health insurance to small groups and individuals in New Mexico.

He is also a general internist who first practiced on the Navajo Nation, and he has dedicated himself to developing rural health programs.

Over the past three decades, he built a distinguished career in health systems administration and delivery system reform across the country and we are fortunate to have him in New Mexico.

I give you, Dr. Hickey.

Chair LANDRIEU. Thank you.

Dr. Hickey, please and you have five minutes.

STATEMENT OF MARTIN HICKEY, M.D., CEO, NEW MEXICO HEALTH CONNECTIONS, ALBUQUERQUE, NM

Dr. HICKEY. Chairman Landrieu, Ranking Member Risch, and distinguished Senators, thank you for the opportunity to testify today about the early success of the New Mexico small business exchange.

New Mexico legislated a state-based exchange board in March of just this year. The board consists of 13 highly representative members of groups including small business, consumers, Native Americans, Hispanics, physicians, hospitals, health insurers.

Within five months, the board and it's very capable CEO and team selected an experienced private exchange vendor, developed a statewide plan for marketing, trained over 500 health care guides, set the rules for an open market exchange, and succeeded in launching a fully operational enrollment website, Be Well New Mexico, on October 1.

In this time of national glitches and confusing rhetoric, the board, our very supportive governor, Susanna Martinez, the ex-

change health insurers, and all New Mexicans are very proud of the early enrollment successes that I will detail.

You got a background on myself. I have been CEO and a senior manager in insurance companies, medical groups, hospitals. I have seen this business from every single side. And what I am so proud of is that I have always dwelt to on fixing access to care, and I can tell you that this board that has come together from literally both sides of the aisle in New Mexico, has come together passionately to assure access to care.

New Mexico is 23 percent uninsured, second only to Texas, has 200,000 uninsured and 118,000 of them are eligible for financial assistance.

And the Board gets this. Only 47 percent of the population has employer-sponsored insurance, the lowest in the Nation which has an average of 58 percent.

Our State exchange is unique from most others and we call it a hybrid. Because the exchange formed so late, we did not have time to implement an individual exchange this year. We were, however, able to procure a competitive contract with Get Insured, an information technology company with seven years of experience in building private exchanges.

Next month, they will begin work on implementing the technology for an individual exchange which will be ready to rollout for enrollment in October of 2014.

In the meantime, we have had to depend upon the federal exchange, but Be Well New Mexico has a calculator, is educational; and when the federal exchange becomes fully operational, people will be informed.

The small business exchange is also unique in that it not only offers employers a choice of plan but offers choice to each of their employees as well.

The employer enters the site, selects a metal level and a reference plan. The employer designates a percentage of premiums that will be covered. That then creates a dollar amount made available to the employee for premium support in whatever plan the employee chooses.

Thus, the employees have a choice of any plan of any carrier at that metal level at whatever cost. That is what is so great about New Mexico health insurance exchange for small businesses and their employees. Choice, choice, and choice.

You know what? Even better it works, and it is easy. I did it for my family last week and it was like going down a water slide. There is even a calculator to help an employee choose the right plan based upon generalized use of health care in the past.

I think the following quote from a small business in Albuquerque, an attorney with four employees, sums it up best.

"I was very pleasantly surprised. I thought it was going to be an administrative nightmare and it literally took me 15 minutes. They gave me a quote that would save me $1,000 over what I was paying. I thought this was going to be an all-day thing so I had a Diet Coke handy, was well rested and had a good lunch, and it was almost disappointing that it was so easy. I was blown away."

So, to date, as you said, Senator, 1,143 small businesses in our little State with a number of employees is essentially propelled us

to a potential, once all the enrollment finishes up by the end of the month, of over 8,000 members which already meets the goal that the board had set for the State, and we still have got the rest of the year and all next year to go.

So, as I said, about 500 personal assistors and brokers are very heavily involved as well.

The other thing you emphasized was cost, and basically I will tell you that our superintendent estimates that the rates for next year will be no more than five percent of what they were this year, when the American Society of actuaries said it would be a 34 percent increase. He also set up a very competitive process. I know. I had to go through it.

So, New Mexico small employers now have a great opportunity to cover their employees and do so with a sense of choice and low rates and a system that works.

[The prepared statement of Dr. Hickey follows:]

Senate Small Business and Entrepreneurship Committee Testimony

Wednesday, November 20, 2013

Martin Hickey, MD

Chairman Landrieu and Senators, thank you for the opportunity to testify today about the early success of the New Mexico Small Business Exchange. New Mexico legislated a state based Exchange Board in March of this year. The Board of thirteen is highly representative of the interests of small businesses, consumers, Native Americans, Hispanics, physicians, hospitals, and health insurers. Within five months the Board and its very capable CEO and team selected an experienced private exchange vendor, developed a statewide plan for marketing, trained over 500 "Health Guides," set the rules for an "open market" exchange, and succeeded in launching a fully operational enrollment website, BeWellNM.com on October 1. In this time of national glitches and confusing rhetoric, the Board, our very supportive Governor, Suzanna Martinez, the Exchange health insurers, and all New Mexicans are very proud of the early enrollment successes that I will detail.

A brief background on myself will help reflect the "access to care" culture that the entire Board shares. I am a general internist who started practice on the Navajo Reservation, and then developed the first rural clinic pilots for the Veterans Administration with the assistance of former Senator Domenici. I then went on to become a physician executive for the last 30 years. I have been the CEO or senior executive of large multispecialty physician groups, hospitals, and insurance companies and am currently the CEO of the new COOP health plan, New Mexico Health Connections. I have seen the health industry from all sides and am honored to sit as a carrier representative on the Board. The other Board members bring an equally extensive background of expertise and understanding the needs of New Mexico. New Mexico, which has the second highest state percentage of uninsured at 23%, has about 200,000 uninsured who will qualify for the Exchange, with 118,000 eligible for financial assistance. 96% of businesses in New Mexico have 50 or less employees, and only 47% of the population has employer sponsored insurance, the lowest in the nation which has an average coverage of 58%.

Our State based Exchange is unique from most others and we call it a Hybrid. Because the Exchange formed so late, we did not have time to implement an individual exchange this year. We were, however, able to procure a competitive contract with GetInsured, an information technology company with seven years of experience in building private exchanges. Next month they will begin work on implementing the technology for an individual Exchange which will be ready to enroll applicants in October of 2014 for coverage starting in 2015. For 2014 we have had to depend on the Federal Exchange for individual enrollment, but BeWellNM.com can

estimate individual subsidies, educate our population, and prepare individual/family enrollees for the Federal Exchange when fully operational.

Our Small Business Exchange is unique in that it not only offers employers choices of plans, but also offers choice to each of their employees as well. The employer enters the site and selects a metal level and a reference plan in that level. The employer also designates what percentage of the premium will be covered, the minimum being 50%. That then creates the dollar amount made available to the employee for premium support whatever plan the employee chooses. Thus, the employee has the choice of any plan of any carrier at that metal level at whatever cost is associated with the plan, less the employer's contribution. That is what is so great about the New Mexico Health Insurance Exchange for small businesses and their employees – choice, choice, choice!

And even better, it WORKS and it is EASY. I did it for my family last week and it was like going down a water slide! There is even a calculator to help an employee chose the right plan based on generalized use of health care in the past. The following quote is from an attorney in Albuquerque with 4 employees and comes from an interview with the New Mexico Business First Journal:

"I was very pleasantly surprised. I thought it was going to be an administrative nightmare and it literally took me 15 minutes. They gave me a quote that would save me $1,000 over what I was paying...I thought this was going to be an all-day thing, so I had a Diet Coke handy, was well rested and I had a good lunch, and it was almost disappointing that it was so easy....I was blown away."

To date 1,143 small businesses with 3,192 employees have registered required information with the State Exchange. If they all fully enroll with the average number of dependents (2.6 per employee) that would be a potential total of 8,299 members accessing health insurance through the small business exchange. That number exceeds the initial Exchange Board estimate of 8,000 business members enrolling for all of 2014. And open enrollment continues for small employers monthly throughout the rest of 2013 and all of 2014.

Finally, the "average" cost for a second cheapest silver plan in New Mexico is $282 dollars with a national average of $328. The Superintendent of Insurance estimates that the rates for 2014 are 0 to 5% higher than 2013 after reviewing and approving all rate submissions. The American Society of Actuaries earlier this year predicted a 34% increase on average for New Mexico. But as one of the four carriers working to have the most price competitive rates on the Exchange, I can tell you that competition worked. So, now New Mexico Small employers have a great opportunity to cover their employees and do so with extensive choice and low rates...in a system that works.

Thank you.

Martin E. Hickey, MD

Dr. Hickey, is the CEO of New Mexico Health Connections, a CO-OP not for profit health plan formed under the health reform act to provide health insurance to small groups and individuals in New Mexico. Previously he was a Managing Director of Navigant Consulting developing ACOs, Patient Centered Medical Homes, shared savings, and medical analytics. Prior to joining Navigant, Dr. Hickey was the first President/CEO of Alegent Health Clinic in Omaha, Nebraska. In this role, he built a large multi-specialty group practice for the nine-hospital Alegent Health System in Nebraska and Iowa. Prior to Alegent, Dr. Hickey served as Senior Vice President of Health Care Affairs at Excellus Blue Cross in Upstate New York overseeing Medicare, Medicaid, Care management and all medical directors. From 1997-2002, he served as President and CEO of Lovelace Health Systems in Albuquerque, New Mexico, and as Chief medical Officer prior to that. Dr. Hickey began his career on the Navajo Reservation in the Indian Health Service in Kayenta and Tuba City, and was the first Diabetes Coordinator for Navajo Area Indian Health Service. He then moved to the VA and then to the University of New Mexico. During that time, he set up pilot rural health programs for the VA, and an office of Managed Care Contracting for the University where he was also the Medical Director of the Faculty Practice. Martin is a graduate of the Rush Medical College in Chicago. He also earned his master's degree in Administrative Medicine from the University of Wisconsin, and completed a residency in Primary Care Internal Medicine at the University of Rochester.

Chair LANDRIEU. Thank you, Dr. Hickey. My only question is are you available to come to Washington?

[Laughter.]

Chair LANDRIEU. All right. We will go now to Mr. David Allen.

STATEMENT OF DAVID ALLEN, PRESIDENT AND CEO, DAVID ALLEN ENTERPRISES, LLC, BOULDER, CO

Mr. ALLEN. Madam Chairperson, members of the Committee, thank you for the opportunity to speak with you today about the affects of the Affordable Care Act on my small business and our experience with the Colorado State insurance exchange.

I am the owner and operator of Flatirons Practice Management. We are an independent medical billing company in Boulder, Colorado. We provide medical billing and practice management services to several hundred health care providers in eight states.

I currently employ 33 full-time personnel. Obviously, we are well below the employer mandate threshold of 50 FTEs yet we provide company-paid health insurance to our employees anyway under a small-group plan and have for many years.

We do so because we can and we feel that it is the right thing to do. I myself worked as an employee for other companies before choosing self-employment and I relied on my employers for access to health insurance.

Unfortunately, it has been increasingly hard for me to continue to provide health insurance for my employees. Second only to payroll, health insurance is our next largest expense. Even with annual inflation rates in the one to two percent range, our premiums have increased every year by 20 percent or more.

As much as I wish I could simply pass this along to my customers, they too are experiencing the same pressures to manage rising expenses in their small businesses.

We have done some creative things over the years to reduce the magnitude of the premium increases while maintaining the integrity of our coverage and have been successful in continuing to pay for 100 percent of the cost of the premiums for our employees.

One such tactic was to select an insurance policy that covers only generic pharmaceuticals. Anyone who requires a pharmaceutical that is only available as a brand name product has to purchase it out-of-pocket. As a result of the Affordable Care Act, our carrier has discontinued this policy as it does not meet the minimum standards as stipulated under the law. Due to this one change, our premiums are now scheduled to increase by 52.3 percent in January 2014.

Clearly, absorbing this expense in order to continue to provide the same benefit to my employees is entirely unrealistic. I will have no choice but to require my employees to contribute substantially to the cost of their premiums. The irony is that none of my employees currently take any brand name prescriptions or expect to in the foreseeable future.

This law has turned what was a potential expense for my employees into a guaranteed expense for my employees for something they neither need nor want.

Since the Affordable Care Act is what caused this problem for me, I decided to embrace it and turned to the state SHOP insur-

ance exchange in hopes that it would provide me with more affordable and appealing options.

The first obstacle I encountered was that the website would not allow me to create an account. After my fourth failed attempt, I initiated an on-line chat with one of the exchange support personnel and was told after close to an hour of waiting that they were having technical difficulties with creating accounts and I should try again later.

I did eventually create an account and download the census template. I then began the frustrating experience of attempting to upload the census. I tried unsuccessfully several times and received nonsensical errors such as "wrong file type" when the file I was attempting to upload was the very template that I downloaded from the website.

After initiating my second on-line chat, it eventually came out that my web-browser might be at fault. I find it unfortunate that the website did not disclose any browser limitations before I wasted yet another hour spinning my wheels.

Upon switching browsers, I was able to get the website to acknowledge the file that I was attempted to upload but it ultimately rejected the file on the basis that the date of hire field was not formatted correctly.

My third on-line chat resulted in validation that my data was, in fact, formatted correctly and the website was again experiencing technical difficulties.

Growing increasingly impatient, I resorted to having my assistant manually type the information into the website. What should have taken us minutes to complete instead took us hours.

Having finally uploaded our census, I received 34 insurance plan options from which to choose. I found it challenging to objectively compare and contrast them with our current plan and its 2014 equivalent because we currently offer a tolerable $750 annual deductible to our employees and the lowest annual deductible available to us under the state exchange is $1,500.

In short, the only way we can markedly reduce the cost of our health insurance through the state exchange is to select a policy with a dramatically higher deductible thus shifting the financial burden from me to my employees.

Frankly, I could do this on my own without the assistance of the exchange and have consciously chosen not to pursue high deductible plans in the past because of the financial strain that it would create for my employees. Instead, we opted to make concessions that did not cause a financial strain such as forgoing brand name pharmaceuticals.

On the surface, my company stands to benefit from the Affordable Care Act on the basis that more people will consume health care services provided by my clients thus resulting in more business for me. But this theory hinges on the affordability of the insurance available to the populace.

If my experience is any indication of the unintended consequences of this law, it would appear that the Affordable Care Act accomplished the polar opposite of what the law was designed to do.

Thank you for your attention.

[The prepared statement of Mr. Allen follows:]

Written Testimony
Of

Mr. David M. Allen
President and CEO, Flatirons Practice Management

Before the
U.S. Senate Committee on Small Business and Entrepreneurship
Wednesday, November 20, 2013

Madam Chairperson, members of the committee, thank you for the opportunity to speak with you today about the effects of the Affordable Care Act on my small business and our experience with the Colorado State Insurance Exchange.

I'm the owner and operator of Flatirons Practice Management. We're an independent medical billing company in Boulder, Colorado. We provide medical billing and practice management services to several hundred healthcare providers in eight states. I currently employ 33 full-time personnel. Obviously, we're well below the employer mandate threshold of 50 FTE's yet we provide company-paid health insurance to our employees anyway under a small-group plan and have for many years. We do so because we can and we feel that it's the right thing to do. I myself worked as an employee for other companies before choosing self-employment and I relied on my employers for access to health insurance.

Unfortunately, it's been increasingly hard for me to continue to provide health insurance for my employees. Second only to payroll, health insurance is our next largest expense. Even with annual inflation rates in the one to two percent range, our premiums have increased every year by 20 percent or more. As much as I wish I could simply pass this along to my customers, they too are experiencing the same pressures to manage rising expenses in their small businesses. We've done some creative things over the years to reduce the magnitude of the premium increases while maintaining the integrity of our coverage and have been successful in continuing to pay for 100% of the cost of the premiums for

our employees. One such tactic was to select an insurance policy that covers only generic pharmaceuticals. Anyone who requires a pharmaceutical that is only available as a brand name product has to purchase it out-of-pocket. As a result of the Affordable Care Act, our carrier has discontinued this policy as it does not meet the minimum standards as stipulated under the law. Due to this one change, our premiums are now scheduled to increase by 52.3% in January 2014. Clearly, absorbing this expense in order to continue to provide the same benefit to my employees is entirely unrealistic. I will have no choice but to require my employees to contribute substantially to the cost of their premiums. The irony is that none of my employees currently take any brand name prescription drugs or expect to in the foreseeable future. This law has turned what was a potential expense for my employees into a guaranteed expense for my employees for something they neither need nor want.

Since the Affordable Care Act is what caused this problem for me, I decided to embrace it and turned to the state SHOP insurance exchange in hopes that it would provide me with more affordable and appealing options. The first obstacle I encountered was that the website would not allow me to create an account. After my fourth failed attempt, I initiated an on-line chat with one of the exchange support personnel and was told after close to an hour of waiting that they were having technical difficulties with creating accounts and I should try again later.

I did eventually create an account and download the census template. I then began the frustrating experience of attempting to upload the census. I tried unsuccessfully several times and received nonsensical errors such as "wrong file type" when the file I was attempting to upload was the very template that I downloaded from the website. After initiating my second on-line chat, it eventually came out that my web-browser might be at fault. I find it unfortunate that the website didn't disclose any browser limitations before I wasted yet another hour spinning my wheels. Upon switching browsers, I was able to get the website to acknowledge the file I was attempted to upload but it

ultimately rejected the file on the basis that the date of hire field wasn't formatted correctly. My third on-line chat resulted in validation that my data was in fact formatted correctly and the website was again experiencing technical difficulties. Growing increasingly impatient, I resorted to having my assistant manually type the information into the website. What should have taken us minutes to complete instead took us hours.

Having finally uploaded our census, I received 34 insurance plan options from which to choose. I found it challenging to objectively compare and contrast them with our current plan and its 2014 equivalent because we currently offer a tolerable $750 annual deductible to our employees and the lowest annual deductible available to us under the state exchange is $1,500. In short, the only way we can markedly reduce the cost of our health insurance through the state exchange is to select a policy with a dramatically higher deductible thus shifting the financial burden from me to my employees. Frankly, I could do this on my own without the assistance of the exchange and have consciously chosen not to pursue high deductible plans in the past because of the financial strain that it would create for my employees. Instead, we opted to make concessions that didn't cause a financial strain such as forgoing brand name pharmaceuticals.

On the surface, my company stands to benefit from the Affordable Care Act on the basis that more people will consume healthcare services provided by my clients thus resulting in more business for me. But this theory hinges on the affordability of the insurance available to the populace. If my experience is any indication of the unintended consequences of this law, it would appear that the Affordable Care Act accomplished the polar opposite of what the law was designed to do.

Thank you for your attention.

David M. Allen

David Allen earned his MBA in 1990 from the University of Tulsa, which he attended on a full academic scholarship as an undergraduate, and has done additional post-graduate work in Healthcare Systems Management at the University of Denver. David has 20 plus years of healthcare management experience, including senior-management roles, working for industry leaders such as Quest Diagnostics and GE Healthcare. He has a well-documented track-record of success in managing large, highly-productive organizations with financial responsibility into the hundreds of millions of dollars.

In 2008, David left Corporate America to pursue self-employment and ultimately purchased Flatirons Practice Management, a full-service, independent, medical billing service company in Boulder, Colorado. In the four and one-half years that David has owned the company, they've grown from 17 to 33 FTE's, have expanded into seven additional states, and have widened their services from two to now 10 different medical specialties.

Chair LANDRIEU. Thank you. Our next witness is Mr. Drew Greenblatt. Please identify your state and the kind of exchange you have.

And Mr. Allen, just for the record, you are in Colorado with a state-run exchange that is obviously, according to your testimony, has some difficulties.

Mr. Greenblatt, what is your state and what kind of exchange do you have?

Mr. GREENBLATT. Maryland state and we have the SHOP exchange but it is starting in April.

Chair LANDRIEU. And is it a federal exchange?

Mr. GREENBLATT. I believe Maryland State is trying to do it on its own but I am not positive.

Chair LANDRIEU. A state-run exchange?

Mr. GREENBLATT. State run.

Chair LANDRIEU. Okay.

STATEMENT OF DREW GREENBLATT, OWNER, MARLIN STEEL WIRE PRODUCTS, BALTIMORE, MD

Chair LANDRIEU. Chairwoman Landrieu, Ranking Member Risch, and members of the U.S. Senate Committee on Small Business and Entrepreneurship, thank you for the opportunity to testify before you today.

I am Drew Greenblatt, and I am president and owner of Marlin Steel Wire Products, based in Baltimore, Maryland. Marlin is a manufacturer of wire baskets, wire forms and precision sheet metal fabrications. We make it 100 percent in the USA. We make it here and we ship it to 36 countries, and my favorite is we export to China.

I am pleased to testify on behalf of the National Association of Manufacturers. I am on the Executive Committee of National Association of Manufacturers.

Since you are the Small Business Committee, I thought you would be interested to know that our average member has 35 employees. 97 percent of us provide health insurance for our employees. I mention this because the health and safety of our workers is critical to manufacturers.

As a matter of fact, at Marlin, my company, we hit a huge milestone two weeks ago. We have gone 1800 days without a lost time accident, the thing that I am most proud of in running this company.

This commitment to a safe workplace and the overall health of our employees is critical. To me, offering high-quality health care coverage is part of that mix. Finding this good coverage is personally important to me because my family is in the same plan as all of my employees. So, we are all in this together.

Generally, I have come to expect my health insurance costs to go up about 8 to 12 percent a year. I was startled, I was shocked when our health insurance went up 49 percent this year.

I want to provide health insurance for my employees and their families. We have been doing it for 15 years since I bought the company. But now because it is so high, our plan, in effect, is not viable because it is not affordable.

Ultimately, we were able to secure an alternative coverage plan for my employees because our term ended December 1. My premium, however, is still going up 10 percent. The plan I purchased includes benefits I do not really need nor do my employees want. This is key. The affordability, it has gone up. The cost has gone up despite all the promises our costs would go down.

If I told my clients we are raising your prices 49 percent, they would laugh at me. 49 percent is out of control. Even if I sat down and explained to them, listen you are going to have some new features, they do not want to hear about it; and this is the environment we are in.

I recently discovered the SHOP exchange of Maryland was delayed until April. I am not sure what products it offers. This is the kind of instability that is harmful to our economy.

See, we do not know how much our employees are going to cost this year. We do not know how much they are going to cost next year. How do I quote jobs against my competitors in China? How can I win jobs that are three-year and five-year contracts when I do not know how much my costs are going to be?

I know that the ACA law is not going away and any change is going to have to happen through bipartisan legislation. I urge legislators on both sides of the aisle to look at all the health care laws that are not working and please fix them.

This will not get better with finger-pointing. This is not going to get better with rhetoric or regrets over broken promises. We need practical approaches right now.

Cost was and is and remains our main issue. Reducing the cost of care makes a health care delivery system more efficient and directly impacts the access to coverage.

Chair LANDRIEU. Please wrap up. I am sorry. You have 56 seconds.

Mr. GREENBLATT. 56 seconds. Driving up the cost of coverage and then providing subsidies to some just camouflages the underlying problem. I may not be a supporter of the current system but I would support changes that allow me to continue to provide high quality health care to my employees at a reasonable price.

Thank you for the opportunity to testify today.

[The prepared statement of Mr. Greenblatt follows:]

NATIONAL ASSOCIATION OF
Manufacturers

Leading Innovation. Creating Opportunity. Pursuing Progress.

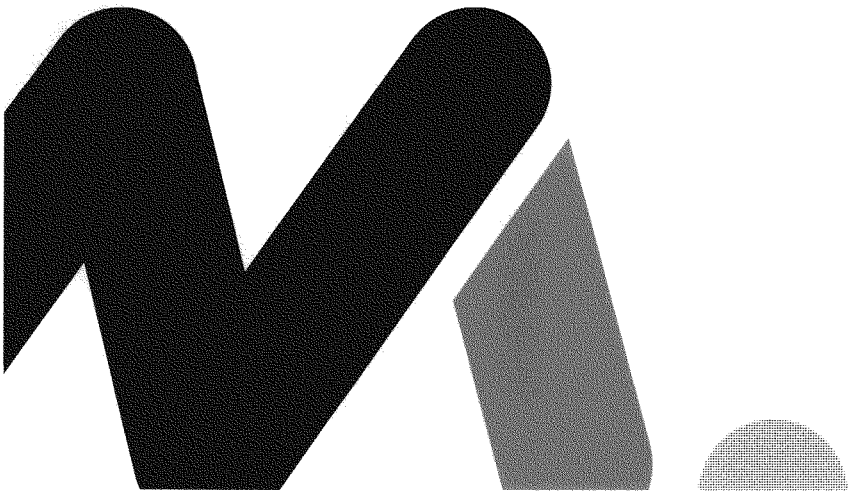
Testimony

of Drew Greenblatt
President and Owner
Marlin Steel Wire Products, LLC
on behalf of the National Association of Manufacturers

before the U.S. Senate Committee on Small Business & Entrepreneurship

"Affordable Care Act Implementation: Examining How to Achieve *a* Successful Rollout of the Small Business Exchanges"

November 20, 2013



TESTIMONY
OF DREW GREENBLATT
PRESIDENT AND OWNER
MARLIN STEEL WIRE PRODUCTS, LLC
ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

"AFFORDABLE CARE ACT IMPLEMENTATION: EXAMINING HOW TO ACHIEVE A SUCCESSFUL ROLLOUT OF THE SMALL BUSINESS EXCHANGES"
NOVMBER 20, 2013
BEFORE THE

U.S. SENATE COMMITTEE ON SMALL BUSINESS & ENTREPRENEURSHIP

Chairwoman Landrieu, Ranking Member Risch, and members of the U.S. Senate Committee on Small Business & Entrepreneurship, thank you for the opportunity to testify before you at today's hearing.

My name is Drew Greenblatt, and I am president and owner of Marlin Steel Wire Products, LLC, based in Baltimore, Maryland. Marlin Steel Wire is a leading manufacturer of custom wire baskets, wire forms and precision sheet metal fabrication assemblies—all produced entirely here in the United States. The customers for our material-handling solutions come from pharmaceutical, medical, industrial, aerospace and automotive industries all over the world. We export to 36 countries. Like so many other manufacturers in the United States that compete in a global economy, Marlin Steel Wire succeeds through innovation, investment and the hard work of our dedicated employees.

When I bought Marlin Steel Wire Products in 1998, we had roughly $800,000 in sales and 18 employees. Last year was our most successful one as a business, with more than $5 million in sales and 29 employees.

I am pleased to testify today on behalf of the National Association of Manufacturers (NAM). The NAM is the nation's largest manufacturing trade association, representing 12,000 member companies consisting of small and large manufacturers in every industrial sector and state. As the voice of 12 million men and women across the country who work in manufacturing, the NAM is committed to achieving a policy agenda that helps manufacturers grow and create jobs. I am proud to serve as a member of the NAM's Board of Directors, and as a member of its Executive Committee. Since we are here at the Senate Small Business and Entrepreneurship Committee, I believe it is important for me to point out that the average size company NAM represents is around 35-40 employees. While most people think of manufacturing companies as large with many employees, that's not the case for a majority of NAM members.

According to NAM member surveys, roughly 97 percent of NAM members provide health insurance for their employees. This is above the national average overall for manufacturers, which is about 72 percent – the highest among all sectors except government. Estimates from the Kaiser Family Foundation place the insurance take-up rate for manufacturing employees offered coverage at 83

percent – again, among the highest across business sectors. I mention this because the health and safety of our workers is important to manufacturers – I take immense pride in the fact that Marlin Steel Wire Products has operated 1,800 consecutive days without a time-loss incident. A safety record like that takes commitment and dedication to a safe workplace and the health of my employees. This translates to providing generous, high-quality health coverage as well.

Marlin Steel Wire Products has provided health insurance to all its workers since I acquired the company in 1998. As a demonstration of the importance I place on safety and health, the plan I have been providing also covered employee's first $1,200 in costs for an individual or $2,400 for families. I am personally vested in making sure our health coverage is as robust as it needs to be. I am on the same health plan as all of my employees. My family is on the same policy as their families. If they aren't covered, I'm not covered.

When healthcare reform was being debated, I was particularly interested in what President Obama had to say about reducing costs by $2,500 per family and was hopeful the plan would in fact reduce costs. The experience I've had since its passage has been disappointing.

Before and since the Affordable Care Act was passed, I could expect my insurance costs to increase somewhere between 8-12 percent every year. That

largely held true until this year. My small group plan carrier came to me this fall and said that in order for me to continue my current policy, premiums for individual-only coverage would require a 49 percent increase over last year. I couldn't absorb an increase of that magnitude, so I needed to find comparable coverage to get myself and my employees into before the plan year starts on December 1.

Three weeks ago, I finalized purchasing coverage for my employees. Ultimately, I was able to secure nearly equivalent coverage for me and my employees, but my premiums still increased by 10 percent from the product I had last year. This was only achievable because my plan year starts on December 1 instead of January 1, 2014.

My old plan was a good, quality product that I liked very much, but we were forced to give it up because it was no longer affordable due to mandates, taxes and fees required under the Affordable Care Act. As an employer with fewer than 50 employees, I was repeatedly assured the ACA did not apply to me and that I would be able to keep my plan – that is simply not my experience. If an employer of any size purchases or provides health coverage for their employees they are affected by the ACA.

I want to provide health coverage for my employees and their families, and I have, but because of the law, the coverage I wanted is no longer available to me because it is unaffordable.

The plan I just purchased includes benefits I don't want nor need and neither did my employees. It certainly did not decrease costs as promised. As I mentioned, if I kept my old plan, I would have been forced to pay 49 percent more than I did last year.

For me, it's frightening to think about what we're going to do about coverage next year and frankly I don't know what lies ahead of us in that regard. I do know that as a business and a nation, we need to stay competitive, but I am coming to the conclusion that we're on track to make ourselves uncompetitive.

I would be laughed out of the room if I told my customers I was going to increase the price I charge by 49 percent – and I'd probably lose every bit of business I have, if I tried. I could try to explain to my clients that they would get all sorts of new features for the 49 percent increase – I'd be told they don't want it or need it. Then, I would have a choice to make, and so would my customers. I feel like I didn't have a choice this year and many small employers find themselves in the same position.

As a manufacturer, I'm generally an optimist, but it's hard for me to imagine how things will get better given the current circumstances. In my state, there's little real competition in the health insurance market. If you want to create real competition, let me purchase coverage from other states or team up with other businesses to negotiate a better deal

As for the SHOP Exchanges, from what I can tell, there has been minimal outreach to businesses from the state to communicate about options under the SHOP Exchange. I have not received even basic information about where they stand in the process of getting them up and running or how they will work. I only recently found out the SHOP exchange in Maryland has been delayed until next April, but I don't know what kind of products will be available. This is the kind of instability that threatens our economic success by inhibiting the ability of businesses like mine to plan ahead. We need to be able to make economic choices and budget for the coming year with certainty and a reasonable level of confidence for two, three or five years out. As things stand, we have no idea how much employee benefits will cost and that is not a comfortable position for any business – particularly if it might be looking to add employees, expand current facilities or invest in new ones.

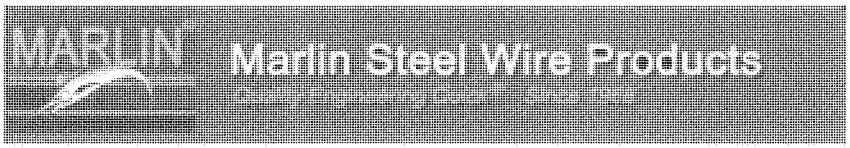
I am well-aware that the Affordable Care Act is law and it is not going to go away or change without bipartisan legislation. On behalf of the NAM, I urge Members of Congress and the Senate on both sides of the aisle to take an

honest look at all health laws that are not working, this one included, and fix them. A 49 percent increase in premiums will not get better with finger pointing, rhetoric, accusations or regrets over broken promises. Practical, real-world approaches to changing the system are what we need.

Conclusion

When I think of healthcare reforms we need, and I think this is true of any businessperson, cost is the main issue. Cost directly addresses the access issue. If we reduce the cost of care in a meaningful way, we make the health delivery system more efficient and we increase access to services. Driving up costs and then providing subsidies just camoflages the underlying problem - cost.

We need to find a way to address this. I may not be a supporter of the current system, but I would definitely support changes that allow me to continue to provide high-quality health care to my employees at a reasonable price. Thank you Chairwoman Landrieu and Ranking Member Risch for the opportunity to testify today.



Drew Greenblatt- President

Drew Greenblatt bought Marlin Steel Wire Products in 1998 when it was a small maker of a commodity product. Since then, it has grown revenue seven-fold. In the face of challenges to the global economy, Marlin Steel has invested more than $3.5 million in robotics in a quest for quality and speed.

Today, Marlin Steel imports nothing and exports baskets and sheet metal fabrications to 36 Countries, including China, Australia and Japan. Worker safety is critical. Marlin Steel has passed 1,700+ consecutive days without a lost-time accident. Marlin Steel has been recognized among the Inc. 5000 fastest growing companies in the U.S. (2012, 2013); the Inner City 100 fastest growing companies in the U.S. (2012, 2013), and Regional Employer of the Year (2007) from Baltimore City and Baltimore County. Drew Greenblatt has been chosen as an International Business Leadership Award Winner from the World Trade Center Institute (2011).

Marlin's secret sauce is Quality Engineering Quick ("QEQ"). Twenty percent of Marlin's employees are mechanical engineers who innovate to save clients' money by improving throughput with engineered wire baskets and custom sheet metal fabrications. Marlin Steel's engineers provide state-of-the-art, computer-driven stress analysis so clients have comfort knowing that their designs will withstand the rigors of their applications.

Greenblatt has testified to the U.S. Congress more than six times on topics including small business, taxation, regulations, trade policy, and techniques to grow the economy. Advocating for a robust manufacturing sector, Greenblatt

believes that factories provide great jobs and superb benefits - a way to grow our middle class with solid meaningful jobs.

Recognized as a leading spokesman for small business manufacturing, he writes a weekly column for Inc.com. He has been featured on CNN, CNBC, NPR, BBC, New York Times, Washington Post, Wall Street Journal, Economist, Fast Company and is a FOX Small Business All Star. Greenblatt serves as an executive board member of the National Association of Manufacturers. He serves as chairman of the board of the National Alliance for Jobs and Innovation and of the Regional Manufacturing Institute of Maryland. He also serves on the Maryland Commission on Manufacturing Competitiveness as well as the Governor's International Advisory Council.

He has a BA from Dickinson College and an MBA from Tulane University. He lives in Maryland with his wife and three sons.

Chair LANDRIEU. Thank you, Mr. Greenblatt, for your excellent testimony, and I am not seeing well with my cold but you did a very good job and I thank you for focusing on fixing it as opposed to the rhetoric associated with another proposal.

All right. Ms. Salter.

STATEMENT OF SHEILA A. SALTER, FOUNDER AND CEO, EARLY2SURG, CHAPEL HILL, NC

Ms. SALTER. Good morning, Madam Chair Landrieu, Ranking Member Risch, and other distinguished members of the Committee. I am honored to be here today and to share my negative impact Obamacare has had on my small business and me.

My name is Sheila A. Salter and I am the sole proprietor of early2surg. I reside in North Carolina and that is a state that has defaulted to the federal exchange.

My company is a marketing/consulting business and the mission is to improve or accelerate the development and commercialization of surgical devices. My primary customers are startup device companies.

I have been in health care for over 35 years. I am well aware of the weaknesses and strengths within our health care system. I do not think there is a person in this great country of ours who does not wish for every individual to have affordable health care.

Obamacare has negatively impacted my business and filled me with uncertainty. I am my business. I planned for many years to have my own business. I invested my time and my money to begin early2surg this past February.

Now, because I have no employees, I am not eligible for SHOP at this time but it would be a reality if and when I could afford to expand. That is in my business plan.

Now, I would like to direct you to either the screen or you have in front of you a chart that I submitted. You know, I was shocked back in September when I received notice from Blue Cross Blue Shield that my health care plan was going to be canceled and it was going to be replaced by one that had been chosen for me at the tune of $584 a month.

Now, if you look at the chart, we all need to be clear on this. There is one health care plan. When I hear people talk about, oh, you know, go to the exchanges, shop, shop, shop. You have one plan. Okay. That plan includes the benefits listed in the left-hand column.

Now, you can see Sheila's plan. Sheila's plan was the one that I chose. I chose my services. I have done that all these years. I chose those services, chose that deductible for $202 a month.

Now, with Obamacare, I have to have those 10 essential benefits. Now, I challenge anybody in this room to look at the services that I selected for myself, noting that I am 61. I know I do not look it and I have no children or history of alcohol or drug abuse yet. Okay.

[Laughter.]

But does anybody here really think that I need all these services on the left-hand column? I do not think so. To have those choices removed from me, to have the government tell me, Sheila, this is

what is best for you, I really, I mean shocked is not the word. It is unacceptable.

It is unacceptable now. It is going to be unacceptable 12 months from now and I am going to never accept for someone to make my health care choice for me.

The only thing that exchanges do, and I have gone on the exchanges, you have the selection of what is your deductible, what is your co-pay, what you are going to do for prescription, are you going to be in network or out of network.

But I do not care if you are a man or a woman, you are going to have maternity and newborn care, you are going to have pediatric services, and you are going to have services that you may or may not need.

You know, that I think there should be a fix to it. I am open to work with anyone to fix that.

So, how has it affected my business? Well, it has impacted how am I going to establish my business, grow my business, expand my business. All of that is going to be delayed.

And as you know, the website is not working exactly up to par but I am concerned with the security of the website. You know, if I have identity theft, if any of us have identity theft, we all know what the consequence of that is. You know, it could wipe me out to the point I would never recover.

So, you know, in our health care business we have a motto, first do no harm. I want to see everybody have affordable health care. That is a given but, you know, there are some fixes that need to be made and I am happy to help with that.

Thank you again.

[The prepared statement of Ms. Salter follows:]

Written Testimony
Of

Miss Sheila A. Salter
Founder & CEO, early2surg

Before the
U. S. Senate Committee on Small Business & Entrepreneurship
Wednesday, November 20, 2013

Good morning Madame Chair Landrieu, Ranking Member Risch and other distinguished members of this Committee. I am honored to have this opportunity to share the negative impact Obamacare has had on my small business and me.

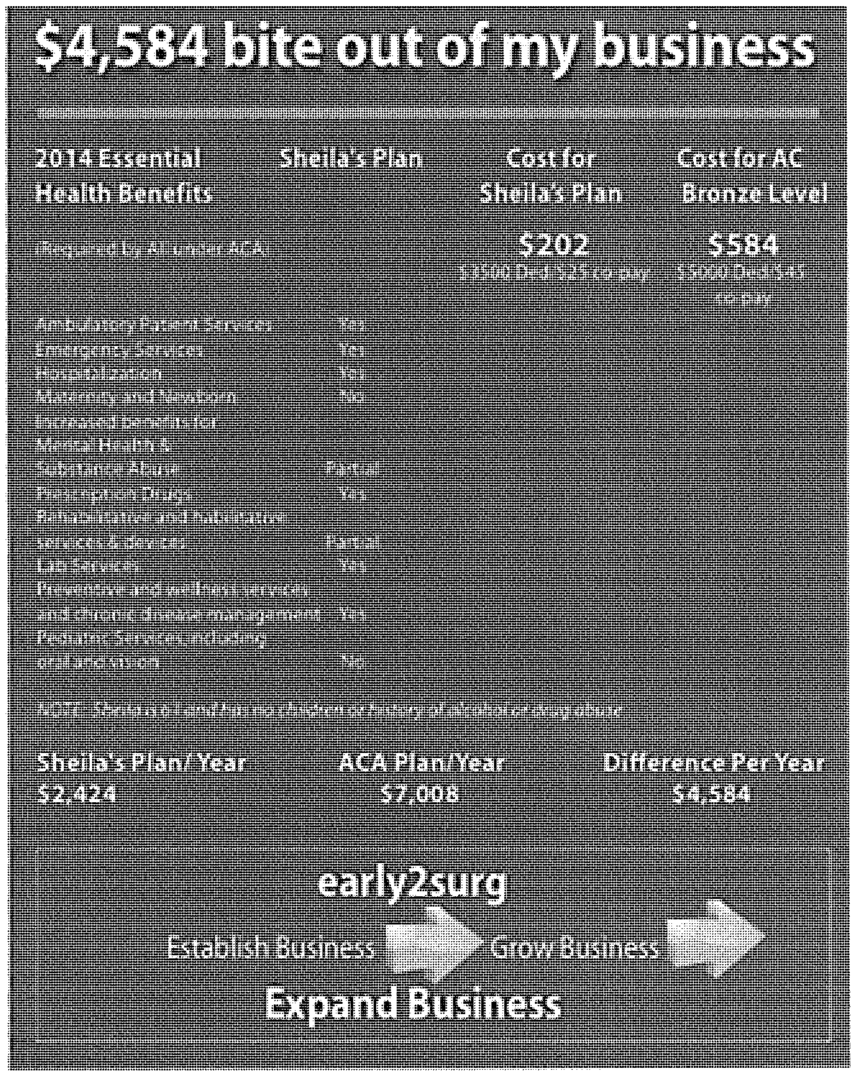
My name is Sheila A. Salter and I am the sole proprietor of early2surg, which is a Marketing Consulting business whose mission is to improve/accelerate the development, and commercial launch of surgical devices for start-up device companies.

For over 35 years my career has been in the healthcare field. I am aware of the many strengths and weaknesses within our healthcare system. I do not think there is a person in this great country of ours that does not wish for every individual to have healthcare.

Obamacare has negatively impacted my business and filled me with uncertainty. I am my business. I planned for many years to have my own business. I invested my time and money to begin early2surg this past February.

I am still establishing the company but my business plan includes growth and eventually, expansion. Because I have no employees I am ***not*** eligible for SHOP at this time, but it would be my reality if and when I could afford to expand.

I'd like to direct you to the screen to clarify my points. (Content embedded below)


$4,584 bite out of my business
2014 Essential Health Benefits
Sheila's Plan
Cost for Sheila's Plan
Cost for AC Bronze Level
(Required by All under ACA)
$202
$3500 Ded $25 co-pay
$584
$5000 Ded $45 co-pay
Ambulatory Patient Services Yes
Emergency Services Yes
Hospitalization Yes
Maternity and Newborn No
Increased benefits for Mental Health & Substance Abuse Partial
Prescription Drugs Yes
Rehabilitative and habilitative services & devices Partial
Lab Services Yes
Preventive and wellness services and chronic disease management Yes
Pediatric Services including oral and vision No
Sheila's Plan/ Year
$2,424
ACA Plan/Year
$7,008
Difference Per Year
$4,584
early2surg
Establish Business
Grow Business
Expand Business

I was shocked when I received notice from BC/BS the end of September my insurance would be cancelled effective January 1, 2014. I looked over the federally mandated 10 Essential Benefits (listed on the left side of the screen) and it was immediately clear to me the federal government has taken away my freedom and ability to select healthcare services I want.

Please look at the column titled "Sheila's Plan" which is the plan I enjoyed ***prior*** to implementation of Obamacare. I was able to shop and find healthcare that suited me for $202/month. The proposed BC/BS replacement policy for $584/month includes services mandated by law and it has a higher deductible and co-pay. Does anyone here think my current policy is substandard?

I emailed my U. S. Congressman, David Price (Democrat) to ask for assistance. Part of his response to me (attached is full response) was to shop on the healthcare.gov website. That site was not working at the time and is still not secure. He also placed blame on the insurance companies and the governor of NC.

Clearly, there is one healthcare plan, which you see on the left hand column. The federal government has legislated this plan is best for everyone, male or female. "Shopping" under the federal law is deciding deductibles, co-pays but it does not allow for one to choose one's own healthcare. I shopped for my healthcare and found one I am very happy with for $202. Having my healthcare freedom of choice taken from me is unacceptable now, 12 months from now, and will never be acceptable.

How has Obamacare affected my business? It has a huge snowball effect. My plans to establish, grow and expand are minimized and delayed. In addition, my potential clients face the same impact. They may delay contracting my services so they can pay their healthcare premiums.

Of course, ramifications of potential identity theft on my company and me could wipe me out financially to the point I could never recover.

In my business we have a motto: **First do no harm**. I am faced with uncertainty and this law has harmed me.

Again, I want everyone to have healthcare. I am happy to assist you in improving or rebuilding an optimal plan for healthcare. **But first do no harm**.

Thank you again.

From: **Rep. David Price** nc04dpinbox@mail.house.gov
Subject: Reply from Congressman Price
Date: November 1, 2013 at 5:30 PM
To: Sasalter@aol.com

Thank you for contacting me regarding the notification you received from your insurance provider about changes to your plan and premium for 2014. Although I cannot speak for your insurance company, I appreciate the opportunity to clarify the relationship between these changes and the Affordable Care Act, and to summarize your health insurance options under the law.

If you have a plan that was "grandfathered" under the Affordable Care Act (one that was in existence on March 23, 2010) and have not made changes to your coverage since then, you can choose to keep your plan. Grandfathered plans do not include important new consumer protections, such as a guaranteed right to appeal disputed insurance decisions and rate reviews that hold insurers accountable for excessive premiums. But if your plan was grandfathered and you are satisfied with it, the law does not require you to leave it. You can learn more about grandfathered plans at: https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/.

If you received a notification from your insurance provider stating that you must enroll in a new plan, the provider is either assuming that your current plan is not grandfathered or has decided to no longer offer the plan. You may decide to purchase the coverage your insurance company is suggesting, but this may or may not be the best option for you. Before deciding how to proceed, I encourage you to visit healthcare.gov to determine which plans are offered in your area and what the bottom-line cost to you would be. Deciding which insurance plan works for you can be confusing, but there are unbiased resources available – online, over the phone, or in person – to help you decide which private insurance company and level of insurance work best for you. You can find these free resources at: localhelp.healthcare.gov/.

Finally, I understand your concern about the rising cost of health care premiums. Although the Affordable Care Act does not prohibit insurance companies from increasing premium rates in response to changing market conditions, it does make them justify their rate increases, prohibit them from charging higher rates due to pre-existing medical conditions, and require them to spend at least 80 percent of premiums on medical care – or refund the difference to you. In addition, many individuals and families are eligible for subsidies, tax credits, and cost sharing that will reduce the amount you pay for your premiums and out-of-pocket expenses. To determine if you are eligible for these features, visit healthcare.gov. You can find out more about this part of the law at: https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/.

Unfortunately, the North Carolina General Assembly and Governor Pat McCrory refused to set up a state-run insurance marketplace, which could have attracted more competition between insurers, produced plans better tailored to the state's needs, and resulted in lower premiums.

I am under no illusion that the health care law is perfect, but I also know the health insurance marketplace we had before was badly broken and needed to be repaired. I remain confident that the Affordable Care Act will produce better care at a more affordable cost as it is fully implemented, and I am willing to work with anyone who wants to amend the law to make it work better. I am not, however, willing to go back to the system we had before, or tell the many North Carolinians who lack affordable coverage that they have to wait yet another year to get the insurance they so desperately need.

I hope this information is helpful, and please continue to keep in touch on issues of concern.

Sheila A Salter Bio

Sheila A Salter is CEO and founder of early2surg, a Marketing Consulting LLC that focuses on meeting the marketing needs of start-up, small-sized, and medium-sized surgical device companies. In the 20+ years that Sheila worked at Covidien Surgical (formerly Tyco Healthcare and US Surgical), she commercialized more products than anyone else in the company's history. One of Sheila's many areas of expertise is in the Minimally Invasive and General Surgery fields, particularly involving laparoscopic procedures for Bariatric, General, Foregut, Colo-Rectal, Urology, and GYN surgeries.

Sheila was born in South Carolina and graduated from the University of South Carolina with a Bachelor of Science degree in Nursing. Sheila was the first person in her family to graduate from college. Sheila's interest in nursing began in her first job as a nursing assistant at the age of fifteen. Sheila worked during summers to pay for college as well as receiving a small scholarship and some student loans. Sheila's interpersonal skills, initiative and drive led her to move from nursing to medical sales.

Sheila has worked in the healthcare industry for over 35 years. One of her goals was to eventually have her own business and do what she enjoys most: assisting others in fulfilling their dreams in the development and global commercialization of surgical devices. In February of 2013, Sheila was able to realize that goal and launched early2surg using her personal savings. Sheila is now able to combine her many skills and extensive knowledge to bring innovative surgical device products to the global market.

Chair LANDRIEU. Thank you very much.
Ms. Evans.

STATEMENT OF CONNIE EVANS, PRESIDENT AND CEO, ASSOCIATION FOR ENTERPRISE OPPORTUNITY, ARLINGTON, VA

Ms. EVANS. Good morning, Chair Landrieu, Ranking Member——

Chair LANDRIEU. Welcome back.

Ms. EVANS. Thank you very much for having me back. Ranking Member Risch and members of the Committee, my name is Connie Evans and I am the president and CEO of the Association for Enterprise Opportunity, AEO, the national member organization and the voice of micro-business in the United States.

For more than 21 years, AEO and its more than 450 member and partner network of non-profit lenders and business development organizations have provided critical services, access to capital and business counseling to under served entrepreneurs in micro-businesses all across the country.

The importance of our topic today, health insurance and its value to micro-businesses can not be overstated. Similarly, our discussion of how certain elements of the Affordable Care Act are changing the health care landscape could not be timelier.

Before we proceed to the topic, however, I would like to give the Committee some statistics about micro-businesses, those businesses with under five employees, that AEO released just last week.

The report, Bigger Than You Think, the Economic Impact of Micro-Business in the United States, tells a powerful story of how the Nation's smallest businesses make an outsized contribution to our economy.

There are 26 million micro-businesses in the United States or about 92 percent of all businesses. The ripple effect of direct, indirect, and induced economic activities of these firms is quite impressive.

Total employment of more than 41 million Americans, total economic impact of nearly $5 trillion, and total revenue contributions of $135 billion to federal, state, and local governments just in 2011.

In other words, although these main street businesses are small, their combined impact is quite significant. Despite advantages, however, many would-be entrepreneurs are reticent to leave their jobs due to concerns about health care access.

For decades the inability to obtain health insurance has been a barrier for those who are interested in starting a business. It is well documented that access to health insurance drives employee decisions.

Before the ACA removed pre-existing conditions as a barrier to obtaining health insurance, employees often chose to stay with employers even though they were unhappy with their employment. The inability to access health insurance prevented those who might have otherwise left their jobs and start businesses.

As the Chair expressed this morning, indeed, the Robert Wood Johnson Foundation does project that nearly 1.5 million Americans, including 25,000 just in the Chair's home State of Louisiana, will become self-employed thanks to insurance reforms of the Affordable Care Act.

The entrepreneurs and micro-businesses that AEO members serve have had the unfortunate choice of hamstringing their revenues by providing health insurance to their employees or losing their employees to larger companies who can provide that insurance.

The ACA he reforms to the health insurance market, in our opinion, were necessary and we hoped that these changes would lead to better prices and more choices.

Our optimism is based largely on the exchanges, also referred to as new marketplaces, which allow individuals or small businesses to pool together statewide to obtain insurance.

It is with profound disappointment that the federal rollout of this program is in complete disarray. While most of the government's attention has been focused on fixing the individual exchange, and the small business exchange or SHOP has been treated as a secondary concern.

We fear that implementation of the federally facilitated SHOP will continue to suffer delays. Even though the law requires individuals to obtain health insurance by March 2014, many plans for individuals and businesses end at the end of 2013.

Decisions about coverage have to be made whether or not the Federal Government can successfully rollout the exchanges. We note that many individuals have received notices saying that their coverage will be discontinued because that plan does not comply with the ACA and the insurance companies have advised these customers to shop in the exchanges but, of course, the exchanges are not up and running so there is much frustration over what to do in the meantime.

Do they just go without insurance and allow a gap in coverage? What do they tell their employees?

In closing, our message is not based on any political leaning or philosophical notion regarding health insurance. We just want it to work. We urge the Congress and the Administration to come together to make it work for the 26 million micro-businesses on the front lines of our economy.

Thank you for the opportunity to appear before you today and I look forward to answering any questions the Committee may have.

[The prepared statement of Ms. Evans follows:]

Senate Committee on Small Business and Entrepreneurship

Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges

November 20, 2013

Connie E. Evans
on behalf of the Association for Enterprise Opportunity (AEO)

Good morning Chair Landrieu, Ranking Member Risch and Members of the Committee. My name is Connie Evans, and I am the President and CEO of the Association for Enterprise Opportunity (AEO), the national member organization and voice of microbusiness in the United States. For more than 21 years, AEO and its more than 450 members and partner network of nonprofit lenders and business development organizations have provided critical access to capital and business counseling to underserved entrepreneurs and microbusinesses all across the country.

The importance of our topic today – health insurance and its value to microbusinesses—cannot be overstated. Similarly, our discussion of how certain elements of the Affordable Care Act (ACA, P.L. 111-148) are changing the healthcare landscape could not be timelier.

Before we proceed to that topic, however, I would like to give the Committee some statistics about microbusinesses—those businesses with under 5 employees—that AEO released just last week.

The report, *Bigger Than You Think: The Economic Impact of Microbusinesses in the United States,* tells a powerful story of how the nation's smallest businesses make an outsize contribution to our economy. There are 26 million microbusinesses in the United States, or about 92% of all businesses. The ripple effect of direct, indirect, and induced economic activity of these firms is impressive: total employment of more than 41 million Americans, total economic impact of nearly $5 trillion, and total revenue contributions of $135 billion to federal, state, and local governments in 2011.[1] In other words, although these main street businesses are small, their combined impact is significant.

Furthermore, starting a business and creating a job is a pathway to upward mobility and poverty alleviation, especially for women and people of color. Our research shows that the median net worth of business owners is almost two and a half time greater than that of non-business owners; for a Latino man, the difference is five times higher for business owners compared to non-business owners; for an African-American woman, the difference is more than ten-fold.[2]

Despite these advantages, many would-be entrepreneurs are reticent to leave their jobs due to concerns about healthcare access, a recognized phenomenon called "job-lock."[3] For decades, the inability to obtain health insurance has been a barrier for those who are interested in starting a business. It is well documented that access to

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[1] "Bigger Than You Think: The Economic Impact of Microbusinesses in the United States," The Association for Enterprise Opportunity, November 2013.
[2] Ibid.
[3] Madrian Gruber (2002). "Health Insurance, Labor Supply and Job Mobility: A Critical Review of the Literature." National Bureau of Economic Research.
http://www.nber.org/papers/w8817.pdf?new_window=1

health insurance drives employee decisions.[4] Before the ACA removed pre-existing conditions as a barrier to obtaining health insurance, employees often chose to stay with employers even though they were unhappy with their employment. The inability to access health insurance prevented those who might have otherwise left their jobs to start businesses.[5] Indeed, the Robert Wood Johnson Foundation projects that nearly 1.5 million Americans, including 25,000 in the Chair's home state of Louisiana, will become self-employed thanks to insurance reforms in the Affordable Care Act.

Not only has access to health insurance stood in the way of those wanting to start businesses, it has also greatly impacted small business growth. For small businesses that needed to offer health insurance to their employees to be competitive, additional health insurance costs presented a real problem. For these reasons, small business owners, in a January 2013 Wells Fargo/Gallup poll named healthcare costs as their greatest concern; 54% said the costs were "hurting a lot."

The entrepreneurs and microbusinesses that AEO's members and partner network serve have had the unfortunate choice of hamstringing their revenues by providing health insurance to their employees or losing their employees or potential employees to larger companies who can provide that insurance. They have struggled to provide insurance because insurance companies dropped them if an employee got sick.

Given the statistics that we just cited, it is no wonder that AEO applauded the disruption in the health care market that the ACA caused, because the previous health insurance market fell flat when it came to the self-employed and microbusinesses.

The ACA reforms to the health insurance market, in our opinion, were necessary and we hoped that these changes would lead to better prices and more choices. Our optimism is based largely on the exchanges, also referred to as new marketplaces, which allow individuals or small businesses to pool together statewide to obtain insurance. The logic behind the exchanges is that if microbusinesses can belong to a large pool rather than try to obtain insurance one business at a time, more insurance companies will be interested in insuring the pool. Therefore, since more plans will be offered, free market competition will drive the prices down. Our members, and the entrepreneurs they serve, have been looking forward to a break

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[4] See Field & Shapiro, "Employment and Health Benefits," Institute of Medicine, 1993; Bundorf, "Employee demand for health insurance and employer health plan choices," *Journal of Health Economics*, 2002; and Anand, "The Effect of Rising Health Insurance Costs on Compensation and Employment," Yale University, 2011.

[5] Linda Blumberg, Sabrina Corlette, et al (2013). "The Affordable Care Act: Improving Incentives for Entrepreneurship and Self-Employment." Robert Wood Johnson Foundation.

in prices and better access to health insurance, both on the individual and small business exchanges.[6]

It is with profound disappointment that the federal rollout of this program is in complete disarray. While most of the government's attention has been focused on fixing the individual exchange, the small business exchange (or SHOP) has been treated as a secondary concern. We fear that implementation of the federally facilitated SHOP will continue to suffer delays.

Even though the law requires individuals to obtain health insurance by March 2014, many plans for individuals and businesses end at the end of 2013. Decisions about coverage have to be made whether or not the federal government can successfully roll out the exchanges. There will be a scramble for enrollment through brokers and private plans outside the exchanges to obtain coverage because many health insurance plans expire at the end of the calendar year.

We note that many individuals have received notices saying that their coverage will be discontinued because their plan does not comply with the ACA and the insurance companies have advised these customers to shop in the exchanges. But the exchanges are not up and running, so there is much frustration over what to do in the meantime. Do they just go without insurance and allow a gap in coverage? What does an employer tell its employees about when to expect coverage? These are real problems that microbusinesses around the country are facing.

In closing, our message is not based on any political leaning or philosophical notion regarding health insurance. We just want it to work. We urge the Congress and the Administration to come together to make it work for the 26 million microbusinesses on the front lines of our economy.

Thank you for the opportunity to appear before you today and I look forward to answering any questions the Committee may have.

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[6] As a note, it is important to remember that the self-employed and sole proprietors must shop in the individual exchange, not as small businesses. The self-employed account for 70% of all businesses in the United States.

AEO Association for EnterpriseOpportunity
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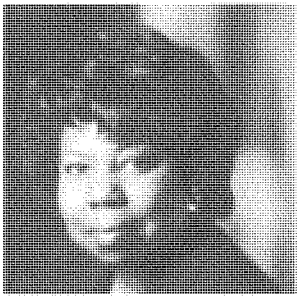

Connie Evans

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Connie Evans is the President and CEO of the Association for Enterprise Opportunity (AEO), the national nonprofit organization and business trade association representing the U.S. microbusiness development industry. AEO has nearly 400 member organizations that provide training, technical assistance and resources to entrepreneurs across the United States.

Connie's joining of AEO in March 2009 was a logical next step in her career as a visionary leader, strategist, activist, and social entrepreneur who has founded three organizations. In 1986 she was the founding president of the award-winning Women's Self-Employment Project, the first and largest urban microenterprise development organization in the U.S. and the first adaptation of the Grameen Bank model to a U.S. urban setting. Evans also pioneered one of the first matched-savings program -- Individual Development Accounts -- in the country. In 2000 she founded WSEP Ventures, a social enterprise-hybrid organization developed to serve as a catalyst for social change, economic development and community empowerment. At WSEP Ventures, Evans launched Capital Bridge C3, a fellowship program supporting emerging social entrepreneurs. And in 2007, Evans founded CSolutions Consulting, an advisory boutique specializing in solutions that address social change.

An international development consultant, with over 25 years experience, she has been recognized and utilized by such groups as the World Bank, the Clinton Administration, a host of local government and private and independent sector organizations. With international experience spanning 43 countries, Evans draws on her expertise in developing and implementing strategies to further economic development, health and social change in communities.

Evans started her career in community mental health as a master-level psychologist. Her commitment to improving the health and life options for disadvantaged women and their families moved her to "harness the marketplace" for solutions. As the Assistant Director of a Hull House Association affiliate in Chicago, Evans became the Project Director for the first resident managed public housing site in the city. She helped low-income women to organize, develop leadership skills, and learn business to take control over a multi-million dollar enterprise.

Evans has lectured in universities throughout the United States and is a frequent panelist and keynote speaker at conferences around the globe. She has many distinguished awards. A sampling includes being named the Inaugural Twink Frey Social Activist in 2006; the 1996 Chicagoan of the Year by Chicago

Magazine who recognized her contributions in making Chicago a better place to live. Her leadership and commitment to community service and social change has also been recognized with the first Teknion Humanitarian Award in 1999; Gloria Steinem Woman of Vision Award; 1998 Community Leader of the Year presented by the African American MBA Association at the University of Chicago; and the Chicago Community Service Fellowship Award by the Chicago Community Trust.

Evans' broad experiences across the worlds of business and finance compliment her skills in development finance. She served two elected terms on the Board of the Federal Reserve Bank of Chicago, and was the first African American woman to hold such a position. Evans was appointed by President Clinton to the CDFI Advisory Board, a fund in the Department of the Treasury. She also received appointments from President Clinton to the U.S. Delegation to preparatory meetings for the Summit of the Americas, to the U.S. Delegation to preparatory meetings for the United Nations Fourth World Conference on Women in Beijing, and again for Beijing Plus Five.

A strong advocate of good governance in nonprofits, Evans has nearly 20 years of service on philanthropic foundation boards, and serves on a number of national and international boards including the Social Venture Network. She is also the Chair of the Chicago Committee for the African Women's Development Fund, based in Ghana.

Chair LANDRIEU. Thank you very much and all of you for your testimony. It was all helpful to helping us work forward to try to fix this bill for the benefit of our small businesses and individual contractors and self-employed.

I am going to take five minutes for questions. We will do a five-minute round alternating—I am sorry, Mila. I am so sorry to miss you. I will tell you this cold is really knocking me for a loop.

Ms. Mila, go right ahead, Ms. Mila Kofman.

STATEMENT OF MILA KOFMAN, EXECUTIVE DIRECTOR, D.C. HEALTH BENEFIT EXCHANGE AUTHORITY, WASHINGTON, DC

Ms. KOFMAN. Thank you. Thank you very much, Madam Chairwoman Landrieu and thank you Ranking Member Senator Risch, and members of the Committee.

My name is Mila Kofman and I am the Executive Director of the District of Columbia's Health Benefit Exchange Authority, otherwise known as DC Health Link.

Senator Landrieu, thank you so much for your leadership and advocacy on behalf of the Nation's small businesses, both for your home State and nationwide. It is truly I appreciated all the work that you have done through the years for the small business community.

It is my honor to be here today to share with you what we have done here in the District of Columbia. The District was an early leader with the Affordable Care Act implementation.

In March of 2012, Mayor Gray signed legislation creating the DC Health Benefit Exchange Authority. We are a private-public partnership with seven voting members who are small business owners and experts in health insurance and health care financing. We also have four government members who serve as nonvoting.

In the District, it really did take a village to bring success to date. We had a very strong partnership with all of our agents, government agencies. We also had a very strong partnership early on in our policy decisions. We had policy workgroups, stakeholders who helped us make our policies and set our priorities.

We had strong support from Mayor Gray and his entire administration as well as the City Council and Congresswoman Norton. We had the political support we needed to move forward.

We also had strong relationships in collaboration with the business community here in the District, business associations who represent the small business owners here. We also had strong support from the Federal Government and especially Gary Cohen and his entire team.

On October 1, we opened for business; and as you know, it was reported that we were one of four states that opened on time and did not go down and we have not gone down. We are fully open for business and we welcome everyone, every individual who lives in the District, every small business that is in the District, and now I look forward to serving many of you and your staff. It was a great pleasure to be designated as a provider of health benefits to all of you.

I want to know that we had very strong partnerships with our insurance industry. We have four major insurance companies selling to small businesses through DC Health Link and I think the

best insurance companies in the Nation, Aetna, United, CareFirst Blue Cross Blue Shield, and Kaiser Permanente.

They offer 267 different products to small businesses, something for everyone. If you want zero deductible plan, it is there. If you want an HSA high deductible health plan, it is there, and everything in between at all price points.

Our carriers offer nationwide physician and provider networks as well as very robust local and regional networks, and we are very proud to offer full employer and employee choice.

So, when a small business comes in, it is very easy to create an account. DCHealthLink.com is our web address. When a small business comes in, the small business decides how much to contribute and what options to offer to employees.

For the first time, a small business can offer the types of options that only in the past have existed for the large employers. A small business can pick what to contribute and pick a level of benefits like the gold level and employees have 112 different products to choose from.

The small business gets one invoice and we clearly say how much the small business has to contribute and how much to withhold from the paychecks of employees.

We also did not, we decided to take advantage of the private market innovations so we did not negotiate rates or benefits. We let the insurance companies compete and, boy, did they compete.

After we made all of their premiums public, one company came back in lowering their rates twice. Another company came in and lowered their rates once and a third company came in and lowered their rates and offered additional product.

So, we have seen real private market competition work. When insurance companies compete, small businesses and individuals benefit from that competition.

Chair LANDRIEU. Please try to wrap up please.

Ms. KOFMAN. Thank you, Madam Chair.

I just want to note and thank the D.C. Chamber of Commerce, the Greater Washington Area Hispanic Chamber of Commerce, and the Restaurant Association of the Metropolitan Washington area. They had been our strong partners, and they are part of our success.

I also want to note that the insurance brokers especially of the National Association of Health Underwriters has also been a critical part to our success.

I look forward to answering any questions you may have.

[The prepared statement of Ms. Kofman follows:]

U.S. Senate Committee on Small Business and Entrepreneurship
"Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges"
November 20, 2013

Testimony of Mila Kofman, J.D., Executive Director, DC Health Benefit Exchange Authority

Good morning Chairwoman Landrieu, Ranking Member Risch and members of the Committee. My name is Mila Kofman and I am the Executive Director of the District of Columbia's Health Benefit Exchange Authority. Thank you for your leadership and advocacy on behalf of small businesses. It is an honor to be here today to testify about DC Health Link – the District of Columbia's new on-line Marketplace for individuals and small businesses in DC. We are also proud to have been selected by the Office of Personnel and Management to serve as the health exchange for Members of Congress, Senators and your designated staff and look forward to serving you in that capacity.

The District of Columbia decided early to be a leader in ACA implementation. We were among the first to apply to be a state-based exchange. We expanded Medicaid quickly after the ACA was signed into law. Our agencies began working together to develop our health insurance marketplace in 2011. On March 3, 2012 Mayor Gray signed legislation creating the DC Health Benefit Exchange Authority. The Authority is a private-public partnership with seven voting members. They are private citizens including small business owners in the District. Four government officials serve as non-voting members.

Our success is due to the broad collaboration we have had with our partner agencies in District government, strong community participation in the development of our policies and priorities for the Marketplace, leadership and support from our elected officials, our collaboration with the business community, a close working relationship with health insurance companies and support from our federal government partners especially the team at HHS and CMS. We had strong support from Mayor Gray and all members of the City Council, as well as from Congresswoman Norton. To have a successful October 1 launch of DC Health Link, it took a village.

DC Health Link opened for business on October 1, 2013. It was reported that we were one of only four states to be successfully up and running that morning. Since Day 1 we have seen strong interest by people and businesses in competitively priced quality health insurance. Between October 1 and November 13, we have had more than 84,272 unique visitors to our website (DChealthlink.com), nearly 20,000 accounts have been created by individuals to shop, compare and choose health insurance, and nearly 700 employer accounts have been created.

We at DC HealthLink think that the District of Columbia has the best marketplace in the nation for small businesses. Four major insurers have traditionally served the District's small businesses: Aetna, CareFirst Blue Cross Blue Shield, Kaiser Permanente and United Healthcare. We worked with each insurer to ensure all would sell to small businesses through DCHealthLink.

There is a product for everyone, fitting a small business' needs and budget. Insurers are offering 267 different products – HMOs, PPOs, zero-deductible plans, and HSA-compatible high deductible coverage, plans with broad nationwide provider networks and robust local and regional networks – and full employer choice that allows each small business to offer its workers a choice of insurers, plans, and different levels of coverage. Small businesses, like large employers, can finally offer their employees choices.

When we were implementing our marketplace for small businesses, we prioritized employer and employee choice. An employer who opens an account at DCHealthLink.com can choose what options to offer their workers. Each employer can offer its workers:

- one health plan from one insurer;
- all health plans (HMOs, PPOs) in all levels (bronze, silver, gold, and platinum) from one insurer; or
- all health plans from all insurers in one level of coverage, e.g. gold level has 112 different plans from all four insurers.

An employer receives one invoice reflecting all choices by workers. That invoice reflects the amount the employer choses to contribute and the amount that should be withheld for the employee contribution. Very simple, one bill, and more choice for employees in small businesses than ever before.

The DC Exchange chose not to negotiate benefits or rates. We decided instead to rely on private market competition. We have created one big marketplace for individuals, families and small businesses. After a transition period, all health insurance in the individual and small group markets will be sold through our web portal. All prices and products are transparent in one place. This policy passed the DC Council unanimously. The creation of one big marketplace has been critical to creating real competition. After the four insurers initially filed proposed rates and they became public, three of them resubmitted lower rates. One lowered its proposed rates twice, and another submitted additional products. Insurers know that when a consumer sees all prices, consumers are in the driver's seat. They know that prices must be competitive and low enough to attract buyers. We created real competition in prices and people and small

businesses benefit.

A critical part to our success is the strong support we have had from our business community. Throughout the development of DC Health Link, we worked with the DC Chamber of Commerce, the Greater Washington Area Hispanic Chamber of Commerce, and the Restaurant Association of Metropolitan Washington. This summer, we formalized these partnerships. These three organizations are trusted sources of information for DC small businesses. They each host at least monthly DC Health Link educational and enrollment events. They are conducting door-to-door outreach to small businesses in targeted areas. They are also reaching large businesses, many of whom employ part-time workers who are not eligible for employer-provided benefits and who will benefit from our individual and family DC Health Link marketplace. All have posted information about DC Health Link on their websites and all are prominently displayed on DCHealthLink.com as our partners. And, they are utilizing social media to help educate, encourage, and enroll small business owners and their employees through DC Health Link.

To-date, they have hosted 44 small business outreach and training sessions, promoted DC Health Link at another 51 community events, have made individual contact with over 2000 businesses, have more than 10,000 twitter followers, and have had more than 170,000 visits to their websites.

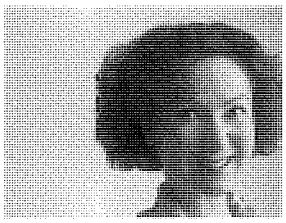
Similarly, we have worked closely with the health insurance broker community. We see insurance brokers as a vital and core sales force. We worked closely with local professional broker associations and have a formal relationship with the National Association of Health Underwriters (NAHU). Early in implementation, NAHU assisted us with expert support on many of our stakeholder policy working groups. NAHU also conducted all broker training for us.

We have created a successful business partnership with CVS – which has 59 stores in the District. They have displays with DC Health Link brochures in each location, they promote DC Health Link at their in-store health screening events, and they are hosting 36 DC Health Link enrollment events during open enrollment.

Our success reflects the community based approach we have taken. Stakeholder policy working groups helped us develop consensus based policy recommendations. Diverse stakeholders worked together to help build DC Health Link. I want to take this opportunity to thank them and recognize that it took a village to build the nation's leading SHOP marketplace.

For all of these reasons, I am proud to be here today to discuss our success and why DC Health Link is the best health insurance marketplace in the nation for small businesses. Thank you again for the invitation to testify and I look forward to answering your questions.

Mila Kofman



Executive Director Kofman's Testimonies Before the Council of the District of Columbia

Mila Kofman is the Executive Director of the DC Health Benefit Exchange Authority. Appointed to the position by a unanimous vote of the Board of Directors, Kofman is a nationally recognized expert on private health insurance markets and has worked with states and all stakeholders to implement health insurance reforms. Her approach is informed by her hands-on experience as the former Superintendent of Insurance in Maine implementing health insurance reforms, being a former federal regulator working with states to implement HIPAA reforms of the 1990s, studying state-based reform efforts and markets, and working with employer purchasing coalitions seeking to leverage purchasing power for sustainable financing of medical care.

From March 2008 to May 2011 as the Superintendent of Insurance in Maine, Kofman regulated a multi-billion dollar insurance industry, heading an agency with 70+ staff and a multi-million dollar budget. A gubernatorial appointee, she was nominated and first confirmed in 2008 and in 2010 was renominated and unanimously reconfirmed to a new term. Her effective alliances with business groups, the insurance industry, consumer and patient advocates, physicians, trial attorneys, and sister state agencies helped to improve the state's insurance market for both consumers and companies. The property and casualty market improved its ranking to third best in the nation. Kofman was successful in her priority legislative initiatives with some having passed unanimously. She also successfully undertook agency restructuring. She realigned resources to clear backlogs and improve services to the regulated community; created a market conduct examination unit responsible for ensuring compliance with the state's laws; created a formal and more effective enforcement process, going from a few to dozens of active enforcement cases; and improved consumer services processes making it easier for consumers to get help. Kofman improved transparency and government accountability by holding public hearings around the state on health insurance rates, efforts that were recognized by the White House and served as a model in other states.

In addition to serving on the Governor's Steering Committee on health reform implementation in 2010, Kofman served in key leadership positions at the National Association of Insurance Commissioners (NAIC). She was elected Secretary/Treasurer of the northeast zone and served on the NAIC's Executive Committee, she chaired the Health Insurance Regulatory Framework Task Force (responsible for ACA changes to NAIC models), co-chaired the Consumer Information Working Group (statutory working group under ACA with diverse membership of regulators, industry, consumers, physicians, agents, and other stakeholders), and was a member of the (B) Health Insurance and Managed Care Committee, the Exchanges Working group, the Executive Committee's Professional Health Insurance Advisors Task Force, and Anti-Fraud Task Force. She was also a member of the Life Insurance and Market Regulation committees. She held the NAIC seat on URAC's Board of Directors.

From 2001 to 2008, Kofman was an Associate Research Professor and Project Director at the Georgetown University Health Policy Institute. She studied state private health insurance market reforms, regulation, products (including alternative products like discount cards), and financing strategies. She rejoined the

faculty at Georgetown University Health Policy Institute in July 2011 as a Research Professor and Project Director.

In addition to more than 30 peer reviewed publications, her work included papers on group purchasing and private-public purchasing partnerships (pre-cursors to exchanges). She led ground breaking research on associations, which continues to be used widely. Ms. Kofman was the first in the nation to document the third cycle of health insurance scams (a report published by BNA) – research that informed a GAO study and a subsequent Congressional hearing. She has testified before the US Senate, the US House of Representatives, and state legislatures. She also served as an expert witness in civil and criminal cases. Kofman served on the NAIC Consumer Participation Board of Trustees for 6 years, the Board of Directors for URAC for 5 years, and was co-editor for the Journal of Insurance Regulation for 3 years. In 2007, she was recognized by the American Council on Consumer Interests and was the 2007 Esther Peterson Consumer Policy Forum Speaker.

Ms. Kofman was a federal regulator at the US Department of Labor (1997-2001). She worked on legislation and implemented HIPAA and related laws. She was honored with the Labor Secretary's Exceptional Achievement Award. In 2000, she was appointed Special Assistant to the Senior Health Care Advisor to the President at the White House to work on legislative and regulatory initiatives -- the Patient's Bill of Rights, long-term care insurance, nursing home reform, and ERISA reform.

She has appeared on NPR, CNN, CBS Evening News, ABC News and has been cited in BusinessWeek, Consumer Reports, the NY Times, the Wall Street Journal, the Washington Post, the LA Times, the Chicago Tribune, Forbes, US News & World Report, AM Best, AP, and other press. Her blogs have appeared in Huffington Post, Health Affairs, and The New Republic.

Ms. Kofman holds a J.D. from Georgetown University Law Center and a B.A. in Government and Politics from the University of Maryland (summa cum laude).

Chair LANDRIEU. Thank you very much.

Before I start my line of questioning, I would like to submit for the record a letter from the State of Minnesota, the governor, Mark Dayton, who was a member of the Senate, and he quotes, and I will put the rest in the record, Mnsure, which is—sure's focus on small business as a result of our State's decision to create a Minnesota-made exchange that best provides for the needs of Minnesotans. Virtually every health care organization, business organization or respected expert strongly supported our state exchange in designing something that would work for us.

And he could not be here. Minnesota could not testify, but they have some excellent information. I would like to submit that to the record with no objection.

Let me respond in my time first to my good friend and Ranking Member's reference to my not supporting Senator Enzi's amendment. Senator Enzi is here. He can most certainly explain his amendment.

But I want to say for the record the reason that I voted against it, and I remember the Democratic caucus, is because it would have eliminate the cap on lifetime limits.

So, people could basically exceed their limits and I thought that was wrong and it would also have knocked young adults off their parents plans which is one of the strongest features of the Affordable Care Act.

So, I would say Senator Enzi, of course, can defend himself in his rebuttal. His bill which I voted against and many Democrats did not keep the promise. It gutted in the bill.

Now, I have a bill that will actually keep the promise and happily last week in the House of Representatives both Republicans and Democrats overwhelmingly voted to support some version of the Keep Your Promise Bill that would extend that for a year. That would help you, Ms. Salter, because you could actually keep your plan.

So, I wanted to put that in the record.

My first question would be to you, Ms. Salter. When did you start your current business?

Ms. SALTER. I just started my business this past February.

Chair LANDRIEU. Okay. So, you have been in business about nine months.

Ms. SALTER. Uh-huh.

Chair LANDRIEU. And you are just starting.

Now, I want to put into the record that not only if my bill could pass, and I hope that you could support it or a version of it, you could keep the plan that you want. But if you chose to go to another plan, I want to put in the record, if you make $27,500 a year in your business, assuming you have no additional income, you will actually save $4,986 because of the premium that you and your business will receive.

If you make $32,000 a year, your annual cost of your premium, even in North Carolina where the State itself chose not to help you by setting up their own exchange—they let it be set up by the Federal Government—so, your State made that decision, not to us—you would save, you would pay every year $919 and you would save $4,257.

If your business makes $35,000 in your first year and it goes up to 40 or 45,000, your premium, you would still save $2,823. So, I am sorry that your exchange is not working as well. That is what we are here to do. But there are some benefits that hopefully you can come to appreciate as we move forward.

Ms. Kofman, let me ask you. The D.C. exchange has gotten some very good feedback, and as you said, both bipartisan, Republican and Democrat. It is understood.

What would you say are the two most important features that caused your exchange to be so beneficial to your small businesses? Was it the way it was designed, was it the cooperative nature, what was it and what would you recommend to others trying honestly to fix this and to make it work for their small businesses?

Ms. KOFMAN. Thank you, Madam Chair.

There were several elements that were critical to us. We wanted to build the exchange from the ground up, community-based effort, priorities, policies that we adopted were very much stakeholder driven. The decisions we made reflect the stakeholders who were involved in helping us build DC Health Link.

The other critical part to us is the huge choices that are available to small businesses, 267 different products, everything, HMOs, PPOs, no deductible, high deductible, everything from all of the major insurance companies.

And our value proposition is we want to make it as easy as possible to small businesses to be able to offer coverage and offer small businesses the kind of clout they never had in the past, the clout that large employers have enjoyed for many, many years.

That as well as the business community in the District stepping up to the plate, putting politics aside and helping us make hard decisions and helping us to build this DC Health Link to provide services that small businesses need and want and are desperate for in terms of affordability and predictability and an opportunity to offer great options to their workers.

So, it took a village and the small business community was definitely a strong part of it.

Chair LANDRIEU. Thank you so much.

Senator Risch.

Senator RISCH. Madam Chairman, back to the Enzi proposal again. I heard your explanation. You voted against it because it eliminated lifetime caps that were required under Obamacare and it eliminated the 26-year-old coverage which was required under Obamacare. But this is exactly the point.

You did not promise us that if we politicians like your policy, we are going to let you keep it. You said, if you like your policy, you can keep it. There were a lot of people that wanted to buy policies that cost less and that did not have lifetime caps lifted, and there were a lot who wanted to buy plans that did not cover their 26-year-old.

But you did not let us do that and that is the problem. The American people want to be free. We are smart people. We can make our own decisions. We do not need the Government telling us what we have to have. And that is the biggest complaint I get from Idahoans, from Americans, saying why are the politicians in

Washington, D.C., constantly telling us what we should do for ourselves.

And that is the basic problem with all of this. Whenever you try to socialize an industry or nationalize an industry like has been done here, it has never worked. It has been tried in every communist country in the world. It has been tried in all kinds of socialist countries, and it never works, and it is not going to work here.

Well, let me ask a couple of questions. First of all, Mr. Nold, I am told that there have been 150,000 small group plans that have been canceled in your state. Is that true?

Mr. NOLD. Sir, I am not familiar with the number there. At the Department of Insurance is the agency that handles the mechanisms for that. I will be glad to provide that information to you.

Senator RISCH. Well, I have got it. They said there are 150,000 small group plans that have been canceled. On the other side of the ledger through November 8th, 309 have signed up again. That is a big problem it seems to me. We have 150,000 canceled and 309 signed up.

Mr. NOLD. Certainly with the small group, it is to note that the open enrollment period that affects individuals is not the same with small groups. There is a continuous open enrollment period available to small groups. They can sign up anytime during the year.

Senator RISCH. Got it.

Ms. Kofman, first of all, let me say that it is really encouraging to hear that you were one of five, did you say, that made the rollout work October 1. Is that what you said?

Ms. KOFMAN. In the morning of October 1, Bloomberg news was reporting we were one of four jurisdictions——

Senator RISCH. Four.

Ms. KOFMAN [continuing]. That went live without a glitch that morning.

Senator RISCH. That is really good to hear that they were working. People were able to sign up. They were able to get on and do what they wanted to do. That is a really, really good thing.

What is the population of the District?

Ms. KOFMAN. We are a small population jurisdiction, about 640,000.

Senator RISCH. I am told that in the first month with you up and running, no glitches, everything is working well and with that kind of a population, that you had only five enrollees in the first month. Is that true?

Ms. KOFMAN. No, that is not true.

Senator RISCH. What is the number?

Ms. KOFMAN. I can provide your office with the exact numbers. We did issue the most recent numbers as of November 13. We had close to 700 employer accounts created. In terms of individuals who completed their applications both for premium reductions and full premiums, we were at about 1350 for full-price applications and close to 2000 for reduced price. Each application could be a family of 10. We only count applications.

In terms of account holders who selected a plan, over 1100 account holders selected a health plan and 565 account holders said they wanted to be invoiced to pay.

Now, they are not required to pay until December 15. So, I just want to make sure that people who are residents of the District are reminded of that. We are not asking for people to pay early. If they want coverage to be effective January 1, they do have to make their payment by December 15.

Senator RISCH. So, by my calculation then, a little under one percent of the population in the District signed up. Would that be fair?

Ms. KOFMAN. I can provide you better numbers. Right now folks who are shopping and making decisions, there is a lot of activity through DCHealthLink.com.

I am encouraging both small businesses and individual shoppers to take their time. Selecting health insurance is not an easy decision and if you are not working with a broker who can help you through it, you really do have to take your time.

I can tell you as a former insurance regulator myself, insurance is very complicated. Consumers who get a 150-page document which is their insurance contract which has the exclusions and what is included is very complicated. So, although we have made it much easier through our webpage to shop and compare apples to apples, we provide four-page coverage summaries that make it much easier than before to shop. It is still not a quick decision and we encourage everyone to take their time.

Chair LANDRIEU. Thank you, Ms. Kofman.

Senator Booker, and let me welcome you to this Committee and welcome you to the United States Senate. I look forward to your leadership. You have already been a champion of small business and you are just a perfect person to join us in our effort to help them.

Senator BOOKER. Thank you very much, Chairwoman. I want to thank you and I want to thank the Ranking Member.

These are the things you need to teach the new guy, how to turn on your microphone.

But I want to thank the Chair and I want to thank the Ranking Member both who took times out of your busy schedule to sit and meet with me and help me get along my way.

This is such an important issue for the State of New Jersey that I am very grateful to have the opportunity. I want to thank all the panelists. They have been informative. I wish we had more time and I look forward to reading more of your testimony that was submitted into the record.

Mr. Greenblatt, first of all, I appreciate your Jersey connection, a guy who vacations in Jersey, and you have some Jersey boy aura sp to you.

[Laughter.]

I want to say to you, first and foremost, as the geologists say, you rock. And you rock not because of your Jersey connection because I feel one of a kinship with you, both you and I in the last month have come down to Washington. You get to go home I think; I am going to stick it out here and battle it out.

But you deal with pragmatism and I have had to deal with it. I cut 25 percent of my employees as a mayor. One of the reasons I had to cut so much is because health costs were going up so much, my taxpayers could not afford it.

I had to balance the budget for every year. So do you. And the challenge that you have which I have seen working with local manufacturers in my city that I wanted to expand is that you said you export products to China. Right?

Mr. GREENBLATT. Yes.

Senator BOOKER. You are competing globally, right?

Mr. GREENBLATT. Absolutely.

Senator BOOKER. I would like you a lot and when you compete globally, you are competing against countries in Europe and Asia and across the globe, right?

Mr. GREENBLATT. Absolutely. Right.

Senator BOOKER. And many of those countries have different health care systems and most of those countries, most of our competitor Nation's have much lower health care costs, right?

Mr. GREENBLATT. Absolutely. This is a challenge for us. Take Canada, their health insurance is included, is part of the system but their taxes are 15 percent. Our taxes are 40 something percent.

Senator BOOKER. God bless you.

Mr. GREENBLATT. This makes it challenging to compete with Canada.

Senator BOOKER. I want to compete with Canada in every way except for Toronto, their Mayor, they have challenges there.

[Laughter.]

So, my point to you is that your pragmatism I love because this is not about politics, it is not about the pugilism that is profoundly prodigious sp in Washington. It is about solving problems, lowering costs, giving access; and small business people like you want to compete with the big boys. Right?

Mr. GREENBLATT. Absolutely.

Senator BOOKER. And what I see in my city is many folks have a hard time keeping employees who could easily go to other companies who have better health insurance plans.

In fact, you probably know people that will go to a company and get less salary for better health insurance. Is that not correct?

Mr. GREENBLATT. I think that is one of our positive attributes that we have such a good plan.

Senator BOOKER. Right. And so the key here, and the goal here, is to make sure that we take this variable which has made small businesses get so crushed in the past that it helps them be more competitive, not only in keeping employees locally but also competing against other countries that have lower health care costs, call it socialism or whatever you want, they have lower health care costs and you are competing against them because you internalize those costs and many of those companies do not. Right?

Mr. GREENBLATT. You are right.

Senator BOOKER. So, that is the pragmatism. We are not here to score political points. I do not care about in the next election. I care about solving the problems. And when you look at polls, they might not like politicians but most people are saying right now, fix the dagnab thing which you are saying. Right?

Mr. GREENBLATT. Absolutely.

Senator BOOKER. And so, Mr. Hickey, who has no New Jersey connection.

Dr. HICKEY. Actually I do.

[Laughter.]

Senator BOOKER. You do. In my last 90 seconds, sir, would you please, you are well down the field. You have a functioning exchange. You heard the good Jersey boy, Mr. Greenblatt, and Mr. Allen's problems.

Could you please tell us what the future could look like for them and how to solve the very real problems they brought up?

Dr. HICKEY. Number one, put together an exchange board that is from both sides of the aisle but, as you say, they care about the people of New Jersey. Our board has people——

Senator BOOKER. I am sorry to interrupt you, sir. I do not know if you know about my governor. He is a very quiet, soft-spoken not to many people know who he is.

[Laughter.]

But he did not participate in the exchanges. We have one of the best local insurance-based knowledge there is and we did not engage in that in New Jersey. We left it up to the Federal Government. So we are way behind you in Kentucky, not a place that we like to be in New Jersey. But continue. Or New Mexico.

Dr. HICKEY. Yes. And that board being made up of people even though they were vitriolic against the ACA. Once they got on that board, they said we have an obligation, a fiduciary duty to the people of New Mexico, and we are going to make this work.

Senator BOOKER. Right and left coming together.

Dr. HICKEY. Right. And we all came together. We have a great Chairman. He is also a doctor. We all came together and we met and we met and we met and resolved the issues. We hired an excellent CEO and we hired a company, a previous private exchange vendor, a SHOP in a box is what we call it, and it already worked and we knew it would work.

Senator BOOKER. My time has expired but we do not have time. People are hurting right now. We have got to fix this before the next election and I appreciate you showing us the way forward.

Chair LANDRIEU. Thank you very much, Dr. Hickey.

Senator Enzi.

Senator ENZI. Thank you, Madam Chairman.

I had not anticipated getting into my Congressional Review Act. But since it has been brought up several times, I will.

One of the reason that it included some things that you would prefer not to have in it is that when the Federal Register is published and says that there is going to be this huge cost of people losing their insurance even though the President has promised that if they like their insurance they can keep it, your choice is not to pick from the things that are in there.

You have to reverse the whole regulation. The whole regulation would have made it possible for people to keep their insurance if they liked it.

So, you also have a very limited time to be able to bring up a Congressional Review Act and have that kind of a forced eight-hour debate and then up or down vote on a regulation. And I took advantage of that window.

After that window closes, the only people that can make a difference would be through the majority leader which means that the majority side could have brought up things that would have left out

the one or two things that were in that regulation that they did not like and they could have made it so that people could keep their insurance if they liked it provided it did not have those two things.

That is not how it works and there has not been any effort in the meantime to do that. Now that it has been exposed, there is a tremendous effort and interest, and Senator Johnson has a bill that would comply with what I think the Chairman said would be acceptable to go ahead and fix it so that people who like their insurance can keep it, although it should have been done three years ago so that the insurance companies would have had the opportunity to adjust to the time, to have their actuarial stuff together for this particular time and I think it would have helped out businesses.

There are actually three changes that I would like to make in Obamacare; and if we made those three changes, it would make more of a difference in jobs and the economy than the stimulus package did.

One of those would be to change those hours for part-time from 30 to 40, and that is kind of the standard by the Small Business Administration, and this is the Small Business Committee. So, I would hope that we would do that.

I had a 10-step plan for fixing health insurance before the President ever became a Senator, and one of the things in that was small business health plans, and we had an opportunity to do that that would allow small businesses to group together through their association, any association, across state lines, nationwide, so they would have a big enough group that they could effectively negotiate with any insurance company.

There is another proposal that would have allowed them to self-insure on those big groups. Those would have provided a lot of advantages for small business. Those are not available.

Small business owners in Wyoming are asking me what can be done. Wyoming did not do an exchange. It is the least populated state in the Nation. It is less populated than the District of Columbia, and we have a lot of miles between places, and we have extremely small towns, and we only have two insurance companies that are interested in serving there.

Under prescription part D, we only had two companies providing prescriptions until we did prescription part D. And one of the things that surprised us, suddenly 48 companies wanted the business in Wyoming even though it was a small populated state.

What was the effect? Before the law even went into effect, it dropped prices by 25 percent and gave people choices. We could have had that same thing here but we do not.

So, I want to thank you all for the testimony that you had. I had some pretty specific questions that I would ask just quickly.

Mr. Allen, you mentioned that drugs cost 52 percent more because of the name brand requirement. Could you expand on that just a little more?

Mr. ALLEN. Yes. So, the plan that we have presently covers only generic drugs, and the difference in premiums to go to the new policy that includes the brand-name drugs, the difference in the premium is 52.3 percent.

Senator ENZI. I think you said that none of your employees were using brand-name drugs?

Mr. ALLEN. That is correct. In preparation for my testimony today, I did a poll among my employees and not one single person is presently taking or has any plans to take any pharmaceuticals that are only available as a brand-name product.

Senator ENZI. Thank you.

I think there are a number of great examples there, and I appreciated Mr. Greenblatt's comments about his sales to China and how he bids those three or five years in advance, and sometimes he could not use a little bit of stability in what his prices are going to be, and he is not getting that under the exchange.

I thank the Chair.

Chair LANDRIEU. And I thank the Senator from Wyoming.

Senator Shaheen, who also comes from a small State, just to put for the record as the Senator knows, there are 576,000 people in Wyoming less than in the District of Columbia. One chose the exchange, one chose not.

Senator.

Senator SHAHEEN. Thank you very much, Chair Landrieu and Ranking Member Risch for holding the hearing. Thank you all for being here. I am sorry I missed your spoken testimony this morning but I do think it is very important for all of us to hear from small businesses.

In New Hampshire, 96 percent of our employers are small businesses. It is a brilliant foundation of our economy, and the frustrations that you have shared are ones that I think everybody on this panel appreciates and shares in terms of how to make this law work and what we can do better.

You know, one of the biggest concerns that I have heard from New Hampshire small businesses is about the cost of health care, and Mr. Greenblatt, you and Senator Booker engaged in a back and forth on that this morning.

But small businesses currently in New Hampshire are paying 18 percent more than large businesses because of administrative costs. So, finding a way to address the challenges that you face is going to be critical.

And you know, looking at what we can do to fix this legislation I think is very important. In that vein, I have all offered a bill that would delay open enrollment in the individual market because that is the immediate problem that we are facing in New Hampshire, and I did that because we want to make sure that people have time to enroll.

Now, fortunately with the SHOP exchanges, that is an ongoing opportunity. But New Hampshire like Wyoming, like a number of other states, also has not chosen to do a state to exchange; and so we are very much struggling with what is happening at the federal level.

I wonder for Mr. Nold and Ms. Kofman as you have participated in state exchanges that are working, if you could talk about the reaction of those businesses that are enrolled in the SHOP exchanges in the District of Columbia and in Kentucky and how they are feeling at this point about the product that they are getting.

Mr. Nold, maybe you would go first.

Mr. NOLD. Sure. As you are aware, the enrollment process will in the small-group exchange, the SHOP exchange, is really a two-step process.

The first step is the employer themselves will come to the exchange and shop and try to determine which plans they want to offer to their employees. Once they go through that process and pick the plans that they want to offer, then the employees are given a 30-day open enrollment opportunity to go on line and pick the one they want.

So, it takes a little longer in the SHOP to really get to the point where you actually are enrolling. So, that process has to be completed. That is, the open enrollment period for the employees has to be completed.

We have a participation requirements in Kentucky that says that 75 percent of the employees have to participate. If they do not, then the employer, so that takes time.

We have gotten to the point where now employers have selected plans and the open enrollment period is ongoing where employees can come in and choose.

So, what I am trying to say is that it is difficult to say how that is all going to happen. It is again predicting the future. So, but we are very, very encouraged about the numbers. I mean, we have had over 93 employers that have gotten to the point where their employees are now picking plans.

Senator SHAHEEN. Great. Thank you. Ms. Kofman.

Ms. KOFMAN. Thank you. I will just share with you a theme small businesses have shared with me of their experience. So, one small business is growing and they never offered coverage in the past. So, this is the first time they can offer coverage to their workers and themselves because if the workers are not covered it is likely the owner is not covered either. So, one small business was very excited about that.

Another small business I spoke to on October 1 said, the owners said, based on his quick review of all the products he will save 12 percent, at least 12 percent. At that point in time he has not made a decision of the products he wanted to offer.

And another small business I spoke to said they were very happy not to be paternalistic any longer. They can just decide how much to contribute and let their employees decide which HMO or PPO or insurance company to select.

So, anecdotally, small businesses that I have talked to have been very, very pleased with the product offerings, the range of offerings, and the price is.

Senator SHAHEEN. Thank you.

Thank you, Madam Chair.

Chair LANDRIEU. Thank you very much.

Senator Johnson, thank you for joining us.

Senator JOHNSON. Thank you, Madam Chair.

In solving any problem, in negotiation, the first thing you want to do is figure out what you can agree on. There are a couple of things I can agree right off the bat with you, Madam Chair.

You know, we need to fix this bill, and there is a lot to fix. Secondly, it sounds certainly in your opening statement that you are

giving states a lot of credit and we are having real problems on the federal level.

I agree. The federal level I do not think has any capability of doing this. The states are far better, a far better place to start solving these problems.

So, I want to start my first question with Mr. Nold. Did Kentucky need a 1600-page bill with 20,000 plus pages of regulations to do this small business exchange?

Mr. NOLD. Uh——

Senator JOHNSON. Quickly.

[Laughter.]

You could have done it on your own. Could you not?

Mr. NOLD. We tried to do it back in 1990, the early 1990s and it——

Senator JOHNSON. You did not need a federal bill. Did you?

Doctor Hickey, did you really need a 1600-page bill and 30,000 pages, 20 or 30,000 pages of regulations, to do this in New Mexico?

Dr. HICKEY. That set up some of the rules and regulations, Senator, but we had a 60-page bill creating the exchange.

Senator JOHNSON. So, you could have done it far easier. We did not need a federal solution. We did not need to take over one sixth of our economy to start doing these things.

So, again I will stipulate. Another thing we agree on. I think a small business exchange is a good idea. It is a sharing of the risk pool.

Dr. HICKEY. Right.

Senator JOHNSON. It is a good idea.

Dr. HICKEY. Right, right. And we had a very supportive Republican governor doing it and a Democratic legislature and they compromised on this bill and we moved right out of the gate. I think states are a great place to start.

Senator JOHNSON. To paraphrase Senator Booker, this is not about politics. It should not be. It is really about solutions. I would say it is really about recognizing reality. It is about telling the truth.

In fact, the matter is the American people have not been told the truth. Let us talk about cost. You know, we were guaranteed that if you pass this law, the cost for an average family plan would be reduced by $2500 per year.

Ms. Salter, by the way, did a great job here. I want to ask you, because you have the exact experience, if you have a health care plan and that add, we will say, ambulatory patient services, is that going to increase the cost or decrease it?

Ms. SALTER. If I have one now?

Senator JOHNSON. Yeah.

Ms. SALTER. It will increase.

Senator JOHNSON. Doctor Hickey, if you add emergency hospital services to that, is that going to increase the cost or decrease it?

Dr. HICKEY. They are automatically covered.

Senator JOHNSON. But again, in other words, if you add coverages to a health insurance plan, is that going to increase the cost or decrease the cost?

Dr. HICKEY. That generally will increase the cost but the state, again coming back to the state, the state had the authority under

the federal bill to decide what essential benefits were going to be covered.

Senator JOHNSON. But again, I am just talking about the truth of what promises were made here and we were promised that the health care law would actually decrease costs but all of the added costs, all the added coverages, all the added mandates have increased costs. Correct?

Dr. HICKEY. Sir, if I could point out to you that 25 percent of the premiums that you pay today goes to cover the uninsured and the services they get from wherever they get them from.

So, in fact, I think, is where the opportunity, once those people get covered, the insurance companies will have a major opportunity——

Senator JOHNSON. Right, that is ——

Dr. HICKEY [continuing]. To lower the cost.

Chair LANDRIEU. Please let him answer.

Senator JOHNSON. But that is really not——

Chair LANDRIEU. Please let him answer.

Senator JOHNSON [continuing]. What the business people are experiencing.

Chair LANDRIEU. Senator Johnson, please let him answer.

Go ahead.

Senator JOHNSON. Well, I have such limited time here so I have got to move quickly.

I do want to talk about the other totally broken promise. Fraud, and it is massive fraud. It was a political deception that if you like your health care plan you could keep it. While I do appreciate that Senator Enzi pointed that out if you like your health plan you can keep it which again I appreciate Madam Chair's, her attempt, but her bill only covers those individuals who participate in the individual market where we are going to see, I believe, because of those increase in cost, 49 percent, 52 percent increase in insurance premiums, we are going to see a massive loss of employer-sponsored coverage coming next year.

So, I guess I would certainly encourage Madam Chair to take a look at my bill which actually is all inclusive, and it is not quite so onerous on forcing insurance companies to do what they may not be able to do because of state regulators.

So, I would really like you to take a look at your law versus my law and I would like to start working with you folks to actually start giving Americans in the freedom, allow them to keep their ability to choose the types of health care plans that they can afford, that they actually want.

So, thank you, Madam Chairman.

Chair LANDRIEU. Thank you. I will look forward to doing that. Your bill, of course, guts be Affordable Care Act. Mine fixes it. We will talk about that later.

Senator Vitter.

Senator VITTER. Thank you, Madam Chairman.

First of all, I wanted to give a quick update. At one of our last hearings about Obamacare and small business, we had a very compelling witness from Louisiana, Larry Katz, the owner of Dot's Diner. And unfortunately—I have followed up with him in response to his testimony, and unfortunately, it has gone from bad to worse

due to he was forced to cancel policies he provided before in particular so that many of his employees could still be eligible for a subsidy on the exchange.

Now, he followed the law by giving 90-day notice and he also asked and hired a consultant to come in to help his employees with the Obamacare exchange application.

However, all the website problems have pretty much shut down their ability to purchase insurance on the federal exchange for now. The consultant next coming in December 1st which gives them two weeks to enroll.

If his employees go to the individual market, they will see an average premium increase of 54 percent; and if they cannot get plans there on the exchange, there will be 30 individuals who were previously happy with their employer-based coverage who will not have any coverage. So, that is a very real-world but unfortunate update.

In terms of questions, Ms. Kofman, I wanted to ask you a few particularly based on Congress and congressional staff going to the D.C. SHOP exchange under the special carveout rule for Congress.

Are there more than 50 members of Congress or employees that will procure insurance on this D.C. SHOP exchange?

Ms. KOFMAN. I am sorry. All of the enrollment for employers is protected information, and I am not able to share with you any specific details about the Congressional enrollment.

Senator VITTER. Based on the size of Congress, 535 members and the size of their employee base, would you expect that number to be more than 50?

Ms. KOFMAN. More than 50 people enrolling?

Senator VITTER. Yes.

Ms. KOFMAN. Oh, yes, I am sorry. I did not understand your question. That is correct. The provision under the Affordable Care Act that speaks about Congressional enrollment essentially overrides the small business size and that is how you are able to avail yourself of the same choices that small businesses have in the District.

Senator VITTER. Correct. Is there any other large employer, meaning over 50, who gets the same treatment and gets to go to that exchange?

Ms. KOFMAN. So, At this time, the Congressional provision—the Congressional prevision only applies to Congress. In 2016——

Senator VITTER. Forget about the Congressional provision.

Right now, for 2013, 2014, going into 2014 is there any other large employer who has the opportunity to go to the D.C. SHOP exchange or whose employees can?

Ms. KOFMAN. In the city, we made a decision to limit the size of the small business market to up to 50 workers.

Senator VITTER. So, Congress is the only large employer who gets that special treatment?

Ms. KOFMAN. It is a function of one of the provisions in the Affordable Care Act.

Senator VITTER. Okay. And is there any large employer who gets this huge subsidy well above the normal income-based subsidies of Obamacare in that exchange?

Ms. KOFMAN. So, small businesses in the District, they also, many contribute 100 percent to the premium just as you have heard from other witnesses. Small businesses, especially nonprofits, in the District provide platinum plus level of coverage to their workers and contribute 100 percent. Many contribute 100 percent toward the premiums so they do better than Congress.

Senator VITTER. But again, Obamacare has a clear distinction between under 50 and over 50. So, my question was. Are there any other large employers, which means over 50, who go to an exchange, go to the D.C. SHOP exchange at all or go there and contribute this big subsidy?

Ms. KOFMAN. So, in the District, we do not allow larger employers to come in. In 2016, larger employers up to 100 can come in starting in 2016, and then it will be a policy decision for the District whether or not to expand the DC Health Link to larger-sized employers.

Senator VITTER. What, in your opinion, justifies this completely different and better treatment for Congress?

Ms. KOFMAN. Congress gets the same treatment as all small businesses in the District. You have the same——

Senator VITTER. Congress is not a small business. It is not under 50 employees.

Ms. KOFMAN. So, by going through DC Health Link, you get access to everything that small businesses in the District get. By choice——

Senator VITTER. I understand.

Chair LANDRIEU. Your time is up.

Senator VITTER. But my question is. What in your opinion justifies this completely different——

Chair LANDRIEU. Senator Vitter, I am very sorry. Your time is up so let me answer that question.

The Federal Government is not a small business. The Federal Government is a large business and the Federal Government, Congress, employees, postal workers as you know very well because you have studied this issue very well is under the same as large businesses in America; and that insurance premium is shared between the worker and the government, their employer.

Now, that is not the subject of this hearing. We can talk about it. We have debated it. You have had ample time to debate that on the floor. So, if you do not mind that, let us take that debate to the floor.

Senator VITTER. Madam Chair, can I briefly the respond?

Chair LANDRIEU. No, you may not and your time——

Senator VITTER. Can I briefly respond?

Chair LANDRIEU. I will give you 20 seconds to respond because you have a lot of time on the floor on this issue and Ms. Kofman does not.

Senator VITTER. Well, I certainly did not have a 25-minute opening statement here so I would just like to briefly respond.

Chair LANDRIEU. You have plenty time on the floor. You can respond. Ms. Kofman does not have the time.

Senator VITTER. You are right that Congress is not a small business. It is a large employer and it is treated completely differently than any other large employer and far better by being able to go

to this exchange, the only large employer that is allowed to do that. And by being able to get a huge subsidy, only large employer that is able to do that for this period or any time soon.

Chair LANDRIEU. And if your bill passes, the only large employer that will not be able to get insurance would be you and your staff.

Thank you all very, very much. I really appreciate it. It has been an excellent hearing. We are going to go to the second panel.

[Pause.]

Excuse me. Welcome back. Thank you all so much and let us begin with our second panel. If you will just briefly introduce yourself.

In light of the time, we would like to extend this for another 30 minutes. It is very, very important.

Most of the members have left accept Senator Vitter and myself. So, we will stay here and debate this or get testimony on the record.

If you would proceed please—I am sorry. Senator Booker is also here.

If you would introduce yourself briefly and begin. Ms. Borzi.

STATEMENT OF HON. PHYLLIS C. BORZI, ASSISTANT SECRETARY, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR, WASHINGTON, DC

Ms. BORZI. Thank you, Madam Chair. Good morning, or I guess it is afternoon by now, to you, Chair Landrieu.

Chair LANDRIEU. Can you speak into your mic please? You have got to lean and I am very sorry. It is uncomfortable but you have to lean forward.

Ms. BORZI. Thank you very much for inviting me here this morning. I am Phyllis Borzi. I am the Assistant Secretary of Labor for the Employee Benefits Security Administration and I am here today to discuss the Department of Labor's activities related to communicating with small business about the opportunities and requirements that exist under the Affordable Care Act.

The department's Employee Benefits Security Administration or EBSA is committed to helping small businesses and employees understand and benefit from the law.

The health insurance market place premium tax credits and notices to employees of coverage options available through the marketplace are all designed to expand access to affordable health coverage.

For small businesses, the small business health options program, the SHOP exchange, offers one-stop shopping to enable small businesses to find and compare private health insurance options. The SHOP is administered by HHS and the states.

The marketplaces will help individuals and small businesses evaluate their private health insurance options for coverage effective January 1, 2014. The new Fair Labor Standards Act Section 18B notice gives employees information about coverage options available through the marketplace and, if applicable, information about their employer-offered coverage.

Employers covered by the FLSA are required to provide this key notice of coverage options to each employee no later than October 1, 2013. For all new employees hired after that date, employers

have to provide the notice within 14 days of the employee's start date.

Now, although there is a statutory duty on employers to provide this notice, there is no fine or penalty under the statute for failing to do so.

On May 2, the department issued Technical Release 2013–2 providing guidance on the coverage options notice, as well as model notices. We are increasingly using model notices in an effort to be helpful to small businesses because a model notice makes the notice requirement far less burdensome.

Without a model notice, employers need to figure out for themselves how to comply with statutory requirements or hire somebody to help them.

EBSA worked with HHS and our other sister agencies to develop the model notices. We also received feedback from employers. The model notice serves as a compliance assistance tool for employers but employers are not compelled to use these notices.

There is one model notice for employers who offer health plans to their employees and a second one for employers who do not offer health plans. These notices are posted on our website in multiple formats for easier use by employers and are also available in Spanish.

The two model notices make the process for shopping for health care coverage easier for both employers and employees. For example, the model notice for employers who offer health care coverage deliberately contains more information than the minimum statutory requirements for this notice. Why? Because then employees will have more information about their coverage options inside and outside of the marketplace.

This also creates efficiencies for employers because the extra information in the model notices matches exactly the marketplace employer coverage tool designed by HHS which is part of the single streamlined application for the coverage in the marketplace.

This means that an employer who uses our model notice will not face additional requests for information from the marketplace about coverage with respect to the employee because the model notices satisfy both the FLSA and the HHS requirements.

Outreach and compliance assistance are very high priorities for EBSA. We partner with HHS, Treasury, IRS, and the Small Business Administration using a multifaceted approach that——

Chair LANDRIEU. Please try to wrap up.

Ms. BORZI. Certainly—coordinated online information linked to other agencies, webinar trainings and compliance and participant assistance.

In addition, we have benefit advisors that are available to assist small employers with compliance both through our website and through our toll-free hotline.

I think I will stop there and be happy to take any questions.

[The prepared statement of Ms. Borzi follows:]

TESTIMONY OF PHYLLIS C. BORZI
ASSISTANT SECRETARY OF LABOR
EMPLOYEE BENEFITS SECURITY ADMINISTRATION
BEFORE THE
SENATE COMMITTEE ON SMALL BUSINESS
AND ENTREPRENEURSHIP
UNITED STATES SENATE

November 20, 2013

Introductory Remarks

Good morning Chair Landrieu, Ranking Member Risch, and Members of the Committee. Thank you for inviting me to discuss the Department of Labor's (Department) activities related to communicating with small businesses about the opportunities and requirements that exist under the Affordable Care Act. The Department's Employee Benefits Security Administration (EBSA) is charged with the administration of the Employee Retirement Income Security Act of 1974 (ERISA), and is committed to protecting the security of health, retirement, and other employee benefits for America's workers, retirees and their families.

The Affordable Care Act will extend health care coverage to millions of Americans. Many provisions of the Affordable Care Act are designed to expand access to affordable healthcare coverage. These include provisions for coverage to be offered through the Health Insurance Marketplace (Marketplace), premium tax credits to assist individuals and small businesses in purchasing coverage, and employer notices to employees of coverage options available through the Marketplace. For small businesses, the Small Business Health Options Program (SHOP) offers "one-stop shopping" to enable small businesses to find and compare private health insurance options.

The Department, Treasury, and HHS work together to administer and provide compliance assistance with respect to many aspects of the Affordable Care Act, particularly the consumer protection provisions. The Departments share responsibility for issuing regulations and other guidance. Other provisions such as the Marketplace and SHOP rules are administered by HHS and the States, while the employer-shared responsibility and tax credit provisions are administered by IRS and Treasury. We also work closely on outreach with HHS, Treasury, the Small Business Administration (SBA), and others to ensure that small business owners know the facts about the Affordable Care Act.

EBSA works to provide understandable and easily accessible communications about the law's requirements. Our approach to date has been to work together with plans, issuers, consumers, providers, States, and other stakeholders to help members of the regulated community come into compliance with the law and to help individuals and small businesses understand and benefit from the law, as intended.

Expanding Access to Affordable and Comprehensive Health Care Coverage

New Notice Requirement

The new Marketplaces will help individuals and small businesses evaluate private health insurance options for coverage effective January 1, 2014. The Affordable Care Act creates a new Fair Labor Standards Act (FLSA) section 18B requiring employers to provide a notice to employees of coverage options available through the Marketplace and, if applicable, information about their employer-offered coverage. Employers covered by the FLSA[1] are required to provide this key notice of coverage options to each employee, regardless of plan enrollment status or part-time or full-time status.

To assist employers with their notice obligations, on May 8, 2013, the Department issued Technical Release 2013-02 providing temporary guidance on FLSA section 18B, as well as model notices. These model notices serve as a compliance assistance tool for employers, but they are not compelled to use these notices. One model notice is for employers who offer a health plan to some or all employees, and a second model notice is for employers who do not offer a health plan. The model notices are also available in Spanish. The Department developed the model notices after engaging in outreach and receiving feedback from employers. The Technical Release also outlines the statutory content requirements so that employers may tailor the models to their own situations. Many employers find this information through our website – the Technical Release was the second most visited page on our website last fiscal year. The model notices and related FAQs are popular as well.

The model notices respond to requests from employers to assist them as they communicate with their employees about coverage in the Marketplace and to help answer the many questions employees may have. In particular, the model notice for employers who offer a health plan contains more information than the minimum statutory content requirements and assists employees by providing them with information about their coverage options inside and outside the Marketplace. This model notice will create efficiencies for employers because it matches the Marketplace Employer Coverage Tool designed by HHS (which is part of the single-streamlined application for Marketplace coverage). Accordingly, employers who use the model notice will not face additional requests for information about coverage with respect to an employee. The model notice is posted on EBSA's website in multiple formats for easier use by employers.

Employers that prefer to organize their notices differently, or to provide more or less information are free to do so, as long as the notices still meet the minimum statutory content requirements. To comply with the statute, the notice must inform employees how to contact the Marketplace, and describe the services it provides. It must inform employees that, depending on their income and the coverage offered by their employer,

[1] The Department's Wage and Hour Division provides guidance relating to the applicability of the FLSA in general, including an Internet compliance assistance tool to determine applicability of the FLSA.

they may be eligible for a premium tax credit if they purchase coverage through the Marketplace. The notice must include a statement informing employees that, if an employee purchases a qualified health plan through the Marketplace, he or she may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

Covered employers were required to provide the notice to all current employees no later than October 1, 2013.[2] For all new employees hired on or after that date, employers must provide the notice within 14 days of the employee's start date. Employers have several options for delivering the notice, including hand delivery, first-class mail, or electronic delivery. As explained in guidance released September 11, 2013, there is no fine or penalty under the statute for failing to provide the notice.

Tax Credits and Market Reforms

Many small businesses that offer coverage to lower-wage workers may receive a tax credit. In addition, as explained in the FLSA notice requirements, individuals may qualify for a premium tax credit depending on household income if they purchase health insurance through the new Marketplace, but only if their employer does not offer coverage, or offers coverage that does not meet certain standards. Treasury administers these provisions.

The insurance market reforms under the Affordable Care Act improve health coverage for small businesses and individuals by providing important protections. These reforms include extending dependent coverage up to age 26; prohibiting preexisting condition exclusions for children under age 19 and for all individuals beginning in 2014; and prohibiting lifetime dollar limits on essential health benefits. Most individuals are now able to receive coverage without cost sharing for recommended preventive services, such as blood pressure, diabetes and cholesterol tests, regular well-baby and well-child visits, routine vaccinations and many cancer screenings. The Departments have worked together to release guidance and inform the public about these important reforms.

Outreach and Compliance Assistance

Outreach and compliance assistance are high priorities for the Departments and, as previously mentioned, our approach emphasizes helping employers, especially small employers, to understand and comply with requirements of the law. We partner with the Departments and SBA, using a multi-channel approach that includes coordinated online

[2] The statute provided that the FLSA notice requirements take effect on March 1, 2013, in accordance with Department of Labor guidance. The Department issued guidance on January 24, 2013, explaining that the notice requirement would not take effect March 1 so that the notice could be coordinated with HHS's educational efforts and Treasury guidance. Delaying the effective date to October 1, 2013, provided employers sufficient time to comply with the notice requirements while ensuring that employees received the information at a meaningful time coordinated with the open enrollment period for the Marketplace.

information linked to the other agencies, webinar trainings, and consumer and participant assistance.

We work with the SBA in a number of ways to reach small business owners. Our staff assisted in presentation materials for educational webinars last spring, which the SBA has subsequently promoted to their networks of small business owners. Additionally, we work to co-promote other Affordable Care Act educational opportunities through e-blasts, social media postings, and BusinessUSA, the Federal one-stop shop business information. These coordinated efforts are very effective in letting the small business community know about our outreach events and assistance available from EBSA.

Most recently, EBSA hosted a two-day compliance assistance webcast with representatives from Treasury and HHS on September 17 and 18 titled "The Affordable Care Act Compliance Assistance Webcast." This webcast, available online, provides employers with practical information, helpful tips, and clarification on the new law. Topics included information on the FLSA notice, implementation of key market reforms, and the new Marketplace and SHOP.

EBSA engages in extensive outreach and compliance assistance activities throughout the year to help with the implementation of the Affordable Care Act and the Marketplace. The following are examples of activities and materials:

- Health Benefits Education Campaign. Through this Campaign, EBSA develops and distributes educational materials and tools and conducts outreach on Federal health care benefits laws for employees, employers, plan administrators, issuers, third party administrators, and state insurance department staff. The Campaign sponsors compliance assistance seminars in coordination with the State Insurance Commissioners across the country to help increase awareness and understanding of the Federal health care benefits laws. The two-day seminars, focusing on small business owners, include presentations from Treasury and HHS (or the State) on the exchanges and the tax credits.

- Panel discussions and other speeches related to Affordable Care Act guidance. EBSA participates in panel discussions across the country providing technical assistance to employers, health plans, issuers, third party administrators, lawyers, and other stakeholders in the regulated community.

Information on EBSA's upcoming events is available on our website. We also have a dedicated Affordable Care Act web page[3] and a consumer page[4] that together provide a comprehensive compilation of the most up-to-date guidance, tools and resources on the market reforms and the Marketplace, including links to related resources from other agencies and organizations. The dedicated web page has had over 1.5 million visitors and last fiscal year was the most-visited page on EBSA's website.

[3] http://www.dol.gov/ebsa/healthreform/

[4] http://www.dol.gov/ebsa/healthreform/consumer.html

In addition to outreach activities, EBSA receives inquiries directly from employers, consumers, providers, insurers, and health benefits attorneys and consultants regarding employer group health plans. Many of the inquiries that EBSA receives are through its website and/or toll free hotline (1-866-444-EBSA) where EBSA's Benefits Advisors are the first point of contact. Other calls received by EBSA are handled directly by EBSA staff who develop the regulations.

EBSA's Benefits Advisors field inquiries related to individuals' health benefits and plan compliance with the requirements of the rules. When EBSA receives a health benefits or compliance inquiry, trained Benefits Advisors effectively use fact-finding techniques and their knowledge of the law to determine the nature of the inquiry and provide a response and/or informal dispute resolution if needed. The Departments have coordinated to assure that inquirers get the most complete response. With training between the Departments, the Benefits Advisors answer many questions and assess if it is necessary to refer inquirers to Treasury or HHS. EBSA's Benefits Advisors have responded to almost 47,000 inquiries related to the Affordable Care Act, including over 9,400 requests for compliance assistance.

Enforcement

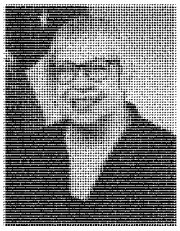
The Department and Treasury generally enforce the Affordable Care Act requirements for private, employment-based group health plans. HHS and the States generally have primary enforcement responsibility with respect to health insurance issuers. For consumers with questions or complaints, regardless of which Federal or State Agency they call, the Agencies work together, as appropriate, to ensure violations are addressed.

The Departments receive inquiries and complaints from participants, beneficiaries, providers, and other stakeholders and work with these individuals and the regulated community to correct any violations. Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits for consumers. The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the law.

Our approach is to emphasize assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and comply with the new law.

Conclusion

Thank you for the opportunity to testify at this important hearing. The Departments are implementing the Affordable Care Act to work toward better and more affordable health care coverage. We recognize the challenges facing small businesses and are available for outreach and to provide assistance to help them understand and benefit from the law.



Phyllis C. Borzi

Assistant Secretary, U.S. Department of Labor

Biography:

Phyllis C. Borzi was confirmed on July 10, 2009 as Assistant Secretary of Labor of the Employee Benefits Security Administration (EBSA). EBSA oversees approximately 707,000 private-sector retirement plans, approximately 2.3 million health plans, and a similar number of other welfare benefit plans that provide benefits to approximately 141 million Americans. As agency head, she oversees the administration, regulation and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA).

Previously, Ms. Borzi was a research professor in the Department of Health Policy at George Washington University Medical Center's School of Public Health and Health Services. In that position, she was involved in research and policy analysis involving employee benefit plans, the uninsured, managed care, and legal barriers to the development of health information technology. In addition, she was of counsel with the Washington, D.C. law firm of O'Donoghue & O'Donoghue LLP, specializing in ERISA and other legal issues affecting employee benefit plans, including pensions and retirement savings, health plans, and discrimination based on age or disability.

From 1979 to 1995, Borzi served as pension and employee benefit counsel for the U.S. House of Representatives, Subcommittee on Labor-Management Relations of the Committee on Education and Labor. In 1993, she served on working groups dealing with insurance reform, workers' compensation and employer coverage in connection with the Clinton Task Force on Health Care Reform.

Borzi is a charter member and former President of the American College of Employee Benefit Counsel and served on its Board of Governors from 2000-2008; former member and former co-chair of the Advisory Board of the BNA Pension & Benefits Reporter; former member of the Advisory Committee of the Pension Benefit Guaranty Corporation; and former member of the Advisory Board of the Pension Research Council, The Wharton School, The University of Pennsylvania; and former member of the Board of the Women's Institute for a Secure Retirement (WISER). In 2008, she was appointed by the U.S. District Court for the Northern District of Ohio and served as a public member of the Administrative Committee for the Goodyear retiree health trust.

Borzi has published numerous articles on ERISA, health care law and policy and retirement security issues and has been a frequent speaker to legal, professional, business, consumer and state and local governmental organizations. An active member of the American Bar Association, Borzi is the former chair of the ABA's Joint Committee on Employee Benefits. She holds a Master of Arts degree in English from Syracuse University and a J.D. from Catholic University Law School, where she was editor-in-chief of the law review. She is a member of the District of Columbia Bar and is admitted to practice before the U.S. Court of Appeals for the District of Columbia Circuit and the U.S. Supreme Court.

Chair LANDRIEU. Thank you very much.

Mr. Cohen, please introduce yourself briefly and get into your testimony. Thank you.

STATEMENT OF GARY COHEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, BALTIMORE, MD

Mr. COHEN. Thank you, Chair Landrieu and members of the Committee. I am Gary Cohen. I am privileged to serve as Director of the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services, and thank you for the opportunity to discuss the many benefits the Affordable Care Act provides for small businesses.

I was very pleased, as I know you were Madam Chair, to hear from our state partners from Kentucky and New Mexico and the District of Columbia about their successes in building small business marketplaces at the state level.

From the very beginning we encouraged every state to set up their own marketplaces because we believe that states were in the best position to create those marketplaces in hallway that would best serve the residents of their states.

We have worked very closely and, indeed, every day with our state partners to help them stand up those exchanges, and we take great pride in the success that they have had.

But I think it is also important to remember that the reforms of the Affordable Care Act are not just about the exchanges. They go beyond the exchanges to the entire small business market.

As you know did in your opening statement, Madam Chair, many small businesses that would like to offer health benefits to their employees have faced significant challenges in the market as it exists today.

Premiums have been going up, double digit, 20 plus percent every year. Small businesses have been charged 18 percent more for the same type of coverage that the larger employers pay; and most importantly, they were subject to wide variations and high volatility in premiums based on the type of work that the business did, based on the health status and demographic characteristics of their employees. So, a small construction company would pay more than an accounting firm of the same size for the same coverage.

Small employers often face significantly higher rates if they had older workers or more women in their workforce than others. Because of the small risk pool, if even one employee became sick, rates for the entire company would skyrocket.

The Affordable Care Act is changing all of that and transforming this market. Most importantly, we are expanding the risk pool to all of the small business enrollees in an entire state. We are spreading the risk among all of those employers.

We are saying that you cannot charge more just because some people get sick or are women, and there are limits to how much more you can charge people because of their age.

So, the whole point of this is for the small business market to function more like the large group market has functioned and, as

you noted, Madam Chair, where premiums have been significantly lower.

In addition, what we have said is that insurance should be real insurance. It should not run out just as soon as you have an illness that requires a hospital visit. It should provide the essential benefits that were determined by states and were pegged in most cases to what was prevalent in the small group market today.

So, these are not a bunch of new benefits that nobody ever thought about or wanted to have. This is what small businesses had today and what we said is that it is the type of coverage that is real coverage so that people do not find that if they become sick and they all of sudden have to go to the doctor or go to the hospital, oh, you do not have that coverage. You do not have hospital coverage. You do not have prescription drug coverage. It is real coverage.

Now in addition, the Affordable Care Act created the small business health care tax credit to help small employers of 25 or fewer employees who earn an average of less than $50,000 a year, and if the employer pays at least 50 percent of the premium cost of their employees, they qualify for a tax credit.

That tax credit has been in effect and hundreds of thousands of small businesses have already benefitted from it. Beginning in 2014, the tax credit increases to up to 50 percent of the employers contribution to their employees health care costs.

I just want to touch very briefly on some of the things that we have done to make sure that small businesses are aware of these benefits and options, and in particular I want to say that we have worked very closely with the agent-broker community.

We understand that most small businesses do obtain coverage from an agent, using an agent or a broker. We have done a series of many webinars and trainings for literally tens of thousands of agents and brokers who participated in those so they can understand how to participate in the SHOP exchange.

In addition, our regional offices have conducted many, many workshops and programs across the country to inform small business about the benefits of the Affordable Care Act.

Thank you very much.

[The prepared statement of Mr. Cohen follows:]

STATEMENT OF
GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

AFFORDABLE CARE ACT IMPLEMENTATION:
EXAMINING HOW TO ACHIEVE A SUCCESSFUL ROLLOUT OF THE SMALL BUSINESS EXCHANGES

BEFORE THE

U.S. SENATE COMMITTEE ON
SMALL BUSINESS & ENTREPRENEURSHIP

NOVEMBER 20, 2013

Statement of Gary Cohen on

"Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges"

U.S. Senate Committee on Small Business and Entrepreneurship

November 20, 2013

Chairman Landrieu, Ranking Member Risch, thank you for the opportunity to discuss the many benefits that the Affordable Care Act will provide for small businesses. Although many small employers would like to offer health benefits to their employees, they have faced many challenges. Historically, small businesses have been charged 10 to 18 percent more for the same benefits compared to large employers.[1] It has been difficult for employers to comparison shop among issuers. Small businesses employing women or workers with chronic or high-cost illnesses, or with pre-existing conditions, have faced higher insurance rates in most states. Because small firms have fewer employees to pool, premiums can vary dramatically from year to year due to changes in just one or two workers' health status or because of small changes in the ratio of male to female employees. The Affordable Care Act removes these obstacles for most plans and fosters more predictable rates while it helps small employers provide their employees with high-quality, affordable health care coverage that cannot be taken away or priced so high that it is out of reach for most businesses just because someone gets sick.

On October 1, 2013, the Health Insurance Marketplace opened, providing Americans, including small businesses, with a new way to shop for health insurance coverage. The Small Business Health Options Program (SHOP) will provide small businesses with a new, streamlined way to purchase the high quality health care coverage. There is no limited open enrollment period for the small group market, which means that small businesses can generally buy coverage for their employees on or off the Marketplace at any time during the year.

[1] http://www.commonwealthfund.org/~/media/Files/Publications/In%20the%20Literature/2006/May/Benefits%20and%20Premiums%20in%20Job%20Based%20Insurance/Gabel_benefitspremiumsjobbased_925_itl%20pdf.pdf

Reforms are Already Helping to Make Insurance More Affordable and Comprehensive

The Affordable Care Act is already ensuring that small employers get better value for their premium dollar. Before the Affordable Care Act, Americans watched insurers raise their premiums year after year, often without explanation or anyone reviewing the rates to ensure they are appropriate. As a result, premiums doubled over a decade, while benefits were often pared back. In an effort to slow health care spending growth and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more for most plans in the individual and small group markets, shedding light on arbitrary rates.

The average premium increase for small businesses in 2012 was 4.7 percent, which is 19 percent lower than the average requested premium increase.[2] Americans saved an estimated $866 million on their health insurance premiums in the small group market in 2012 after rate review. The Affordable Care Act's requirements for transparency and a justification of rate increases is working—more than a third of insurers' requests for rate increases of 10 percent or more ultimately resulted in issuers imposing a lower rate increase than requested or no rate increase at all.

The rate review program works in conjunction with the 80/20 rule (also called the Medical Loss Ratio rule),[3] which requires insurance companies to spend at least 80 percent of premiums on health care, and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits in the individual and small group markets. If insurance companies fail to do so, they must provide rebates to their customers. In 2012, the 18.2 million small business owners and their employees covered by this 80/20 rule saved an estimated $1.0 billion upfront on their premiums because of the rule and other Affordable Care Act programs.[4] Additionally,

[2] Rate Review Annual Report, September 2013.
http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm
[3] MLR Final Rule: https://www.Federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act
[4] Based on internal analysis of the MLR Public Use File for 2012. Public use file available at http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf

small group market consumers saved $207 million in rebates, with families accounting for 3.1 million enrollees receiving an average rebate of approximately $123 per family.[5]

Group health insurance plans have to comply with restrictions in the annual dollar limits they can place on essential health benefits. The lowest permissible annual limits has been increasing since September 23, 2010, and for plan or policy years beginning in 2014, group health plans will be prohibited from imposing annual dollar limits on essential health benefits. Because of this change, Americans will no longer worry about hitting an annual cap, which could have forced them to either pay out of pocket for health care costs above the dollar limit or forgo necessary care.

New Market Rules Make Coverage More Affordable

In the past, most small businesses were subjected to wide variations and high volatility in premiums based on the type of work they did or the health status of their workers. A small construction company often would pay more than an accounting firm of the same size for the same coverage. Small employers often faced significantly higher rates if they had older workers or more women on the payroll. And because of the small risk pool, if even one employee or dependent became ill, rates for the entire firm often would skyrocket. The market reforms in the Affordable Care Act have helped address these practices.

For plan years beginning in 2014, new market rules will ensure that premiums for most health insurance plans available to small employers will not vary based on what type of small business they cover or the health status of the firm's employees. Premiums can only vary by age, tobacco use, family size, and geography. Most small businesses can get coverage without being penalized due to the health status or gender of their employees or because an employee becomes ill, with limits on additional premiums for older employees. And because generally, risk pools in state small group markets will be merged beginning in 2014, small businesses will be shielded from the impact of one employee becoming ill.

[5] http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-08-01-2013.pdf

Small employers and their employees can also buy coverage with confidence that health insurance plans will cover the important health care services they need. Most small group insurance plans, including all plans in the SHOPs, must cover essential health benefits[6] that are based on what a typical small business offers in the market today. These benefits— which must be equal in scope to a typical employer health plan—include items and services such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These plans must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the average percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer could expect to be responsible paying out of pocket for approximately 30 percent of the cost of care for the essential health benefits the plan covers. These tiers will allow business owners to compare plans with similar levels of coverage, which, along with comparing premiums, provider participation, and other factors, will help them make more informed decisions.

Last week, the Administration announced that insurers can offer consumers and small businesses the option to renew their 2013 health plans in 2014, without change, allowing them to keep their plans. To access this option, insurers must notify enrollees that they can purchase coverage through the Health Insurance Marketplace where they can potentially qualify for premium tax credits. And they must tell consumers what protections they are giving up to keep the plan they have. Older plans cannot be sold to new customers in 2014, which would undermine the Marketplace and drive up premiums for millions of hard-working Americans.

The Affordable Care Act created the Small Business Health Care Tax Credit to help small employers of lower wage workers afford a significant contribution towards workers' premiums. An employer may qualify for a tax credit if it has fewer than 25 full-time equivalent employees making an average of less than $50,000 a year. To qualify for the Small Business Health Care Tax Credit, an employer must pay at least 50 percent of the premium cost of employee-only (not family) coverage for each of its employees. Starting in 2014, the tax credit is worth up to

[6] http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

50 percent of the employer's contribution towards employees' premium costs (up to 35 percent for tax-exempt employers) when coverage is made available through the SHOP. The tax credit will help lower the cost of offering health care coverage. Hundreds of thousands of small businesses have already benefited from the tax credit in 2011.[7]

Small Business Health Options Program (SHOP)

SHOPs in every state offer a single point of entry for small employers and their employees to apply for coverage, and if eligible, the employer may qualify for a tax credit worth up to 50 percent of the employer's premium contribution.

In 2014 and 2015, in most states, the SHOPs will be open to small employers with 50 or fewer full-time equivalent employees. In 2016, the program will be open to businesses with 100 or fewer full-time equivalent employees, and states could choose to expand eligibility to businesses of that size before 2016. In 2014, the Federally-facilitated SHOPs will allow employers to choose one qualified health plan from a range of plans to offer their employees. Many state-based SHOPs are giving employers the option to let their employees choose from a number of plans from multiple insurance companies and in 2015 Federally-facilitated SHOPs will provide that option as well.

Beginning in August, we launched a dedicated call center for employers to learn more about SHOP and to get answers to some of their basic questions on the Affordable Care Act. We continue to receive calls from all 50 states and DC, though we redirect callers from state-based SHOPs to the appropriate state call center.

Where permitted by the state, agents and brokers will play a vital role in the SHOPs, as they do in the small group market today. Agents and brokers act as trusted counselors, providing service at the time of plan selection and enrollment and customer service throughout the year. The SHOP call center is also available to assist agents, brokers, Navigators, and other Marketplace Assisters working on behalf of small employers.

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[7] http://www.whitehouse.gov/the-press-office/2012/02/16/fact-sheet-president-obama-s-budget-expands-simplifies-small-business-he

One of the most important tasks is ensuring that small businesses understand the new options available to them. CMS is working closely with the Small Business Administration (SBA), which is leading outreach to small businesses, and with the Departments of Labor and the Treasury. For example, CMS regularly presents during a weekly webinar series called "ACA 101" sponsored by the Small Business Majority and SBA – with dates for the webinar in place through the end of the year. CMS also has extensive information about the SHOP on HealthCare.gov, which is also available on the business aggregation site BusinessUSA.gov.

State-based SHOPs

We are already seeing success with state-based SHOPs. For example, the Kentucky SHOP – known as Kynect - has seen higher than expected enrollment in small group plans. Much of this success can be attributed to the Kynect staff's positive working relationship with the small business community in Kentucky, including the Chamber of Commerce. The Kynect team met regularly with small employers to answer questions and keep them informed of progress in establishing the Marketplace and how it would impact them and their employees. Kynect also made it a priority to develop a strong working relationship with the state's agent and broker community.

Several states have decided to operate their own SHOP Marketplaces while the Federal Government operates the Individual Marketplace for that state. We will explore this option with additional states in future years. In addition, nearly all state-based SHOPs have begun to implement employee choice, where employers can choose to select a level of coverage from which their employees select individual plans from a variety of insurance companies, and employers receive one bill and make one payment each month regardless of the number of plans chosen by employees. We have seen success with this model in New Mexico, where hundreds of small employers have already offered SHOP coverage to their employees to date.

Conclusion

For too long, small business owners have struggled to keep up with the ever-rising cost of health insurance for their employees. The Affordable Care Act makes it easier for businesses to find better coverage options and builds on the current employer-based insurance market The SHOP, combined with new insurance reforms and tax credits provided by the Affordable Care Act,

gives employers new options to provide their employees with high quality, affordable health care coverage. The SHOP allows employers to avoid the confusion that can currently come with looking for coverage, allowing them to make an apples-to-apples comparison between plans and apply using a streamlined application. I look forward to continuing to work with you to improve the health care options for America's small businesses.

Gary M. Cohen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

Cohen recently served as General Counsel for the California Health Benefit Exchange and served as the Director of the Division of Insurance Oversight in CCIIO for two years prior to becoming the Deputy Administrator and Director of CCIIO. Prior to joining CCIIO, Cohen served as Chief of Staff to Congressman John Garamendi, and was General Counsel of the California Department of Insurance under Commissioners Garamendi and Steve Poizner. He also served as General Counsel of the California Public Utilities Commission and was a partner at the law firm Keker & Van Nest, LLP.

Chair LANDRIEU. Thank you very much.
Ms. Markowitz.

STATEMENT OF MARIANNE O'BRIEN MARKOWITZ, REGIONAL ADMINISTRATOR, REGION V, U.S. SMALL BUSINESS ADMINISTRATION, CHICAGO, IL

Ms. MARKOWITZ. Chair Landrieu and members of the Committee, thank you for having me here today to discuss SBA's efforts to educate small businesses about the Affordable Care Act.

As SBA's Regional Administrator for Region V, I serve as the agency's principal representative for Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. In this role, I oversee SBA's Affordable Care Act outreach through our seven district offices in the Midwest.

America's 28 million small businesses are the backbone of our economy, creating two out of every three net new jobs and employing half of America's work force.

At SBA, we are committed to providing entrepreneurs with the tools and the resources they need to start and grow businesses. This includes an aggressive outreach effort around the Affordable Care Act to ensure that small business owners have the facts that they need to make sound business decisions for their businesses and their employees.

With a nationwide network of 68 district offices, SBA is uniquely positioned to provide outreach and education on the Affordable Care Act. Since February 2013, we have participated in more than 1200 Affordable Care Act outreach events reaching over 68,000 small business owners and stakeholders across the country.

I have personally presented at over 20 health care forums, and my team in Region V has participated in an additional 100 plus events throughout the Midwest.

These events are often hosted in partnership with local chambers and other community organizations and enable SBA to connect with a wide range of entrepreneurs.

In conjunction with our federal partners at the Department of Health and Human Services, the Department of Labor, and other agencies, SBA provides small business owners with the most updated information on the Affordable Care Act.

We continue to educate entrepreneurs on issues such as the impact of the law based on a businesses size, the tax credits available for small companies, and the eligibility and enrollment details relevant to the individual marketplace.

I cannot emphasize enough that there is a great deal of misinformation about the health care law and the small business community. In my travels, I frequently meet with small business owners who are anxious and apprehensive about how the Affordable Care Act may impact their business.

When I speak at outreach events, many entrepreneurs, regardless of the size of their business, often mistakenly believe that they will be affected by the employer shared responsibility rules. I am able to reassure them that this is not the case.

In fact, 96 percent of all businesses and most of the businesses that I encounter in these sessions are too small to be impacted. Of

the remaining four percent, the vast majority already provide health care that meets these standards required by the law.

When entrepreneurs have access to accurate information, they are able to have their questions answered. They can leave better equipped to make educated decisions about what is best for their unique business.

SBA also promotes the benefits available to small businesses through the SHOP marketplace. Whether it is a state-run exchange or a federal program, these new marketplaces are designed to give small businesses with generally up to 50 full-time employees the same purchasing power and options enjoyed by larger companies.

While there is no requirement for employers to participate, the marketplaces provide a tremendous opportunity for many small business owners who want to purchase quality, affordable health insurance for their employees.

In addition to these efforts, SBA has developed a robust online and digital toolkit that complements our in-person counseling activities and provides business owners with on-demand access to the latest information about the Affordable Care Act.

We have created extensive online content at both SBA.gov and businessUSA.gov. These sites together receive more than 2 million visitors per month. We also launched a direct enewsletter which reaches more than 1 million subscribers.

In participation with the Small Business Majority since July, we have held more than 35 Affordable Care Act one-on-one webinars for small businesses across the country. These popular online sessions which take place every Thursday have reached more than 16,000 entrepreneurs and have been very well received.

SBA leverages our extensive resource partner network to help educate small businesses on the Affordable Care Act. Earlier this year, we held a series of apprehensive webinar trainings for our Small Business Development Centers, our Women's Business Centers and our SCORE counselors.

Working with over 1 million entrepreneurs annually, these partners are able to expand our Affordable Care Act outreach efforts and serve as a resource on the law in their communities.

As the Affordable Care Act continues to be implemented, SBA is committed to collaborating with our federal partners in ensuring that small business owners have the facts and resources they need to understand and benefit from the law.

Thank you again for the opportunity to testify today. I look forward to your questions.

[The prepared statement of Ms. Markowitz follows:]

U.S SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

WRITTEN TESTIMONY OF

MARIANNE O'BRIEN MARKOWITZ
REGIONAL ADMINISTRATOR
REGION V
U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

U.S. SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

NOVEMBER 20, 2013

Chair Landrieu, Ranking Member Risch and members of the Committee – thank you for having me here today to discuss the U.S. Small Business Administration's (SBA) efforts to educate small businesses about the Affordable Care Act.

As SBA's Regional Administrator for Region V, I serve as the agency's principal representative in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. In this role, I oversee SBA's Affordable Care Act outreach through our seven district offices in the Midwest.

America's 28 million small businesses are the backbone of our economy, creating two out of every three net new jobs and employing half of America's workforce. At SBA, we are committed to providing entrepreneurs with the tools and resources they need to start and grow businesses. This includes an aggressive outreach effort around the Affordable Care Act to ensure that small business owners have the facts they need to make sound decisions for their businesses and employees.

SBA is uniquely situated to provide outreach and education around the Affordable Care Act, thanks in large part to our network of 68 district offices. Since February 2013, we have participated in more than 1,200 Affordable Care Act outreach events throughout the country, reaching over 68,000 small business owners and stakeholders. I have personally presented at more than 20 health care forums and my team in Region V has participated in an additional 100 plus events across the Midwest. Often hosted in partnership with local chambers and other community organizations, these town hall meetings and roundtable discussions enable SBA to connect with a wide range of entrepreneurs.

Moreover, in conjunction with our federal partners, SBA provides small business owners with the most updated information on the Affordable Care Act. We continue to educate entrepreneurs on issues such as the impact of the law based on size, tax credits available for small companies, and eligibility and enrollment details relevant to the Small Business Health Options Program (SHOP) Marketplace.

There is a great deal of misinformation about the health care law. In my travels, I frequently meet with small business owners who are anxious and apprehensive about how the Affordable Care Act may

impact their businesses. When I speak at outreach events, many entrepreneurs, regardless of their business's size, often mistakenly believe that they will be affected by the Employer Shared Responsibility rules. I am able to reassure them that this is not the case. In fact, 96 percent of all businesses, and most of the businesses I encounter in these sessions, are too small to be impacted. Of the remaining four percent, the vast majority already provide health care that meets the standards required by the law.

When entrepreneurs have access to accurate information and are able to have their questions answered, they leave better equipped to make educated decisions about what is best for their businesses.

SBA also educates small businesses about the benefits available to them through the SHOP Marketplace. Whether a state-run exchange or the federal program, these new marketplaces are designed to give small businesses with generally up to 50 full-time employees the same purchasing power and options enjoyed by larger companies. While there is no requirement for employers to participate, the marketplaces provide a tremendous opportunity for many small business owners who want to purchase quality, affordable health insurance for their employees.

SBA has developed a robust online and digital effort to provide additional information about the Affordable Care Act, including a direct e-newsletter that reaches more than one million subscribers. We've also created extensive online content at both SBA.gov and BusinessUSA.gov, which together receive more than 2 million visitors per month.

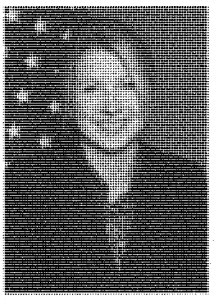
And since July, in partnership with Small Business Majority, SBA has held more than 35 Affordable Care Act 101 webinars for small businesses across the country. The webinars, which take place every Thursday, have had over 16,000 attendees and have received very positive feedback.

SBA also continues to leverage our resource partners to help educate small businesses about the Affordable Care Act. Earlier this year, we held a series of comprehensive webinar trainings for our staff, federal partners, and our extensive network of Small Business Development Centers, Women's Business Centers, and SCORE. These partners, working with over one million small businesses each year, are able to expand our outreach efforts and serve as resources on the Affordable Care Act for small businesses in their communities.

As the Affordable Care Act continues to be implemented, SBA is committed to leveraging our resources and federal partnerships with the Department of Health and Human Services, Department of Labor, and others to ensure that small business owners have the facts and resources they need to understand and benefit from the law.

Thank you for the opportunity and I look forward to your questions.

Marianne O'Brien Markowitz
Regional Administrator
Region V
U.S. Small Business Administration



In August 2009, Marianne O'Brien Markowitz was named Regional Administrator for SBA's Midwest Region. She has responsibility for the states of Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.

As Regional Administrator, Markowitz is the principal representative of SBA in the Midwest and provides interface with regional, state and local elected and appointed officials, trade organizations and small business communities across the region.

Markowitz recently served as the Chief Financial Officer for Obama for America and was previously a financial operations consultant for the launch of the Obama Exploratory Committee and resulting Campaign. For more than 17 years, Markowitz provided finance and risk management expertise to a host of leading global institutions including Switzerland-based corporation Syngenta, Inc.—the world's largest agrochemical company—where she served as a lead international treasury/financial operations consultant. While at Syngenta, Inc., she was tasked with designing and implementing a global treasury operation and financing post demerger. Prior to that, she served as a treasury and risk manager for one of the largest pharmaceutical benefit management companies Express Scripts, Inc.

Additionally, while at Mallinckrodt, Inc., a medical device firm, Markowitz worked to create the global treasury department after its divestiture from IMC Global.

In addition to designing and implementing financial operations departments, Markowitz has a deep background in running treasury and risk management departments, assessing insurable risks and evaluating insurance, treasury and financing alternatives.

In all her roles, Marianne Markowitz specialized in helping private sector companies successfully design and implement new systems or scale their existing processes, systems and staffing to meet the needs of a hyper-growth environment.

Markowitz received her B.S. in business administration from the University of Missouri and her MBA from DePaul University. She and her husband Jeffrey are the proud parents of Maura.

Chair LANDRIEU. Thank you. Our hearing has gone 15 minutes over time but this is so important I want to continue the questioning. I think we have gotten a lot of valuable testimony on the record as we continue to try to fix and improve the Affordable Care Act.

But let me ask all three of you briefly my first question. We have the Department of Labor represented here, Ms. Borzi. We had the Center for Medicaid and Medicare, CMMS. We have Small Business Administration.

The three of you all are primarily responsible to helping implement the Affordable Care Act at the federal level, and there has been undoubtedly justified criticism of what has happened so far at the federal level and in those states where governors, mostly Republican but some Democrats, have refused to set up their own exchange and ask you to come in and do it. There has been some difficulty.

So, my question is. What are you going to promise to do better, what are you working on specifically? And I want 30 seconds each of you starting with you, Ms. Markowitz. And what did you learn this morning that could help you do a better job? Starting with you.

Ms. MARKOWITZ. Sure. Thank you, Chairman Landrieu.

Chair LANDRIEU. Speak into the mic. You have to press your back button.

Ms. MARKOWITZ. Sorry. What the SBA is focused on is outreach and we continue more than ever to get the word out to small businesses. One of the biggest problems that we run into is the misinformation in the small business community.

Chair LANDRIEU. Which is purposefully I think in large measure but go ahead.

Ms. MARKOWITZ. It is very prevalent. Most of the rooms that I walk into are filled with small businesses. They are nowhere near the size that would be impacted by the employer shared responsibility provision and yet they are positive that they will be impacted by this. So, we cleared that up.

Chair LANDRIEU. Just for the record, could you clear that up now that when you walk into a room it is mostly filled with businesses that are of what size?

Ms. MARKOWITZ. Well under 50 employees.

Chair LANDRIEU. And are they affected by it at all?

Ms. MARKOWITZ. Not at all.

Chair LANDRIEU. So, no business in America that is under 50 employees are affected at all by the employer shared responsibility.

Ms. MARKOWITZ. No. In fact, that represents 96 percent of all overall businesses. In addition to not being impacted by the employer shared responsibility, those 96 percent of businesses have, you know, access to new benefits and protections that they never had before.

So, often I walk into a room and there can be a very negative perceptions of this Act and they have not begun to explore the benefits that are available to them because they are so confused by the misinformation.

Chair LANDRIEU. Okay. Mr. Cohen.

Mr. COHEN. Thank you. What we are doing and I will not surprise you, we are working very hard to improve the online experi-

ence. I am pleased to say that we actually have made significant improvements, and I keep hearing every day that more and more people are able to get through the application in a reasonable period of time and get enrolled in coverage.

There is actually a story on NBC news today is the story about the healthcare.gov roll out outdated, and I think it is. I think we have moved on significantly from where we were before.

In terms of what I learned today, I was really impressed by all the three states talking about the involvement of their stakeholder communities, and I think we have done that.

But it is different at the federal level frankly than it is at the state level but I think we need to work really hard to make sure that we are working with the agent-broker community, the issuer community, the consumer community, the small business community, and so forth to make sure that everybody gets to the benefits of this law.

Chair LANDRIEU. Ms. Borzi.

Ms. BORZI. I have had the same experience that my colleagues had. I do a lot of small business roundtables. There is a lot of misinformation. People, not only do they not understand that the employer responsibility penalty does not apply to them, what I found remarkable is that they do not understand that the small business tax credit is already available, has been available since the law was signed, and these are small businesses who are trying to do the right thing by their employees which is providing coverage.

I know, Madam Chair, that you are very interested in the notice requirement that we administer. We are trying very hard to make sure that people understand that this can be an opportunity for small businesses to understand a little bit better about their responsibilities and I certainly will promise you that we will work closely with your staff and the others, the staff of the other members of the Committee, to try to make the experience of having to fill out these forms clearer and easier.

Chair LANDRIEU. I appreciate that. In my last few minutes, I want to submit the forms that the Department of Labor put out that I found very, very confusing, new health care insurance marketplace coverage.

First of all, it should have said that if you receive this as an employer and you are under 50 people, disregard it. It is not appropriate for you. Over 50, this is what, and so I am going to submit something that we have come up with that might be a more clear form, and I hope that you all will work on that.

Once the website gets up, people can have a better walk-through experience because the consumer experience with this is extremely important.

So, thank you all very much and I will come back a few. I think it is Senator Johnson and then Senator Booker.

Senator JOHNSON. Thank you, Madam Chair.

Mr. Cohen, in general what is happening to the insurance premiums, the gross premiums now, not after taxpayer subsidy, what is happening to the insurance premiums of young, healthy individuals under the Affordable Care Act?

Mr. COHEN. I think they vary a lot from state to state and even within a state, region to region. I do not think it is possible to make a, you know, broad, general statement about that.

Senator JOHNSON. I would like to enter into the record, I guess it is the Republican staff Committee has put together a summary sheet of what is happening, and I can say, for example, in the State of Illinois somebody 27 years old, a male is going to an experienced a 104 percent increase, a female about a 42 percent——

Chair LANDRIEU. Could you clarify, though, is that with subsidies or without?

Senator JOHNSON. That would be the gross premium.

Chair LANDRIEU. That is without subsidy.

Senator JOHNSON. Yes.

Chair LANDRIEU. But the bill has subsidies in it so let the record——

Senator JOHNSON. I understand that.

Chair LANDRIEU [continuing]. Reflect that so we will not be confused.

Senator JOHNSON. The point being is the only way that anybody is going to, not the only way, but one of the prevalent ways that people actually see their share of health premiums reduced is because taxpayers are going to subsidize their care.

In Wisconsin—let me finish, Madam Chair—in Wisconsin, the cost of a male 27 years old will increase about 125 percent, a female about 77 percent.

While that has to do really with the fact that we are a community rating, we are limiting the insurance premium rate on older, sicker individuals and we are increasing the premiums, making the younger, healthier people pick up that burden, right? Is that not correct? Is that not redistribution?

Mr. COHEN. Well, what I think we are hoping to do is increase the number of younger people who are actually covered because the rate of coverage is——

Senator JOHNSON. Right. So, they can get in the pool and pay a lot more than they were currently paying in the individual marketplace. Correct?

Mr. COHEN. Well, what——

Senator JOHNSON. I mean——

Mr. COHEN. We are expanding the risk pool so we can spread the risk across the whole population. That is the idea behind the law.

Senator JOHNSON. Mr. Cohen, let me ask you as the expert in the CMMS. When did you realize that what the President was saying that if you like your health care plan you can keep your health care plan, if you like your doctor you can keep your doctor period, when did you—did you believe that ever?

Mr. COHEN. The law provides that issuers could continue plans as grandfathered plans as long as they wanted to into the future. So that the law——

Senator JOHNSON. Well——

Mr. COHEN [continuing]. The law was designed to enable that what the President said.

Senator JOHNSON. Yes, but my——

Mr. COHEN [continuing]. To be true and it was really up to the insurance industry to make decisions as they have in the past.

Senator JOHNSON. Let me explore that. My bill, If You Like Your Health Plan You Can Keep It Act uses the President's exact same language in the bill. The problem with the President's, the grandfather clause in the Affordable Care Act, yeah, you can keep your plan as long as you totally change it.

What we did is we took out these as long as you totally change it, we did not force some of those initial essential health benefits on to those plans.

So, the fact of the matter is you could not keep your plan unless you changed it.

Mr. COHEN. Grandfathered plans are not subject to the essential health benefit requirements.

Senator JOHNSON. But there are other things they are subject to, guaranteed issue, maximum, over the lifetime maximum.

Mr. COHEN. No. They are not subject to guaranteed issue. In fact, it is quite the opposite you cannot add more people onto a grandfathered plan under the law.

Senator JOHNSON. I am not asking to add more people.

Mr. COHEN. Well, guaranteed issue, that is what you are talking about.

Senator JOHNSON. Well, okay. Lifetime maximums. We will get you the list of the changes required in that grandfather clause because we extract that in my bill.

But anyway getting back to my question. Did you believe that if people like their health care plan they would be able to keep it, across-the-board that nobody would lose their health care plan if they wanted it?

Mr. COHEN. I believe that the law provided an opportunity for insurance companies to have grandfathered plans which would make President's——

Senator JOHNSON. What about——

Mr. COHEN [continuing]. Promise to be true and it was also true that the large majority of Americans who have employer-sponsored coverage through large employers were also able to keep their plans.

Senator JOHNSON. But every American? I mean, for example, did you realize that state high risk pools like in Wisconsin which covers 22,000 Wisconsinites, did you believe those things would still be available after implementation of Obamacare?

Mr. COHEN. Well, before the Affordable Care Act, every American was not able to keep his or her health plan. You could lose it——

Senator JOHNSON. That is not what we are talking about.

Mr. COHEN [continuing]. Because you could lose it if you got sick——

Senator JOHNSON. Listen. We are talking about the promise made that if you like your health care plan you can keep it. I have got a couple in Wisconsin, both cancer victims, that have been dropped, will be dropped from the high risk pool because it becomes obsolete January 1.

You knew that as a health care expert, correct?

Mr. COHEN. The law did not require states to drop their high risk pools. The law allows states to continue the high risk pools. So, I do not think that is a requirement of the law. That was a decision made by the State of Wisconsin.

Senator JOHNSON. But you knew those things would be gone?

Mr. COHEN. No.

Senator JOHNSON. You really believed, did you really believe that every American would be able to keep their health care plan and their doctor? You believe that to be a true statement?

Mr. COHEN. Well, there is nothing in the law that requires anybody to lose their doctor.

Senator JOHNSON. I am just asking you whether you believe that.

Mr. COHEN. I believe that the law contained provisions that would enable that to be true but it also is a private market solution. So, it is not government mandated health care. It is up to insurance companies what products they offer in the marketplace. Insurance companies were given the option, the ability to maintain the existing plans as grandfathered plans, and if they do that, people are able to keep those plans.

Senator JOHNSON. Are you surprised——

Mr. COHEN. That is the choice——

Chair LANDRIEU. I am sorry. Time.

Senator JOHNSON. Are you surprised millions of Americans are losing their health care plan? Are you surprised by that?

Mr. COHEN. Well——

Senator JOHNSON. Are you surprised? Just yes or no. Are you surprised that millions of Americans are losing health care plans?

Mr. COHEN. I am not surprised or unsurprised. I did not have an opinion as to what the market would do. I knew what the law provided.

Chair LANDRIEU. Senator Johnson, thank you for sharing such clarifying comments.

Senator Booker.

Senator BOOKER. First of all, I want to thank the Chair. You held this hearing at a difficult time with a lot of political noise and nonsense and rancor.

You know, it reminds me of a great President who once said, it is not the critic counts, it is not the man who points out that the strong man stumbles or the doer of deeds could have done better, it is the person actually in the arena whose face is marred with blood and sweat. It is not the man in the arena this time; it is the woman. Thank you for holding this hearing and bringing right and left together to discuss practically what is going to help Americans.

And so, I have a very simple question which is fueled by my frustration. I want to form a new caucus already and I have only been here 20 days, and it is the what is going to grow American businesses, what is going to help small businesses which, as you rightfully pointed out, are the job creators right now that are driving our economy right now.

And what was before, I do not want to go back. I am not putting this country in reverse to go back to a time where small businesses were getting crushed because they were losing good employees because they did not have health insurance.

Small businesses were getting crushed because those who tried to step up to the plate and provided insurance in a globally competitive market who were competing as countries who fixed this problem with lower health care costs, forcing small businesses to either internalized this or put their workers in the corner.

We have got to figure out a way to fix this in a way that is going to grow and strengthen small businesses. The idea in itself is very good, that we can find a way to create a competitive business environment for small businesses so they do not have to worry about this fear.

I agree with the Ranking Member. This is about freedom from fear. I know tons of businesses that lived in that fear. So, the one thing that has already been discussed that you forget rhetoric, practically you are seeing what I am seeing, is that when you go around the State of New Jersey there is so much confusion fueled by politicians and media of folks about the facts.

96 percent of businesses are not affected here, and yet I have small businesses in New Jersey who think somehow it is going to shake them and are not even aware that there are federal subsidies to help them.

And so, in this state of mass confusion, fueled by media and politicians, please tell me from your experience what is the best way to cut through all this mishegoss—that is a Jersey term—all this mishegoss and get to what the facts are?

How can we get the truth to small businesses who need to be freed, liberated from fear and know how this actually could help them? Anybody?

Ms. MARKOWITZ. Well, thank you, Senator.

Senator BOOKER. With a name like O'Brien Markowitz, you are about bringing things together, building bridges.

[Laughter.]

Ms. MARKOWITZ. This is true.

You know, it is really about outreach and education and bringing the focus onto the benefits that are available for the 96 percent of small businesses that are not only not affected by the employer shared responsibility provision but that have all of these benefits that they cannot focus on because of the misinformation, and that is what we as an agency are entirely focused on.

We work with our federal partners. HHS has been a great partner in this outreach as have some of our state partners.

Once a business gets rid of that fear that you allude to which is very real, they can focus on the fact that there are these tax credits, be very excited about focusing on and exploiting those for their business.

They understand more about the broader reform and that they cannot be discriminated for having a diverse workforce, for employing women, for employing sicker or older employees. I mean, these are things that once a business find out about the 80–20 rule and they understand that all of these benefits are available to them because of this important reform, they are very excited about it and that is what we are out there doing, creating more outreach and creating more educational opportunities.

Senator BOOKER. So if you witness the relief, even the excitement from real companies, who you do not ask them if they are Republican or Democrat, you just ask how can we help the company and you see it which I have seen with my eyes, the relief many businesses feel.

Can I ask you very pragmatically, when you are explaining things, is there anyone change or anything practically that we

could do here in Washington, besides listen to ourselves speak, to actually help this bill get a little better than it is now? Practically is there anything that you might want to suggest that could help this Committee?

Ms. MARKOWITZ. I mean, honestly, what you are doing today is very helpful, bringing the focus on to the truth, you know, and the benefits that are available for small businesses.

I think as the exchanges move forward and I know HHS is working around the clock. For instance, in my outreach before the launch, the focus on these businesses is really on the broader reform once they get through the misinformation.

After the launch, it really is surprisingly it remained on that. They were not so focused on the website issues. They are really focused on this broader reform and how it impacts their business.

The elephant in the room was the pricing, and now that the launch has happened for the SHOP exchanges, even though they may not be fully functional, and HHS is working on that, there is pricing information.

So, with this information, it is just more information. The businesses can go away, do the analysis and figure how SHOP can eventually be a resource for their business.

It is really all about information, education, outreach, and getting the truth out and cutting through all of the misinformation.

Mr. COHEN. Very quickly I would just add, you know, one of the reasons why the states' exchanges have been so successful is frankly they had had resources available to them to do a lot of this outreach because under 1311 we were able to give them grants and we have been limited in terms of what we were able to do.

Chair LANDRIEU. And why were you limited?

Mr. COHEN. Just because of the appropriation. We do not have funding under the appropriation process to do as much. We do outreach but to do as much as we would like to do so that is one area if we could work together in a bipartisan way just to get in the facts out, that would be wonderful.

Chair LANDRIEU. Ms. Borzi, your last word.

Ms. BORZI. Just one quick thing. The thing that troubles all businesses regardless of size, but it is particularly important for small businesses, is uncertainty.

So, there is lots of misinformation but there is also lots of uncertainty because they keep hearing that it is going to be repealed, it is going to be changed, this is going to happen, that is going to be happening.

It is very important as all of us go out to be able to say to small businesses, this is what is going to happen when, because it is not just 96 percent of them are not affected. It is that this Act can actually give you positive benefits like more choice, the ability to get coverage which you were not able to get for your employees before.

Chair LANDRIEU. Thank you very much. This has been an excellent hearing and let me particularly thank Senator Booker. This has been an extraordinary first full hearing for you attend.

Senator BOOKER. You always remember your first.

Chair LANDRIEU. Yes, and you will remember this one, and it has been an extraordinary privilege to be here with you. And Senator Johnson thank you for participating all the way to the end.

I started this morning by saying, and I knew this hearing would be full of a lot of strong opinions, but I started this morning by saying, as Mark Twain said, that a lie can go half way around the world before truth gets out of bed and puts its boots on in the morning.

This hearing was held to get the truth out about the benefits of the Affordable Care Act to small business and the challenges that are presented to us.

As Americans, I think if we work together, we could meet those challenges.

The meeting is adjourned.

[Whereupon, at 12:34 p.m., the Committee was adjourned.]

APPENDIX MATERIAL SUBMITTED

Opening Statement of Senator Michael B. Enzi
Small Business Committee Hearing
Affordable Care Act Implementation: Examining how to achieve a successful rollout of the Small Business Exchanges
10:00 am, Wednesday, November 20, 2013
428 Russell

Thank you, Madam Chairman and Ranking Member Risch, for holding this important hearing to discuss the issues surrounding the roll out of the SHOP exchanges and the consequences for small businesses in this country.

I think we can all agree that the goal of affordable health care coverage for employers and individuals in this country is a shared one. The disagreement arises in how we believe this goal is best accomplished. I've worked on health care issues for years as a member of the Health, Education, Labor and Pensions Committee and the Finance Committee. I've worked on my own 10 step plan for health care reform and with a number of members on some of their ideas. As a former small business owner, I have been especially cognizant of the needs of small

businesses and appreciate the opportunity to take a more targeted look at how the roll out of the SHOP exchanges and surrounding activities are affecting our small businesses.

What I've heard from small businesses in Wyoming as recently as last Thursday is in line with the information we are starting to receive nationally – small businesses are seeing increases in premiums, fewer insurance options available for their employees, and several businesses are losing health care coverage they like and were told they could keep.

This issue of keeping what you like is one I spoke about extensively back in September 2010. I talked about this particular promise and how it was impossible to keep. I'm sorry to say that what I thought would happen is what we're seeing now – millions of Americans, including small businesses, are receiving cancellation notices because their plans don't meet the requirements of the health care law.

I tried to correct this problem back in September 2010. I filed, and the Senate voted on, a resolution of disapproval, S.J.

Res. 39, that would have overturned the so-called grandfather rule in the health care law and allowed small businesses to truly keep the plan they had if they liked it. My resolution dealt only with this rule and didn't touch or repeal other areas where folks might have issues, like lifetime limits. Unfortunately, the resolution failed on a party-line vote on an issue that should be bipartisan.

To add to the injustice of cancelled plans and a breach of the "if you like it, you can keep it" promise, the SHOP exchange roll out has been delayed to the point that small businesses will be left with woefully little time to review plans and make decisions about what insurance option they will carry, if any, before losing coverage in January 2014. If the federal SHOP exchange issues are fixed by the November 30 deadline the Administration has set, businesses will only have until December 15 to shop for and choose a new health care plan for their employees and likely themselves for 2014. At the same time, however, employers will also have to continue running their businesses.

We often hear folks on both sides make remarks about small businesses being the backbone of the U.S. economy and the driver of our economic growth. How are we helping our small businesses expand their businesses, hire more employees and continue to grow our economy when we burden them with regulations and break promises made that affect their ability to provide health care coverage for their employees and themselves – effectively undermining their bottom line? The short answer is, we're not. We need to address these issues and I'm pleased we have a forum today to discuss the issues more extensively and hopefully also discuss ways to address them. Thank you, Madam Chairman.

United States Senator Marco Rubio, Statement for the Record to Committee on Small Business and Entrepreneurship

November 20, 2013

"Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges."

There are lots of reasons to be nervous about Obamacare, especially if you're a small business owner or worker. Think of working class Americans who right now are working 40 hours a week, but because of ObamaCare, employers are going to be cut back workers' hours to 29 hours a week. Think about the small businesses that want to invest, expand, and grow our stagnant economy, but are afraid to do so because it would trigger the ObamaCare mandate. I've met these people and talked to these people. These are not billionaires, these are not millionaires, these are hard working class Americans who are on the verge of being punished because this law was built on broken promises.

As I traveled through Florida this summer, I repeatedly heard these Obamacare concerns from my constituents. In Gainesville and Jacksonville, entrepreneurs wanted to expand and hire more workers but were in a holding pattern because Obamacare is full of unknowns. Businesses couldn't plan for the future or commit to hire new employees as long as Obamacare's mandates, taxes, and regulations remain unclear or too burdensome.

This is devastating to people trying to provide for their families. Thousands of Florida families will be taking home less income due to their hours being capped at 29 per-week rather than the 32 hours-per-week allowed before ObamaCare. Especially for families living paycheck-to-paycheck, cutting their hours and income is exactly how ObamaCare devastates middle class Americans and the economic opportunity America used to provide her people.

In Pensacola, a grocery store owner told me he might stop offering insurance to his employees because he had some seniors working for him and it was going to be too expensive to keep doing so. Obamacare's onerous regulations now make it easier for this employer to drop coverage, pay the Obamacare tax, and have these workers buy their own insurance on the newly created exchange.

These are the stories I heard from Floridians this summer, and they are the ones I continue to hear from people now – in calls, letters, emails, meetings here in DC and visits throughout Florida. And they are the fears and worries that have only gotten worse as this ObamaCare rollout has turned out even worse than imagined.

The reason why I'm so passionate about ObamaCare is because it is undermining, for millions of people, the ability to achieve the American Dream. We cannot stand by and allow America - where talent and hard work has always meant that the sky is the limit - to be destroyed by an

ObamaCare law that puts a ceiling on people's dreams and a cap on the aspirations of job creators. We can't allow this to be a place, just like so many other places in the world, where our message to job creators is: 'Don't grow too big, or government will come after you.'

Regardless of if you are a Republican, a Democrat, or an Independent- this issue is bigger than that, it's bigger than politics. This is really about people. And this morning I highlighted the plight that small businesses in Florida are facing, but hundreds of thousands if not millions of others will soon face. This law is going to hurt millions of middle-class Americans in the ways that I've just described. I hope that this hearing will result in some productive discussion and debate on ways that we can provide some relief to Americans who may soon lose their jobs, businesses, or healthcare insurance as we continue to find out exactly what is in this devastating, job-killing law.

Post-Hearing Questions for the Record
"Affordable Care Act Implementation:
Examining How to Achieve a Successful Rollout of the Small Business Exchanges"
November 20, 2013

Submitted to Ms. Kofman, District of Columbia
From Ranking Member Risch

On November 14, 2013, the President publicly recognized the failure of the exchange rollout and announced his proposal to grandfather individual plans, and despite being fired after his statement, DC Exchange Commissioner, William White, said the proposal undercuts the exchanges, including the District's DC Health Link, by making it more difficult for them to operate. According to data reported by insurers participating in the exchange, DC HealthLink had only FIVE enrollees in the first month (for reference, see http://www.politico.com/story/2013/11/obamacare-enrollments-washington-dc-99589.html, included in the record).

How do you consider five enrollees in an entire month a success?

Since DC Health Link opened for business on October 1, 2013, there has been a strong response from residents and small business owners in the District. For example, as of November 13, 2013, there were 19,706 household accounts created and 696 small business accounts created on DCHealthLink.com. Of those, 3,303 households had completed an application for coverage and 1,115 households had chosen a health plan for 2014. As of December 10, the number of accounts created increased to 33,019. Employer accounts increased to 982. The number of completed applications for coverage totaled 5,603, a significant increase of 2,300 in one month. These numbers have continued to rise, reflecting the pent up demand for affordable, quality health insurance in our community.

Four national insurance companies are participating in DC Health Link – Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente, and UnitedHealthcare. Small businesses have 267 different plan options from all four major carriers. District residents have 34 different health insurance options to choose from including HMOs, PPOs, point of service plans, and health savings account-compatible high-deductible plans from three major carriers.

How do you respond to Commissioner White's concerns about the President's proposal?

Please see below statement from the Department of Insurance, Securities and Banking.

http://disb.dc.gov/release/department-statement-regarding-non-affordable-care-act-compliant-health-plans

Wednesday, November 27, 2013

Department Statement Regarding Non-Affordable Care Act-Compliant Health Plans

Today, the District of Columbia's Department of Insurance, Securities and Banking announced that it will not exercise the discretion delegated to state insurance commissioners in the U.S. Department of Health and Human Services' transitional policy from Nov. 14 that would permit carriers to continue renewing non-Affordable Care Act-compliant health plans for policy years starting between Jan. 1 and Oct. 1, 2014.

"The department carefully considered all factors involved in this decision – District residents, the industry and the unique characteristics of our market – and concluded that there are greater benefits to continuing the District's Affordable Care Act implementation efforts as planned," said Chester A. McPherson, interim commissioner for the department. "The department believes this approach provides more certainty for residents and carriers by subjecting all health plans to the same standard as outlined in the law."

Specifically, the additional elements of the Affordable Care Act's essential health benefit requirement ensure that District residents have comprehensive coverage to meet their health care needs. Also, our review concluded that the future rate impact of the transitional policy would be more significant to District residents than continuing implementation as intended.

In making its decision, the department received input from the District's Health Benefit Exchange Authority, carriers operating in our market, public interest organizations and District residents. Residents or issuers with questions regarding the department's implementation of the Affordable Care Act should contact Philip Barlow, associate commissioner for insurance, at philip.barlow@dc.gov.

Post-Hearing Questions for the Record
"Affordable Care Act Implementation:
Examining How to Achieve a Successful Rollout of the Small Business Exchanges"
November 20, 2013

The Honorable Phyllis C. Borzi
From Ranking Member Risch

1. The week before the October 1 requirement that nearly all businesses provide a "Notice of Coverage Options" document to full-time and part-time employees, the Administration announced there would not be any fines or penalties for failure to distribute the document at that time.
    a. **Can you say with certainty that small businesses will never face fines, penalties, or litigation for failure to distributing the document to new employees within 14 days of their start date?**

    Employers covered by the Fair Labor Standards Act[1] are required to provide a notice of coverage options available through the Marketplace to all current employees no later than October 1, 2013. For all new employees hired on or after October 1, 2013, employers must provide the notice within 14 days of the employee's start date. Employers have several options for delivery of the notice, including hand delivery, first-class mail, or electronic delivery.

    As explained in guidance released September 11, 2013, there is no fine or penalty under the statute for failing to provide the notice.[2] To assist employers with their notice obligations the Department of Labor issued model notices based on feedback from employers. One model notice is for employers who offer a health plan to some or all employees, and a second model notice is for employers who do not offer a health plan. Employers that prefer to organize their notices differently, or to provide more or less information (as long as it still meets the minimum statutory content requirements), are free to do so.

From Senator Michael B. Enzi

1. The Administration continually emphasizes "choice" for small employers and individuals under the health care law. Recent press reports about the Administration's Request for Information on Stop Loss Insurance suggest that the Administration is contemplating steps to limit self-insured and stop loss options for smaller and medium-size plans.

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[1] The Department's Wage and Hour Division provides guidance relating to the applicability of the FLSA in general, including an Internet compliance assistance tool to determine applicability of the FLSA. The FLSA Coverage and Employment Status Advisor can be found at http://www.dol.gov/elaws/esa/flsa/scope/screen9.asp.
[2] *See* Affordable Care Act Regulations and Guidance, Notice to Employees of Coverage Options, FAQ on Notice of Coverage Options, available at www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html.

a. Can you confirm that the Administration is not drafting regulations or planning any executive actions along those lines?

The Departments of Labor, Health and Human Services (HHS), and the Treasury (Treasury) issued a Request for Information Regarding Stop Loss Insurance (77 FR 25788, May 1, 2012) to gain better information regarding how this product is being used. In particular the Department is interested in how it impacts small employers (who may not be as well positioned to absorb the financial risks). The Departments have not taken any additional steps to address the use of stop-loss insurance through rulemaking since the publication of the joint Request for Information in May 2012.

2. Stop-loss insurance coverage is offered by various entities to cover aggregate group and individual losses that exceed certain agreed upon thresholds. Such coverage is provided to an employer maintaining a self-funded group health plan, and in such cases, the self-funded group health plan is providing health coverage to individual participants, not the stop-loss insurer. Stop loss coverage is appropriately considered as liability insurance in Code section 9832(c)(1)(C). Treasury also recognized that stop-loss should not be considered a "specified health insurance policy" in the final regulations implementing Code sections 4375 and 4376. Further, HHS exempted stop-loss policies from the reinsurance contribution requirements.

a. Consistent with the treatment of stop loss insurance coverage under these areas of the law, will the Administration continue to recognize stop loss coverage as liability insurance when implementing other provisions enacted under the Patient Protection and Affordable Care Act?

Stop-loss insurance generally is not subject to Federal consumer protections applicable to health insurance, including certain patient protections under the Affordable Care Act. It is similarly not subject to State health insurance laws including coverage laws, rating policies, and other State consumer protections applicable to health insurance.

Written Questions for the Record
Gary Cohen's Hearing
"Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges"
Before
Senate Small Business Committee

November 20, 2013

Senator Risch

1. **U.S. Department of Health and Human Services Secretary Sebelius has testified before Congress that the federal SHOP exchange will be operational by the end of November. She has also testified that in order to have plans active by the law's deadline of January 1, 2014, small businesses must enroll on the federal exchange by December 15, 2013. Even if the Administration meets its projection of November 30, 2013, that leaves small businesses with *only16 calendar days* to enroll on the federal SHOP exchange. The entire small business community of at least 29 states- those choosing to take advantage of the federal exchange, as well as those states that were unable to successfully implement their own SHOP exchange- is relying on this exchange to provide health coverage for their employees.**
   - **Will the federal SHOP exchange be operational (operational meaning the ability for a small business to successfully enroll online at healthcare.gov and hold an active health care policy for its employees by January 1, 2014) by November 30, 2013?**

     Answer: We are exploring options to ensure that small businesses have access to coverage in the SHOP market. We are currently doing our assessment and we will have a process for enrollment in place by the end of November.

   - **What specific tasks remain to be completed in order to achieve operability of the federal SHOP exchange website?**

     Answer: In advance of the October 1 opening of the SHOP, CMS worked to prioritize essential website functionality to ensure that consumers would be able to apply for eligibility and select a plan on the October 1st launch date. We continue to work through our punch list of software and hardware fixes to enhance the user experience for consumers and to bring online delayed features.

   - **If the federal SHOP exchange website is *not* operational by November 30, 2013, how will the Administration address the additional delay? Will the Administration provide any relief to small businesses wishing to purchase insurance for their employees on Healthcare.gov?**

Answer: We are exploring options to ensure that small businesses have access to coverage through the SHOP Marketplace. We are currently doing our assessment and we will have a process for enrollment in place by the end of November. Small businesses can enroll at any point in time during the year, and are not limited to the same open enrollment period that exists for the individual market, giving business the opportunity to provide coverage at any time.

- **Can you confirm that small businesses will be able to purchase health insurance for their employees by November 30, 2013?**

  Answer: Small businesses will be able to purchase health insurance for their employees both in the existing small group market – as they do today – and through the SHOP Marketplace. Small employers are already able to complete a paper application for the SHOP and to go online and view basic plan and pricing information. Employers can also call the dedicated SHOP call center to learn more about SHOP and to get answers to some of their basic questions on the Affordable Care Act. We will have a process in place by the end of November to ensure that small businesses have access to coverage through the SHOP Marketplace.

2. **The Administration keeps referring plans under the health care law as "better," but has yet to define the term. After our July ACA hearing, your office provided in a statement to this Committee that "[f]or small employers that choose to offer coverage, the reforms in the law will help employers and their employees have access to better coverage at a *lower cost* in 2014." Three small businesses testified on November 20, 2013 before your testimony, that the law, in fact, has had the polar opposite effect for their small businesses.**
   - **Can you explain how these plans are "better" when they 1) require consumers to pay for coverage they do not need, 2) significantly increase costs to small businesses, and 2) restrict small businesses, including the small business witnesses who testified on November 20, 2013 in front of this Committee, from expanding and providing health insurance for their employees?**

     Answer: Historically, small businesses have been charged 10 to 18 percent more for the same benefits compared to large employers.[1] Before the Affordable Care Act was enacted, nearly all small group plans covered many, if not all, essential health benefit categories outlined in the Affordable Care Act. However, in the past, most small businesses were subjected to wide variations and high volatility in premiums based on the type of work they did or the health status of their workers. A small construction company often would pay more than an accounting firm of the same size for the same coverage due to use of industry rating factors. Small employers often faced significantly higher rates if they had sicker workers or more women on the payroll. Because premiums could vary

[1] http://www.commonwealthfund.org/~/media/Files/Publications/In%20the%20Literature/2006/May/Benefits%20and%20Premiums%20in%20Job%20Based%20Insurance/Gabel_benefitspremiumsjobbased_925_itl%20pdf.pdf

based on a group's actual or projected health care costs, and because each small business formed its own, isolated risk pool, if even one employee or dependent became ill, rates for the entire firm often would skyrocket. The market reforms in the Affordable Care Act have helped address these practices.

For plan years beginning in 2014, new market rules will ensure that premiums for most health insurance plans available to small employers will not vary based on industry or the health status of the firm's employees. Premiums generally can vary only by age, tobacco use, family size, and geography. Most small businesses can offer employees coverage without having to pay higher premiums due to the health status or gender of their employees with limits on how much higher premiums can be for older employees than for younger employees. And, due to these reforms, and because issuers will generally have to treat all of their non-grandfathered plans in a state's small group market as a single risk pool beginning in 2014, small businesses will be shielded from the impact of one employee becoming ill.

Small employers and their employees can also obtain coverage with confidence that health insurance plans will cover the important health care services they need. Most small group insurance plans, including all plans in the SHOPs, must cover essential health benefits that are based on what a typical employer plan offers in the market today. These benefits include items and services such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care.

In addition the Affordable Care Act provides new protections for consumers to limit their deductibles and other out-of-pocket costs. Beginning in 2014, the maximum deductible allowed in a small group health plan is $2,000 for a single individual and $4,000 for a plan covering more than one individual. Consumers will no longer need to worry that their health insurance coverage will leave them with medical bills they cannot afford.

- **How do you justify the CMS statement that employers will see lower costs in 2014 when that statement directly contradicts the astronomical increases that small businesses, including these three witnesses, are seeing in their plan costs for 2014 on the SHOP exchanges?**

Answer: In an effort to slow health care spending growth and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more for most plans in the individual and small group markets, shedding light on arbitrary rates.

The average premium increase for small businesses in 2012 was 4.7 percent, which is 19 percent lower than the average requested premium increase.

Americans saved an estimated $866 million on their health insurance premiums in the small group market in 2012 after rate review.

The Affordable Care Act's requirements for transparency and a justification of rate increases are working—nearly one-third (28 percent) of small group insurers' requests for 2012 rate increases of 10 percent or more were modified by the issuer or rejected by the state -- ultimately resulting in issuers charging a lower rate increase than requested or no rate increase at all.

This trend continued in 2013: according to the National Survey of Employer-Sponsored Health Plans, conducted annually by Mercer,[2] growth in the average total health benefit cost per employee slowed to just 2.1 percent in 2013. While cost growth has slowed among employers of all sizes, it was lowest for small employers in 2013. Among those with 10 to 499 employees, average cost rose by only about 1 percent.

- **If the SHOP options available were so great, how do you explain the thousands of small businesses that have rushed to renew their policies early outside of the exchanges to avoid these large premium increases on January 1, 2014?**

Answer: It's up to private insurance companies to decide what products they offer in the market and it then is up to each small business to choose whether or not to renew such a plan or look for a new plan for its employees.

- **Immediately after these small business witnesses testified that the ACA has directly increased costs and restricted the competitiveness and growth of their businesses, you testified that the law has "no impact" on small businesses of 50 or fewer employees. Could you explain your statement, which is obviously false in light that all three of these witnesses fall into this category?**

Answer: The Affordable Care Act specifically exempts employers with fewer than 50 employees from the employer responsibility requirement. It also created the Small Business Health Care Tax Credit to help small employers of lower wage workers afford a significant contribution towards workers' premiums. An employer may qualify for a tax credit if it has fewer than 25 full-time equivalent employees making an average of less than $50,000 a year. To qualify for the Small Business Health Care Tax Credit, an employer must pay at least 50 percent of the premium cost of employee-only (not family) coverage for each of its employees. Starting in 2014, the tax credit is worth up to 50 percent of the employer's contribution towards employees' premium costs (up to 35 percent for tax-exempt employers) when coverage is made available through the SHOP. The tax credit will help lower the cost of offering health care coverage. In 2012, the

[2] http://www.mercer.com/press-releases/1565095

most recent year for which complete data are available, over 185,000 employers received more than $535 million in tax credits.

3. **In its response to concerns raised by this Committee of the critical tasks that have delayed establishment of the federal exchanges (as reported by GAO), and the situation where no insurers signed up to offer coverage on the Mississippi exchange, your office provided that "CMS has been pleased with the response from insurers to participate in the Marketplaces."**
   - **How do you respond to states like Washington, which has successfully secured only one carrier on its SHOP exchange, which will offer SHOP plans in only two counties in the State?**

     Answer: There has been great interest by issuers in offering coverage on the Marketplaces. Nationwide, there are already 185 issuers offering 3,257 plans on the SHOP Marketplaces. A major problem in the existing insurance market has been a lack of competition in some areas, especially rural ones. In many states, we have seen new issuers offering plans on the Marketplace that were not offering plans before, and we hope that in future years, the number of issuers will continue to increase.

UNITED STATES SENATE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED TO WILLIAM NOLD, DEPUTY EXECUTIVE DIRECTOR FROM RANKING MEMBER RISCH

OFFICE OF THE KENTUCKY HEALTH BENEFIT EXCHANGE

February 4, 2014

William Nold submits the following in response to post-hearing questions from Ranking Member Risch:

1. Kentucky is reporting that 48,507 individuals have signed up for Medicaid through Kentucky's health exchange, kynect. This represents more than 80% of all those enrolling through the exchange.

    a. **How many of these Medicaid enrollees are newly eligible due to the expansion of Medicaid versus those who are considered "woodworkers" and would have qualified under eligibility requirements prior to expansion?**

    b. **What percentage of the State budget will Medicaid enrollees represent to each of the proceeding five years?**

Response:

Sufficient data is not yet available to make this calculation. An estimate of those who will be considered woodworkers for SFY 2014 is 17,059.

Following is a breakdown of Medicaid as a percentage of the State budget for the proceeding five years. Please note the Medicaid and Commonwealth figures represent all fund; General, Federal and Agency Restricted funds:

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Medicaid Benefits Actual Payments	5,236,550,418	5,845,670,323	5,971,857,771	5,957,911,371	5,796,606,989
Commonwealth of KY Actual Expenditures (rounded to nearest $100)	23,013,240,000	24,688,933,000	24,434,732,000	23,217,632,000	23,268,007,000
DMS Benefits % of State Expenditures	22.75%	23.68%	24.44%	25.66%	24.91%

2. The State received $253 million from taxpayers to start its exchange to enroll—to date—about 11,500 people in private health insurance. That is $22,000 per enrollee in private health insurance.

   a. How can you justify this expense to the taxpayer?

   b. Once the federal grant money to establish kynect is exceeded, how will Kentucky continue to fund the exchange?

   c. What percentage of the total State budget will this represent?

Response:

The federal grants awarded to the Commonwealth were fully justified in the grant applications submitted to HHS. I would reference these grant applications and the various reports relating to them for a more complete answer to this question. However, for the record, it should be noted that any cost-benefit analysis based solely on the grant amounts and the number of individuals enrolled in private health insurance is misplaced. The grants awarded have afforded Kentucky with an opportunity to develop a new eligibility and enrollment system for Medicaid (the previous system was nearly 20 years old) and Qualified Health Plans offered through the exchange. This system will serve millions of Kentuckians for many years. Beyond enrollment, the grants have supported many of the technical requirements of a state-based exchange mandated by the ACA, including the "no wrong door" obligation and the ability for persons enrolling in Medicaid in Kentucky to have the opportunity to enroll on-line to a number of human service programs, an option not previously available to them. Lastly, it should be noted that as of January 31, 2014, the number of individuals enrolled in qualified health plans in Kentucky has quadrupled from the number at the time of the previous testimony.

In the future, the Commonwealth plans to fund the exchange with a premium assessment on plans offered on and off the exchange, not unlike the assessment that was previously used to support the state's high risk pool. The Office of the Kentucky Health Benefit Exchange (OKHBE) will not be receiving any general fund dollars from the State. By SFY 16, the estimated annual operating budget need to fund the Exchange on an annual basis upon full implementation and roll out is estimated at less

than $27 million annually. As a ~~Therefore the~~ percentage of the total State budget, the amount that will be allocated to the OKHBE is approximately one-tenth of one percent.

3. A November report from Deutsche Bank states that the "metrics continue to suggest high risks of adverse selection in the population that is enrolling into the Kentucky exchange. Specifically, the data shows no improvement in the age mix of the population enrolling into the exchange, while a much higher percentage of applicants continue to choose more benefits-rich platinum and gold plans relative to the lower cost bronze options"

   a. **What percentage of those between 18 to 34 years of age are enrolling in private bronze or silver plans through kynect?**

   b. **What percentage of those between 35 to 64 years of age are enrolling in private bronze or silver plans through kynect?**

Response:

Based on 44,001 enrollments in private health insurance as of January 31, 2014, note the following:

Age	18 - 34	%	Age	35 - 64	%
Bronze	1,229	2.8%	Bronze	3,209	7.3%
Silver	3,929	8.9%	Silver	12,435	28.3%
Total	5,158	11.7%	Total	15,644	35.6%

4. According to the office of Governor Beshear, as of November 22, 1,063 small businesses had started an application, but only 407 completed the process, to be eligible to offer coverage to employees. This is in comparison to 150,000 small group plans being cancelled.

   a. **How can you characterize 407 completed enrollments versus 150,000 cancellations of small business health plans a "success?"**

Response:

The characterization that 150,000 small group plans in Kentucky had been cancelled is erroneous. Except for "grandfathered" plans, the ACA requires plans in the individual and small group markets that are issued or renewed on or after January 1, 2014 include

specific benefits and follow specific rating requirements in order to be compliant. As part of a transition to ACA compliant plans and, as required by long-standing Kentucky law, insurers sent notices to all policyholders in the individual and small group markets advising them of these requirements. The characterization of these notices as "cancellations" is inaccurate.

Furthermore, all policyholders in the individual and small group markets were offered the opportunity to early renew their coverage in order to delay the time when these policies must be ACA compliant. Also, in accordance with the transitional relief provided by President Obama, many policyholders were able to delay ACA compliance until late 2014.

5. Many small businesses in Louisville hire individuals from bordering states, such as Indiana. As these small businesses consider options on the State SHOP exchange, they are discovering that the providers in Kentucky are considered in-network. Therefore, for an individual who lives out of state, there will be no hospitals, facilities or doctors nearby for that person or their family to visit.

   a. **What kind of choice is this providing small businesses that want to offer coverage to their employees? More importantly, what good would this health coverage be to their employees?**

   b. **Do you intend on addressing this problem for small businesses, and if so, how?**

Response:

Qualified health plans offered on the exchange must meet the minimal network adequacy requirements established under Kentucky law and the ACA. This is not a new phenomenon. While some issuers may include out-of-state providers in their approved networks, and many do, others may not. Except for "emergencies" there is no legal requirement that issuers provide coverage for out-of-state providers.

Post-Hearing Questions for the Record
"Affordable Care Act Implementation:
Examining How to Achieve a Successful Rollout of the Small Business Exchanges"
November 20, 2013

Submitted to Ms. Markowitz, SBA
From Ranking Member Risch

1. After this Committee's July hearing on the ACA, I asked the SBA to provide figures of the funds used to support its outreach efforts, and SBA could not provide an answer. Since July, the SBA has held numerous ACA webinars and educational sessions across the country. I have been informed that SBA has also instructed each of its District Offices to hold a certain amount of outreach activities per month. SBA has also informed this Committee that it pays a Senior Policy Advisor, whose duties are *primarily* devoted to ACA "educational efforts."

- **Although SBA "does not track employee time expended on ACA educational efforts," please provide 1) the average amount of time these educational sessions and webinars last, 2) the exact number of trainings and webinars conducted as December 11, 2013, and 3) the salary level of, or compensation provided to, the staffer(s) who runs them?**

    1. *Each ACA webinar is approximately one hour. In-person events can range from one-hour to full-day events.*

    2. *From February through December 11, 2013, SBA held 37 ACA webinars, and participated in nearly 1,500 local events, which, together, have educated over 75,000 small business owners, entrepreneurs, and other individuals.*

    3. *Each of our 68 district offices participate in ACA outreach events. These trainings are typically facilitated by a Regional Administrator, District Director or Deputy District Director, whose pay grades range from GS 14 – SES.*

- **What is the salary level of the "Senior Policy Advisor" whose primary duties are devoted to the ACA?**

    - *The Senior Policy Advisor is a GS-15.*

- **What are the names and salary levels of each individual that has contributed to SBA's health care blog, "Health Care Business Pulse?"**

    - *The individuals who contribute (by drafting the blog posts, etc.) to SBA's health care blog have the following titles and pay grades:*
        - *Senior Policy Advisor – GS-15*
        - *Policy Advisor – GS-14*
        - *Deputy Assistant Administrator, Office of Communications & Public Liaison – GS-14*

- *Deputy Press Secretary – GS-12, currently open*
- *Online Media Coordinator – GS-13*
- *Special Assistant for Public Engagement – GS-9*

UNITED STATES SENATE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

TESTIMONY OF WILLIAM NOLD, DEPUTY EXECUTIVE DIRECTOR

OFFICE OF THE KENTUCKY HEALTH BENEFIT EXCHANGE

November 20, 2013

Documents for the Record

900 KAR 10:020. Kentucky Health Benefit Exchange Small Business Health Options Program.

Small Business Health Options Program (SHOP) Paper Application for Employers.

Small Business Health Options Program (SHOP) Paper Application for Employees.

On-line application for Employer

Fact Sheets used in education and outreach Program

Cabinet for Health and Family Services

Office of the Kentucky Health Benefit Exchange

(New Administrative Regulation)

900 KAR 10:020. Kentucky Health Benefit Exchange Small Business Health Options Program.

RELATES TO: KRS 194A.050(1), 42 U.S.C. 18031, 45 C.F.R. Parts 155, 156

STATUTORY AUTHORITY: KRS 194A.050(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Office of the Kentucky Health Benefit Exchange, has responsibility to administer the state-based American Health Benefit Exchange. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the operation of a Small Business Health Options Program in accordance with 42 U.S.C. 18031 and 45 C.F.R. parts 155 and 156.

Section 1. Definitions.

(1) "Agent" is defined by KRS 304.9-020(1).

(2) "Annual open enrollment period" means the period each year during which a

qualified employee may enroll or change coverage in a qualified health plan through an exchange.

(3) "Annual renewal date" means the date following twelve (12) months from the first day of the first coverage month and every twelve (12) months thereafter.

(4) "Children's Health Insurance Program" or "CHIP" is defined by 42 C.F.R. 457.10.

(5) "COBRA" means continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

(6) "Department of Health and Human Services" or "HHS" means the U.S. Department of Health and Human Services.

(7) "Employer identification number" means a unique numerical identifier which is used to identify a business, partnership, or other entity.

(8) "Full-time employee" is defined by 45 C.F.R. 155.20.

(9) "Full-time equivalent employee" shall be the number of employees determined by using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

(10) "Group participation rate" means the number of eligible employees enrolled in a group health plan in relation to the number of employees eligible to enroll in the group health plan.

(11) "Health plan" is defined by 42 U.S.C. 18021(b)(1).

(12) "Indian" means any individual as defined by 25 U.S.C. 450b(d).

(13) "Initial open enrollment period" means the period during which a qualified employee may enroll in health coverage through an exchange for the 2014 benefit year which shall:

(a) Begin October 1, 2013; and

(b) Extend through March 31, 2014.

(14) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based exchange conditionally approved by HHS under standards set forth in 45 C.F.R. §155.105 to offer qualified health plans on January 1, 2014.

(15) "Kentucky Health Insurance Premium Payment Program" or "KHIPP" means a Kentucky Medicaid program that pays the costs of some or the entire employee portion of employer-sponsored health insurance premiums.

(16) "Medicaid" means coverage in accordance with Title XIX of the Social Security Act, 42 U.S.C. sections 1396 et seq. as amended.

(17) "Medicare advantage plan" means a Medicare program under Part C of title XVIII of the Social Security Act, which provides Medicare Part A and B benefits through a private insurer.

(18) "Metal level of coverage" means health care coverage provided within plus or minus two (2) percentage points of the full actuarial value as follows:

(a) Bronze level with an actuarial value of 60 percent;

(b) Silver level with an actuarial value of 70 percent;

(c) Gold level with an actuarial value of 80 percent; and

(d) Platinum level with an actuarial value of 90 percent.

(19) "Minimum essential coverage" is defined by 26 C.F.R. 1.5000A-2.

(20) "Participation agreement" means an agreement between the Office and a small employer participating in the KHBE Small Business Health Options Program.

(21) "Plan year" means a consecutive twelve (12) month period during which a health plan provides coverage for health benefits.

(22) "Premium" is defined by KRS 304.14-030.

(23) "Qualified employee" means an individual employed full-time by a qualified employer who has been offered health insurance coverage by the qualified employer through the SHOP.

(24) "Qualified employer" means a small employer that elects to offer, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP.

(25) "Qualified Health Plan" or "QHP" means a health plan that has in effect a certification issued by the KHBE that it meets the standards described in 45 CFR 156 subpart C.

(26) "Qualifying event" means an event described in Section 9 (1) of this administrative regulation.

(27) "Reference plan" means the selection of a single plan on which an employer will base their contribution and employees are then able to elect other plans and pay the premium differential.

(28) "Service area" means a geographical area in which an individual shall reside or be employed in order to enroll in a QHP.

(29) "Shared responsibility payment" means a penalty imposed for failing to meet the requirement to maintain minimum essential coverage in accordance with 26 U.S.C. Section 5000A.

(30) "SHOP" means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide employees, spouses and their dependents with access to one or more QHPs.

(31) "Small employer" of "small group" means for a plan year beginning:

(a) Before January 1, 2016, an employer who employed an average of at least two (2) but no more than fifty (50) full-time employees on business days during the preceding calendar year; or

(b) On or after January 1, 2016, an employer who employed an average of at least one (1) but no more than one hundred (100) full-time equivalent employees on business days during the preceding calendar year and who employs at least one (1) employee on the first day of the plan year.

(32) "Special enrollment period" means a period during which a qualified employee who experiences certain qualifying events may enroll in, or change enrollment, in a QHP through the KHBE outside the initial and annual open enrollment periods.

(33) "TRICARE" means the Department of Defense health care program administered serving active uniformed service members, retirees and their families.

Section 2. Employer Eligibility and Participation Requirements.

(1) Beginning October 1, 2013, a small employer shall be eligible to purchase health insurance coverage for its small group through the KHBE SHOP if the employer is a small employer that:

(a) Elects to offer, at a minimum, a full-time employee coverage in a QHP through the KHBE SHOP; and

(b) 1. Has its principal business address in the service area and offers coverage to its full-time employees through the KHBE SHOP; or

2. Offers coverage to each eligible employee through the KHBE SHOP serving that employee's primary work site;

(c) Has a valid federal employer identification number; and

(d) Has a group participation rate of at least seventy five (75) percent in accordance with subsection (6) of this section.

(2) A small employer participating in more than one SHOP and meeting the criteria in subsection (1) of this section, shall offer coverage to its employees whose primary work site is in the service area of the KHBE SHOP.

(3) A small employer may submit an application to participate in KHBE SHOP:

(a) Via the KHBE website at www.kynect.ky.gov;

(b) By telephone by contacting the KHBE customer service center;

(c) By mail; or

(d) In person.

(4) A qualified employer who ceases to be a small employer solely by reason of an increase in the number of employees shall be eligible to participate in the KHBE SHOP until the employer:

(a) Fails to otherwise meet the eligibility criteria of this section; or

(b) Chooses to no longer purchase health insurance coverage for qualified employees through the KHBE SHOP.

(5) As part of the verification of an application of the employer application, a small employer shall submit:

(a) An employee census that includes the name, address, and social security number of all eligible employees;

(b) Proof of a federal employer identification number; and

(c) Copy of most recent Employer's Quarterly Unemployment Wage and Tax

Report, if applicable.

(6) A calculation of a group participation rate shall not include in the count of eligible employees an employee:

(a) Enrolled in:

1. A group health plan offered by a second employer;

2. A group health plan offer through the spouse of the employee;

3. An individual health plan;

4. Medicare, including a Medicare advantage plan;

5. Medicaid or CHIP;

6. TRICARE or other veteran's health coverage;

7. A parent's health plan;

8. Coverage identified in 45 C.F.R. 156.602; or

9. Coverage recognized by HHS as meeting the requirement for minimum essential coverage under 45 C.F.R. 156.604.

(b) Issued a certificate of exemption from the shared responsibility payment by KHBE or HHS; or

(c) Not residing in the service area of at least one QHP offered by the employer.

(7) If a small employer's group participation rate falls below the requirement in subsection (1)(d) of this section during a plan year, the qualified small employer shall be eligible to participate in the KHBE SHOP through the remainder of the plan year.

(8) If the information submitted by a small employer is inconsistent with the eligibility standards in this section, the employer shall have thirty (30) days after a notification of the inconsistency to present documentation to support the employer's application or

resolve the inconsistency.

(9) A qualified small employer participating in the KHBE SHOP shall:

(a) Disseminate information to its qualified employees about the process to enroll in a QHP through the KHBE SHOP;

(b) Make a contribution toward the premium of any qualified employee in accordance with Section 4 of this administrative regulation;

(c) Remit to the KHBE, employer and employee contributions upon receipt of invoice from the KHBE;

(d) Notify the KHBE of a change in eligibility status of an employee or dependent of an employee enrolled in a QHP within thirty (30) days of the event; and

(e) Enter into a participation agreement with the KHBE.

(10) A small employer may designate an agent to:

(a) Perform an employer function on behalf of the employer; or

(b) Assist an employee with enrollment and plan selection.

(11) A small employer participating in a SHOP may be eligible for small employer health insurance tax credits in accordance with 26 USC 45R.

Section 3. Employer Selection of Qualified Health Plans.

(1) A small employer shall make available to a qualified employee:

(a) A single QHP;

(b) All available QHPs at a single metal level of coverage; or

(c) If metal levels are contiguous, one (1) or more QHPs at more than one (1) metal level of coverage.

(2) A qualified employer may apply for coverage through the KHBE SHOP for its

small group at any time in a year.

(3) The employer's plan year shall consist of the 12-month period beginning with the qualified employer's effective date of coverage.

Section 4. Minimum Contribution.

(1) If a small employer selects one (1) QHP to offer to a qualified employee in accordance with Section 3 of this administrative regulation, the small employer shall:

(a) Define a percentage contribution of at least fifty (50) percent toward a premium for employee-only coverage under the QHP; and

(b) Apply the employer contribution determined in paragraph (a) of this subsection toward a QHP selected by the employee.

(2) If a small employer selects more than one (1) QHP to offer to a qualified employee in accordance with Section 3 of this administrative regulation, the small employer shall:

(a) Select a QHP to serve as a reference plan on which a contribution shall be based;

(b) Make a percentage contribution of at least fifty (50) percent toward a premium for employee-only coverage under the reference plan; and

(c) Apply the employer contribution determined in paragraph (b) of this subsection toward a QHP selected by the employee.

(3) If a small employer elects to provide dependent coverage, the small employer may make a contribution toward a premium for dependent coverage.

Section 5. Annual Employer Election Period.

(1) On an annual basis a small employer shall have a thirty (30) day period prior to

the completion of the employer's plan year and before the annual open enrollment to change the employer's participation in the KHBE SHOP for the next plan year.

(2) During the employer annual election period, a small employer may change the:

(a) Method by which the qualified employer makes QHPs available to qualified employees in accordance with Section 3 of this administrative regulation;

(b) Employer contribution towards the premium of a qualified employee made in accordance with Section 4 of this administrative regulation; and

(c) QHP or QHPs offered to qualified employees in accordance with Section 3 of this administrative regulation.

Section 6. Employee Eligibility.

(1) An employee shall be eligible to enroll in a QHP through the KHBE SHOP if the employee receives an offer of coverage from a qualified employer.

(2) An employee shall submit an application to enroll in a QHP:

(a) Via the internet at www.kynect.ky.gov;

(b) By telephone by calling the KHBE customer service center;

(c) By mail; or

(d) In person.

(3) If the information submitted by an employee is inconsistent with the eligibility standards in this section, the employee shall have thirty (30) days after a notification of the inconsistency to present documentation to support the employee's application or resolve the inconsistency.

(4) A qualified employee may designate an individual or organization as an authorized representative.

(5) An eligible employee who does not want to enroll in a QHP offered by a qualified employer shall waive coverage.

(6) A small employer shall be notified if a qualified employee enrolled in a QHP terminates coverage in the QHP.

Section 7. Enrollment and Effective Dates of Coverage.

(1) A qualified employee shall select a QHP or change a QHP offered by a qualified employer in accordance with Section 3 of this administrative regulation during:

(a) The initial open enrollment period;

(b) An annual open enrollment period as set forth in Section 8 of this administrative regulation;

(c) A special enrollment period set forth in Section 9 of this administrative regulation; or

(d) An enrollment period outside of the employer's open enrollment period as set forth in Section 8(3) of this administrative regulation, only for a qualified employee who is newly eligible,

(2) The length of an initial open enrollment period and annual open enrollment period shall be:

(a) Thirty (30) days; and

(b) At the request of a small employer, extended up to a maximum of fifteen (15) additional days.

(3) Coverage in a QHP shall be effective:

(a) If plan selection is made prior to December 15, 2013, during the initial open enrollment period, January 1, 2014;

(b) If open enrollment ends between the first and fifteenth day of any month, the first day of the following month;

(c) If open enrollment ends between the sixteenth and the last day of any month, the first day of the second following month; and

(d) Upon receipt of the full first month's premium from a small employer.

(4) For a renewal, the effective date of coverage shall be an employer's annual renewal date.

(5) For a special enrollment period, the effective date of coverage shall be in accordance with subsection (5) and (6) of Section 9 of this administrative regulation.

(6) (a) Except for the death of an employee or dependent of an employee, the effective date for cancellation of coverage shall be the last day of the month during which an issuer terminates an employee's or dependent of an employee's coverage.

(b) The effective date for cancellation of coverage for the death of an employee or dependent of an employee shall be the date of death.

(7) Unless an employee changes coverage due to a qualifying event, a premium shall not change until the employer's annual renewal date.

Section 8. Annual Open Enrollment Period.

(1) A qualified employee shall select a QHP or change QHPs during an annual open enrollment period that shall be:

(a) No less than thirty (30) days; and

(b) Prior to the end of the employer's plan year.

(2) If a qualified employee enrolled in a QHP remains eligible for coverage, the qualified employee shall remain enrolled in the QHP selected the previous year unless:

(a) The qualified employee enrolls in another QHP; or

(b) The QHP is no longer available to the qualified employee.

(3) (a) A newly added employee who becomes eligible after the beginning of the plan year and prior to the annual enrollment period shall have thirty (30) days prior to the date the newly added employee becomes eligible for employer-sponsored coverage to enroll in a QHP.

(b) The effective date of coverage of a newly added employee is the first day of the month following the month the newly added employee becomes eligible for employer-sponsored coverage.

Section 9. Special Enrollment Period.

(1) A qualified employee or dependent of a qualified employee may enroll in a QHP or a qualified employee may change QHPs during a special enrollment period if:

(a) The qualified employee or dependent of a qualified employee loses minimal essential coverage;

(b) The qualified employee gains a dependent through marriage, birth, adoption, or placement for adoption;

(c) The qualified employee or dependent of the qualified employee enrolls or fails to enroll in a QHP due to an error, misrepresentation, or inaction of an officer, employee, or agent of the KHBE or HHS;

(d) The qualified employee or dependent of the qualified employee demonstrates to the KHBE that the QHP in which the qualified employee or dependent of the qualified employee is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(e) The qualified employee or dependent of the qualified employee gains access to new QHPs as a result of a permanent move;

(f) The qualified employee or dependent of the qualified employee demonstrates that the qualified employee or dependent of an employee meets other exceptional circumstances;

(g) The qualified employee is an Indian who may change from one QHP to another QHP one time per month;

(h) The qualified employee or dependent of the qualified employee loses eligibility for coverage under Medicaid or CHIP; or

(i) The qualified employee or dependent of a qualified employee becomes eligible for premium assistance through KHIPP.

(2) A qualified employee or dependent of a qualified employee has thirty (30) days from the date of a triggering event described in paragraphs (a) through (g) of subsection (1) of this section to select a QHP through the KHBE SHOP.

(3) A qualified employee or dependent of a qualified employee has sixty (60) days from the date of a triggering event described in paragraphs (h) and (i) of subsection (1) of this section to select a QHP through the KHBE SHOP.

(4) A dependent of a qualified employee shall not be eligible for a special enrollment period if a small employer does not offer coverage to a dependent.

(5) Except as provided in subsection (6) of this section, the effective date of coverage for an enrollment during a special enrollment period if a qualified employee selects a QHP shall be:

(a) Between the first and the fifteenth day of any month, the first day of the following

month; and

(b) Between the sixteenth and the last day of any month, the first day of the second following month.

(6) (a) In the case of birth, adoption, or placement for adoption, the effective date of coverage shall be the date of birth, adoption, or placement for adoption; and

(b) In the case of marriage, or in the case where a qualified employee loses minimum essential coverage as described in subsection (7) and (8) of this section, the effective date of coverage shall be the first day of the following month.

(7) Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801–6(a)(3)(i) through (iii).

(8) Loss of minimum essential coverage does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) A situation allowing for a rescission as specified in 45 CFR 147.128.

Section 10. Employer Voluntary and Involuntary Termination from KHBE SHOP.

(1) (a) An employer may terminate its participation in KHBE SHOP at any time and for any reason by providing written notice to KHBE.

(b) The earliest effective date of termination shall be the last day of the calendar month following the calendar month in which notice is given.

(2) An employer may be terminated from participation in KHBE SHOP if the employer:

(a) Fails to pay a premium in accordance with Section 4 of this administrative regulation;

(b) Fails to meet the employer eligibility requirements established in Section 2 of this administrative regulation; or

(c) Commits fraud or misrepresentation.

(3) The effective date of employer termination from participation in the KHBE SHOP shall be:

(a) The date of notification of termination for non-payment of premiums, if the condition in subsection (2) (a) of this section is met,

(b) The last day of the plan year, if the condition in subsection (2) (b) of this section is met; or

(c) The last day of the calendar month following the month in which an employer shall be notified of the termination by the KHBE, if the condition in subsection (2) (c) of this section is met.

900 KAR 10:020

APPROVED:

Carrie Banahan
Executive Director
Office of the Kentucky Health Benefit Exchange

5/28/13
Date

APPROVED:

Audrey Tayse Haynes
Secretary
Cabinet for Health and Family Services

6/1/13
Date

900 KAR 10:020

PUBLIC HEARING AND PUBLIC COMMENTS:

A public hearing on this administrative regulation shall, if requested, be held on July 22, 2013, at 9:00 a.m. in the Public Health Auditorium located on the First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by July 15, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until July 31, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40621, (502) 564-7905, Fax: (502) 564-7573

REGULATORY IMPACT ANALYSIS AND TEIRING STATEMENT

Administrative Regulation Number: 900 KAR 10:020
Contact Person: Carrie Banahan (502) 564-7940

1. Provide a brief summary of:

   (a) What this administrative regulation does: This administrative regulation establishes the policies and procedures relating to the operation of a Small Business Health Options Program in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. parts 155 and 156.

   (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the policies and procedures relating to the operation of a Small Business Health Options Program.

   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that small businesses are aware of the small business health options program which will allow them to enroll employees in qualified health plans offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156 and qualify for small employer health insurance tax credits pursuant to 26 U.S.C. 45R.

   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed requirements for the small business health options program and how small businesses may enroll employees in qualified plans to be offered on the Kentucky Health Benefit Exchange to comply with the statute and qualify for small employer health insurance tax credits pursuant to 26 U.S.C. 45R.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:

   (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

   (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

   (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

   (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect approximately 2,500 small businesses that may purchase health insurance for their employees on the Kentucky Health Benefit Exchange and potentially qualify for small employer health insurance tax credits.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

   (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will be able to submit an application online to purchase health insurance coverage for their employees through the Exchange, provide supporting documentation, and contribute at least 50% of the premium towards an employee coverage.

   (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost will be incurred by the entities.

   (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will benefit each small business as it may ease the administrative burden of administering their health insurance program and may benefit certain employers through health insurance tax credits.

5. Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

   (a) Initially: No additional costs will be incurred to implement this administrative regulation.

   (b) On a continuing basis: No additional costs will be incurred.

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforcement of this administrative regulation will be from Kentucky Office of Health Benefit Exchange existing budget. No new funding will be needed to implement the provisions of this regulation.

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

8. State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

9. TIERING: Is tiering applied? (Explain why or why not)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 900 KAR 10:020
Contact Person: Carrie Banahan
Phone number: 502-564-7940

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation affects the Office of the Kentucky Health Benefit Exchange within the Cabinet for Health and Family Services.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.050(1), 42 U.S.C. § 18031, and 45 C.F.R. Parts 155 and 156.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation on a continuing basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 900 KAR 10:020
Contact Person: Carrie Banahan, 564-7940

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

2. State compliance standards. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet, and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the operation of a Small Business Health Options Program in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. parts 155 and 156.

3. Minimum or uniform standards contained in the federal mandate. The Affordable Care Act establishes the creation of the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act. The "Kentucky Health Benefit Exchange" (KHBE) is the Kentucky state-based exchange conditionally approved by HHS established by 45 C.F.R. 155.105. An Exchange must establish a Small Business Health Options Program (SHOP). A SHOP is designed to assist qualified small employers in the state in enrolling their employees in qualified health plans in the state's small group market.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

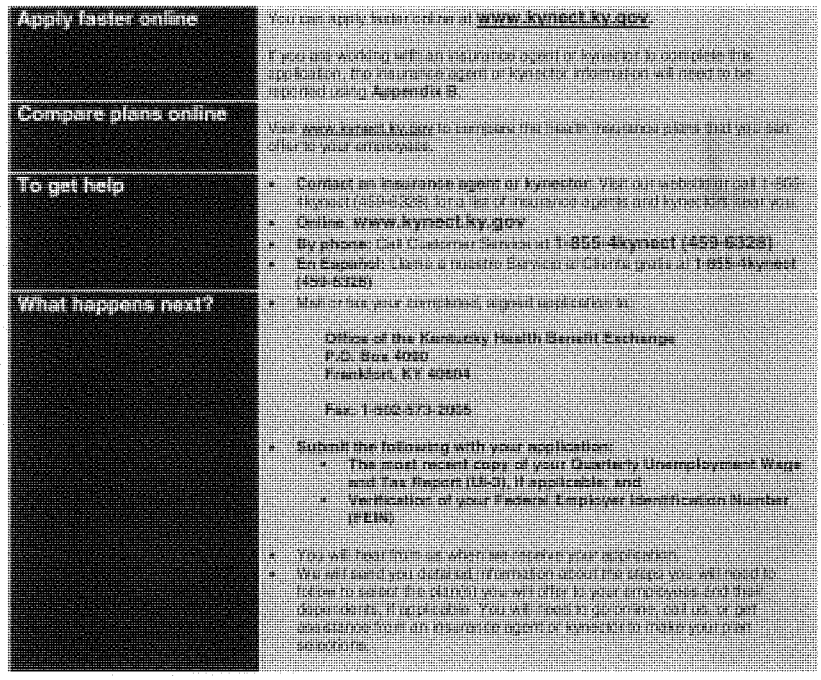
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements than those required by the federal mandate.

kynect
Kentucky's Healthcare Connection

Small Business Health Options Program (SHOP)
Insurance Application for Employers

kynect, Kentucky's Healthcare Connection, offers a new way for small employers to offer health insurance to their employees through the SHOP. The SHOP is open to all small business owners with 50 or fewer employees.

THINGS TO KNOW



Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify to participate in the SHOP through kynect and to gather information about the employees to whom you are offering health insurance coverage.

kynect
Kentucky's Healthcare Connection

Small Business Health Options Program (SHOP)
Insurance Application for Employers

STEP 1 Are you eligible to participate in SHOP?

1. Are you a small employer (50 or fewer employees)?	☐ Yes ☐ No
2. Will you offer, at a minimum, all full-time employees (working an average of 30 hours or more per week) coverage to a health insurance plan through the SHOP?	☐ Yes ☐ No
3. If your principal business address is in Kentucky, will you offer coverage to all full-time employees? OR If you have a worksite in Kentucky, will you offer coverage to all full-time employees at this worksite?	☐ Yes ☐ No

If you answered **No** to any of these questions, you do not qualify to participate in the SHOP.
If you answered **Yes** to all of these questions, continue to Step 2.

STEP 2 Employer and Contact Information

1. Company Name	2. Federal Employer Identification Number (FEIN)
3. Doing Business As (DBA)	4. Year of Incorporation/Establishment
5. Employer Type ☐ Church/church-affiliated ☐ Foreign government ☐ State/local government ☐ Private sector	6. If you marked private sector, check one of the following: ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ 1040 Schedule C Business ☐ Tax-exempt organization
7. Primary Business Address	

8. City	9. State	10. Zip Code	11. County

Employer Primary Contact

12. First name, Middle initial, Last name & Suffix	13. Title
14. Mailing Address ☐ **Check here if same as primary business address**	

15. City	16. State	17. Zip Code	18. County

19. Preferred Phone Number ☐Home ☐Work ☐Cell ( )	20. Secondary Phone Number ☐Home ☐Work ☐Cell ( )
21. Fax Number ( )	22. Email Address
23. Preferred Spoken Language (if not English)	24. Preferred Written Language (if not English)

If you need help with your application, contact an insurance agent or a kynector. You can also apply faster online at **www.kynect.ky.gov** or by calling **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

STEP 3 Employees to Whom You Are Offering Coverage

Attach separate sheets to add more employees or employee dependents.

1

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (OPTIONAL)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

2

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (OPTIONAL)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐ Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

3

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address(OPTIONAL)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

4

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (OPTIONAL)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

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5	1. Employee Name (First name, Middle initial, Last name)		2. Social Security Number	3. Gender ☐ Male ☐ Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (OPTIONAL)		6. Phone Number ( )	
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)	10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No	
11. Home Address	12. City	13. State	14. Zip Code	15. County
Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)				
16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee	

6	1. Employee Name (First name, Middle initial, Last name)		2. Social Security Number	3. Gender ☐ Male ☐ Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (OPTIONAL)		6. Phone Number ( )	
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary (OPTIONAL)	10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No	
11. Home Address	12. City	13. State	14. Zip Code	15. County
Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)				
16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee	

STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- **My right to appeal.** If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action.

Signature	Date (mm/dd/yyyy)

If you need help with your application, contact an insurance agent or a kynector. You can also apply faster online at **www.kynect.ky.gov** or by calling **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

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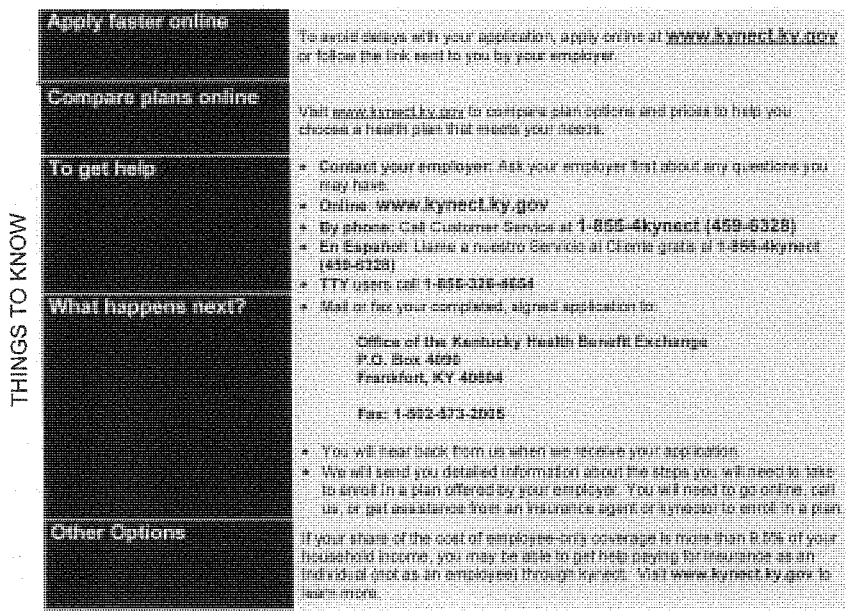
Small Business Health Options Program (SHOP)
Insurance Application for Employees

Use this application to give us more information about you and the dependents that you may want to cover through the health coverage offered by your employer.



Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to collect additional information about you or any dependents you may want to cover through your employer-sponsored health insurance plan.

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Kentucky's Healthcare Connection

Small Business Health Options Program (SHOP)
Insurance Application for Employees

If someone else is helping you fill out this application, use Appendix B to give us that person's information.

Who is your employer?	Company Name

Get started with your application below.

STEP 1 Information about You, the Employee

1. First name, Middle initial, Last name & Suffix		2. Social Security Number
3. Date of Birth (mm/dd/yyyy)	4. Gender ☐ Male ☐ Female	5. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

6. Home Address - ☐ **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**

7. City	8. State	9. Zip Code	10. County

11. Mailing Address **(Only required if different from Home Address)**

12. City	13. State	14. Zip Code	15. County

16. Email Address

17. Primary Phone Number ☐Home ☐Work ☐Cell ( )	18. Secondary Phone Number ☐Home ☐Work ☐Cell ( )
19. ☐ Check here to allow kynect to send text message alerts to your primary phone number.	20. ☐ Check here to allow kynect to send text message alerts to your secondary phone number.
21. Preferred Language Spoken (if not English)	22. Preferred Written Language (if not English)

23. Are you of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐ No

24. Race - **(OPTIONAL)**

☐ White	☐American Indian	☐Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐Alaska Native	☐Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐Asian Indian	☐Korean	☐ Native Hawaiian	☐ Other Pacific Islander

- Do you want coverage for yourself only? **Skip to Step 3.**
- Do you want coverage for your dependents? **Go to Step 2 to enter your dependents' information.**
- Do you **not** want to enroll in the coverage offered by this employer? **Skip to Step 4.**

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STEP 2 Information about your Dependents

Provide details for each dependent who is applying for coverage. Use additional pages if needed.

Dependent 1

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (OPTIONAL) ☐Yes ☐ No

8. Race - (OPTIONAL)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

9. Does DEPENDENT 1 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 1's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

Dependent 2

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (OPTIONAL) ☐Yes ☐ No

8. Race - (OPTIONAL)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

9. Does DEPENDENT 2 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 2's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

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Dependent 3

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (OPTIONAL) ☐Yes ☐ No

8. Race - (OPTIONAL)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

9. Does DEPENDENT 3 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 3's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

STEP 3 Additional Questions

1. Is anyone on this application **American Indian or Alaska Native?**
☐**YES. If yes,** answer questions a and b. ☐**NO. If no,** go to question 2.

a. Who? _____
b. Is this person a member of a federally recognized tribe, band, nation, community or other group?
☐Yes. If yes, answer questions c-e. ☐No. If no, go to question 2.
c. What tribe? _____
d. What state is this tribe primarily located in? _____
e. Is this person eligible to receive Indian Health Services? ☐ Yes ☐ No

2. Does anyone on this application have **other health coverage** now, including dental and major medical coverage that is not Medicaid or KCHIP?
☐**YES.** If **yes**, answer the question below. ☐**NO**
Name of insurance company: _____

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STEP 4 Do not want employer-sponsored coverage

☐ **I am waiving my employer-sponsored coverage.**

What is the reason for waiving the health coverage offered by this employer?

☐ I have individual private insurance
☐ I have insurance from another job
☐ I have insurance through my spouse/partner
☐ I have insurance through a parent
☐ I have Medicare
☐ I have Medicaid or CHIP
☐ I have TRICARE
☐ I have VA coverage
☐ I don't live in health plan service area
☐ I don't wish to participate
☐ I have an exemption

STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect how much payment assistance I can get.
☐ **Yes**, I want to apply to register to vote. An application will be mailed to me. ☐ **No**, I don't want to register to vote.

- **My right to appeal.** If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action.

Signature	Date (mm/dd/yyyy)

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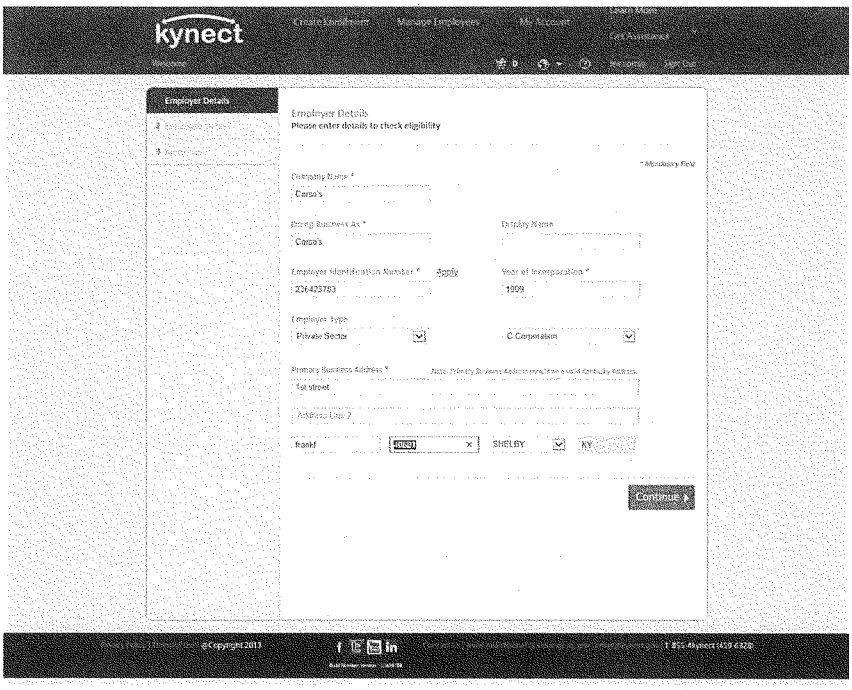
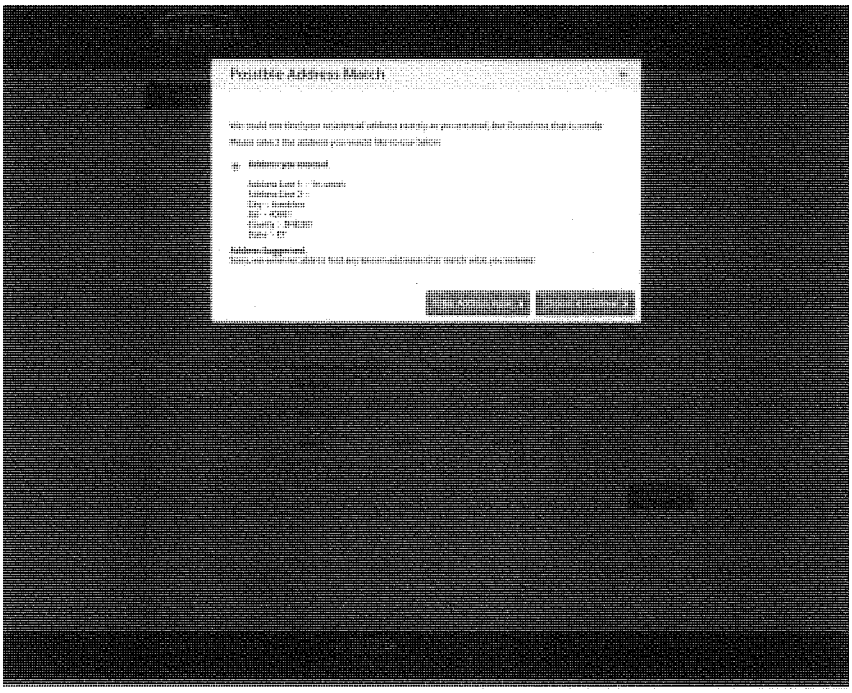
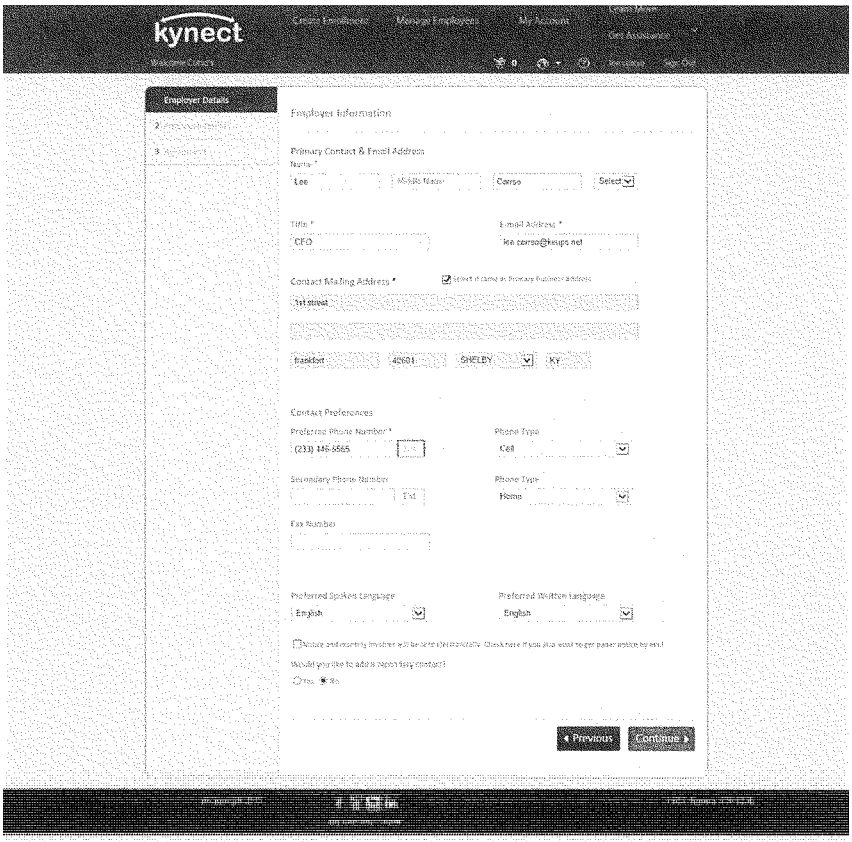
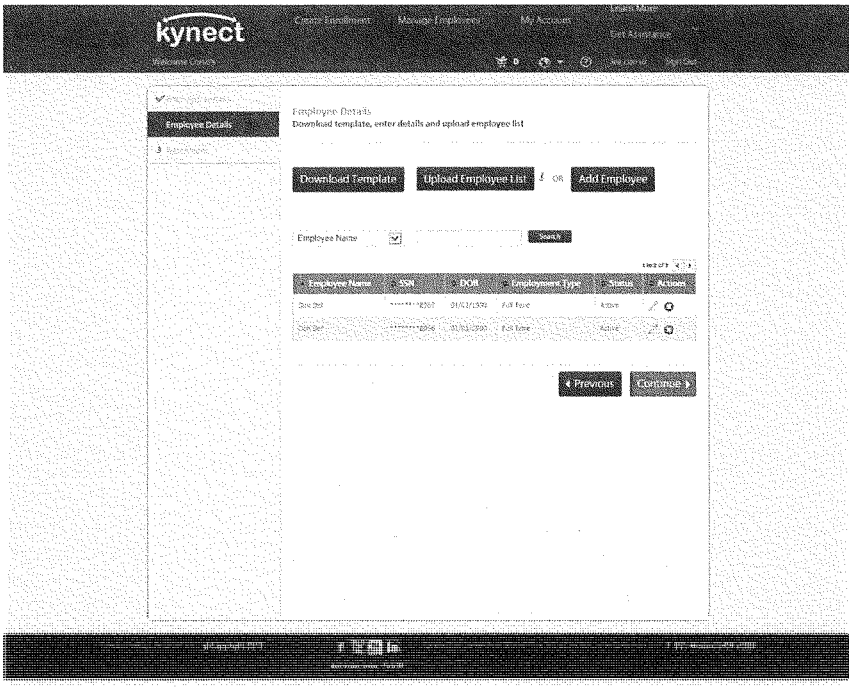
Employer Profile



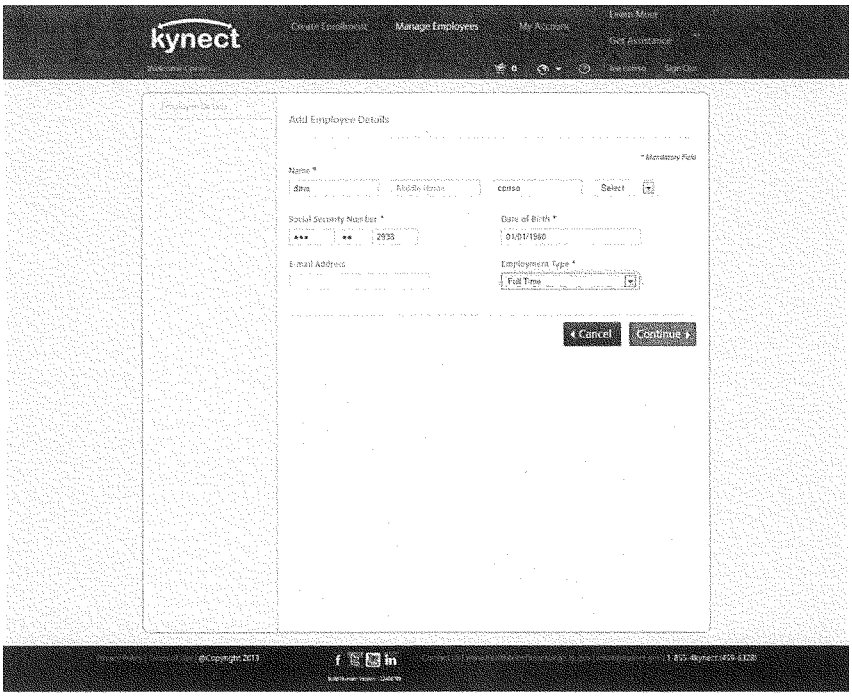

Possible Address Match

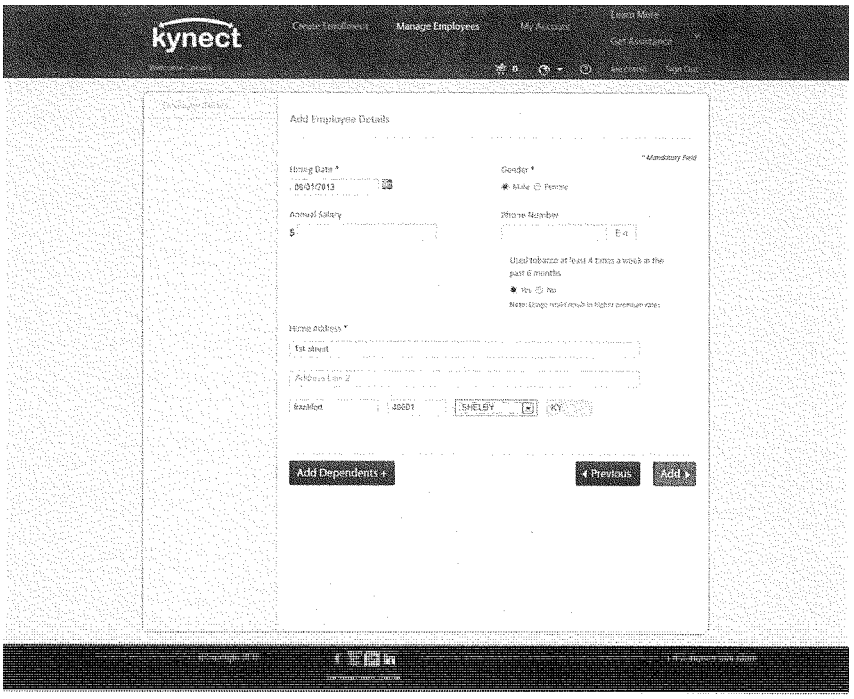

kynect
Create Enrollments
Manage Employers
My Account
Employer Details
Employer Information
Primary Contact & Email Address
Name *
Lee
Middle Name
Corrso
Select
Title *
CFO
E-mail Address *
lee.corrso@kspis.net
Contact Mailing Address *
Select if same as Primary Business Address
1st street
Frankfort
40601
SHELBY
KY
Contact Preferences
Preferred Phone Number *
(233) 445-6565
Ext
Phone Type
Cell
Secondary Phone Number
Ext
Phone Type
Home
Fax Number
Preferred Spoken Language
English
Preferred Written Language
English
Would you like to add a representative/agent?
Yes
No
Previous
Continue

Employee Roster

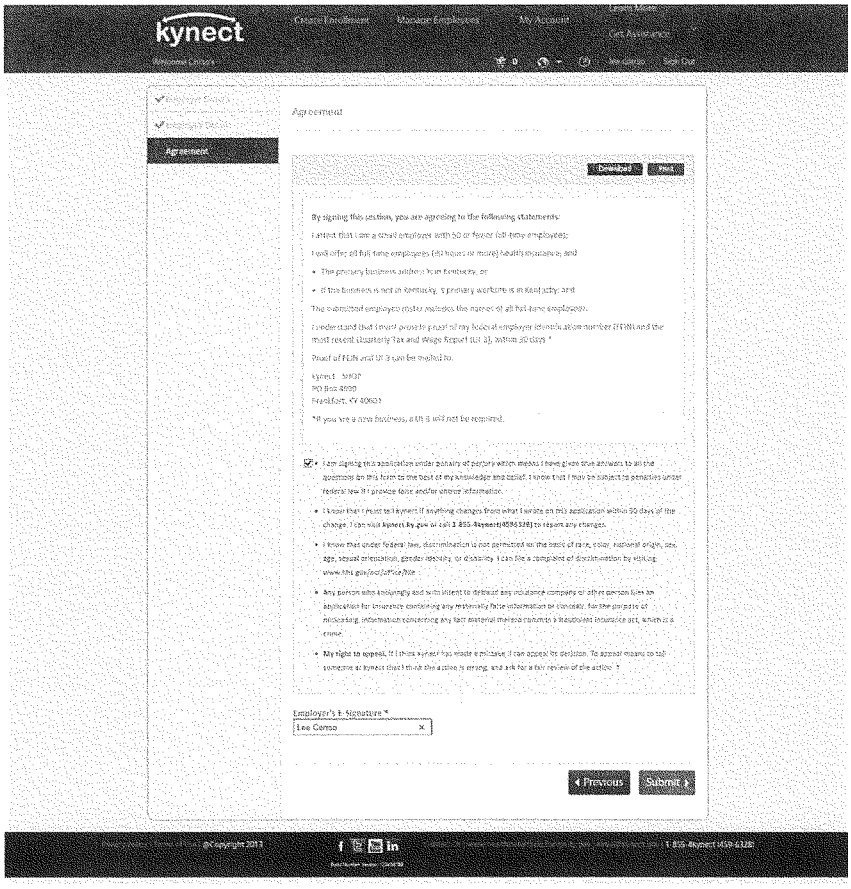


Add Employee Details

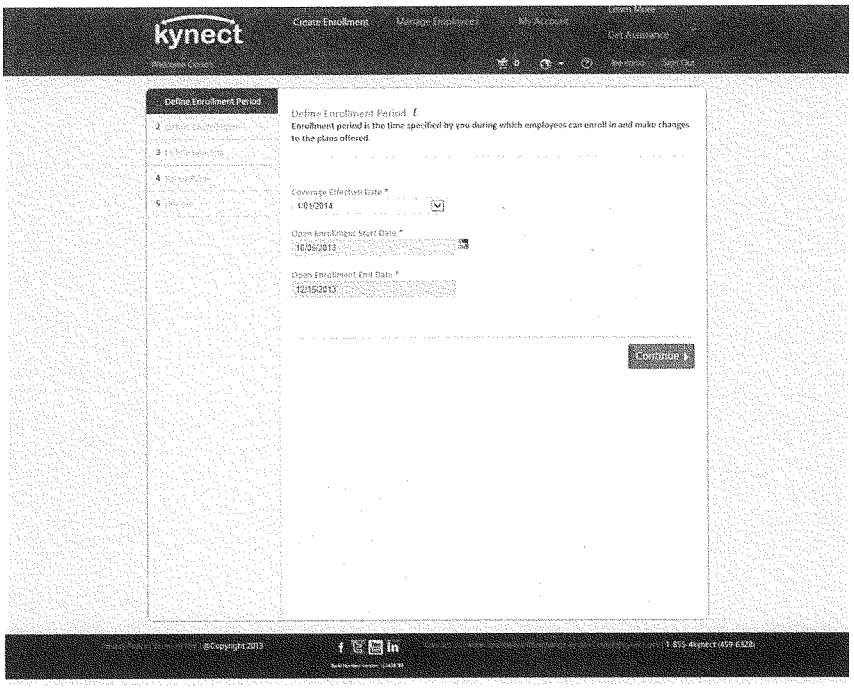

kynect
Manage Employees
Add Employee Details
* Mandatory Field
Name *
Select
Social Security Number *
Date of Birth *
01/01/1960
E-mail Address
Employment Type *
Full Time
Cancel
Continue


kynect
Manage Employees
Add Employee Details
* Mandatory Field
Hiring Date *
06/01/2013
Gender *
Male
Female
Annual Salary
$
Uses tobacco at least 4 times a week in the past 6 months
Yes
No
Home Address *
1st street
Address Line 2
Add Dependents +
Previous
Add

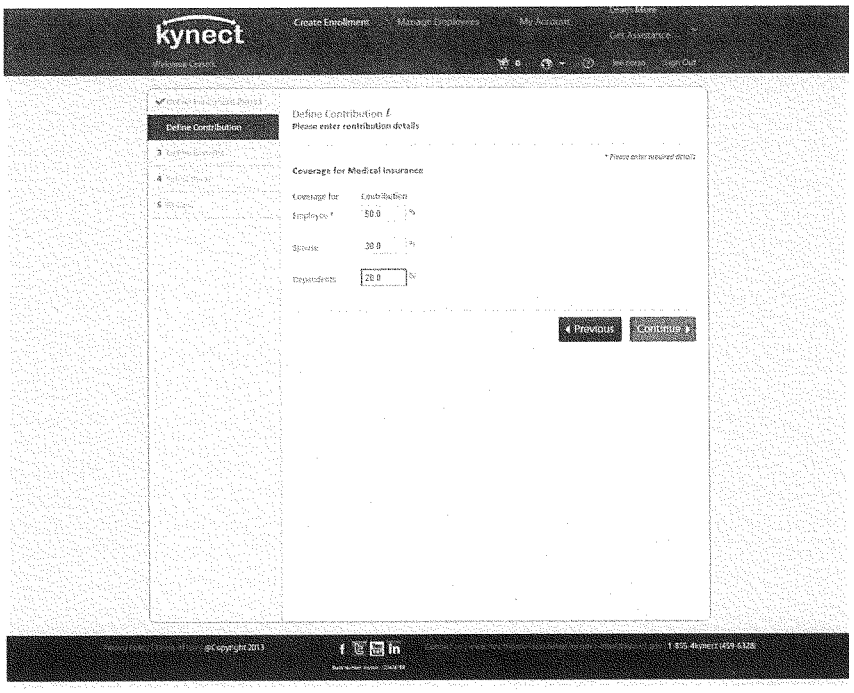
Agreement


kynect
Agreement
Agreement
Download
Print
By signing this section, you are agreeing to the following statements:
Previous
Submit

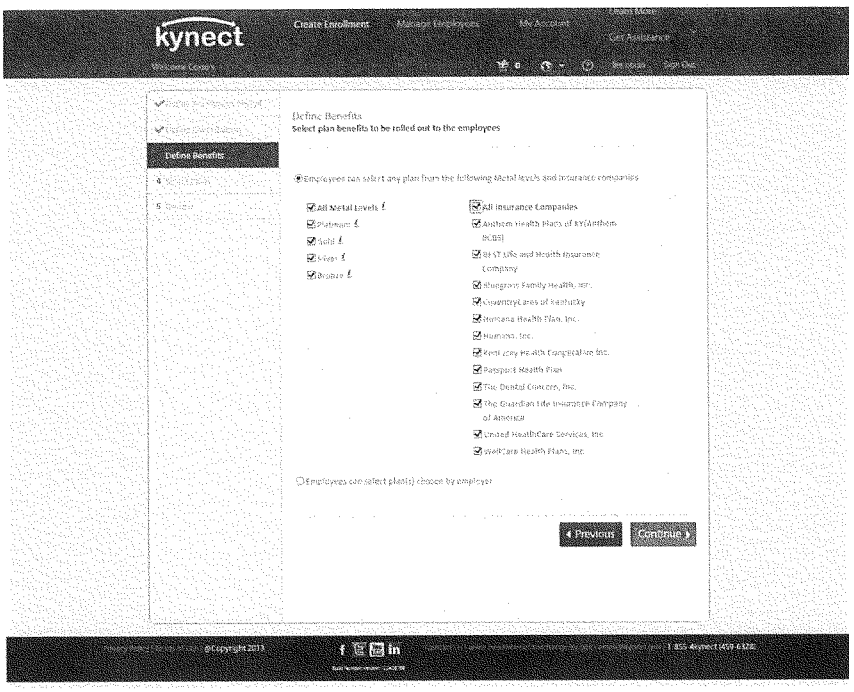
Define Enrollment Period

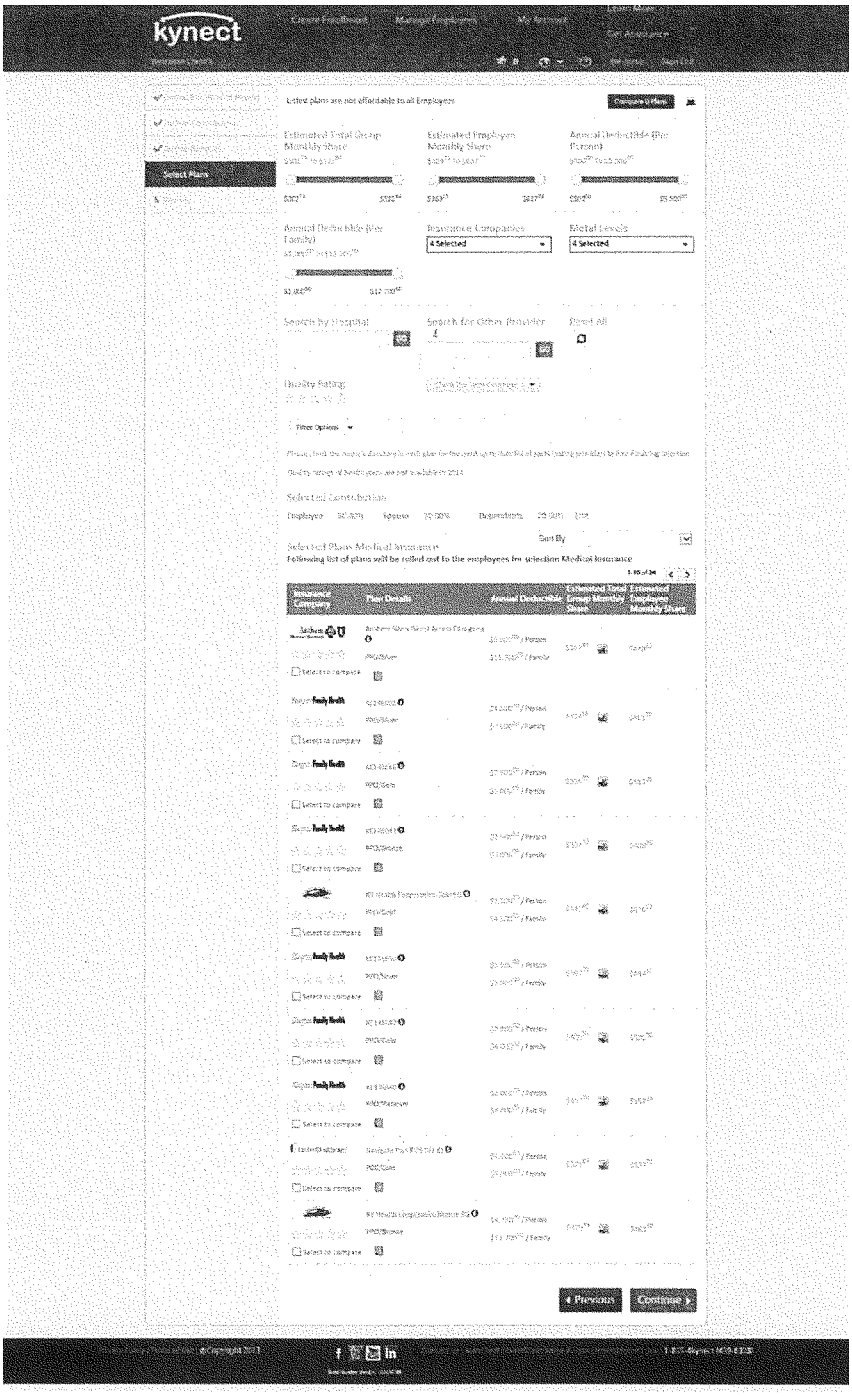


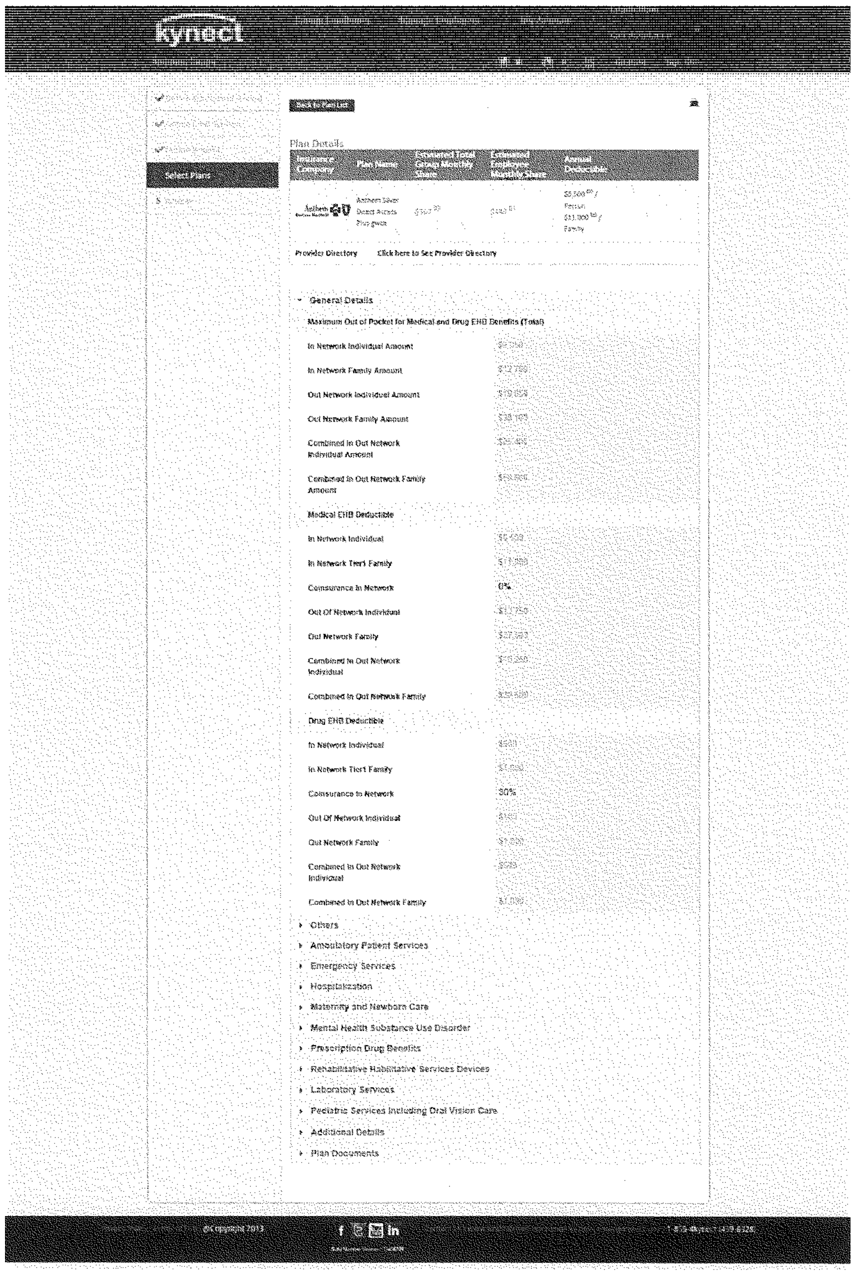
Define Contribution

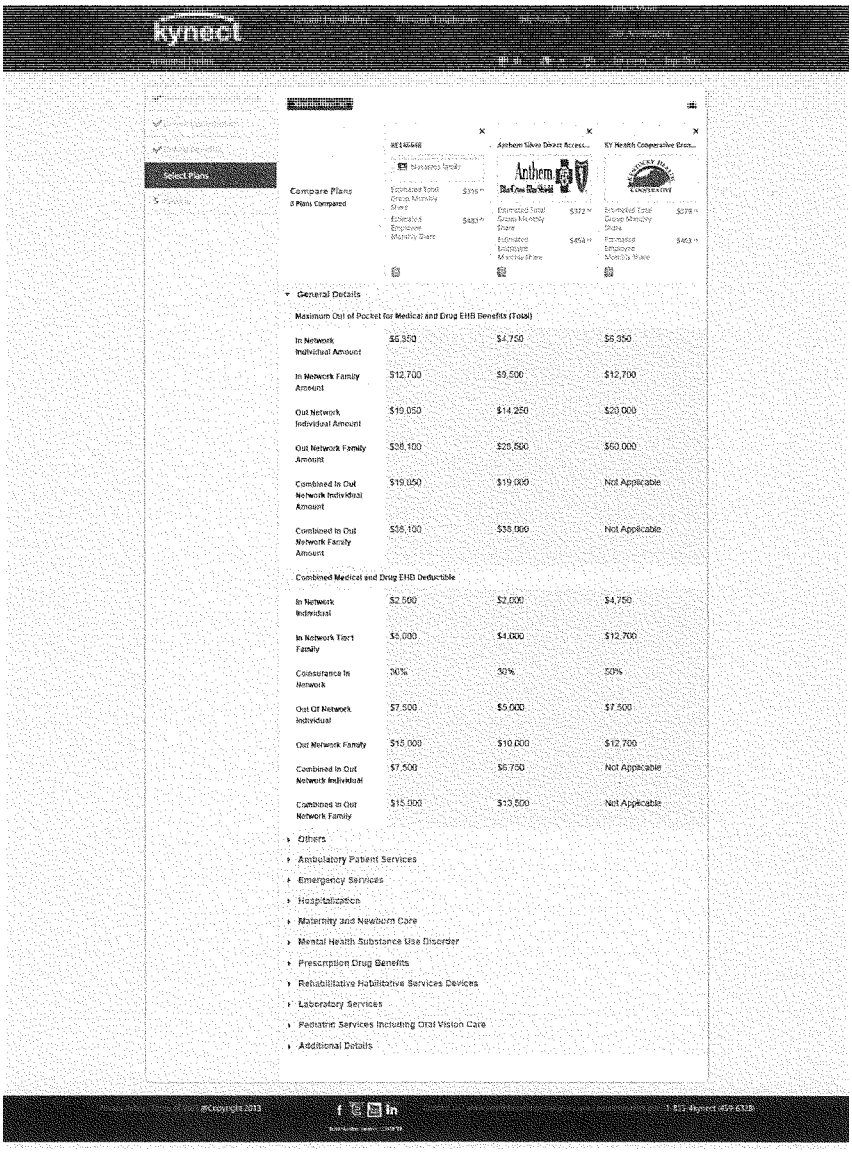


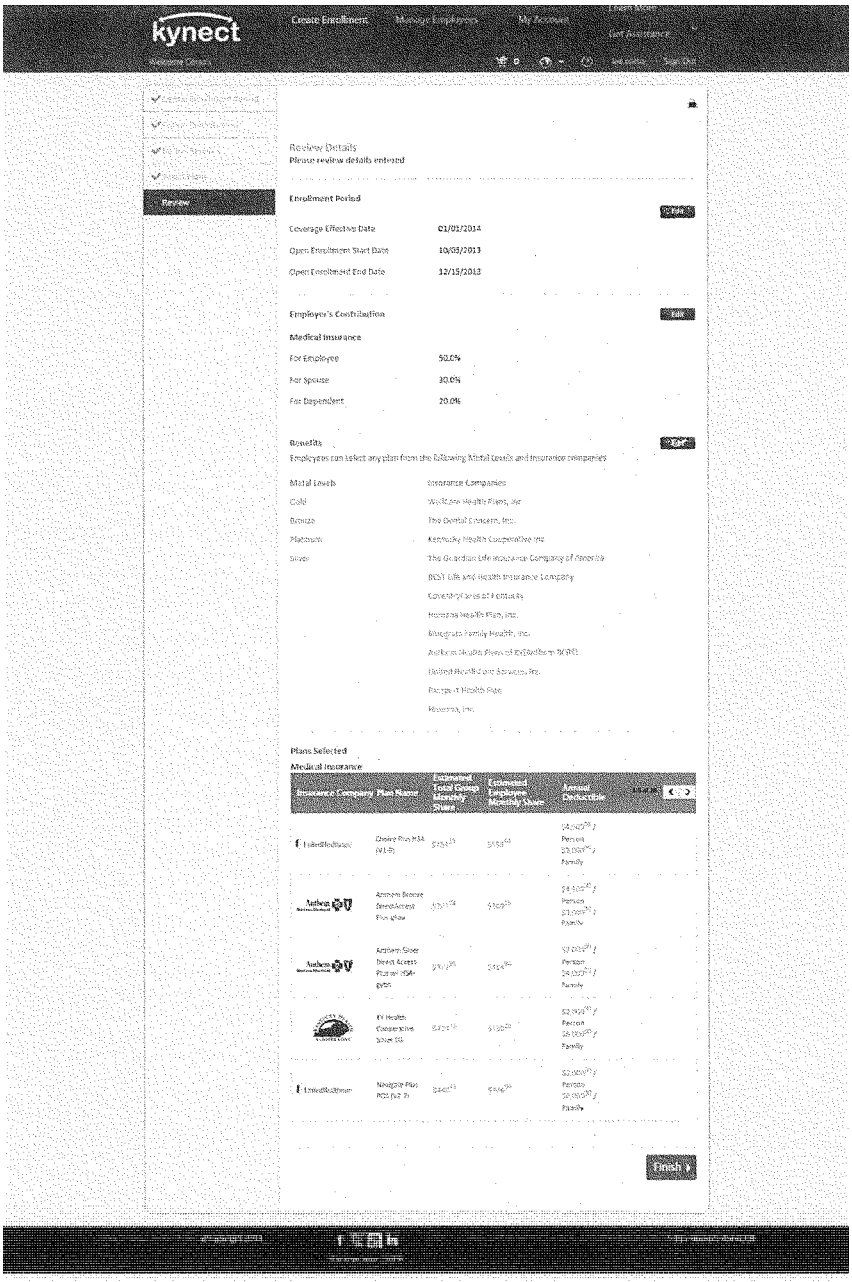
Define Benefits

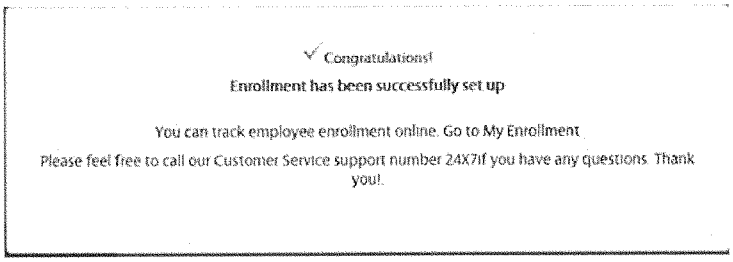


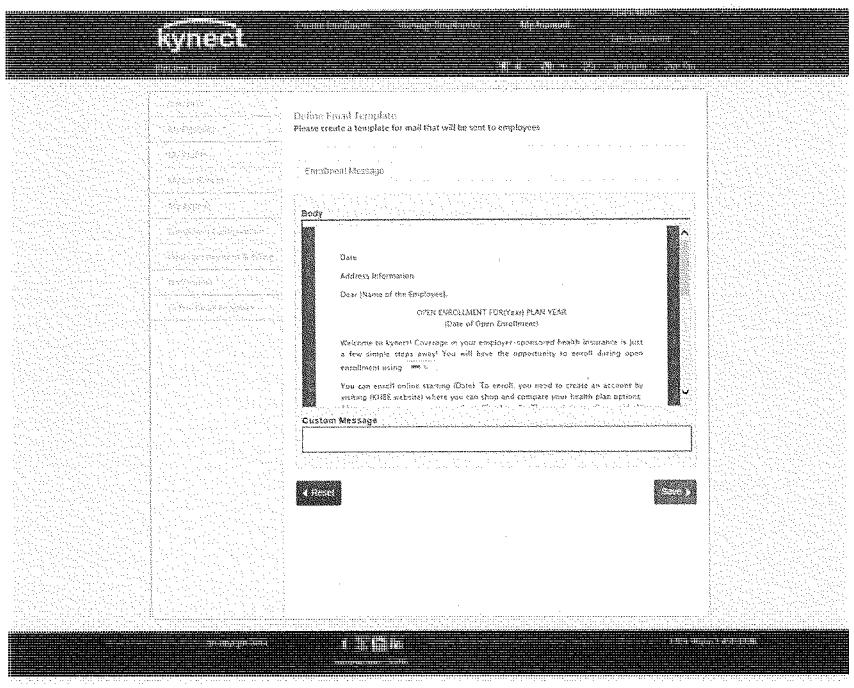

kynect
Create Enrollment
Manage Employees
My Account
Live Assistance
Select Plans
Active plans are not affordable to all Employees
Compare Plans
Estimated Total Group Monthly Share
Estimated Employer Monthly Share
Annual Deductible (Per Person)
Annual Deductible (Per Family)
Insurance Companies
4 Selected
Metal Levels
4 Selected
Search by Hospital
Search for Other Provider
Reset All
Quality Rating
Filter Options
Selected Contribution
Employee
Spouse
Dependents
Sort By
Selected Plans Medical Insurance
Following list of plans will be rolled out to the employees for selection Medical Insurance
Insurance Company
Plan Details
Annual Deductible
Estimated Total Group Monthly Share
Estimated Employer Monthly Share
Select to compare
Previous
Continue

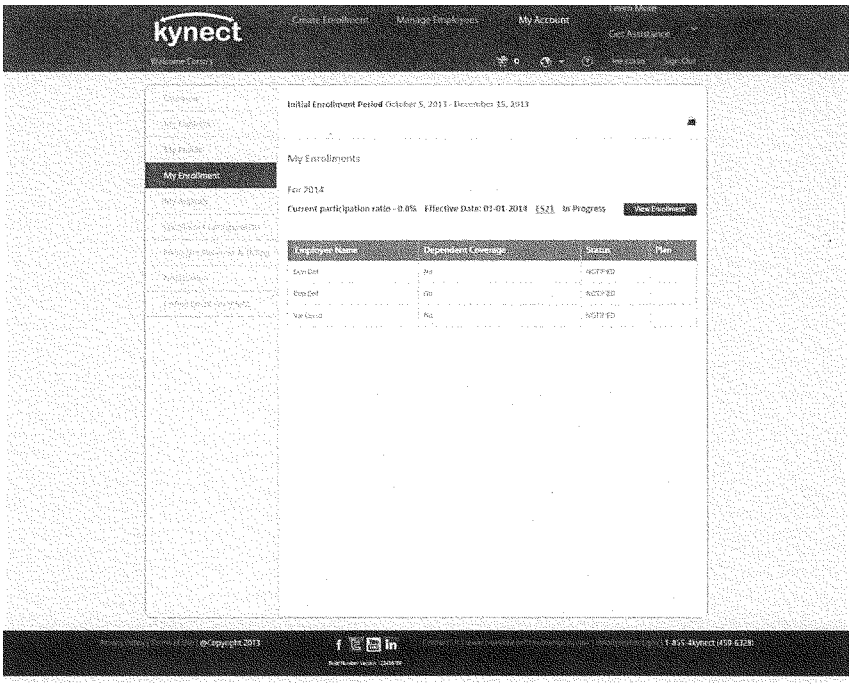

kynect
Back to Plan List
Plan Details
Insurance Company
Plan Name
Estimated Total Group Monthly Share
Estimated Employee Monthly Share
Annual Deductible
Select Plans
Anthem Silver Direct Access
$5,500.00 / Person
$11,000.00 / Family
Provider Directory
Click here to See Provider Directory
General Details
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)
In Network Individual Amount
In Network Family Amount
Out Network Individual Amount
Out Network Family Amount
Combined In Out Network Individual Amount
Combined In Out Network Family Amount
Medical EHB Deductible
In Network Individual
In Network Tier1 Family
Coinsurance In Network
0%
Out Of Network Individual
Out Network Family
Combined In Out Network Individual
Combined In Out Network Family
Drug EHB Deductible
In Network Individual
In Network Tier1 Family
Coinsurance In Network
30%
Out Of Network Individual
Out Network Family
Combined In Out Network Individual
Combined In Out Network Family
Others
Ambulatory Patient Services
Emergency Services
Hospitalization
Maternity and Newborn Care
Mental Health Substance Use Disorder
Prescription Drug Benefits
Rehabilitative Habilitative Services Devices
Laboratory Services
Pediatric Services Including Oral Vision Care
Additional Details
Plan Documents

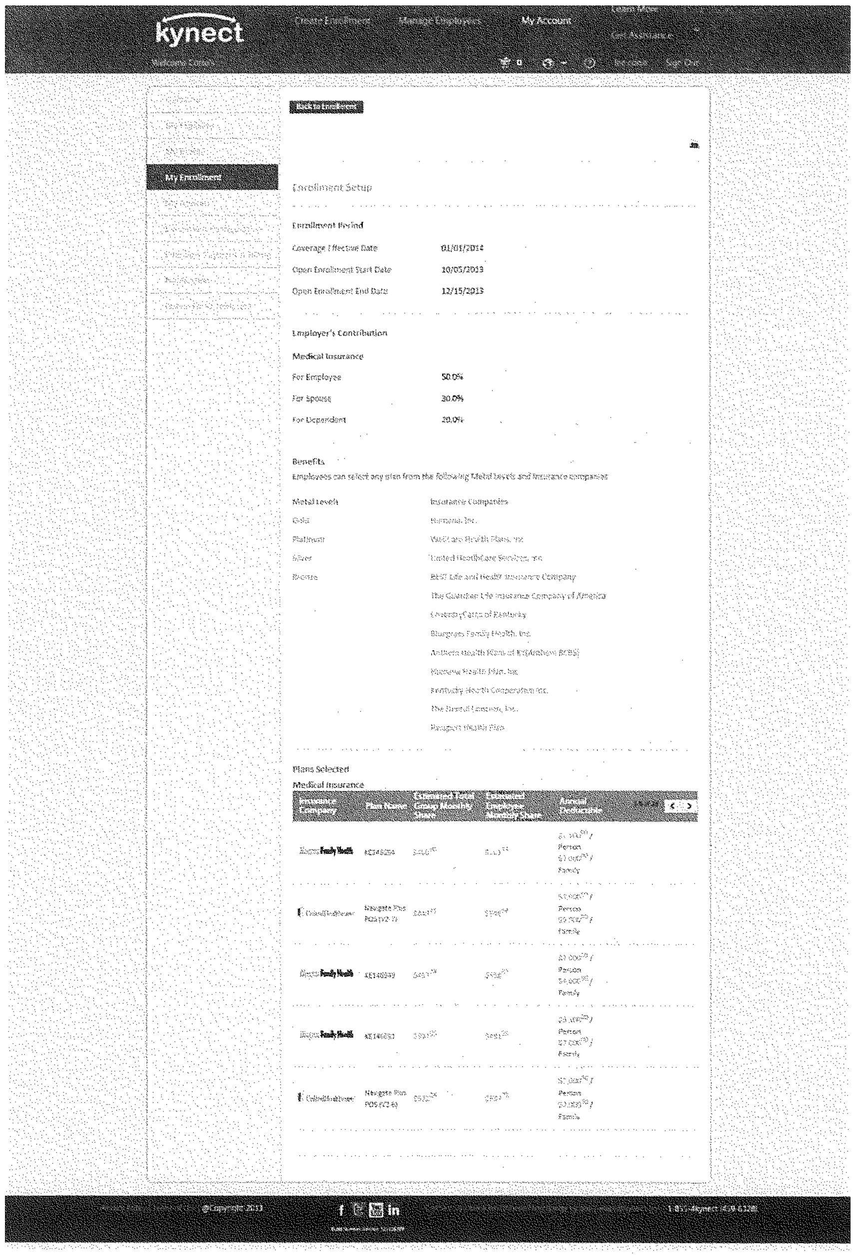

kynect
Select Plans
Compare Plans
0 Plans Compared
Anthem Silver Direct Access...
KY Health Cooperative Gran...
General Details
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)
In Network Individual Amount
$6,350
$4,750
$6,350
In Network Family Amount
$12,700
$9,500
$12,700
Out Network Individual Amount
$19,050
$14,250
$20,000
Out Network Family Amount
$38,100
$28,500
$50,000
Combined In Out Network Individual Amount
$19,050
$19,000
Not Applicable
Combined In Out Network Family Amount
$38,100
$38,000
Not Applicable
Combined Medical and Drug EHB Deductible
In Network Individual
$2,500
$2,000
$4,750
In Network Tier1 Family
$5,000
$4,000
$12,700
Coinsurance In Network
30%
30%
50%
Out Of Network Individual
$7,500
$5,000
$7,500
Out Network Family
$15,000
$10,000
$12,700
Combined In Out Network Individual
$7,500
$6,750
Not Applicable
Combined In Out Network Family
$15,000
$13,500
Not Applicable
Others
Ambulatory Patient Services
Emergency Services
Hospitalization
Maternity and Newborn Care
Mental Health Substance Use Disorder
Prescription Drug Benefits
Rehabilitative Habilitative Services Devices
Laboratory Services
Pediatric Services Including Oral Vision Care
Additional Details

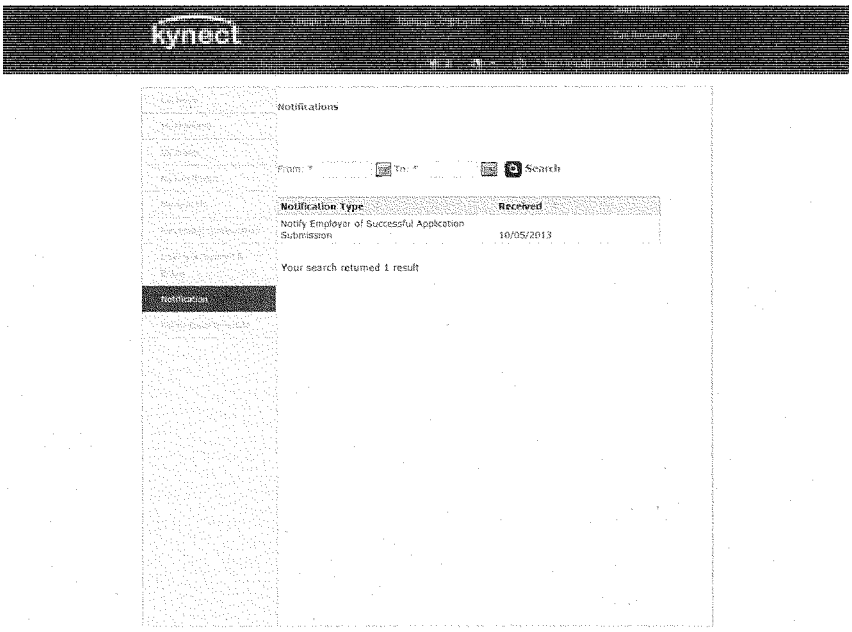

kynect
Create Enrollment
Manage Employees
My Account
Live Assistance
Review
Review Details
Please review details entered
Enrollment Period
Coverage Effective Date 01/01/2014
Open Enrollment Start Date 10/01/2013
Open Enrollment End Date 12/15/2013
Employer's Contribution
Medical Insurance
For Employee 50.0%
For Spouse 30.0%
For Dependent 20.0%
Benefits
Employees can select any plan from the following Metal Levels and Insurance companies
Metal Levels
Insurance Companies
Gold
Bronze
Platinum
Silver
Plans Selected
Medical Insurance
Insurance Company
Plan Name
Annual Deductible
Check

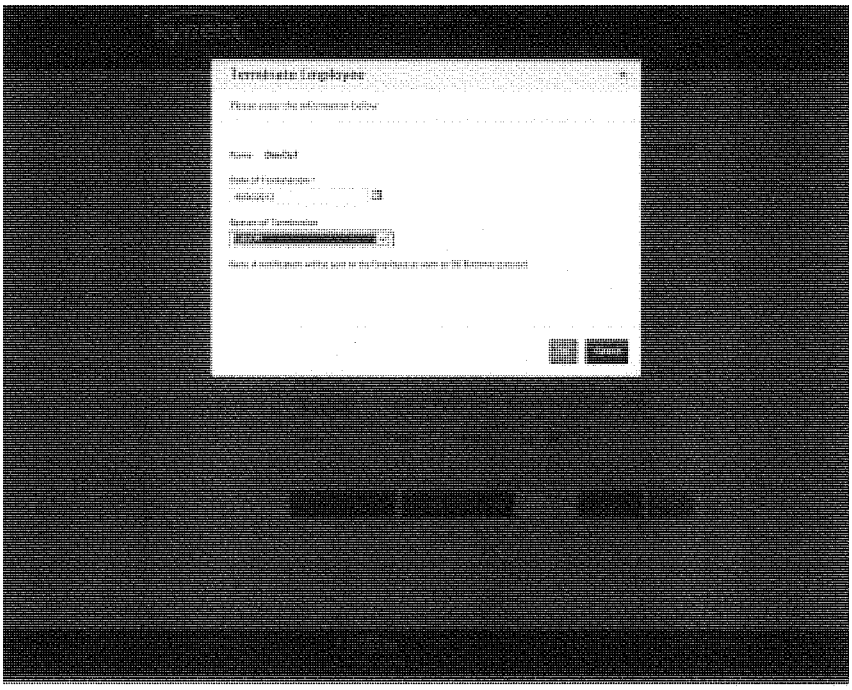

Congratulations!
Enrollment has been successfully set up
You can track employee enrollment online. Go to My Enrollment
Please feel free to call our Customer Service support number 24X7if you have any questions. Thank you!.

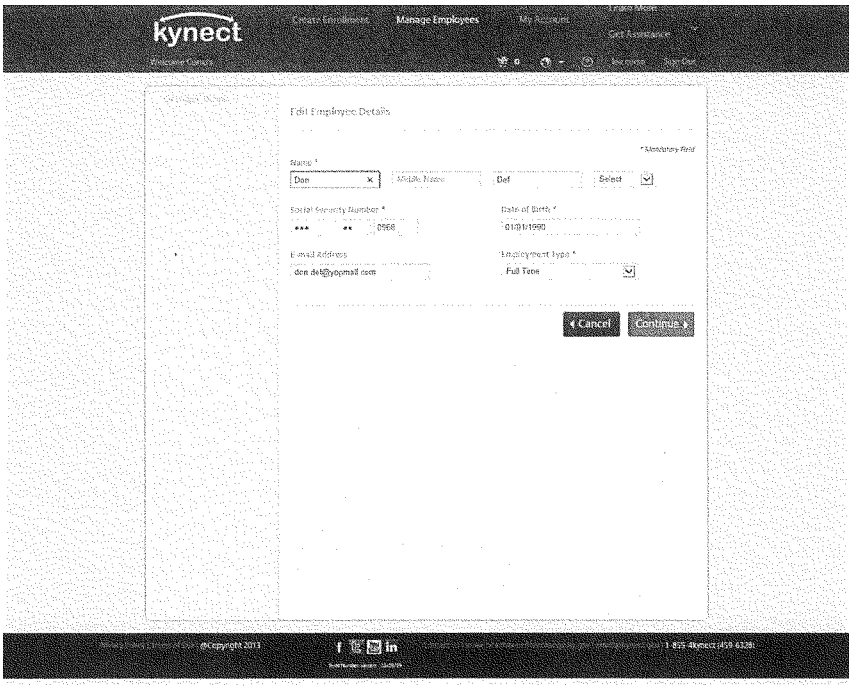

kynect
Define Email Template
Please create a template for mail that will be sent to employees
Enrollment Message
Body
Date
Address Information
Dear (Name of the Employee),
OPEN ENROLLMENT FOR(Year) PLAN YEAR
(Date of Open Enrollment)
Welcome to kynect! Coverage on your employer-sponsored health insurance is just a few simple steps away! You will have the opportunity to enroll during open enrollment using
You can enroll online starting (Date). To enroll, you need to create an account by visiting (KHBE website) where you can shop and compare your health plan options.
Custom Message
Reset
Save

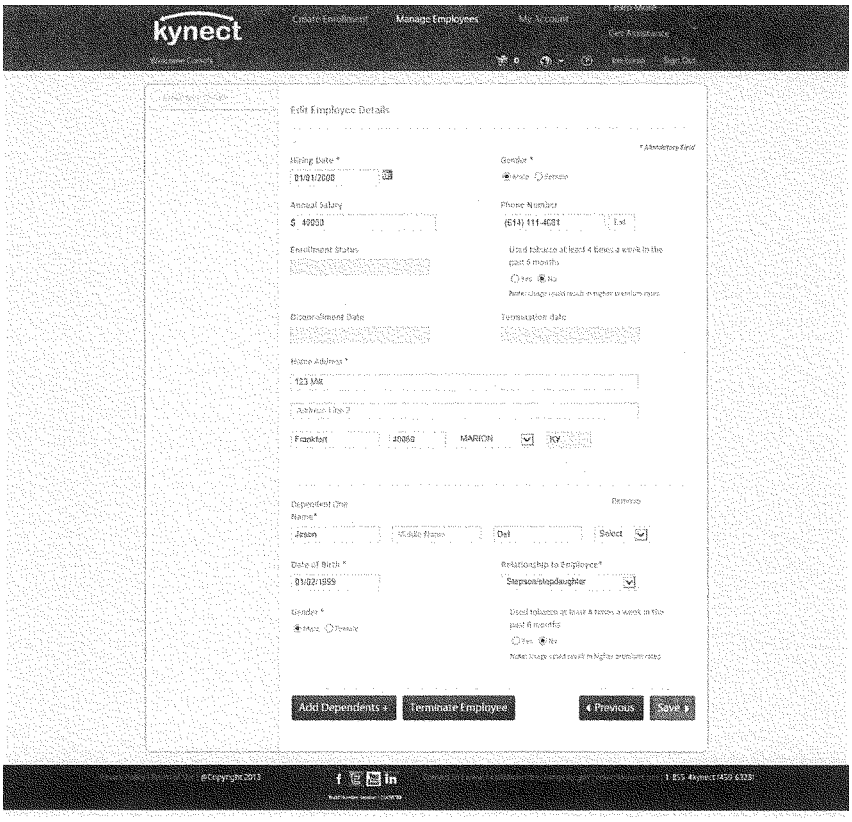

kynect
Create Enrollment
Manage Employees
My Account
Learn More
Get Assistance
Initial Enrollment Period October 5, 2013 - December 15, 2013
My Enrollments
My Enrollment
For 2014
Current participation ratio - 0.0%
Effective Date: 01-01-2014
In Progress
View Enrollment
Employee Name
Dependent Coverage
Status
Plan
@Copyright 2013

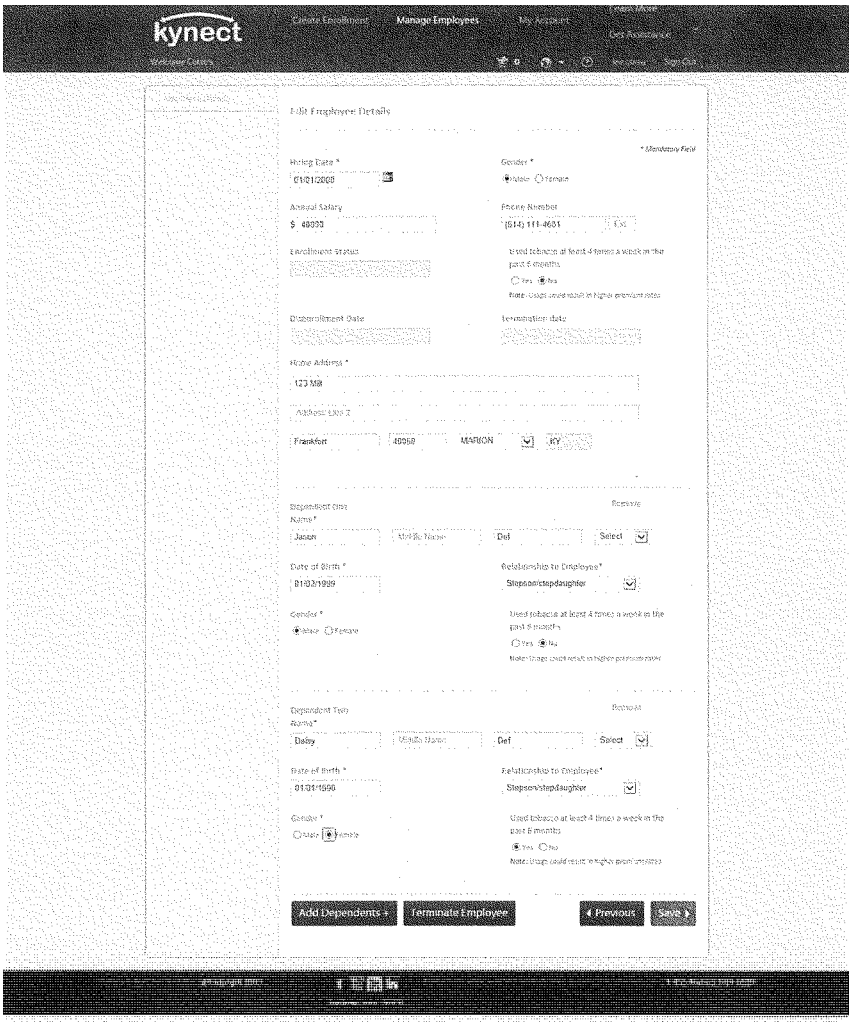

kynect
Create Enrollment
Manage Employees
My Account
Learn More
Get Assistance
Sign Out
My Enrollment
Back to Enrollment
Enrollment Setup
Enrollment Period
Coverage Effective Date
01/01/2014
Open Enrollment Start Date
10/05/2013
Open Enrollment End Date
12/15/2013
Employer's Contribution
Medical Insurance
For Employee
50.0%
For Spouse
30.0%
For Dependent
20.0%
Benefits
Employees can select any plan from the following Metal Levels and Insurance companies
Metal Levels
Insurance Companies
Gold
Humana, Inc.
Platinum
Silver
United HealthCare Services, Inc.
Bronze
The Guardian Life Insurance Company of America
Bluegrass Family Health, Inc.
Plans Selected
Medical Insurance
Insurance Company
Plan Name
Estimated Total Group Monthly Share
Estimated Employee Monthly Share
Annual Deductible
Bluegrass Family Health
Navigate Plus POS (V2-7)
Navigate Plus POS (V2-6)
Person
Family
@Copyright 2013
1-855-4kynect (459-6328)

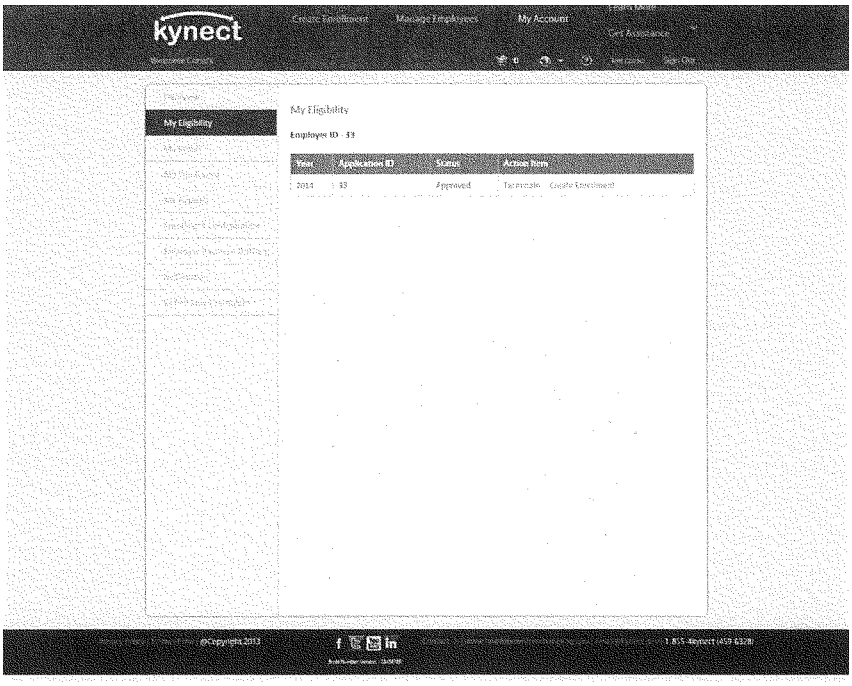

kynect
Notifications
From: *
To: *
Search
Notification Type
Received
Notify Employer of Successful Application Submission
10/05/2013
Your search returned 1 result
Notifications

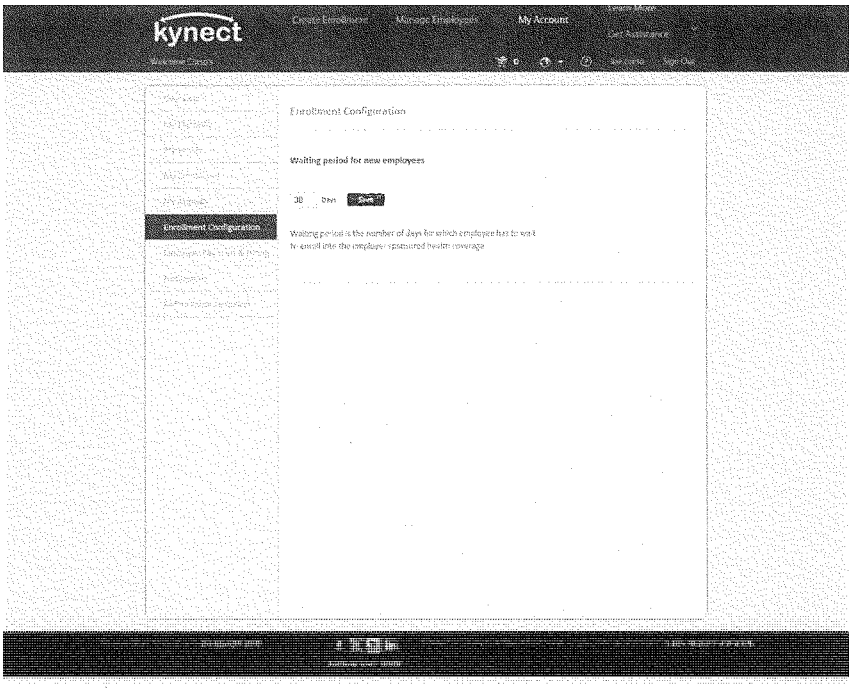



kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
Edit Employee Details
* Mandatory Field
Name *
Don
Middle Name
Def
Select
Social Security Number *
Date of Birth *
Email Address
Employment type *
Full Time
Cancel
Continue
©Copyright 2013

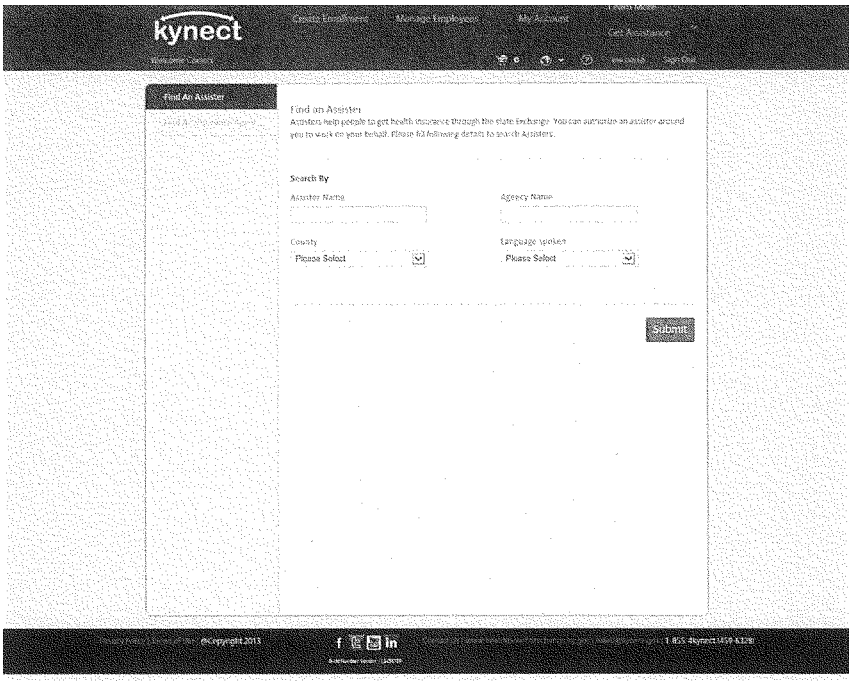

kynect
Create Enrollment
Manage Employees
My Account
Edit Employee Details
* Mandatory Field
Hiring Date *
01/01/2008
Gender *
Male
Female
Annual Salary
$ 40000
Phone Number
(614) 111-4081
Ext
Enrollment Status
Used tobacco at least 4 times a week in the past 6 months
Yes
No
Disenrollment Date
Termination date
Home Address *
123 MK
Address Line 2
Frankfort
40068
MARION
KY
Dependent One Name*
Jason
Middle Name
Dal
Select
Date of Birth *
01/02/1999
Relationship to Employee*
Stepson/stepdaughter
Gender *
Male
Female
Used tobacco at least 4 times a week in the past 6 months
Yes
No
Add Dependents +
Terminate Employee
Previous
Save
©copyright2013
1 855 4kynect (459 6328)

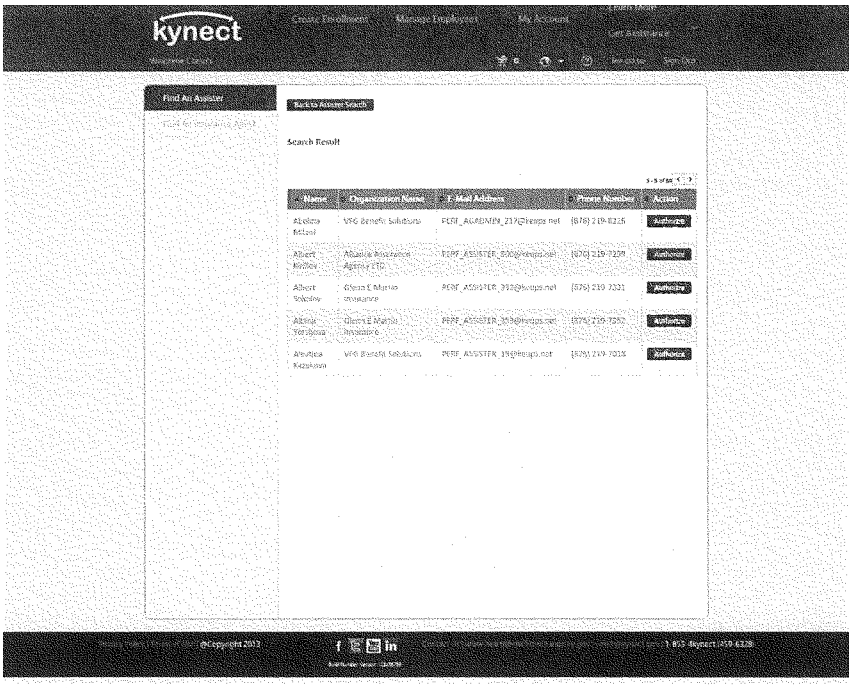

kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
Edit Employee Details
* Mandatory Field
Hiring Date *
01/01/2008
Gender *
Male
Female
Annual Salary
$ 48000
Phone Number
(614) 111-4631
Ext.
Enrollment Status
Used tobacco at least 4 times a week in the past 6 months
Yes
No
Note: Usage could result in higher premium rates
Disenrollment Date
Termination date
Home Address *
123 MB
Address Line 2
Frankfort
40068
MARION
KY
Dependent One
Name *
Jason
Middle Name
Def
Select
Date of Birth *
01/02/1999
Relationship to Employee *
Stepson/stepdaughter
Gender *
Male
Female
Used tobacco at least 4 times a week in the past 6 months
Yes
No
Note: Usage could result in higher premium rates
Dependent Two
Name *
Daisy
Middle Name
Def
Select
Date of Birth *
01/01/1999
Relationship to Employee *
Stepson/stepdaughter
Gender *
Male
Female
Used tobacco at least 4 times a week in the past 6 months
Yes
No
Note: Usage could result in higher premium rates
Add Dependents +
Terminate Employee
Previous
Save

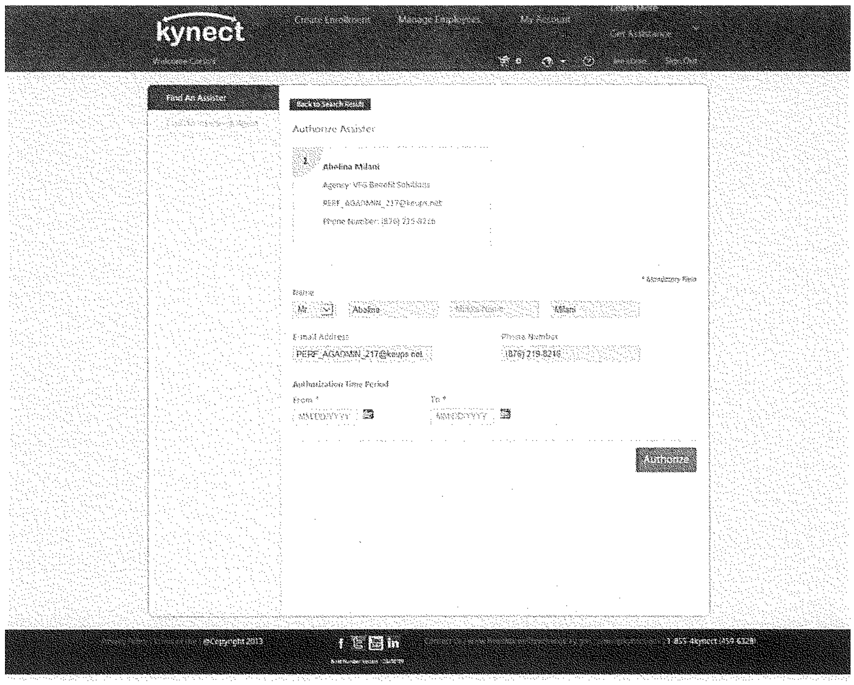

kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
My Eligibility
My Eligibility
Employee ID - 33
Year
Application ID
Status
Action Item
2014
33
Approved
Terminate
Create Enrollment
©Copyright 2013
1-855-kynect (459 6328)

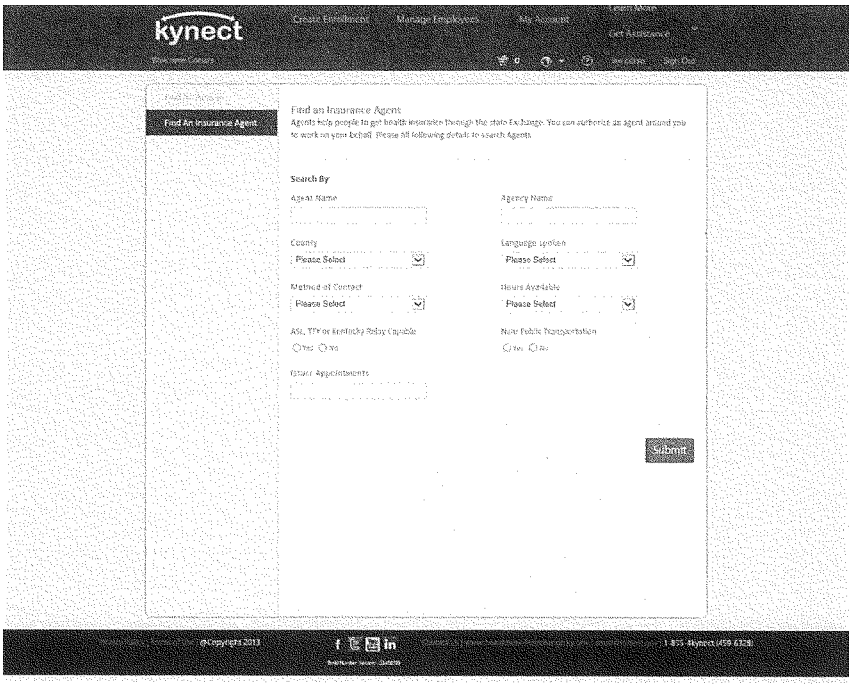

kynect
Create Enrollment
Manage Employers
My Account
Learn More
Get Assistance
Sign Out
Enrollment Configuration
Waiting period for new employees
30
Days
Save
Waiting period is the number of days for which employee has to wait
to enroll into the employer sponsored health coverage

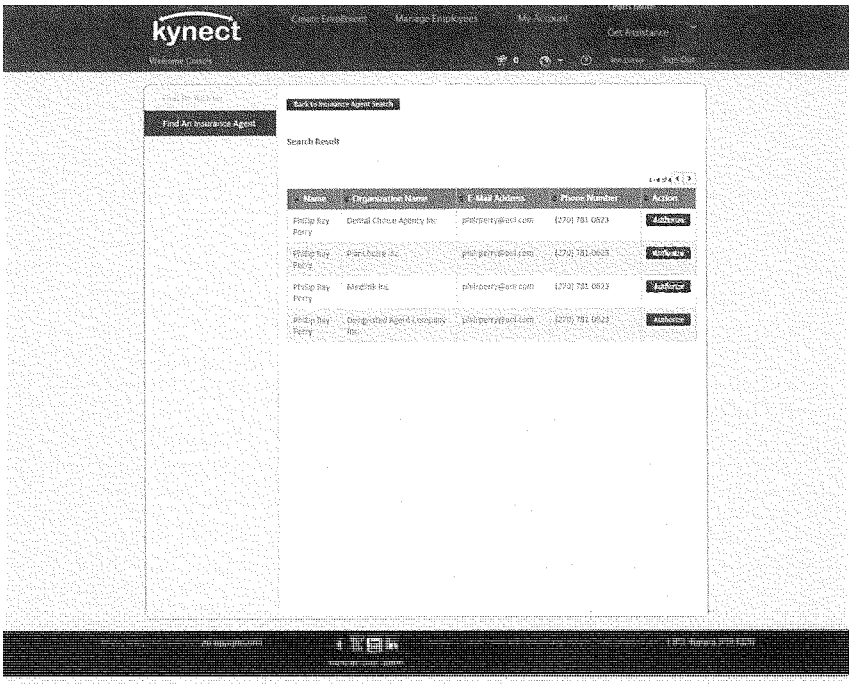

kynect
My Appeals
No Appeals Found
My Appeals

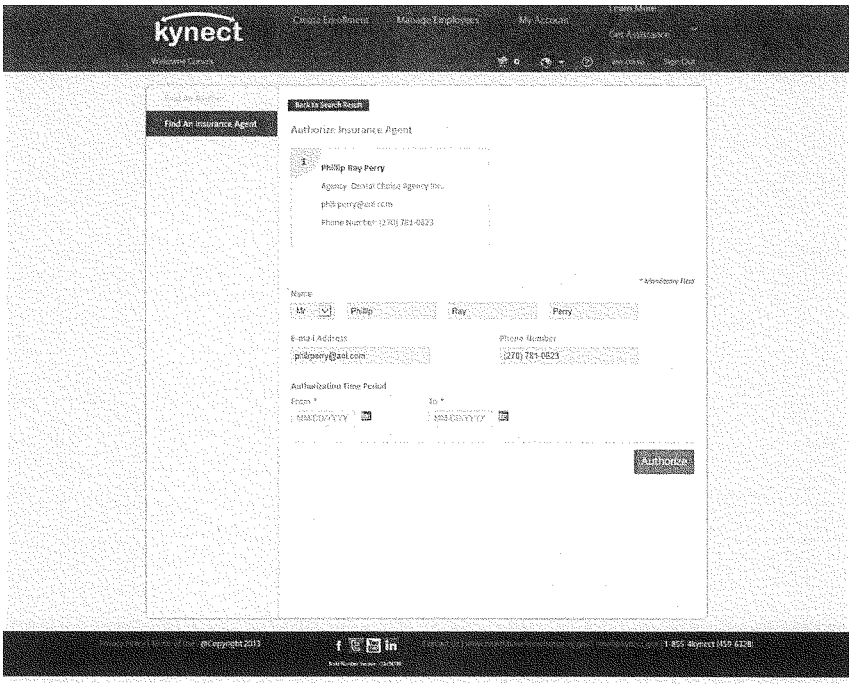

kynect
Find An Assister
Find an Assister
Search By
Assister Name
Agency Name
County
Please Select
Language Spoken
Please Select
Submit

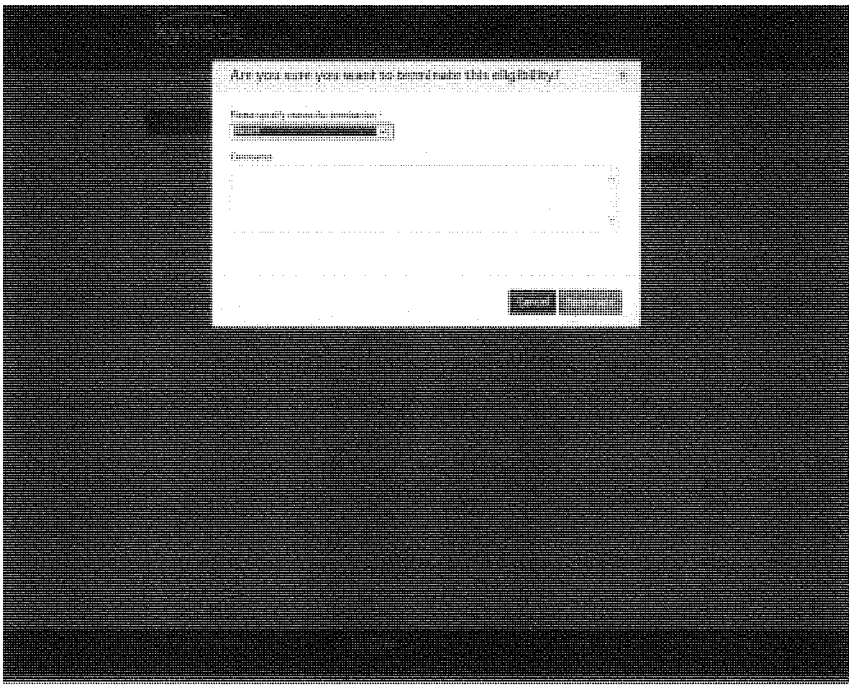

kynect
Find An Assister
Back to Assister Search
Search Result
Name
Organization Name
E-Mail Address
Phone Number
Action
Authorize


kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
Find An Assister
Back to Search Result
Authorize Assister
Abelina Milani
Name
Abelina
Milani
E-mail Address
Phone Number
Authorization Time Period
From *
To *
Authorize


kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
Sign Out
Find An Insurance Agent
Find an Insurance Agent
Agents help people to get health insurance through the state Exchange. You can authorize an agent around you to work on your behalf. Please fill following details to search Agents.
Search By
Agent Name
Agency Name
County
Please Select
Language spoken
Please Select
Method of Contact
Please Select
Hours Available
Please Select
ASL, TTY or Kentucky Relay Capable
Near Public Transportation
Yes
No
Open Appointments
Submit
©copyright 2013


kynect
Find An Insurance Agent
Back to Insurance Agent Search
Search Result
Name
Organization Name
E-Mail Address
Phone Number
Action
Philip Ray Perry
Dental Choice Agency Inc
philperry@aol.com
(270) 781 0823
Redirect
Philip Ray Perry
Medlink Rx
philperry@aol.com
(270) 781 0823
Redirect
Philip Ray Perry
philperry@aol.com
(270) 781 0823
Redirect

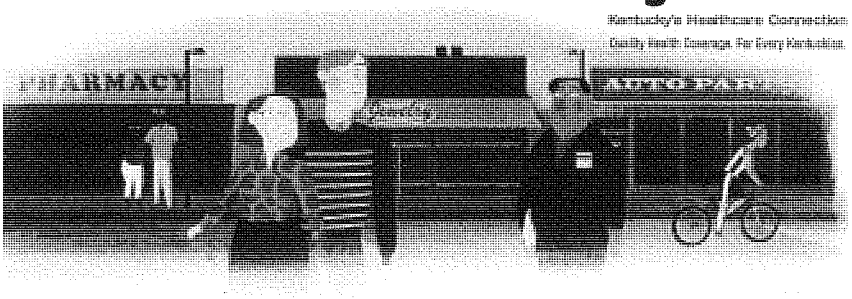

kynect
Create Enrollment
Manage Employees
My Account
Get Assistance
Find An Insurance Agent
Back to Search Result
Authorize Insurance Agent
PhilSip Ray Perry
Agency: Dental Choice Agency Inc.
phil-perry@aol.com
Phone Number: (270) 781-0823
* Mandatory Field
Name
Mr
Philip
Ray
Perry
E-mail Address
philperry@aol.com
Phone Number
(270) 781-0823
Authorization Time Period
From *
To *
Authorize


Are you sure you want to terminate this eligibility?


kynect
My Eligibility
My Eligibility
Employee ID - 35
Year
Application ID
Status
Action Item
2014
35
Termination Pending
©Copyright 2013

Small Business
fact sheet

kynect
Kentucky's Healthcare Connection
Quality Health Coverage For Every Kentuckian



New options for health coverage are good for business.

As an employer, you want to do what is best for your employees and your business. You may have found a lack of health insurance options to meet the needs of your business. kynect can help.

kynect is a health insurance marketplace that gives small businesses access to a new range of health plan choices. kynect makes it easier to compare a variety of qualified health plans from private insurance companies. As the employer, you decide the level of coverage provided to your employees. This is how much a health plan will cover of your employees' medical expenses. To help you make that decision, all health plans starting in 2014 will be classified into one of four metal categories:

Bronze *Silver* *Gold* *Platinum*

As the metal level increases in value, so does the percentage of medical expenses that a plan will cover. This means that the platinum level plan will cover the highest portion of medical costs at time of care. It will also have the highest premium cost. You can choose a plan with a higher premium and pay a lower out-of-pocket cost. Or, you can choose a plan with a lower premium and pay a higher out-of-pocket cost.

SHOP for lower insurance costs.

kynect will assist small group employers in enrolling their employees in health plans through the Small Business Health Options Program (SHOP). Small businesses can use kynect if they have 50 or fewer employees. Tax credits may be available for businesses with 25 or fewer full-time employees. To qualify for tax credits through kynect, a business must meet three requirements:

1. Employ 25 or fewer full-time employees.
2. Pay at least 50% of the premium for employees.
3. Meet a group average annual wage of less than $50,000.

Example of a Small Business Receiving Tax Credits

Business	Beauty Shop with 10 Employees Main Street Hair
Employees	10 full-time employees
Wages	$250,000 total or an average of $25,000 per employee
Employee Health Insurance Cost	$70,000
2013 Tax Credit	$24,500 (35%)
2014 Tax Credit	$35,000 (50%)

To learn more about tax credits, please consult the interactive calculator for Small Business Tax Credits at healthbenefitexchange.ky.gov
Tax credit amounts may vary based on employee size and average annual wages.

kynect.ky.gov 1-855-4kynect (459-6328)

Simplified solutions, greater choice.

kynect will help you provide affordable insurance to your employees and make it easy to manage. You make the big decisions. We help with the details and billing.

- **Easy comparisons.** kynect lets you easily compare a variety of health plans offered by private insurers. Plans on kynect follow a new set of consumer-friendly rules. You can go online to **kynect.ky.gov** or call **1-855-4kynect (459-6328), TTY: 1-855-326-4654.**

- **Employer choice.** You decide whether or when to participate in kynect. There is no designated open-enrollment period. After October 1, 2013, you can enroll according to your policy's renewal date or whenever you choose.

- **Employer control.** You choose the level of coverage, the amount of your contribution toward your employees' coverage and any amount you may want to contribute to family or dependent care. If you don't want to contribute to dependent coverage, you can encourage your employees to contact kynect to buy individual coverage for their family members.

- **Expanded choices.** kynect levels the playing field by giving you and your employees access to more plans.

- **No unexpected costs.** Your costs remain the same no matter which plans your employees choose because you control the amount of your contribution. This helps you control your budget.

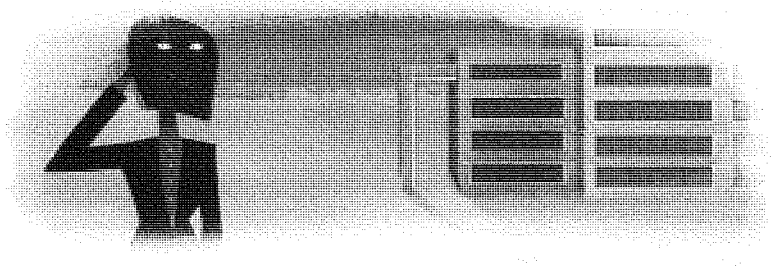
- **Simple administration.** One monthly bill. Plus, you can keep working with your current insurance agent. If you aren't working with an insurance agent, kynect can help you find an insurance agent or provide other assistance at no cost to you.

Coverage can begin as soon as January 2014.

Employer-sponsored health insurance is valuable for a number of reasons. People who are insured are protected against uncertain and high medical expenses. They are more likely to get healthcare. Health insurance also improves health outcomes and lowers mortality.

Employers with more than 50 employees that do not offer affordable insurance or offer coverage that does not meet the minimum standards may be subject to penalties starting in January 2015. Businesses with less than 50 employees that do not provide health coverage will not face a penalty.

Employees with health insurance are more likely to be productive workers. Offering health insurance can also help your business attract employees. It is a good business decision because of the favorable tax treatment to both the employer and the employee.



With almost half of all Americans receiving their health insurance from their employers, you – the business owner – play an important role. Many small businesses already offer health coverage. It helps them recruit and retain employees who are healthier, happier and more productive. kynect is good business for you and your employees.

kynect.ky.gov 1-855-4kynect (459-6328)

Quality Health Insurance Plans

that fit your budget

kynect

Applying is free, easy & confidential

At kynect, you can see your coverage options, all in one place, with one application. You can compare a wide variety of health insurance plans. kynect lets you make apples-to-apples comparisons of costs and coverage to help you decide which one is right for you.

Enrollment begins October 1, 2013, and coverage starts January 1, 2014. Federal law now requires that most individuals have health insurance or pay a penalty starting in 2014. Medicaid and Medicare coverage meet the requirement.

Through kynect, you can find out if you are eligible for Medicaid and help with monthly insurance bill payments or out-of-pocket costs.

Get the health benefits you need

Health insurance plans may also be called Qualified Health Plans or QHPs. All plans must offer the same 10 core benefits. These core benefits are also called essential health benefits and include:

- Doctor Visits
- Hospitalization
- Emergency Care
- Maternity and Newborn Care
- Pediatric Care, including Dental and Vision Care
- Prescriptions
- Medical Tests
- Mental Health Care and Substance Abuse
- Physical, Speech and Occupational Therapy
- Wellness

Plans must cover preventative care at no extra cost to you, including flu and pneumonia shots and routine vaccinations. Plans must also cover most cancer screenings, such as mammograms and colonoscopies. You will see exactly what each plan offers and can compare them side-by-side when you shop for a plan.

Find the plan that is right for you

When you compare health insurance plans on kynect, the plans are put into four "metal" levels. The levels are based on how you and the plan can expect to share the costs of care:

Bronze *Silver* *Gold* *Platinum*

The levels Bronze, Silver, Gold and Platinum do **not** reflect the quality or amount of care the plans provide. The level you choose affects how much your premium costs each month and what portion of the bill you pay for things like hospital visits or prescription medications. It also affects your total out-of-pocket costs — the total amount you will spend for the year if you need lots of care.

kynect.ky.gov 1-855-4kynect (459-6328)

Balancing monthly premiums with out-of-pocket costs

As with all health plans, you will have to pay a monthly premium. But it is also important to know how much you have to pay out-of-pocket for services when you get care.

In general, when choosing your health plan, keep this in mind: the lower the premium, the higher the out-of-pocket costs when you need care, and the higher the premium, the lower the out-of-pocket costs when you need care.

What to consider when choosing your plan

Think about the healthcare needs of your household when considering which health insurance plan to buy. Do you expect a lot of doctor visits or need regular prescriptions?

If you do, you may want a Gold or Platinum plan.

If you don't, you may prefer a Bronze or Silver plan. But keep in mind that if you get in a serious accident or have an unexpected health problem, Bronze and Silver plans will require you to pay more of the costs.

Can I get a minimum coverage plan?

kynect also offers "catastrophic" plans to people under 30 years old and those that qualify for "hardship exemptions." A catastrophic health plan is minimum coverage designed to provide an emergency safety net for unexpected medical costs. Preventive services would be covered at no cost before the deductible.

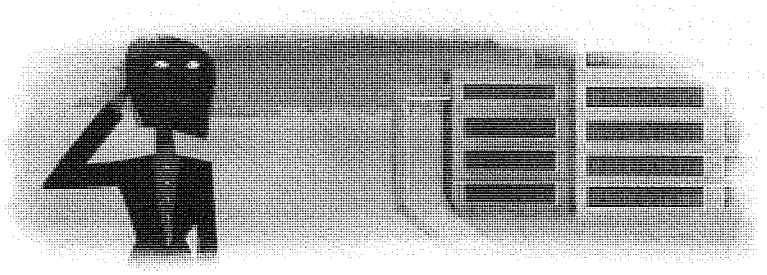
A hardship exemption is determined by the Federal government. To find out more, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

Why get health insurance?

Health coverage gives you protection and peace of mind. If you get sick or have an accident, you will have access to medical care. And starting in 2014, no one can be denied health coverage because of a pre-existing condition.

Help is available

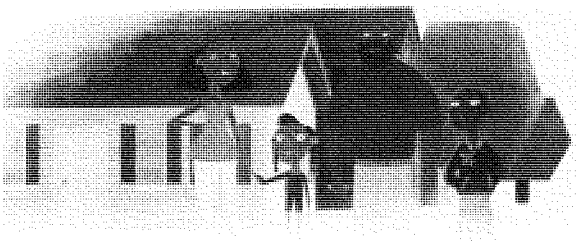
kynect has special groups ready to help you – Insurance Agents, kynectors and Customer Service. To learn more or to find an Insurance Agent or kynector, go to **kynect.ky.gov**. Customer Service is available at **kynect.ky.gov** or **1-855-4kynect (459-6328), TTY: 1-855-326-4654**.



kynect.ky.gov 1-855-4kynect (459-6328)

Individuals and Families
fact sheet

kynect
Kentucky's Healthcare Connection
Quality Health Coverage. For Every Kentuckian.



Getting Kentuckians Covered.

Kentuckians can soon buy health coverage a new way: through kynect, Kentucky's Healthcare Connection. kynect will offer choices of health plans at a good value. Coverage cannot be denied or canceled, even if you have a condition like high blood pressure or diabetes.

kynect can help you find quality coverage. It can help even if you were denied coverage before or could not afford it. It's a new kind of health insurance marketplace – convenient and easy to use.

Open enrollment begins October 1, 2013.

It's easy to apply, and coverage can begin as early as January 1, 2014. Just fill out one application to see if you can save money. kynect will show plans and prices. It also checks for low-cost or free coverage through Medicaid and KCHIP, the Kentucky Children's Health Insurance Program. Open enrollment ends March 31, 2014.

Help to shop.

There will be plenty of places to find out more about kynect. You can visit **kynect.ky.gov** or call customer service at **1-855-4kynect (459-6328), TTY: 1-855-326-4654.** When enrollment starts, we will have special groups trained and ready to help you

- **Insurance Agents**
- **kynectors**
- **Customer Service**

All these groups can help you find the best healthcare plan for you, your family and your budget. Free help is available in person, by phone and online.

Quality plans to meet your needs.

kynect health plans offer peace of mind. All plans will cover essential health benefits like doctor visits, trips to the hospital or emergency room, medicine and care for pregnant women and children.

Plans you can afford.

Many people know they need health insurance, but are concerned about cost. To make sure health coverage is affordable, kynect will help people find out if they qualify for:

Help with monthly bills: Just enter your income to see if you qualify. Payment assistance can lower your monthly bill.
Help with out-of-pocket costs: You may qualify for discounts on out-of-pocket expenses, like the co-payment when you go to the doctor.
Medicaid: Medicaid is low-cost health coverage for those who qualify, including people with disabilities and lower incomes. There are no premiums, but there may be some co-payments.

Compare health plans more simply.

With kynect, comparing different health plans is simple. Health plans offered on kynect will be in one of four new metal categories: Bronze, Silver, Gold and Platinum. As the metal level increases in value from Bronze to Platinum, so does the percentage of medical expenses that the plan will cover. For example, you could choose a Platinum plan with a higher premium and pay a lower out-of-pocket cost. Or you could choose a Bronze plan with a lower premium and pay a higher out-of-pocket cost.

kynect.ky.gov **1-855-4kynect (459-6328)**

In the chart below, you can see how different people may qualify for government help with the cost of health insurance. These examples are only estimates and may not apply to your situation. Costs will also vary based on what metal level of plan is selected.

Many people will qualify for help with insurance payments.

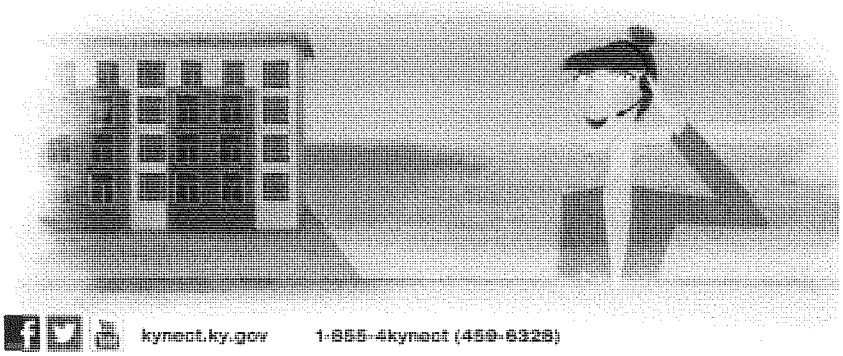
You are	*You qualify for*	*Your estimated cost to buy health insurance*
An individual 18 or older making less than $15,857*	Medicaid, a government program	No cost
An individual 18 or older making $20,000*	Payment assistance that you can use to pay for your insurance premium, and special discounts to pay less when you receive medical care**	Your estimated cost is $67 per month or $800 per year, if you pick the second-least-expensive Silver plan
An individual 18 or older making over $45,960*	You do not qualify for payment assistance or special discounts, but you are still eligible to buy health insurance through kynect	
A family of four making less than $32,500*	Medicaid, a government program	No cost
A family of four making $48,000*	Payment assistance that you can use to pay for your insurance premium, and special discounts to pay less when you receive medical care**	Your estimated cost is $252 per month or $3,024 per year if you pick the second-least-expensive Silver plan
A family of four making $80,000*	A tax credit that you can use to pay for your insurance premium**	Your estimated cost is $634 per month or $7,600 per year, if you pick the second-least-expensive Silver plan
A family of four making over $94,200*	You do not qualify for payment assistance or special discounts, but you are still eligible to buy health insurance through kynect	

*Income levels are based on the year 2013 **You must enroll through kynect to be eligible for payment assistance and special discounts

Make Sure You're Covered.

The new federal law requires most people over age 18 to have public or private health insurance or face fines beginning in 2014. To make sure you are covered, you need to enroll in health insurance before March 31, 2014.

kynect also has a special program for businesses with 50 or fewer employees. It is called the Small Business Health Options Program or SHOP.



kynect.ky.gov 1-855-4kynect (459-6328)

EBSA also provides the following comment For The Record:

With respect to the quote by Sen. Landrieu on page 115, lines 1 through 6, please note that the FLSA section 18B notice requirement applies to employers to which the FLSA applies. The FLSA generally applies to employers employing one or more employees who are engaged in interstate commerce and who have not less than $500,000 in annual dollar volume of business. DOL's Technical Release 2013-02 (attached), which provides guidance on the notice, sets forth a description of employers subject to the notice requirement.

H&R BLOCK®

December 4, 2013

Senate Committee on Small Business & Entrepreneurship
Attn: Editorial and Document Section
Rm: 428A
Russell Senate Office Building
Washington, D.C. 20510

RE: Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges

H&R Block is the world's largest consumer tax services provider. During our most recent fiscal year, which ended on April 30, 2013, we prepared more than 22 million U.S. tax returns. More than 5 million of those were prepared by small business owners who own and operate, through our franchise program, more than 40% of our 10,000 retail tax offices.

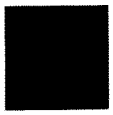
The Patient Protection and Affordable Care Act (ACA) creates a new intersection between health care and taxes. Since the law was enacted in 2010, we have been studying the impact to individual taxpayers and small businesses. Small business owners are tasked not only with navigating these complex provisions to understand the impact to their personal federal tax return filing requirements, but also the impact to their businesses and employees.

As a result, we have a strong interest in identifying taxpayers' knowledge and understanding of the tax implications of the ACA. To that end, we conducted two surveys with ORC International, one in September 2012, and one in April 2013. During the past tax season we also conducted a series of panel discussions engaging the general public, government officials, nonprofit organizations and small businesses.

The surveys indicate consumers know very little about the ACA's tax impact, including both the availability of tax subsidies and the shared responsibility payment. Specifically,

- three out of four taxpayers don't know what it takes to become eligible for health insurance under the new law,
- 35 percent of respondents aged 18-34 were not aware of the possible tax penalty for not obtaining health insurance, and
- 44 percent of the respondents indicated that they were most likely to seek out information on the ACA from their employer.

Yet, our surveys and panel discussions echo the testimony of Ms. Marianne O'Brien Markowitz, Regional Administrator of the U.S. Small Business Administration, before the Committee on November 20th, 2013: that there is a great deal of misinformation surrounding the ACA among small business owners.



H&R BLOCK®

In the next few months, millions of these taxpayers will turn to their trusted tax advisors to file their 2013 federal income tax returns. H&R Block believes this presents a significant opportunity to perform educational outreach and our 80,000-plus tax professionals and associates will be doing their part to help fill the education gap. You can see an example of our efforts at helpth.com

We are also partnering with GoHealth, a web-broker entity (WBE), to provide enrollment assistance for our clients who may be in the market for health insurance. On November 25, the Department of Health and Human Services issued proposed regulations that would allow WBEs to assist small employers and their employees enroll in health insurance through the Small Business Health Options Program. We are encouraged by this development as we believe it would help achieve a successful rollout of these small business exchanges.

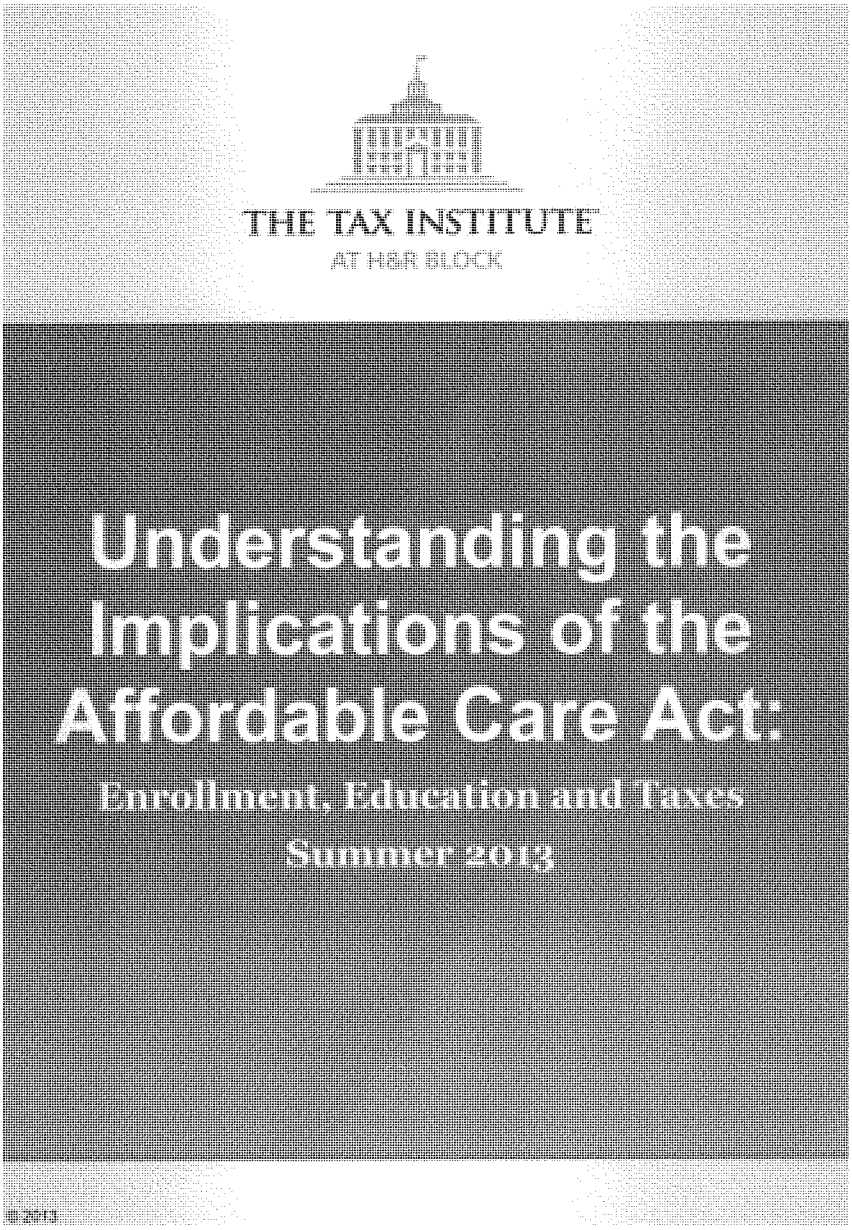
We have attached the following report, which summarizes our surveys and panel discussions mentioned above: *Understanding the Implications of the Affordable Care Act: Enrollment, Education and Taxes*. The section on small businesses starts on page 11.

We would welcome the opportunity to discuss this report as well as our unbiased education and outreach efforts around this new, complex intersection of healthcare and taxes.

Thank you for your consideration.

K Pickering

Kathy Pickering
H&R Block's Vice President of Government Relations and Executive Director of the Tax Institute at H&R Block.


THE TAX INSTITUTE
AT H&R BLOCK
Understanding the Implications of the Affordable Care Act:
Enrollment, Education and Taxes
Summer 2013
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ABOUT THE TAX INSTITUTE AT H&R BLOCK

The Tax Institute at H&R Block is the go-to source for objective insights on federal and state tax laws affecting the individual. It provides nonpartisan information and analysis on the real world implications of tax policies and proposals to policymakers, journalists, experts and tax preparers. The Institute's experts include CPAs, Enrolled Agents, tax attorneys and former IRS agents. Building off more than 10 years of research and analysis from a specialized tax research group at H&R Block, the company launched The Tax Institute in 2007.

ABOUT THIS REPORT

From February through April of 2013, The Tax Institute at H&R Block conducted nationwide panel discussions on the implications of the Patient Protection and Affordable Care Act (ACA). Focused on the intersection of taxes and health care created by the ACA, as well as on education, enrollment and outreach issues, we visited Washington, D.C., Tallahassee, Florida, Sacramento, California and Springfield, Illinois. At each stop, a diverse panel of experts spoke on their areas of expertise, and on the unique challenges they foresaw for each state. Each panel was moderated by an expert from Bloomberg Government, and questions were encouraged from audiences of local government officials, medical professionals, business leaders, non-profits and other associations, and other relevant stakeholders. This report presents the findings and conclusions from the tour, from each stop individually as well as collectively.

ACKNOWLEDGEMENTS

This report, and the tour it has drawn from, would not have been possible without the support and participation of a wide range of groups and individuals. First thanks go to all who attended the panel discussions. Whether as a panelist or audience member, the expertise, insights and questions you brought were truly the lifeblood of the tour and this report. We also thank all of the media organizations that promoted each event and amplified the conversations that came from them. Finally, we thank our partner Bloomberg Government, including all the analysts and staff who contributed to the production of these programs. This report would not have been possible without the help of each of these groups, and again we thank you.

Letter to our readers:

The Patient Protection and Affordable Care Act (ACA) not only contains the most significant reforms the American health care system has seen in decades, but also some of the largest changes to the tax code.

At H&R Block our purpose is to look at life through tax and find ways to help. This groundbreaking law, and the new, inextricable link between health care and the tax code, has created many unique and unprecedented issues for taxpayers and the uninsured. As a result we began to look ahead to the 2014 implementation and asked, "How is this going to affect taxpayers" and, "How can we help?" This is something H&R Block has done for our clients since 1955 – helping to navigate complicated federal laws in a practical way.

With an eye to the fall 2013 open enrollment season when some of the more broad-reaching parts of the ACA will be enacted, The Tax Institute at H&R Block conducted a wide-ranging consumer opinion survey in September 2012. The survey, conducted by ORC International, found that three out of four taxpayers don't know what it takes to become eligible for health insurance tax subsidies under the new law, including that their 2012 tax return could be used as a baseline for the credit. The study also found that while most people are familiar with the requirement to obtain insurance, 44 percent of respondents age 18-34 were not aware that they may face a tax penalty if they fail to obtain insurance.

While many of the current conversations about the ACA are focused on setting up the insurance marketplaces for open enrollment in October, the survey told us that there's also a real need to educate consumers on the tax implications of this monumental law.

This is why we launched a series of panel discussions. The nationwide conversations, which were conducted in partnership with and moderated by Bloomberg Government, brought together thought leaders from the government, the private sector, non-profit groups and academia to talk about challenges and opportunities facing those who will navigate the new system.

After the last discussion, The Tax Institute at H&R Block commissioned another ORC survey in April 2013, which asked the same questions that were asked in September 2012 and tested for questions raised during the discussions. The discussions and survey confirmed that individual awareness remains a challenge, outreach and enrollment efforts are still being developed and refined, and small businesses are eager for information and support.

The bottom line? Implementing the landmark ACA is still a work in progress and strong partnerships among government officials, nonprofit groups, private industry and other key stakeholders will be essential in helping consumers navigate the system.

We hope this report helps to draw attention to the key issues and challenges that consumers must navigate. We at H&R Block look forward to continuing to be part of this important conversation, and working with all stakeholders moving forward.

K Pickering

Kathy Pickering
Executive Director
The Tax Institute at H&R Block

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EXECUTIVE SUMMARY

More than three years after the passage of the landmark Patient Protection and Affordable Care Act (ACA) aimed at overhauling the $2.7 trillion[1] U.S. health care system, implementation has begun in earnest to provide 30 million uninsured[2] Americans with coverage. As the federal government and states work to expand the health care system, there no doubt will be confusion, uncertainty and the occasional setback along the way.

Since implementation relies in part on the U.S. tax code, The Tax Institute at H&R Block partnered with Bloomberg Government to host panels around the country to discuss the challenges, opportunities and potential solutions related to ACA implementation. In early 2013, we traveled to Washington, D.C., Tallahassee, Fla., Sacramento, Calif. and Springfield, Ill. to better understand the road ahead for implementing the ACA and how these key states' differing approaches will affect the uninsured.

The discussions focused on topics such as how to best make large and diverse populations aware of the coming changes; innovative ways to reach audiences and drive enrollment; how these changes affect the way companies provide health care to their employees; and how states are preparing to assist the uninsured in the enrollment process. We found that:

- **Awareness of the implications of the ACA remains low**. People have received information that is inaccurate, incomplete or haven't received any information at all. Frustrations are already elevated, and the appetite for knowledge is low.
- **Outreach and enrollment efforts are still being developed and refined**. The people who will guide consumers through this process have not been fully identified, the scope of their roles has not been solidified, and the tools and techniques they will use have not been finalized.
- **Small businesses are eager for information and support**. Most of these companies lack the capability or resources to manage all their options and responsibilities, and are looking for assistance from the government and the private sector.
- **Technology is an open question**. Whether or not requisite data will be seamlessly and sufficiently integrated will be a critical factor in preventing confusion and delays.

To understand what's ahead for consumers, it is essential to learn what they do or do not know. Despite all the media attention, political discourse and public debate about the forthcoming changes and deadlines for implementing the law, many remain unaware of its benefits and their responsibilities going forward.

- A survey conducted by The Tax Institute at H&R Block and ORC International in September 2012 found that 77 percent of Americans were unaware that their 2012 tax return may be used as a baseline for their income if they choose to take advantage of a tax credit to help subsidize the cost of health insurance. That number remained consistent, at about 73 percent, based on a similar survey conducted in April 2013.
- Approximately 44 percent of 18-34-year-olds were also unaware that they could face a tax penalty if they do not have insurance, which would be imposed in April 2015. On a positive note, the April 2013 survey showed a shift for these respondents. Unawareness among 18-34-year-olds was at 35 percent, some 9 points below the September survey.

The September figures added urgency during our panel discussions. Collectively, the discussions showed the great obstacles that the government, health care providers, insurers, tax preparers and other organizations must overcome in the approaching months and years to educate a large cross-section of the country on their obligations to secure health care coverage and the tax consequences of remaining uninsured. They also highlighted the level of collaboration that will be necessary between the public and private sectors to successfully launch and sustain the new health care system.

In addition to the critical issue of how to raise awareness, participants discussed the challenges of reaching a diverse American population and potential solutions, including lessons learned from the implementation of the federal prescription drug program known as Medicare Part D and the State Children's Health Insurance Program (SCHIP). Questions were also raised about who is best suited to provide that information to consumers and what will happen to one of the largest segments affected by the new law – small business owners and their employees.

Participants in the forums universally agreed that despite the inevitable setbacks, public and private entities must work together to create innovative ways to educate taxpayers and the uninsured about their obligations and opportunities under the ACA. Unique solutions proposed included the use of emerging technology as a way to assist enrollment and provide information, guidance and assistance to small businesses and their employees who are expected to face the most challenges when trying to explain and implement the changes.

Sister Carol Keehan, President and CEO of the Catholic Health Association of the United States and a panelist at the Washington, D.C. panel discussion, put it best: In order to make the system work, we must all "have faith, go forward, fix problems."

The Intersection of Health Care & Taxes

The Requirement to Obtain Insurance

Perhaps the ACA's most widely known feature is the requirement to obtain health insurance coverage. Beginning in 2014, almost all Americans will be required to enroll in a qualified health plan, or be forced to pay a tax penalty. The amount of the tax penalty will be phased in between 2013 and 2016, and will vary based on filing status and income.

Traditionally, the majority of Americans have secured health insurance coverage through their employer[3]. The ACA seeks to maintain the primacy of that system by requiring businesses to provide insurance if they employ more than 50 full-time equivalent workers. Companies at this size that do not offer coverage could face a penalty of up to $2,000 per employee. Some companies will be eligible for tax credits to help buy employee insurance, which again vary based on workforce size and average wages.

Exemptions from the Requirement

Individuals who earn less than $9,750 per year are not subject to the requirement to obtain insurance and the penalty. In addition, recent regulations list the individuals who are exempt from the requirement to obtain insurance and therefore the tax penalty and how such exemptions are to be claimed. In sum, there are eight exemptions, divisible into three categories: those which require an individual to obtain a certificate from an exchange, those which an exchange certificate is available but not required, and those which may only be claimed when filing a tax return. The following is a list of exempt individuals.

- Exchange certificate required
  - A member of a recognized religious sect
  - An individual experiencing hardship
- Exchange certificate *or* claim when filing tax return
  - A member of a health care sharing ministry
  - An incarcerated individual
  - A member of a federally recognized Indian tribe
- Claim only when filing tax return
  - An individual not lawfully present
  - An individual offered coverage by an employer that is unaffordable
  - An individual experiencing the first short-term coverage gap of the calendar year

Tax Credits to Obtain Insurance

The Congressional Budget Office estimates that 22 million Americans will receive tax credits, also known as premium subsidies, to purchase insurance through the exchanges by 2017[4]. Those credits move along a sliding scale depending on a variety of factors.

Families and individuals with incomes ranging between 133 percent and 400 percent of the federal poverty level may be eligible for advance tax credits to help them purchase health insurance. However, these tax credits are only available if the insurance is purchased through one of the new insurance marketplaces, also known as exchanges.

Insurance Marketplaces (Exchanges)

At the time of this report, 17 states and the District of Columbia are planning to open their own state-controlled health insurance marketplaces this October. Just over half the states, 26, will rely on the federal health exchange. Another seven states will offer a hybrid model, working in partnership with the federal program. Each of these approaches provides unique opportunities and challenges for their residents. The states examined in this report are as follows:

	California	Florida	Illinois	National
Type of Exchange	State	Federal	Hybrid	
Uninsured	7,325,500	3,823,100	1,683,800	48,611,600
Total Medicaid Enrollment (FY 2009)[1]	11,027,600	3,402,858	2,884,757	62,900,000
Eligible for the tax credit	2.6 million	1.7 million	667,300	20 million (Families USA) 22 million by 2017 (CBO)
Small businesses (2010)	571,290	387,100	253,500	4,758,500
Small businesses eligible for subsidy[2]	456,500 (79.9%)	246,000 (63.7%)	192,800 (75.8%)	4,015,300 (83.7%)

AWARENESS

By far, the most talked about issue during the discussions was the level of awareness about the forthcoming changes to health care insurance and what stakeholders are doing, and must do, to help educate Americans about their obligations to have coverage and dispel any confusion or misinformation.

"I just think it's really critical that we all know that we have a tremendous amount to gain if we get it right as we come through these changes, and that's going to take every one of us to deploy that information."

Former Sen. Blanche Lincoln (D-Ark.)
February 15, 2013,
Washington, D.C. discussion

The numbers paint a vivid picture about just how much Americans know about the ACA, according to two surveys conducted by The Tax Institute at H&R Block and ORC International. The surveys found that many knew about the risk of a tax penalty for not having insurance coverage: 71 percent in April 2013 (up from 68 percent in September 2012). Yet, in April 2013 an even greater number of respondents, 73 percent, did not know that their 2012 tax return could be used as the baseline for determining their eligibility to receive financial support to pay for health care coverage.

The surveys also reinforced the fact that Americans do not plan to change the way that they do their taxes, despite knowing now that their income will dictate how much of a tax credit they could be eligible to receive as a result of the ACA. Some 84 percent said in April that they would prepare their taxes the same way, up from 78 percent who said the same last year.

"I think the issue of awareness is the single most important issue right now facing this law. And one of the dangers of everybody being responsible is that nobody is responsible," Peter Gosselin, an analyst at Bloomberg Government, said during the Tallahassee, Fla. event.

That could have significant implications for the millions of uninsured Americans who will be affected by the ACA. The population of uninsured in just the three states that The Tax Institute and Bloomberg Government visited – California, Florida and Illinois – is more than 13 million, nearly 3 million of whom are expected to join the health care marketplaces during the first year of open enrollment[7], which begins in October 2013.

	April 2013	September 2012
Yes (Nationwide)	71%	65%
No (Nationwide)	29%	35%
Age 18-34	65%	44%

"Communication is going to be, as it normally is, the biggest challenge," former Sen. Blanche Lincoln (D-Ark.), who was a key player during negotiations for the ACA, said during the Washington, D.C. forum. "There is so much misinformation that people may not even seek out information because they're so angry or upset or so confused by the misinformation that they've already gotten."

And of course the central question is: where will consumers get this information?

According to the April and September surveys, 54 percent of respondents said that they were most likely to ask friends and family. That was followed by 49 percent who said that they would ask an insurance company, 45 percent who said a doctor and 44 percent who said their employer.

"There is no average American family when it comes to health reform because what the program means is very different for different people, depending on their circumstances," Professor Mark Paul, of University of Pennsylvania Wharton School of Health Care Management Department, said during the forum in Washington, D.C.

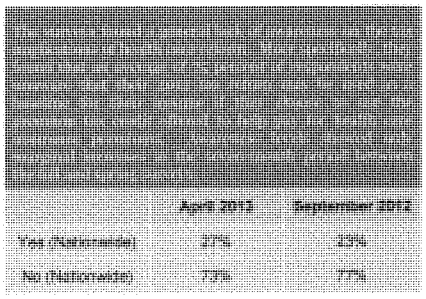
Panelists discussed the awareness gap of some Americans, noting that sometimes it is hard for the information to penetrate.

"I think we all share responsibility in that [awareness and education], and I think starting with the federal government, moving down to the health plans, moving over to the tax professionals, we're all going to play a part in this."

Dr. Michael W. Garner, President and CEO, Florida Association of Health Plans February 28, 2013, Tallahassee, Fla. discussion

"They're either in low-wage jobs or the cost of health care greatly exceeds the price of employment or they have a preexisting condition where the cost of health care is just much too great for them to be able to afford it or it isn't even offered because it's too expensive," Allan Zaremberg, president and CEO of the California Chamber of Commerce, said at the forum in Sacramento.

"For many of the people who don't have access today, it isn't just about: Now you have insurance. It is to be able to show them that this is going to result in better health care for them, that there are clinics available, that there are physicians available, there are nurse practitioners available, there's a health care system that's available for you if you sign up here," he said.



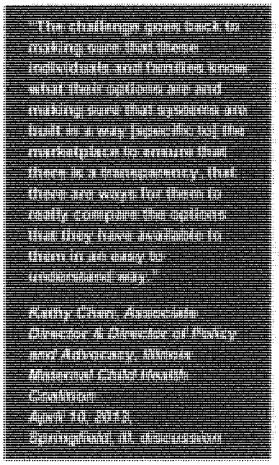
Panelists also highlighted that some of those without existing insurance coverage are not the easiest to reach. Furthermore, the message is not a simple one and needs to be communicated more than just once, as noted by Kathy Chan, associate director and director of policy and advocacy for the Illinois Maternal and Child Health Coalition during the forum in Springfield, Ill.

"One of the marketing things that we keep hearing is that it takes about seven times for somebody to hear a message or hear a name before it really resonates with them. And it takes over 30 times for them to hear either the same or a similar message for them to actually take action," she said.

OUTREACH & ENROLLMENT

While it is relatively easy to draw attention to an issue or raise concerns, the surveys and panel discussions sparked lively debates about how best to conduct the necessary outreach to get Americans to enroll in the health care insurance marketplaces and educate them about the potential tax implications.

Panelists expressed concerns that there are long ways to go to identify the people who will guide Americans through the insurance enrollment process and that the scope of their roles coupled with the tools to accomplish the goal have yet to be finalized. They also noted that enrollment is further complicated by the fact that some states are hosting their own insurance marketplaces and other states are allowing residents to enroll in the federal marketplace.



To succeed, outreach and enrollment would have to go far beyond using communications tools such as advertising and traditional and social media. Additional efforts and support would have to come from community organizations, local and state officials and authorities, health care providers, among many others. The consensus that emerged during the forums was that it must be an "all of the above" implementation plan.

"I think that awareness never ends," said Rose Naff, CEO of Florida Health Choices, one of that state's insurance marketplaces. "The marketplaces will have to do a much broader awareness campaign. And in Florida, that program will be grants given by the federal agency to navigators and other persons."

While each state's circumstances are unique based on its population and its approach to implementing the ACA, the overall message is largely the same: enroll to ensure better health, receive information about financial assistance available to help pay for insurance and help slow soaring health care costs.

California provided a snapshot of one aggressive effort focused on overcoming the challenges. The state has the seventh largest uninsured population in the country with more than 7.3 million without coverage[8], and nearly 60 percent of that population is Hispanic[9].

"We are fortunate here in California that the state did choose to create their own exchange, Covered California" said Larry Levitt, vice president of special projects at the Kaiser Family Foundation. "I've been in discussions with Covered California here about their plans for outreach, and they're appropriately worried about the task ahead of them but have done a tremendous job of thinking about how to tailor these messages to the diversity of the state."

He noted that the state was working with community groups and various types of media including outlets that focus on certain ethnic communities and radio. "Radio often is a very effective source for some communities," Levitt said during the Sacramento forum.

Another panelist pointed to other recent examples to help foreshadow what the ACA's first year of open enrollment will look like in California. "It took California four years before its own State Children's Health Insurance Program reached maximum enrollment back in the late 1990s," said Dylan Roby, director of Health Economics and Evaluation Research Programs at the UCLA Center for Health Policy Research.

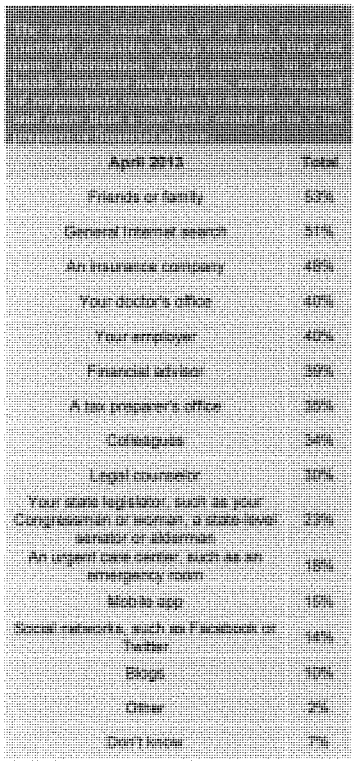
To date, the state's Medicaid program currently only has about 61 percent enrollment of those eligible, according to Roby. "So there is concern in California about making sure that people are actually using the services that they're entitled to, taking advantage of those subsidies, enrolling in Medi-Cal."

On the other coast, Florida also has a high population of uninsured (20 percent[10]). Unlike California, the state chose not to create its own health insurance marketplace which means residents can enroll through the federal government marketplace. Millions are expected to enroll and many are expected to be eligible for the tax credits. The state has had experience with reaching out to its communities to enroll them in health programs before, such as Florida Healthy Kids, a public-private partnership that provides young children health care.

Other more recent programs also offer insight into best practices on how to inform a hard-to-reach population. For example, Medicare Part D was launched in 2006 to help seniors lower the cost of the medicine they needed through federal subsidies.

"If you look at the educational efforts that have been directed to older people regarding Medicare Advantage options and Medicare Part D, the prescription drug plan, when that was first introduced, everybody said, 'Oh, older people will never be able to understand their options, never be able to make rational choices,'" said Professor Marshall Kapp, Director, Center for Innovative Collaboration in Medicine & Law, Florida State University. "The educational effort has worked pretty well in those areas. So we do have some models to emulate perhaps."

Today, just a few years after Medicare Part D began, there has been a significant proliferation of new technologies that will aid enrollment. Mobile technology will help the uninsured sign up on the spot with a portable electronic device such as a tablet or smartphone, whether it is at a hospital, doctor's office, pharmacy, or clinic – virtually anywhere.



April 2012	Total
Friends or family	53%
General Internet search	51%
An insurance company	46%
Your doctor's office	40%
Your employer	40%
Financial adviser	39%
A tax preparer's office	35%
Colleagues	34%
Legal counselor	30%
Your state legislator, such as your Congressman or woman, a state-level senator or alderman	21%
An urgent care center, such as an emergency room	18%
Mobile app	15%
Social networks, such as Facebook or Twitter	14%
Blogs	10%
Other	2%
Don't know	7%

"We believe mobile apps touch a substantial number in this population. When we've gone out and tested, we've been amazed at how many folks at various income strata have access to cell phones and have use of various social media," said Paul Keckley, executive director for the Deloitte Center for Health Solutions. "So what we're trying to work through is the right method of pushing to them information and teachable moments, when their decisions about where they get care from clinic or [emergency department] or somewhere can be influenced and they can be enrolled and at least begin that enrollment process through a mobile app."

One additional place they could enroll might be at their tax preparer's office, which panelists suggested would be a natural fit because millions of Americans use their services each year and the new health care law is closely tied to their annual tax returns.

Illinois Deputy Governor Cristal Thomas recognized that, "There will be a lot of assisters out there who may not be grantees but will be interacting with a population and will want to help them, help get them information or help them apply and that will include employers. That will include providers, hospitals. It will include tax preparers."

"That effort is already well underway. Even now our professionals are educating clients across the country about these issues," said Kathy Pickering, Executive Director of The Tax Institute at H&R Block.

Small businesses may also have a role to play in educating their employees. Some employees who do not interact with the health care system – largely because they are healthy – could still need basic information, such as what is a deductible, premium and tax credit, Laura Minzer, executive director for the Health Care Council at the Illinois Chamber of Commerce said during

the Springfield, Ill. event. "I think many small employers see that they can be the go-to entity for that."

Minzer was not alone in advocating the concept of using small business employers as the conduit for information about the coming changes because that is where the bulk of Americans spend most days.

"It's really important that the government have the consistent, friendly message that an employer can deliver to the employee because that's where they are on a regular basis," said Allan Zaremberg, president and CEO of the California Chamber of Commerce.

SMALL BUSINESSES

The small business community has received significant attention as the ACA takes effect, with some policymakers and commentators expressing concerns about the costs to small businesses that may not have the necessary resources or capital to make healthcare available.

The April and September surveys found that employers are a significant resource for employees to receive information about health care, and 40 percent of those polled said that they would trust their employer to help them enroll for health insurance. That would suggest that small businesses will still need to communicate how their workers can receive health care coverage through the federal or state health insurance marketplaces.

> "It's important that they get a consistent message ... [employees] can't get two different messages from two different employers. So we have to make sure that the message is consistent."
>
> Allan Zaremberg, President and CEO, California Chamber of Commerce
> March 21, 2013
> Sacramento, Calif. discussion

But one of the biggest concerns will be the risk for further bureaucracy that could leave small businesses drowning in confusion and paperwork. Many small businesses operate on slim margins, and to create additional red tape related to offering health insurance coverage could have significant effects on their bottom lines. As one forum participant put it, many business owners are not just the chief executive officer, they're also responsible for many additional roles, leaving little time for sorting out complications.

"I always say to my own members, 'the guy who is changing your oil is the CEO, the director of HR, he's got six employees.' You just can't make this so complex," said Sister Carol Keehan, president and CEO of the Catholic Health Association of the United States.

> "That person who has 49 employees and says 'I don't have a penalty, so I'm going to drop my health care,' we don't want that to happen. I think that's really clear. We want to do everything we can to continue to make sure that that employer is responsible."
>
> Allan Zaremberg, President and CEO, California Chamber of Commerce
> March 21, 2013
> Sacramento, Calif. discussion

Others strongly echoed the call for simplicity. "The more simplified we can make it from a government's perspective in dealing with small business, certainly from the incentives to provide health care, the more successful we'll be," Zaremberg said.

Some also expressed concern that small businesses that do offer health insurance may decide to drop that benefit and send their employees to the health insurance marketplaces. Putting aside the public policy debates associated with such a shift, the system must be ready for an influx of these workers. During such a transition the businesses would need to provide comprehensive information to employees who will then have the responsibility to go enroll in the new marketplaces.

"Especially when you are talking to those mid-level employers, mid-size employers that are kind of on that bubble, it's causing a lot of anxiety and

angst," said Minzer. "But I think the good news is there are options that are opening up when we talk about the exchange and the benefit to, value to, employers."

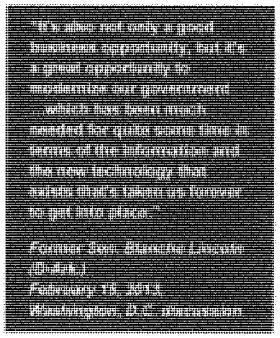
"I think it's important to think of these small business owners not just as carriers of the message but, in fact, as targets of the messages as well," said Larry Levitt, vice president of special projects at Kaiser Family Foundation.

TECHNOLOGY

While health care uses some of the most sophisticated technology to evaluate and diagnose patients, other parts of the system, such as making patient medical records electronic and allowing the seamless transfer of information between providers, have been racing to catch up. When policymakers adopted the new health care law, technology was seen as a major factor to help speed and improve care as well as lead to increased efficiencies and cost savings.

During the panel discussions, questions arose about whether the new enrollment systems will be sufficiently robust and interconnected. Other questions included:

- Can the enrollment forms be filled out electronically and continue to be accurate?
- Will the individual's income reported on their tax returns populate the forms?
- Will that information be accurate and will the formulas properly calculate the tax credit or tax penalty owed by the taxpayer for coverage?



"When you think about the incredible interoperability and connectivity you're going to have to have, the IT functionality of all of this is enormous," said Minzer, executive director of the Health Care Council for the Illinois Chamber of Commerce.

Specifically, the system faces the question of whether the requisite data will be seamlessly and sufficiently integrated to support the individual enrollee and his or her family. For example, state marketplaces will need federal income tax information, via queries sent to the Internal Revenue Service to determine eligibility for tax subsidies to help pay for health coverage.

"Even if California puts all this energy into getting the system up, if on October 1, 2013, they send a query to the federal government, to the IRS and say: 'What's line 40 of your 1040 form for this person and nothing comes back or the wrong number comes back and it doesn't calculate it appropriately, then people will start to get disenfranchised," said Dr. Roby of UCLA's Center for Health Policy Research.

Dr. Roby also noted that there were technology-related issues early during the Medicare Part D prescription drug program enrollment period a few years ago, which led to confusion and delays for some seniors who were unable to get their medications on time. On top of that, the ongoing political duels in Washington related to the budget sequestration efforts could further undermine connecting states and the IRS to help enrollment. That could leave consumers "between a rock and a hard place," Dr. Roby said.

Additionally, this greater connectivity between tax returns and the health insurance business raises questions about ensuring that information provided, such as Social Security numbers and income details, remain secure.

There are safeguards already in place to protect such sensitive information and that will have to extend to the new systems. That will open opportunities for entrepreneurship, but in the meantime could cause some angst as the health care infrastructure races to catch up to the rest of the business world in the technology field.

"The irony is there are almost 4,000 HIT [health information technology] vendors in the U.S. system with all kinds of apps… So it's a market that's being consolidated fast. It's a market where its standards – not just privacy and security, but technical standards – are very much a work in process," said Keckley of Deloitte.

CONCLUSION

The nationwide panels hosted by The Tax Institute at H&R Block and Bloomberg Government led to a robust discussion about awareness, outreach, enrollment, small businesses and technology as the federal and state governments work to implement the Patient Protection and Affordable Care Act.

New surveys and the discussions during the tour showed that there is still significant work to be done during the coming months and years, particularly with raising awareness and conducting outreach to ensure enrollment in the health insurance marketplaces is a success. While awareness is relatively high on the need to enroll, numbers are low for people who know that their tax return could be a key piece of information necessary to help them receive financial support to help pay for coverage.

That knowledge will be crucial as organizations work to reach out to those uninsured Americans and explain to them their obligations and how to sign up for coverage. Complicating that process is the fact that those who will guide them through that process have not yet been fully identified and their roles have not been completely worked out. Further, the discussions also highlighted the challenges of reaching certain constituencies and the lengths it will require to educate them.

It is not just uninsured Americans who need assistance: small businesses are one constituency that is also vital to support because many of them lack the capacity or resources to navigate the new health care options. Some are looking to the marketplaces to assist during this time of uncertainty. That's particularly important because employees think of their bosses as a primary and trusted resource for information about their health care options.

Some of these issues can and likely will be solved by technology, whether it's a mobile application on a tablet computer or smartphone, or integrated systems that help uninsured Americans obtain a tax credit to pay for insurance coverage. This can improve and speed coverage, and ultimately help to stem costs and improve efficiencies.

As new parts of the landmark health law take effect, there are still many questions to answer. The forums around the country highlighted just how much active and ongoing engagement from all types of stakeholders – private, public and traditional ones in the health care industry and other, newer faces – will be necessary to help ensure success. We look forward to continuing to foster and participate in these discussions that engage policymakers, state administrators, businesses and taxpayers as we all face the road head toward full implementation of health care reform.

APPENDIX

Tour Locations and Participants

February 15, 2013, Washington, D.C.

Moderator: Megan Hughes, Bloomberg TV

Megan Hughes is a Washington D.C.-based correspondent for Bloomberg Television. Hughes covers all aspects of government including regulatory reform, lobbying, tax policy and healthcare legislation. Hughes is also a reporter for Bloomberg Government, or BGOV, Bloomberg's data, research and news product offering exclusive insight into the intersection of business and government policy.

Hughes has reported extensively from the campaign trail of the 2012 presidential election. She provided live coverage of the Super Tuesday primary from the battleground state of Ohio and was stationed in Iowa for the state's caucus in January. Hughes also covered the U.S. Supreme Court hearing of the Affordable Care Act, state labor disputes and the showdowns over collective bargaining rights in Wisconsin and Ohio. In 2011, she interviewed governors from around the country at the National Governors Association meeting in Salt Lake City, Utah.

Prior to joining Bloomberg in 2011, Hughes covered politics in Washington D.C. for CNN Newsource, Hearst and Bloomberg. Prior to that, Hughes served as a Washington correspondent for Cox Media Group, where she covered the 2008 Presidential election, President Obama's inauguration, the Virginia Tech shootings and other stories for Cox television affiliates around the country. Hughes has also reported internationally, covering world events and feature stories from South Africa, Thailand, South Korea and more. Earlier in her career, Hughes reported for WRAL-TV in Raleigh and WIS-TV in Columbia, South Carolina.

A native of Cleveland, Ohio, Hughes earned both her bachelor's and master's degrees from Northwestern University, majoring in journalism with a concentration in political science

Panelist Biographies

Former Sen. Blanche Lincoln, (D-Ark.)

On November 3, 1998, Senator Blanche L. Lincoln made history when she became the youngest woman ever elected to the United States Senate at the age of 38 – a milestone that still exists today. Lincoln made history again on September 9, 2009, when she became the first female to serve as chairman of the Senate Agriculture, Nutrition and Forestry Committee in its 184-year history.

During her 16-year career in the U.S. Congress, first as a two-term member of the House of Representatives and then as a two-term member of the U.S. Senate, she built a reputation as a results-oriented, bipartisan legislator. She served on several committees in Congress, including the House Committee on Agriculture, House Energy and Commerce Committee, Senate

Committee on Agriculture, Nutrition and Forestry, Senate Committee on Energy and Natural Resources, Senate Special Committee on Aging and the Senate Finance Committee, and is widely recognized as a national leader in the areas of agriculture, anti-hunger, aging, healthcare, international trade, taxes and energy policy.

As one of the Finance Committee's top-ranking Democrats, Lincoln was named the first woman Democratic Senator to lead a Finance Committee subcommittee. During her time on the Finance Committee, she went on to chair two subcommittees and helped develop and pass legislation reducing taxes, improving healthcare and expanding international trade.

A senior member of the Energy and Natural Resources Committee, Senator Lincoln worked to produce bipartisan legislation improving energy efficiency and enhancing domestic energy supplies including nuclear and renewable sources.

In her fight against hunger, she founded the Senate Hunger Caucus and used her chairmanship of the Senate Agriculture, Nutrition and Forestry Committee to author and enact the largest investment in child nutrition programs ever. The new law was deficit-neutral, established nutritional standards for school lunches for the first time, received strong bipartisan support and was signed into law by President Obama.

As a farmer's daughter, she became known as a champion of production agriculture who fought to ensure that producers were able to continue to provide the safest, most abundant and affordable supply of food and fiber to meet the global needs of the 21st century.

Senator Lincoln is a Helena, Ark. native and received a bachelor's degree from Randolph-Macon Woman's College in Lynchburg, Va.

Professor Mark Pauly, Professor of Health Care Management, University of Pennsylvania, Wharton

Mark V. Pauly holds the position of Bendheim Professor in the Department of Health Care Systems at the Wharton School of the University of Pennsylvania. He received a Ph.D. in economics from the University of Virginia. He is a professor of health care systems, insurance and risk management, and business and public policy at the Wharton School and professor of economics in the School of Arts and Sciences at the University of Pennsylvania. Dr. Pauly is a former commissioner on the Physician Payment Review Commission and an active member of the Institute of Medicine.

One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His classic study on the economics of moral hazard was the first to point out how health insurance coverage may affect patients' use of medical services. Subsequent work, both theoretical and empirical, has explored the effect of conventional insurance coverage on preventative care, on outpatient care and on prescription drug use in managed care. In addition, he has explored the influences that determine whether insurance coverage is available and, through several cost-effectiveness studies, the influence of medical care and health practices on health outcomes and cost. His work in health policy deals with the appropriate design for Medicare in a budget-constrained environment and the ways to reduce the number of uninsured through tax credits for public and private insurance.

Dr. Pauly is co-editor-in-chief of the International Journal of Health Care, Finance and Economics and associate editor of the Journal of Risk and Uncertainty. He has served on the Institute of Medicine panels on improving the financing of vaccines and on public accountability for health insurers under Medicare. He is an appointed member of the U.S. Department of Health and

Human Services National Advisory Committee to the Agency for Healthcare Research and Quality (AHRQ).

Sister Carol Keehan, President and CEO of the Catholic Health Association of the United States

Sister Carol Keehan, DC, RN, MS, is the ninth president and chief executive officer of the Catholic Health Association of the United States (CHA). She assumed her duties as of October 2005. She is responsible for all association operations and leads CHA's staff at offices in Washington, DC, where she is based, and in St. Louis.

Sister Carol worked in administrative and governance positions at hospitals sponsored by the Daughters of Charity for more than 35 years. Most recently, she was the board chair of Ascension Health's Sacred Heart Health System, Pensacola, Fla. Previously, she served for 15 years as president and chief executive officer of Providence Hospital, which includes Carroll Manor Nursing and Rehabilitation Center, in Washington, DC. In the early 1980s, she served as Providence Hospital's vice president for nursing, ambulatory care, and education and training. In addition, she has served in leadership positions at Sacred Heart Hospital, Cumberland, Md. and Sacred Heart Children's Hospital and Regional Perinatal Intensive Care Center, Pensacola, Fla.

Sister Carol has held influential roles in the governance of a variety of health care, insurance and educational organizations. She had been a representative to the International Federation of Catholic Health Care Associations of the Pontifical Council for Pastoral Health Care. She serves on the board of Catholic Relief Services, Baltimore. In addition, she has been a member of several health, labor and domestic policy committees of the United States Conference of Catholic Bishops, Washington, DC, and serves on the finance committee of the Archdiocese of Washington.

Currently, Sister Carol serves on the boards of St. John's University, Queens, N.Y., and the University of St. Thomas, St. Paul, Minn. She has served on the boards of the District of Columbia Hospital Association, of which she is a past chair; Care First/Blue Cross of Maryland and the National Capital Area, Owings Mills, Md., and its affiliate, Group Hospitalization and Medical Services, Inc. In addition, she has previously served on the nominating committee of the American Hospital Association, the finance committee of the Maryland Hospital Association and is a past chair of the Florida State Human Rights Advocacy Commission.

Her numerous awards and honors include the American Hospital Association's Trustee Award; the Pro Ecclesia et Pontifice (Cross for the Church and Pontiff), bestowed by Pope Benedict XVI; the American Cardinals' Encouragement Award; the Medal of Honor and the Monsignor George C. Higgins Labor Advocacy Award from the Archdiocese of Washington; the Seton Legacy of Charity Medal awarded by The Daughters of Charity Emmitsburg Province; LCWR 2011 Outstanding Leadership Award, Leadership Conference of Women Religious, Silver Spring, Md.; the Elizabeth Ann Seton Award, given by SOAR!, Silver Spring, Md.; the Cardinal Joseph Bernardin Award from Catholic Common Ground Initiative, New York; the 2009 Vision Award from Catholic Charities USA; and the Friend of Children Award from Children's National Medical Center, Washington, D.C. Sister Carol was named in 2010 one of TIME magazine's "100 Most Influential People in the World" and has been on Modern Healthcare's list of "100 Most Influential People in Healthcare" several years, having topped the list as number one in 2007.

Sister Carol received honorary doctorates from Niagara University, N.Y.; the College of the Holy Cross, Worcester, Mass.; St. John's University, Queens, N.Y.; The Catholic University of America, Washington, D.C.; Marymount University, Arlington, Va.; and from DePaul University, Chicago. She earned a bachelor of science degree in nursing from St. Joseph's College, Emmitsburg, Md., where she graduated magna cum laude, and a master of science degree in

business administration from the University of South Carolina, Columbia, from which she received the School of Business Distinguished Alumna Award in 2000 and was honored in 2009 as "an outstanding alumna who has served others in a manner that goes beyond what is required by the individual's job or profession."

Paul Keckley, Executive Director for the Deloitte Center for Health Solutions

Paul H. Keckley, Ph.D., is executive director for the Deloitte Center for Health Solutions, a research center within Deloitte LLP. He brings a distinguished 35-year career in health services research and policy analysis in the private sector and academic medicine.

Dr. Keckley is a health economist and a leading expert on U.S. health industry trends and reform. He has testified before Congress and advised policymakers in Republican and Democratic administrations. As executive director of the Deloitte Center for Health Solutions, he leads a team of policy analysts and health services researchers who investigate health care industry business trends and regulatory issues pertinent to state and federal government, health systems, health insurance, device and drug manufacturers and information technology companies.

He is an adjunct professor in the School of Health Systems Administration at Georgetown University, author of the Monday Health Reform Memo and a regular contributor to CNN, Fox News, New York Times, Wall Street Journal, CNBC, Bloomberg, Forbes and the Financial Times among others.

Prior to joining Deloitte, Dr. Keckley served in leadership roles at Vanderbilt Medical Center including international joint ventures, the Vanderbilt Center for Integrative Health, the healthcare MBA program launch and as executive director of the Vanderbilt Center for Evidence-based Medicine (VCEBM).

He completed his B.A.at Lipscomb University, M.A. and Ph.D degrees from The Ohio State University and a fellowship in economic policy at Oxford University.

Moderator: Christopher Flavelle, Bloomberg Government Senior Health Care Analyst

Christopher Flavelle is a health care policy analyst for Bloomberg Government.

He holds a master's degree from Columbia University's School of International and Public Affairs and a bachelor's degree from McGill University.

Before joining Bloomberg Government, he covered the 2009 U.S. stimulus package for ProPublica, the investigative news group in New York.

Panelist Biographies

Dr. Michael W. Garner, President and CEO, Florida Association of Health Plans

Dr. Michael W. Garner serves as president and CEO of the Florida Association of Health Plans (FAHP), the state trade association for HMOs and PPOs in Florida. The association represents 20 health plans serving every health care market in the state, including Commercial, Medicaid, Medicare, Children's Health Insurance and the Federal Employee Health Plan.

Garner received his bachelor's, master's and doctorate degrees from the University of Florida in political science with specialties in health and environmental policy. During this time, he conducted research on the effects of persistent impoverishment on health status and the effects of maternal and child health programs on reducing low weight births and infant mortality.

He has worked for both the private and public sectors and started his career as a health planner with the North Central Florida Health Planning Council in Gainesville, Fla., conducting community needs assessments and implementing Florida's Healthy Start program, a program providing screening and services for pregnant women and infants. After the Health Council, Garner worked for Blue Cross and Blue Shield of Florida (BCBSFL) as a senior policy analyst, focusing on state and federal health policies including mandates (e.g., mental health parity and any willing provider), civil remedy, and the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. From BCBSFL, he worked for a period with the Mayo Clinic in Jacksonville establishing a Medicare outpatient reimbursement system before moving to Tallahassee in 2000, to work for the Florida Legislature. His career with the Florida Legislature included working as a senior analyst with the Legislature's evaluation office, the Office of Program Policy Analysis and Government Accountability (OPPAGA). Garner worked on a wide range of policy issues while with OPPAGA including Medicaid efficiencies, Medicaid fraud and abuse prevention and detection, environmental assessment methodologies and administrative structures in school districts in Florida.

Garner moved to the Florida House of Representatives' Committee on Health Care in 2004 where he served as a senior legislative analyst, with primary focus on Medicaid, KidCare and private health insurance reform. In 2005, he joined the Florida Senate Health Committee where he focused on Medicaid, KidCare, long-term health care, private health insurance and environmental health. During this time, he served as the lead staff on the Senate Select Committee on Medicaid Reform. Garner left the Florida Senate as a chief legislative analyst.

Peter Gosselin, Senior Health-care Analyst, Bloomberg Government

Peter Gosselin is a senior health-care analyst with Bloomberg Government. He was a special economic adviser for health reform at the Department of Health and Human Services and chief speechwriter to Treasury Secretary Timothy Geithner.

Gosselin spent 35 years at newspapers, most recently as chief economics correspondent for the Los Angeles Times.

He has a bachelor's degree from Brown University and an MBA in economics from Columbia Business School.

Professor Marshall Kapp, Director, Center for Innovative Collaboration in Medicine & Law, Florida State University

Marshall Kapp is the director of the Florida State University Center for Innovative Collaboration in Medicine & Law and a faculty member in the FSU College of Medicine and FSU College of Law. Formerly, he served as the Garwin Distinguished Professor of Law and Medicine at Southern Illinois University Schools of Law and Medicine. He also is professor emeritus from Wright State University School of Medicine and served for more than 20 years as a member of the adjunct faculty at the University of Dayton School of Law.

He served from 2004-2010 as the editor of the Journal of Legal Medicine, the official scholarly publication of the American College of Legal Medicine, and was named as an editor emeritus of JLM in 2010. He currently serves as the editor of the Social Science Research Network (SSRN) e-Journal Medical-Legal Studies and serves on the editorial boards of several other major journals in the health law field. He has published and spoken extensively on topics in health law, medical ethics, and law and aging.

Rose Naff, Chief Executive Officer, Florida Health Choices

Rose Naff began her service-driven career in state government at the Florida Department of Insurance. She is a proven leader and innovator in the area of child health policy, outreach, insurance and health care finance. In 1990, Naff joined the Florida Healthy Kids Corporation. Over the course of 18 years, she developed the Corporation into a national model, assisted in implementing state and national health care policies, established fiscal guidelines for programs throughout the country and worked closely with both state and federal legislators. In 2009, she was appointed chief executive officer of Florida Health Choices, Inc. by the Board of Directors.

During her tenure with Florida Healthy Kids, Naff was recognized on numerous occasions for her efforts on behalf of Florida's uninsured children. In 1996, she accepted an Innovation in American Government Award from the Ford Foundation and the Kennedy School of Government at Harvard University. The program was again recognized by Harvard in 2002 as a sustaining model of public-sector innovation of national significance. In addition, Naff received the 2005 Jack Hardy Health Care Communicator of the Year award from the Florida Hospital Association.

Moderator: Christopher Flavelle, Bloomberg Government Senior Health Care Analyst

Panelist Biographies

Larry Levitt, Vice President of Special Projects, Kaiser Family Foundation

Larry Levitt is vice president of special projects for the Kaiser Family Foundation. He previously served as editor-in-chief of kaisernetwork, the Foundation's online health policy news and information service, vice president of communications and director of the Foundation's Changing Health Care Marketplace Project. Before joining the Foundation, Levitt was a senior manager with The Lewin Group, where he advised public and private sector clients on health policy and financing issues. He previously served as a senior health policy advisor to the White House and Department of Health and Human Services, working on the development of President Clinton's Health Security Act and other health policy initiatives. He co-chaired the working group on cost containment in conjunction with the President's Task Force on Health Care reform.

Prior to that, he served as the special assistant for health policy with California Insurance Commissioner John Garamendi, where he co-authored Commissioner Garamendi's "California Health Care in the 21st Century" proposal. Before joining Insurance Commissioner Garamendi's office, Levitt was a medical economist with Kaiser Permanente, where he worked on insurance reform and other public policy issues. He previously managed new program development for the Massachusetts Department of Medical Security, the agency charged with implementing the universal health care plan in Massachusetts. He was responsible for the design of new health programs under the plan and for management of the fund used to reimburse hospitals for uncompensated care. He also served as a senior analyst with the governor's budget office in Massachusetts, where he helped develop that state's universal health care legislation.

He holds a bachelor's degree in economics from the University of California at Berkeley, and a master's degree in public policy from Harvard University's Kennedy School of Government.

Dr. Dylan Roby, Director of Health Economics and Evaluation Research Programs, UCLA Center for Health Policy Research

Dylan H. Roby, Ph.D, is the director of the Health Economics and Evaluation Research Program at the UCLA Center for Health Policy Research. He is also an assistant professor in the Department of Health Policy and Management in the UCLA Fielding School of Public Health.

Roby is currently working on a study of limited English proficient HMO enrollees for the Office of the Patient Advocate, as well as a study predicting the impact of health reform on California's population with the UC Berkeley Center for Labor Research and Education. He is also working on several projects evaluating state programs, including a long-term evaluation of California's Low Income Health Program. He also conducts data analyses and policy research related to hospital financing, health insurance affordability, workers' compensation, chronic care management, managed care and provision of care to the uninsured. In addition to his research, Roby teaches American Political Institutions and Health Policy (HPM 286) and Introduction to Health Services (HPM 100) in the UCLA Fielding School of Public Health.

Roby served as the associate director of the MPH Program from 2010-2012. Prior to becoming the director of Health Economics and Evaluation Research, he was a senior researcher at the Center from 2003 to 2011. Before returning to UCLA, Roby worked for four years as a senior research associate at The George Washington University Center for Health Services Research and Policy. He worked on safety net issues, including data analysis and research on community health centers and public hospitals. During his time in Washington, D.C., he also worked for the National Association of Community Health Centers, the National Governors' Association's Center for Best Practices and the Progressive Policy Institute. Roby was also an instructor at The George Washington University Department of Health Policy. Prior to that, he was a research assistant at the UCLA Center for Health Policy Research.

Roby graduated from UCLA with a bachelor's degree in geography and a minor in public policy. He earned his doctoral degree in public policy from The George Washington University.

Allan Zaremberg, President and CEO, California Chamber of Commerce

Allan Zaremberg is president and chief executive officer of the CalChamber. He took over the top staff position in 1998 after six years as executive vice president and head of CalChamber's legislative advocacy program.

Enhancing the state's economic growth has been the goal of Zaremberg's activities. He has headed statewide ballot campaigns to close the legal loophole that permitted shakedown lawsuits, to assure adequate funding for transportation infrastructure and to oppose anti-business proposals that would have raised the cost of health care, electricity and public works. He led negotiations culminating in comprehensive reforms of workers' compensation, endangered species laws and other key issues.

Before joining CalChamber, Zaremberg served as chief legislative advisor to and advocate for Governors George Deukmejian and Pete Wilson. Zaremberg served as a captain and flight navigator on a KC-135 jet air refueling tanker while in the U.S. Air Force from 1970 to 1975.

He received a B.S. in economics from Penn State University and a J.D. from the McGeorge School of Law, University of the Pacific, where he was a member of the Law Journal.

Moderator: Peter Gosselin, Bloomberg Government Senior Health Care Analyst

Panelist Biographies

Illinois Deputy Governor Cristal Thomas, Deputy Governor of Public Policy, Office of the Governor

Cristal Thomas, MPP was appointed deputy governor by Illinois Governor Pat Quinn in February 2011. In this capacity, Thomas is responsible for overseeing development and implementation of Governor Quinn's public policy agenda.

Before joining the Quinn Administration, she served as regional director for the U.S. Department of Health and Human Services, Region V. Prior to her appointment to the HHS Regional Director's Office, Thomas was executive director of the Ohio Executive Medicaid Management Administration (EMMA), where she provided strategic direction, policy coordination and guided business process improvement projects across six state agencies responsible for service delivery in health care, aging, public health, mental health and developmental disability systems. She also served during the Strickland administration as Ohio Medicaid Director, responsible for administering the Medicaid and State Children's Health Insurance Programs in Ohio, as well as implementing many of the governor's health care initiatives.

Thomas was assistant director of the Illinois Department of Healthcare and Family Services (HFS), the state agency responsible for the Illinois Medicaid and child support enforcement programs. She began her career as a policy and regulatory analyst in the White House Office of Management and Budget, where she focused on federal health care policy.

She is a graduate of Ohio State University and received a master's degree in public policy from the University of Chicago.

Laura Minzer, Executive Director, Health Care Council, Illinois Chamber of Commerce

Laura Minzer currently serves as the executive director of the Illinois Chamber of Commerce's Healthcare Council, one of six business issue councils that serve as the Chamber's primary resource for responding to and influencing healthcare policy. In that role, she serves as the Chamber's lead on health reform, interpreting and responding to state and federal legislation and regulatory issues regarding implementation of the Affordable Care Act and other issues that impact the health insurance market and the broader healthcare system in Illinois. She has also served as a member of the Illinois State Health Improvement Planning Team 2009-2010 and is currently a member of the Illinois Department of Public Health's Leadership Team with their Community Transformation Grant/We Choose Health initiative that supports public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities and help control healthcare spending.

In addition to her role as executive director, she also serves as the associate vice president of Government Affairs for the Chamber, assisting in the management and lobbying of state legislative issues of interest to the Illinois Chamber and its diverse membership, including issues related to healthcare, the budget, taxes, civil law, environment and energy, workforce development and employment law, infrastructure and procurement.

Minzer joined the Chamber in 2007 after spending seven years as a legislative analyst for the Illinois House Republican Caucus, handling policy and budget issues for health and human services and K-12 education.

She has a B.A. in political science and international relations from Boston University.

Michael Koetting, Deputy Director for Planning & Reform Implementation, Illinois Department of Health Care and Human Services (HFS)

Michael Koetting is deputy director for Planning & Reform Implementation at the Illinois Department of Healthcare and Family Services. He oversees implementation of health reform in the Illinois Medicaid program, ensuring that 700,000 new clients can be correctly enrolled by the end of 2013, and will also spearhead substantial changes in the program's delivery system. Prior to joining the department, Koetting was vice president of planning for the University of Chicago Medical Center for 23 years.

He holds an M.A. and Ph.D. in sociology from Harvard University and a B.A. in English from Saint Louis University.

Kathy Chan, Associate Director & Director of Policy and Advocacy, Illinois Maternal and Child Health Coalition

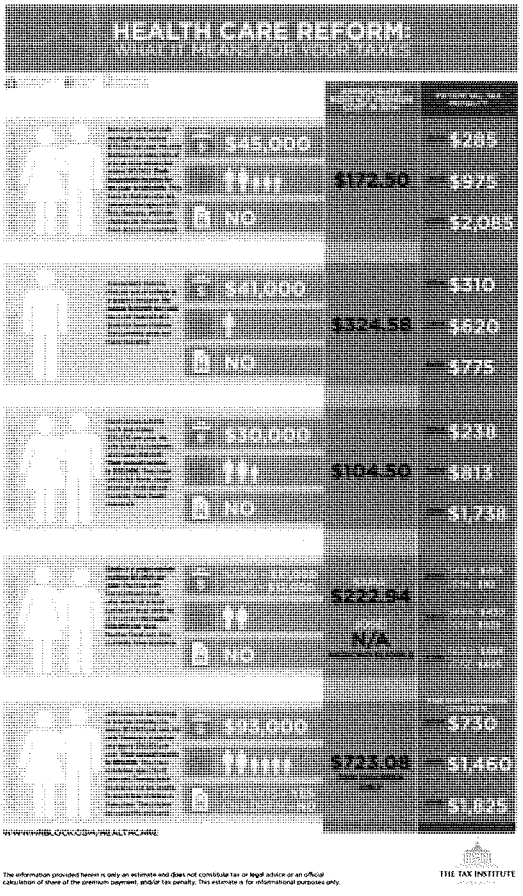
Kathy Chan currently serves as the associate director and provides leadership on advocacy efforts, as well as policy analysis for IMCHC and its four projects. From 2002-2006, Kathy worked at IMCHC on Covering Kids and Families where she built statewide and local coalitions and created and implemented strategies to help families more easily access public health insurance programs. Her efforts helped Illinois gain recognition as a national leader in enrollment. To date, over 2.8 million parents and children in Illinois have public insurance coverage.

Kathy worked briefly in state government with the Illinois Department of Healthcare and Family Services, where she assisted with strategic enrollment efforts and the implementation of All Kids. She currently serves as board chair of IFLOSS, a statewide organization working to improve the oral health status of residents and remains an active volunteer with the Young Nonprofit Professionals Network of Chicago.

Kathy graduated with a bachelor's degree in English from Northwestern University and began her career as an organizer with Green Corps, a field school for environmental organizing.

THE TAX INSTITUTE AT H&R BLOCK HEALTH CARE SCENARIOS

Health Care Reform: What it Means for Your Taxes
Released February 15, 2013



The information provided herein is only an estimate and does not constitute tax or legal advice or an official calculation of share of the premium payment, and/or tax penalty. This estimate is for informational purposes only.

THE TAX INSTITUTE AT H&R BLOCK

ENDNOTES

[1] Centers for Medicare & Medicaid Services, "National Health Expenditures 2011 Highlights," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf (retrieved May 24, 2013).

[2] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012, page 13, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (retrieved May 24, 2013).

[3] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2010," September 2011, Table C-3, www.census.gov/prod/2011pubs/p60-239.pdf (retrieved December 13, 2012).

[4] Congressional Budget Office, "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf (retrieved May 24, 2013).

[5] Kaiser Family Foundation, "Total Medicaid Enrollment," http://kff.org/medicaid/state-indicator/total-medicaid-enrollment-fy2009/, (retrieved May 24, 2013).

[6] Families USA, "A Helping Hand for Businesses: Health Insurance Tax Credits," July 2010, table 1, http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf, (retrieved May 7, 2013). Small businesses are defined as those firms with 25 or fewer employees.

[7] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," http://kff.org/other/state-indicator/total-population/, (retrieved May 24, 2013).

[8] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," http://kff.org/other/state-indicator/total-population/, (retrieved May 24, 2013).

[9] California Health Care Foundation, "California Health Care Almanac," December 2012, page 2, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaUninsured2012.pdf, (retrieved May 24, 2013).

[10] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," http://kff.org/other/state-indicator/total-population/, (retrieved May 24, 2013).

STATE OF MINNESOTA

Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

November 20, 2013

The Honorable Senator Mary Landrieu
Chairman
United States Senate Committee on
Small Business and Entrepreneurship
703 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Landrieu:

Thank you for your outstanding leadership to enable our country's small businesses to purchase more affordable health insurance for their employees. Today's hearing on the implementation of small business exchanges has an important role in that process. Small businesses historically have struggled to provide health insurance for their workers due to high costs and the administrative burden of providing coverage. Without affordable health insurance options, these businesses have been at a disadvantage compared to large employers when it comes to recruiting and retaining talented workers. I am pleased that this dynamic is changing, thanks to the federal Affordable Care Act and MNsure, Minnesota's state-based exchange. Through MNsure, small businesses can more easily purchase more affordable health insurance and provide options for their workers, which are good for their employees and good for their businesses.

MNsure's focus on small business is a result of our state's decision to create a Minnesota-made exchange that best provides for the needs of Minnesotans. Virtually every Minnesota health care organization, business organization, and respected expert strongly supported our state designing its own exchange.

With the flexibility available under the state-based model, MNsure prioritized building the SHOP exchange and has offered small business options from Day One. Across Minnesota, these businesses can choose from a range of insurance options to find a MNsure product that best meets their needs. As of November 14, there were 1,172 small businesses in Minnesota that have signed up to receive coverage from MNsure. This interest is testament to the demand for better coverage options for small business and the benefit of MNsure to this sector in our state.

Through MNsure, small businesses in Minnesota can set up an account, pick plan options, and set the financial contribution that works for them. Businesses also can shop around without any obligation to enroll. Workers select from the employer-defined options and coverage begins on January 1, 2014. Eligible businesses with fewer than 25 workers may also access federal tax credits through MNsure.

MNsure will perform many of the administrative functions that historically have burdened small employers who provide health insurance. Participating businesses will have one monthly bill and online tools for updating and managing business and employee information. These features will enable small businesses in Minnesota to provide more affordable coverage to more workers.

From the Mayo brothers to MinnesotaCare, Minnesota has a proud tradition of excellence and innovation in health care. MNsure will continue this tradition by providing quality coverage options for small businesses, as well as individuals and families.

Thank you again for your outstanding leadership in highlighting the important opportunities for small businesses available through the SHOP exchanges.

Sincerely,

Mark Dayton
Governor

State by State Enrollments, Cancellations, and Premium Increases as of November 20, 2013

Type of Exchange	State	Administration's October predictions of enrollments[1]	ACTUAL # of people who have selected a marketplace plan[2]	Inflated % if October "enrollment" achieved[3]	# of insurance policies cancelled[4]	Premium Increases for Individuals[5]				
						Age	Sex	Pre-ACA	Post-ACA	Change
Federal	Alabama	5,740	624	10.87%	90,000	27	M	155.29	210.1646	35.30%
						27	F	155.29	210.1646	35.30%
						40	M	234.79	256.2385	9.15%
						40	F	234.79	256.2385	9.15%
						64	F	427.77	601.6162	40.66%
						64	M	427.77	601.6162	40.66%
Federal	Alaska	1,400	55	3.79%	5,409	27	M	130.16	284.2147	118.40%
						27	F	233.71	284.2147	21.60%
						40	M	296.56	346.6744	16.90%
						40	F	467.59	346.6744	-5.70%
						64	F	781.5	813.6488	4.10%
						64	M	893.03	813.6488	-17.40%
Federal	Arizona	7,770	799	9.55%	State not tracking	27	M	83	382.708	105.70%
						27	F	117.85	168.708	43.20%
						40	M	117.85	205.7196	60.80%
						40	F	152.91	205.7196	34.50%
						64	F	386.91	482.9427	24.80%
						64	M	348.21	482.9427	38.70%
Partnership	Arkansas	3,670	292	7.96	State not tracking	27	M	94.96	192.4696	102.70%
						27	F	81.64	192.4696	135%
						40	M	81.8	234.6363	186.90%
						40	F	115.81	234.6363	86.60%
						64	F	287.94	550.7895	91.30%
						64	M	268.2	550.7895	105.40%
State-run	California	91,000	35,964	39.86%	800,000	27	M	145.03	206.4498	42.30%

						27	F	145.03	206.4498	42.30%
						40	M	192.22	251.7584	31%
						40	F	192.22	251.7584	31%
						64	F	542.37	590.9821	9%
						64	M	542.37	590.9821	9%
State-run	Colorado	6,440	3,736	58.01%	**249,199** [4]	27	M	272.08	206.7164	-24%
						27	F	272.08	206.7164	-24%
					106,083 cancelled in Indiv. Market	40	M	322.12	252.0835	-21.70%
						40	F	322.12	252.0835	-21.70%
						64	F	746.24	591.7453	-20.70%
					143,116 cancelled in small group market	64	M	746.24	591.7453	-20.70%
State-run	Connecticut	2,310	4,418	191.26%	State not tracking	27	M	120.56	213.899	77.40%
						27	F	191.63	213.899	11.60%
						40	M	154.99	260.8425	68.30%
						40	F	224.14	260.8425	16.40%
						64	F	531.75	612.3063	15.10%
						64	M	373.66	612.3063	63.90%
Partnership	Delaware	560	97	17.32%	State not tracking	27	M	103.71	215.652	107.90%
						27	F	114.75	215.652	87.90%
						40	M	138.57	262.9802	89.80%
						40	F	178.43	262.9802	47.40%
						64	F	500.48	617.3244	23.30%
						64	M	393.93	617.3244	56.70%
State-run	District of Columbia	3,010	164 [11]	5.45%	21,300	27	M	118.33	141.4684	19.60%
						27	F	118.33	141.4684	19.60%
						40	M	153.49	189.7272	23.60%
						40	F	153.49	189.7272	23.60%
						64	F	234.07	424.4052	81.30%
						64	M	234.07	424.4052	81.30%
Federal	Florida	33,390	3,571	10.69%	330,000	27	M	123.49	202.9013	64.30%
						27	F	155.3	202.9013	30.70%
						40	M	172.25	247.4312	43.60%

						40	F	197.55	247.4312	25.20%
						64	F	444.06	580.8243	30.80%
						64	M	393.5	580.8243	47.60%
Federal	Georgia	14,280	1,390	9.73%	400,000	27	M	82.3	209.2535	154.30%
						27	F	110.19	209.2535	89.90%
						40	M	119.57	255.1775	113.40%
						40	F	170.07	255.1775	50%
						64	F	362.31	599.0082	65.30%
						64	M	332.42	599.0082	80.20%
State-run	Hawaii	630	257 [12]	63.49%	State not tracking	27	M	169.02		
						27	F	188.92		
						40	M	188.11		
						40	F	182.06		
						64	F	249.15		
						64	M	245.97		
State-run	Idaho	2,800	338	12.07%	105,000	27	M	118.61	202.0375	70.30%
						27	F	164.82	202.0375	22.60%
						40	M	177.09	246.3778	39.10%
						40	F	251.6	246.3778	-2.10%
						64	F	484.6	578.3516	19.30%
						64	M	440.49	578.3516	31.30%
Partnership	Illinois	10,010	1,370	13.68%	State not tracking	27	M	90.76	171.2818	88.70%
						27	F	124.51	171.2818	37.60%
						40	M	150.08	208.8723	39.20%
						40	F	182.67	208.8723	14.30%
						64	F	387.16	490.3106	26.60%
						64	M	319.55	490.3106	53.40%
Federal	Indiana	8,750	701	8.01%	108,000	27	M	165.82	206.7247	24.70%
						27	F	210.69	206.7247	-1.90%
						40	M	223.6	252.0937	12.70%
						40	F	333.69	252.0937	-24.50%
						64	F	712.21	591.7692	-16.90%
						64	M	692.51	591.7692	-14.50%
Partnership	Iowa	2,870	136	4.74%	1,000	27	M	73.49	163.0553	121.90%

						27	F	111.49	163.0553	46.30%
						40	M	99.68	198.8403	99.50%
						40	F	142.28	198.8403	39.80%
						64	F	303.94	466.7614	53.60%
						64	M	276.09	466.7614	69.10%
Federal	Kansas	3,710	371	10.%	State not tracking	27	M	67.94	154.3706	127.20%
						27	F	103.17	154.3706	49.60%
						40	M	101.57	188.2496	85.30%
						40	F	141.62	188.2496	32.90%
						64	F	423.7	441.9004	4.30%
						64	M	361.82	441.9004	22.10%
State-run	Kentucky	15,400	5,586	36.27%	280000 [5] 130,000 cancelled in Indiv. Market 150,000 cancelled in small group market	27	M	103.84	172.551	66.20%
						27	F	124.08	172.551	39.10%
						40	M	123.2	210.42	70.80%
						40	F	189.38	210.42	11.10%
						64	F	327.93	493.9437	50.60%
						64	M	342.96	493.9437	44%
						Maj. Leader McConnell has reported the State is seeing up to 300% increases. [5]				
Federal	Louisana	6,580	387	5.88%	93,000 [6]	27	M	95.05	193.9388	104%
						27	F	136.21	193.9388	42.40%
						40	M	132.91	236.5017	77.90%
						40	F	199.49	236.5017	18.60%
						64	F	411.69	555.1684	34.90%
						64	M	397.32	555.1684	39.70%
Federal	Maine	1,610	271	16.83%	State not tracking	27	M	185.68	236.0711	27.10%
						27	F	185.68	236.0711	27.10%
						40	M	250.24	287.8806	15%
						40	F	250.24	287.8806	15%
						64	F	513.98	675.776	31.50%
						64	M	513.98	675.776	31.50%
State-run	Maryland	10,500	1,284	12.23%	73,000 [7]	27	M	100.74	140.2246	39.20%
						27	F	132.11	140.2246	6.10%

						40	M	133.21	170.9991	28.40%
						40	F	167.34	170.9991	2.20%
						64	F	361.61	401.4063	11%
						64	M	312.97	401.4063	28.30%
State-run	Massachusetts	17,500	549 [8]	3.14%	State not tracking	27	M	286.49	242.1337	-15.50%
						27	F	286.49	242.1337	-15.50%
						40	M	381.56	276.4691	-27.50%
						40	F	381.56	276.4691	-27.50%
						64	F	572.96	469.3822	-18.10%
						64	M	572.96	469.3822	-18.10%
						181,000 will see at least a 10% increase and 45,757 will see a 30% increase [14]				
Partnership	Michigan	11,270	1,329	11.79%	225,000	27	M	96.44	184.7475	91.60%
						27	F	91.44	184.7475	102%
						40	M	140.24	225.2933	60.60%
						40	F	154.78	225.2933	45.60%
						64	F	375.63	528.8574	40.80%
						64	M	343.09	528.8574	54.10%
State-run	Minnesota	4,690	1,774	37.83%	140,000	27	M	95.29	135.0703	41.70%
						27	F	95.29	135.0703	41.70%
						40	M	116.91	164.7135	40.90%
						40	F	116.91	164.7135	40.90%
						64	F	273.43	386.6515	41.40%
						64	M	273.43	386.6515	41.40%
Federal	Mississippi	4,060	148	3.65%	600	27	M	111.97	236.1559	110.90%
						27	F	150.37	236.1559	57%
						40	M	151.08	287.9841	90.60%
						40	F	231.54	287.9841	24.40%
						64	F	453.22	676.0189	49.20%
						64	M	459.92	676.0189	47%
Federal	Missouri	8,260	751	9.09%	State not tracking	27	M	102.47	200.0471	95.20%
						27	F	155.75	200.0471	28.40%
						40	M	147.6	243.9505	65.30%
						40	F	220.92	243.9505	10.40%

						64	F	586.41	572.6539	-2.30%
						64	M	559.51	572.6539	2.30%
Federal	Montana	2,170	212	9.77%	State not tracking	27	M	148.15	176.1746	18.90%
						27	F	148.15	176.1746	18.90%
						40	M	201.26	214.8389	6.70%
						40	F	201.26	214.8389	6.70%
						64	F	373.78	504.3166	34.90%
						64	M	373.78	504.3166	34.90%
Federal	Nebraska	2,800	338	12.07%	State not tracking	27	M	68.95	170.3561	147.10%
						27	F	90.94	170.3561	87.30%
						40	M	109.16	207.7434	90.30%
						40	F	131.88	207.7434	57.50%
						64	F	395.88	487.6605	23.20%
						64	M	358.62	487.6605	36%
State-run	Nevada	8,050	1,217	15.12%	25,000	27	M	71.71	304.6622	324.90%
						27	F	134.96	304.6622	125.70%
						40	M	119.91	371.5251	209.80%
						40	F	174.9	371.5251	112.40%
						64	F	353.1	872.1247	147%
						64	M	345.17	872.1247	152.70%
Partnership	New Hampshire	1,330	269	20.23%	22,000	27	M	219.24	196.5759	-10.30%
						27	F	219.85	196.5759	-10.60%
						40	M	283.83	239.7175	-15.50%
						40	F	320.75	239.7175	-25.30%
						64	F	733.77	562.7172	-23.30%
						64	M	733.77	562.7172	-23.30%
Federal	New Jersey	6,720	741	11.03%	150,000	27	M	308.17	252.5198	-18.10%
						27	F	420.29	252.5198	-39.90%
						40	M	420.48	307.9392	-26.80%
						40	F	480.11	307.9392	-35.90%
						64	F	702.23	722.862	2.90%
						64	M	697.09	722.862	3.70%
State-run	New Mexico	5,810	172	2.96%	26,000	27	M	70.89	182.3705	157.30%

Federal running indiv. exchange until 2014						27	F	74.19	182.3705	145.80%
						40	M	108.9	222.3945	104.20%
						40	F	113.79	222.3945	95.40%
						64	F	191.03	522.0528	173.30%
						64	M	190.21	522.0528	174.50%
State-run	New York	15,260	16,404	107.5%	100,000	27	M	500.89	298.5612	-40.40%
						27	F	500.89	298.5612	-40.40%
						40	M	500.89	298.5612	-40.40%
						40	F	500.89	298.5612	-40.40%
						64	F	500.89	298.5612	-40.40%
						64	M	500.89	298.5612	-40.40%
Federal	North Carolina	13,370	1,662	12.43%	473,000 [10]	27	M	80.46	214.1707	166.20%
						27	F	123.57	214.1707	73.30%
						40	M	112.58	261.1738	132%
						40	F	151.89	261.1738	71.90%
						64	F	215.97	613.0841	183.90%
						64	M	210.65	613.0841	191%
Federal	North Dakota	770	42	5.45%	36,000	27	M	116.91	198.01	69.40%
						27	F	116.91	198.01	69.40%
						40	M	203.27	241.4664	18.80%
						40	F	203.27	241.4664	18.80%
						64	F	431.42	566.8225	31.40%
						64	M	431.42	566.8225	31.40%
Federal	Ohio	13,300	1,150	8.65%	State not tracking	27	M	174.36	191.1509	9.60%
						27	F	227.53	191.1509	-16%
						40	M	265.21	233.1019	-12.10%
						40	F	372.74	233.1019	-37.50%
						64	F	853.68	547.1877	-35.90%
						64	M	842.04	547.1877	-35%
Federal	Oklahoma	5,880	346	5.88%	None (notification deadline extended)	27	M	89.78	134.8563	50.20%
						27	F	122.67	134.8563	9.90%
						40	M	135.74	164.4526	21.20%
						40	F	181.83	164.4526	-9.60%
						64	F	666.39	386.0389	-42.10%

						64	M	461	386.0389	-16.30%
State-run	Oregon	16,590	219 [13]	.01%	150,000	27	M	95.36	156.2032	63.80%
						27	F	95.36	156.2032	63.80%
						40	M	144.79	190.4844	31.60%
						40	F	144.79	190.4844	31.60%
						64	F	322.75	447.1465	38.50%
						64	M	322.75	447.1465	38.50%
Federal	Pennsylvania	14,420	2,207	15.31%	250,000	27	M	107.95	157.8723	46.20%
						27	F	171.99	157.8723	-8.20%
						40	M	164.29	192.5199	17.20%
						40	F	220.58	192.5199	-12.70%
						64	F	426.67	451.9246	5.90%
						64	M	344.27	451.9246	31.30%
State-run	Rhode Island	840	1,192	141.9%	Existing plans automatically switched	27	M	194.59	202.0544	3.80%
						27	F	278.75	202.0544	-27.50%
						40	M	271.13	246.3984	-9.10%
						40	F	359.48	246.3984	-31.50%
						64	F	569.3	578.4	1.60%
						64	M	569.3	578.4	1.60%
Federal	South Carolina	6,440	572	8.88%	State not tracking	27	M	122.33	200.6361	64%
						27	F	188.02	200.6361	6.70%
						40	M	203.96	244.6689	20%
						40	F	295.48	244.6689	-17.20%
						64	F	586.48	574.3401	-2.10%
						64	M	495.16	574.3401	16%
Federal	South Dakota	1,330	58	4.36%	State not tracking	27	M	94.88	225.2773	137.40%
						27	F	160.43	225.2773	40.40%
						40	M	149.93	274.718	83.20%
						40	F	190.76	274.718	44%
						64	F	383.77	644.8779	68%
						64	M	343.9	644.8779	87.50%
Federal	Tennessee	8,610	992	11.52%	66,000	27	M	80.7	135.9517	68.50%
						27	F	113.1	135.9517	20.20%
						40	M	119.82	165.7884	38.40%

						40	F	156.79	165.7884	5.70%
						64	F	305.93	389.1748	27.20%
						64	M	286.81	389.1748	35.70%
Federal	Texas	44,030	2,991	6.79%	State not tracking	27	M	90.92	153.2042	68.50%
						27	F	125.8	153.2042	21.80%
						40	M	128.88	186.8273	45%
						40	F	186.17	186.8273	0.40%
						64	F	412.96	438.5616	6.20%
						64	M	393.92	438.5616	11.30%
Federal	Utah	3,990	357	8.95%	State not tracking	27	M	109.62	171.9931	56.90%
						27	F	112.93	171.9931	52.30%
						40	M	161.27	183.0056	13.50%
						40	F	161.27	183.0056	13.50%
						64	F	362.38	371.2081	2.40%
						64	M	362.38	371.2081	2.40%
State-run	Vermont	3,990	1,325	33.21%	State not tracking	27	M	148.39	380.342	156.30%
						27	F	148.39	380.342	156.30%
						40	M	169.86	380.342	123.90%
						40	F	169.86	380.342	123.90%
						64	F	222.58	380.342	70.90%
						64	M	222.58	380.342	70.90%
Federal	Virginia	8,890	1,023	11.51%	State not tracking	27	M	109	169.5013	55.50%
						27	F	151.71	169.5013	11.70%
						40	M	161.37	206.7011	28.10%
						40	F	207.3	206.7011	-0.30%
						64	F	643.15	485.2138	-24.60%
						64	M	506.71	485.2138	-4.20%
State-run	Washington	23,800	7,091	29.79%	290,000	27	M	124.28	179.8447	44.70%
						27	F	124.28	179.8447	44.70%
						40	M	181.86	219.3145	20.60%
						40	F	181.86	219.3145	20.60%
						64	F	401.07	514.8227	28.40%
						64	M	401.07	514.8227	28.40%
State-run	West Virginia	1,680	174	10.36%	State not tracking	27	M	146.6	199.2952	35.90%

						27	F	201.28	199.2952	-1%
						40	M	216.92	243.0337	12%
						40	F	284.75	243.0337	-14.70%
						64	F	721.76	570.5016	-21%
						64	M	581.51	570.5016	-1.90%
Federal	Wisconsin	5,530	877	15.86%	State not tracking	27	M	92.5	207.7972	124.60%
						27	F	117	207.7972	77.60%
						40	M	146.17	253.4016	73.40%
						40	F	193.68	253.4016	30.80%
						64	F	431.33	594.8394	37.90%
						64	M	354.42	594.8394	67.80%
Federal	Wyoming	910	85	9.34%	3,200	27	M	159.38	321.5734	101.80%
						27	F	303.41	321.5734	6%
						40	M	274.94	392.1477	42.60%
						40	F	364.4	392.1477	7.60%
						64	F	805.76	920.5346	14.20%
						64	M	728.47	920.5346	26.40%
	TOTALS	494,620	106,185	21%	3,292,500					41%

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THE BENEFITS FIRM

Embrace the moment. Prepare for the future.

Griffin L. Meredith
Senior Vice President

November 19, 2013

Senator McConnell,

Kentucky has been viewed by other states and people in Washington DC as a state that most things have gone correctly with the Health Insurance Marketplace. While it is true that "Kynect" has been operating properly, especially compared to the Federally Facilitated Marketplace, there are still many unresolved problems. In particular, I would like to address SHOP exchanges. Logistically and technologically we are not having the same success in Kentucky with the SHOP exchange as we are with individuals in Kynect. This week I have reached out to numerous Employee Benefit brokers in Kentucky, none of which have finished a Kynect SHOP exchange application.

While I do believe the technical hindrance is a part of the problem, it is not the primary obstacle to the success of the SHOP exchanges. I firmly believe there are flaws to this existence that the current law cannot overcome. Numerous businesses that I work with have decided that with the PPACA there are advantages to their business through Kynect. However, the advantage to their business is to drop their employer sponsored health plan and allow each of the individuals and families to enroll in Kynect.

The intent of the law with SHOP exchanges was to allow small businesses to offer a "group plan" and to continue to take advantage of the small business health insurance tax credit. It was intended to help small employers with less than 25 employees and average annual salaries of less than $50,000 per employee. However, the tax credit was on a sliding scale therefore, the largest credits were going to businesses with less than 10 employees and average annual salaries of less than $25,000. Additionally, this tax credit is only slated to be available for the next two years.

The result of this has been the tax credit the small business receives is substantially less than the subsidized amount the individual is receiving from the Federal Government if the employer simply drops their plan. The business is making a wise decision dropping their plan because the previous "employer paid premium" is now being paid by the Government. Also the "employee paid premium" is significantly lower than if the group continued to offer a plan. This makes offering a plan through the SHOP exchange a disservice to employees and completely superfluous.

Kentucky as well as many other states has small employers whose employees cross state lines everyday from their residences to go to work. In addition, employees of their businesses seek services from providers across state lines. In response to the requirements of PPACA, some insurance carriers in Kentucky have created state specific HMO plans, that are the only networks offered on Kynect. This means with the exception of an emergency, an employee wishing to use services outside of Kentucky (even if they are a resident of that state) is not permitted to do so, and will not have coverage. This is not as large of a market disruption on the individual Marketplace because an employee could enroll in their state specific Marketplace.

This letter is meant to only serve as guidance from actual experience in working with the small businesses of Kentucky. There are steps being made in the right direction, but I do not believe that time and resources going towards SHOP exchanges are one of those steps.

Please let me know how I, my company, or my association may be of assistance in the future.

Sincerely,

Griffin Meredith

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HIG
Houchens Insurance Group
1240 Fairway Street ■ Bowling Green, KY 42103
Phone: 270.781.2020 ■ Fax: 270.843.8808

November 15, 2013

Senator Mitch McConnell
601 W. Broadway
Room 630
Louisville, KY 40202

Dear Senator McConnell:

We are writing to you to explain what we are seeing here in Kentucky and throughout other parts of the country that Houchens Industries, Inc. and the Houchens Insurance Group (HIG) serves regarding our clients' implementation of the Affordable Care Act (ACA). While Houchens, with over 18,000 employees is not a small company, our insurance group (HIG) serves over a thousand small businesses with their insurance needs throughout Kentucky and the United States. The remainder of this letter lays out what we are seeing;

For an agency to represent it's customers responsibly, we need to be able to share all options available. At this point, Kentucky's Healthcare Connection (Kynect) presents us with more challenges than solutions.

To date, we have not enrolled any groups in the Small Business Health Options Program (SHOP) primarily because of the confusion the system has created. Business owners are anxious and frustrated as to what they have to do in order to get pricing. Creating an account within Kynect, and then assigning an agent, takes a considerable amount of time and is not something they should have to do while managing their businesses.

Small business owners are already pressured enough to provide competitive benefits at affordable prices. Now, under Obamacare, they are being assessed a new set of rules to go by and in many cases gives them no choice but to make cutbacks. Most of the groups that our agency represents do not understand these rules and are uncertain about decisions that need to be made. Recent delays in certain parts of the law have added uncertainty surrounding businesses and their ability to hire or expand. In addition, they are cutting back on employees' hours (due to the 30 hour mandate) to avoid reaching the requirement to offer coverage.

The carriers we represent have offered a one year bandaid by allowing groups to renew in December of 2013 verses the facing of these mandates that will be part of group plans that renew

on/after January 1, 2014. While most small groups have opted for this, we see it as confirmation of carrier uncertainty as well.

While we have talked with many businesses that would like to continue to offer coverage to their employees, under Obamacare's mandates they will not be able to afford it and are taking actions to keep their businesses afloat.

We appreciate any help that can be provided to help our small business customers. Our first priority is insuring the continued success and stability of these businesses, but we also recognize that cutbacks will be the result from the implementation of Obamacare and have far reaching impacts to our business and the economy.

We feel strongly that this is only an early indication of what is to come for the fifty plus employers. We also feel that this will have a devastating impact to the economy as it relates to labor force, insurance plans and quality of healthcare.

Sincerely,

Andy Barker
Executive Vice President
Houchens Insurance Group
The Countries 27th Largest Privately Held Insurance Agency

POLITICO

Only 5 enrollments completed in D.C. Obamacare exchange

By: Jennifer Haberkorn
November 8, 2013 01:16 PM EST

Only five people have fully completed the enrollment process in the D.C. insurance exchange, according to information compiled by lawmakers from four of the insurance companies participating in the exchange.

Two people enrolled in CareFirst BlueShield plans during October and three enrolled in Kaiser Permanente plans during the month. No enrollment data has been collected by UnitedHealthcare or Aetna as of Nov. 4 or Oct. 24, respectively, the companies said.

The information was collected by Sens. Chuck Grassley (R-Iowa) and Orrin Hatch (R-Utah).

(Understanding Obamacare: POLITICO's guide to the ACA)

These five have paid their first month of premiums. More have completed applications but not yet paid the premium.

But DC HealthLink spokesman Richard Sorian says the insurers' enrollment figures are "not an accurate depiction of the strong level of interest in the District of Columbia in obtaining quality, affordable health insurance."

As of Oct. 21, 321 DC residents and 426 small business had selected a health plan, Sorian said. Consumers have until Dec. 15 and small businesses have until Dec. 12 to pay for coverage to start on Jan. 1.

(Also on POLITICO: White House: Politics? What politics?)

Many congressional staff will have to sign up on the small business exchange under a provision in the health law.

Total Health Insurance Exchange Grants

Search State Health Facts Data

change indicator (http://kff.org/state-category/health-reform/health-insurance-exchanges/)

TABLE | MAP | CHOOSE A CATEGORY

Download Raw Data | Notes

SUMMARY

Timeframe: 2013 **Data View:** Currency **Locations:** United States, States

Total Health Insurance Exchange Grants

View Table in New Window

Location	Exchange Planning Grant Amount	Exchange Establishment Grant Amount	Early Innovator Grant Amount	Total Exchange Grant Amount
United States	**$44,137,908**	**$4,159,177,032**	**$138,122,850**	**$4,381,437,790**
Alabama	$1,180,312	$8,592,139	NA	$9,772,451
Alaska	NA	NA	NA	NA
Arizona	$999,670	$29,877,427	NA	$30,877,097
Arkansas	$1,200,928	$42,731,407	NA	$43,932,335
California	$529,894	$909,606,370	NA	$910,136,264
Colorado	$1,247,599	$177,683,424	NA	$178,931,023
Connecticut	$996,848	$163,469,612	NA[1]	$164,466,460
Delaware	$999,999	$11,936,639	NA	$12,936,638
District of Columbia	$999,999	$132,573,928	NA	$133,573,927
Florida	NA[2]	NA	NA	NA
Georgia	$1,000,000	NA	NA	$1,000,000
Hawaii	$1,000,000	$204,342,270	NA	$205,342,270
Idaho	$998,220	$68,395,587	NA	$69,393,807
Illinois	$1,071,784	$153,741,352	NA	$154,813,136
Indiana	$965,415	$6,895,126	NA	$7,860,541
Iowa	$1,000,000	$58,683,889	NA	$59,683,889
Kansas	$1,000,000	NA	$10,390[2]	$1,010,390
Kentucky	$469,088	$252,698,351	NA	$253,167,439
Louisiana	$29,391[4]	NA	NA	$29,391
Maine	$999,841	NA[4]	NA[1]	$999,841
Maryland	$999,226	$163,786,430	$6,277,454	$171,063,110
Massachusetts	$1,000,000	$134,581,413	$44,486,362[1]	$180,067,775
Michigan	$999,772	$40,517,249	NA	$41,517,021
Minnesota	$1,000,000	$154,020,465	NA	$155,020,465
Mississippi	$670,125	$20,143,618	NA	$20,813,743
Missouri	$1,000,000	$20,865,716	NA	$21,865,716
Montana	$1,000,000	NA	NA	$1,000,000
Nebraska	$895,075	$5,481,838	NA	$6,376,913

Nevada	$1,000,000	$82,775,083	NA	$83,775,083
New Hampshire	$334,000[2]	$6,267,088	NA	$6,601,088
New Jersey	$1,223,186	$7,674,130	NA	$8,897,316
New Mexico	$1,000,000	$52,879,483	NA	$53,879,483
New York	$1,000,000	$400,633,975	$27,431,432	$429,065,407
North Carolina	$999,999	$86,357,315	NA	$87,357,314
North Dakota	$231,978	NA	NA	$231,978
Ohio	$1,000,000	NA	NA	$1,000,000
Oklahoma	$897,980	NA	NA[2]	$897,980
Oregon	$1,000,000	$242,094,375	$59,917,212	$303,011,587
Pennsylvania	$1,000,000	$33,832,212	NA	$34,832,212
Rhode Island	$1,000,000	$98,128,661	NA[1]	$99,128,661
South Carolina	$304,996	NA	NA	$304,996
South Dakota	$1,000,000	$5,879,569	NA	$6,879,569
Tennessee	$1,000,000	$8,110,165	NA	$9,110,165
Texas	$96,425[2]	NA	NA	$96,425
Utah	$1,000,000	$1,000,000	NA	$2,000,000
Vermont	$1,000,000	$167,124,081	NA[1]	$168,124,081
Virginia	$1,000,000	$5,567,803	NA	$6,567,803
Washington	$996,285	$180,396,014	NA	$181,392,299
West Virginia	$1,000,000	$19,832,828	NA	$20,832,828
Wisconsin	$999,873	NA	NA[2]	$999,873
Wyoming	$800,000	NA	NA	$800,000

NOTES

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Notes

Some of the grant amounts displayed here do not match awarded amounts reported by CCIIO. Some states may have returned a portion or all of the grant funds while others may have received additional redistributed funds. For additional details on Exchange planning grantees see our Exchange Planning Grant indicator. (http://kff.org/health-reform/state-indicator/exchange-planning-grants/)

For additional details on establishment grants see our Exchange Establishment Grant (http://kff.org/health-reform/state-indicator/exchange-establishment-grants/)indicator.

For additional details on early innovator grantees see our Early Innovator Grant (http://kff.org/health-reform/state-indicator/early-innovator-grants/) indicator.

Sources

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Definitions

NA: Not applicable.

FOOTNOTES

1. The Massachusetts Early Innovator Grant, awarded to the University of Massachusetts Medical School, includes a limited amount of funds to support a learning collaborative to promote the development of Insurance Exchange Technologies in Connecticut, Maine, Massachusetts, Rhode Island, and Vermont.
2. Florida Governor Rick Scott has returned Florida's $1 million exchange planning grant. For additional information please see: http://www.ncsl.org/documents/health/ACANews3.pdf

3. Kansas Governor Sam Brownback announced on August 9, 2011 that Kansas was returning its $31.5 million early innovator grant. For additional information please see: https://governor.ks.gov/media-room/media-releases/2011/08/09/kansas-to-opt-out-of-early-innovator-grant
4. Louisiana Health and Hospitals secretary Bruce Greenstein announced on March 23, 2011 that Louisiana would return the $998,416 exchange planning grant. For additional information please see: http://www.ncsl.org/?tabid=22493
5. Governor LePage informed the federal Department of Health and Human Services on April 18, 2012, that Maine will not seek to utilize their Level One Establishment Grant funding and will not be pursuing a State-based Marketplace.
6. The passage of HB 601 ordered the return of $666,000 in unused Exchange Planning grant funds effective July 2011. (House Bill 601. June 22, 2011. http://www.gencourt.state.nh.us/legislation/2011/HB0601.html)
7. Oklahoma Governor Mary Fallin announced on April 14, 2011 that Oklahoma will be returning their $54 million Early Innovator Grant. For additional information please see: http://www.ok.gov/triton/modules/newsroom/newsroom_article.php?id=223&article_id=1601
8. In early 2012, Texas returned $900,000 of their Exchange planning grant to the federal government. http://www.texastribune.org/texas-state-agencies/health-and-human-services-commission/will-texas-implement-federal-health-care-reforms/
9. Wisconsin Governor Scott Walker announced on January 18, 2012 that Wisconsin will turn down the funding from their $38 million Early Innovator Grant. For additional information please see: http://walker.wi.gov/Default.aspx?Page=84c6be7e-6bf7-47bb-9494-7330dd644579

NEW & UPDATED

› **Updated | December 11, 2013**

State Marketplace Statistics

(http://kff.org/health-reform/state-indicator/state-marketplace-statistics-2/)

› **Updated | October 02, 2013**

Status of State Action on the Medicaid Expansion Decision, as of November 22, 2013

(http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/)

ASPE
Issue BRIEF

HEALTH INSURANCE MARKETPLACE: NOVEMBER ENROLLMENT REPORT

November 13, 2013

This issue brief highlights national and state-level enrollment-related information for the first month of the Health Insurance Marketplace (Marketplace hereafter) initial open enrollment period that began October 1, 2013 for coverage beginning January 1, 2014 (see Appendix A for state-level data). It also provides an overview of the methodology that was used in compiling these data (see Appendix B), and includes information about strategies to reach consumers.

These data represent a "snapshot" of Marketplace enrollment that uses comparable definitions for the data elements across states, and between states that are implementing their own Marketplaces (also known as State-Based Marketplaces or SBMs) and states with Marketplaces that are supported by or fully-run by the Department of Health and Human Services (including those run in partnership with states, also known as the Federally-facilitated Marketplace or FFM). Data related to Medicaid and Children's Health Insurance Program (CHIP) eligibility in this report are based on applications submitted through the Marketplaces. Enrollment based on applications submitted through state Medicaid/CHIP agencies will be released in a subsequent report.

It is important to note that the SBM enrollment-related data that are reported in this issue brief may differ from comparable data that have previously been publicly reported on SBM websites or in media reports due to differences in time periods and metric definitions.

The following are highlights of Marketplace enrollment-related information for the first month.

Marketplace Monthly Enrollment-Related Information, 10-1-13 to 11-2-13 (1)	Number
Number of completed applications through the Marketplaces	846,184
Total number of individuals included in completed Marketplace applications	1,509,883
Number of individuals determined eligible to enroll in a Marketplace plan	1,081,592
Number of individuals who have selected a Marketplace plan	106,185

(1) Oct 1- Nov 2 most closely represents the first month of operations since state based Marketplaces generally compile enrollment-related metrics on a weekly basis. Any differences in reporting periods among states are noted in footnotes accompanying the Table in Appendix A.

The first month enrollment experience in the Marketplace exceeds comparable first month enrollment in the Commonwealth Care program in the Massachusetts Health Connector. In Massachusetts, the number of premium-paying enrollees who signed up during the first month of enrollment was 123 or 0.3 percent of the total enrollment of 36,167 at the end of the year.[1]

[1] Source: Commonwealth Health Insurance Connector Authority as cited in the The New Republic, Oct. 23, 2013. Available online: http://www.newrepublic.com/article/115309/obamacare-enrollment-massachusetts-statistics-suggest-it-will-be-slow

Marketplace plan selection of 106,185 is 1.5 percent of the estimated enrollees at the end of the 2014 open enrollment period (Congressional Budget Office (CBO) estimate, May 2013). (See Appendix C for more information on enrollment experiences in other programs.)

Marketplace Website and Call Center Activity

Unique Visitors on the SBM and FFM websites: 26,876,527

Calls to the SBM and FFM call centers: 3,158,436

Overview of Enrollment to Date

To date, 106,185 persons have enrolled and selected a Marketplace plan—this includes those who have paid a premium and those who have not yet paid a premium.

Based on available data, 846,184 completed applications were submitted to Marketplaces during the first month of the initial open enrollment period (10-1-13 to 11-2-13), including applications that were submitted to the SBMs and FFM. These completed applications correspond to a total of 1,509,883 million individuals (persons) who have applied for coverage through the Marketplaces during this time period. This represents 22 percent of the Congressional Budget Office (CBO) estimated 7 million Marketplace enrollment in 2014.[2] (Please see Appendix A for corresponding tables containing state-level data, and see Appendix B for methodological information on how these numbers were derived).

The Marketplaces have helped a total of 1,477,853 persons by determining or assessing[3] that they are either eligible to enroll in a Marketplace plan (used throughout this report—also known as Qualified Health Plans or QHPs) with or without financial assistance, or in Medicaid or the Children's Health Insurance Program (CHIP). To date, 106,185 persons have selected a Marketplace plan—this includes 79,391 in SBMs and 26,794 in FFM. An additional 975,407 persons who have been determined eligible have not yet selected a plan through the Marketplace.

To date, the Marketplaces have processed eligibility determinations and assessments for 98 percent (1,477,853) of the 1,509,883 persons who have applied for coverage – including:

- 1,081,592 persons (73 percent of the total number of persons with processed eligibility determinations / assessments) have been determined eligible to enroll in a Marketplace plan, (including 326,130 persons who have been determined eligible to enroll in a Marketplace plan with financial assistance),
    - 106,185 (10 percent) of the 1,081,592 total Marketplace plan eligible persons have already selected a plan by clicking a button on the website page.

[2] CBO estimates 7 million individuals will enroll in qualified health plans (QHPs) through the Marketplace in 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

[3] Accounts of individuals who have been determined or assessed eligible for Medicaid or CHIP are transferred to state Medicaid and CHIP agencies, which then take any action needed to effectuate enrollment. "Assessment" refers to those FFM states where the state has chosen to retain the ability make the final eligibility determination.

Enrollment includes those who have selected a plan including those who have paid their first month premium and those who have not yet done so.

- 396,261 persons (27 percent of the total number of persons with processed eligibility determinations / assessments) who have been determined or assessed eligible for Medicaid or CHIP.[4]

A total of 502,446, or 1 in 3 of the 1,477,853 people whose eligibility determinations / assessments have been processed, have either been determined or assessed eligible for Medicaid or CHIP or have selected a plan in the Marketplaces. Meanwhile, 722,391 (49 percent) of the 1,477,853 whose eligibility determinations / assessments have been processed are either eligible for financial assistance through the Marketplaces, or have been determined or assessed eligible for Medicaid or CHIP.

An additional 201,137 persons who applied for coverage through the Marketplaces have eligibility determinations that are either pending, not captured in the Marketplace plan and Medicaid/CHIP eligibility counts for a given state, or negative (meaning that they have not been determined eligible to enroll in a Marketplace plan).

The available data on completed applications, eligibility determinations and assessments, and Marketplace plan selection represents a subset of the total number of Americans who have begun exploring the coverage options that are available through the new Marketplaces. There is considerable interest in the new Marketplaces as measured by unique visitors on the SBM and FFM websites (26,876,527), and calls to the SBM and FFM call centers (3,158,436).

These early enrollment-related statistics suggest that, in spite of recent information system and website issues, interest in the Marketplaces is high. For example a Commonwealth Fund survey conducted Oct. 9-27[5] polled adults (ages 19-64) who are uninsured or have individual market coverage and found that most (60 percent) are aware of the Marketplace. Further, the Commonwealth Fund found that 53 percent are aware that financial support is available for Marketplace coverage and 17 percent have visited the Marketplace. Most (58 percent) said they are very likely or somewhat likely to go or go back to visit the Marketplace to enroll in a plan or to apply for the premium tax credit or for Medicaid/CHIP before the open enrollment period ends on March 31, 2014. (See Appendix D for more information).

Marketplace enrollment is expected to increase as technical issues are resolved.

Enrollment Experience in Other Programs

Based on the experience of the Federal Employees Health Benefits Program (FEHBP), Medicare Part D, Massachusetts' Commonwealth Care, and the Children's Health Insurance Program

[4] Most FFMs assess individuals as eligible for Medicaid or CHIP, and the state Medicaid or CHIP agency takes additional steps to finalize an eligibility determination. In states that accept the FFM's eligibility determination, the state will take steps to effectuate enrollment.

[5] http://www.commonwealthfund.org/Publications/Data-Briefs/2013/Nov/Americans-Experiences-Marketplaces.aspx

(CHIP), several factors drive enrollment rates, particularly in the early months of program operation (See Appendix C):

- "Action-forcing" events — such as the end date of an open enrollment period or the start date for benefits — often result in a spike in enrollment activity.
- The length of a program's pre-benefit period (i.e., the period between sign-up/enrollment and the receipt of benefits) also affects rates of initial enrollment: Shorter pre-benefit periods (e.g., 1 month) tend to generate higher initial enrollment rates than longer pre-benefit periods, during which the consumer may perceive little advantage to signing up or enrolling early.

Based on this experience, the Department expects Marketplace enrollment will start slowly, with peaks in December (as the January 1 coverage date approaches) and March (as the close of open enrollment approaches).

Based on available data for the first reporting period, the level of early Marketplace enrollment appears to be consistent with expectations based on the Massachusetts Commonwealth Care experience. Many of the SBMs have experienced first-month enrollment-related activity that exceeds comparable Commonwealth Care enrollment for the first month of open enrollment (See Appendix C for more information).[6]

The SBMs' experience to date regarding the type of eligibility determinations and assessments appear similar to Commonwealth Care's early months of enrollment as well. There were large differences in initial enrollment rates in Commonwealth Care between persons who qualified for plans not requiring a premium payment and persons who did not qualify. Only about 4,000 individuals signed up in the first couple months of the program for plans requiring a premium payment. *The majority of individuals who enrolled in Commonwealth Care during the first year were in plans that did not require the enrollee to pay a premium.* Many of the SBMs have experienced first-month enrollment-related activity with substantial numbers of Medicaid eligible individuals applying to the Marketplace. Enrollment of individuals anticipating paying a premium for coverage is expected to increase as the start date for benefits, January 1, 2014, approaches.

Methodological Overview

This report summarizes available data on enrollment-related activity during the first month of the initial open enrollment period for the Marketplaces – including the number of completed applications, the number of processed eligibility determinations, and the number of completed Marketplace plan selections. The data that are reported in this issue brief have been generated by the information systems of the Centers for Medicare & Medicaid Services (CMS), based on information reported to CMS by SBMs, and information collected by the FFM for states with HHS- supported or fully run Marketplaces (including those run in partnership with states).

[6] Massachusetts auto-enrolled a large number of individuals from the state's uncompensated care pool into Commonwealth Care, a process which began October 1, 2006, before open enrollment became available to the broader Commonwealth Care-eligible population on January 1, 2007. The population that was allowed to enroll starting in January 2007 could qualify for premium subsidies based on income.

Unless otherwise noted, the data in this issue brief represent cumulative Marketplace enrollment-related activity for the 10-1-13 to 11-2-13 reporting period, with information available as of 11-12-13. Data for certain metrics are not yet available for some states due to information system issues. We anticipate that more comprehensive data will be available in future monthly enrollment-related reports as system issues are resolved. (Please see Appendix B for additional methodological information and technical notes, including information about any limitations or clarifications regarding specific data points.)

We believe that the information contained in this issue brief provides the most systematic "snapshot" of enrollment-related activity in the Marketplaces to date because the data for the various metrics are counted using comparable definitions for data elements across states, and between the SBMs and FFM. **It is important to note that the SBM enrollment-related data that are reported in this issue brief represent state data that have been reported to CMS, and may differ from comparable data that have previously been publicly reported on SBM websites or in media reports because that data may be based on different time periods or metric definitions from those used in this report.**

Details on Marketplace Enrollment-Related Activity to Date

The following are highlights of enrollment-related activity in the Marketplaces during the first month of the initial open enrollment period (see Appendix A for state-level data).

Completed Applications – A total of 846,184 completed applications were submitted to the Marketplaces during the first month of the initial open enrollment period (10-1-13 to 11-2-13). This includes 326, 623 completed applications (39 percent of the combined SBM-FFM total) that were submitted to the SBMs, and 519,561 completed applications (61 percent of the combined SBM-FFM total) that were submitted to the FFM. In addition to these applications, the FFM also has 259,107 additional paper and call center applications that are not included in this total.

Based on currently available data, electronically-submitted (online) applications (including applications submitted through the Marketplace websites, as well as any applications that were submitted online through in-person assisters or the call center) accounted for approximately 74 percent of the completed applications that were submitted to the Marketplaces during the reporting period. The remainder of the completed applications (26 percent) were submitted on paper (including applications that were submitted by mail, as well as any applications through in-person assisters or the call center that were filled out on paper). On average, approximately 93 percent of the completed applications that were submitted to the SBMs were submitted electronically, and 67 percent of the completed applications that were submitted to the FFM were submitted electronically.

Number of Persons Applying for Coverage in Completed Applications – The 846,184 completed applications correspond to a total of 1,509,883 persons who have applied for coverage through the Marketplaces during this time period. The total number of persons applying for coverage is higher than the total number of completed applications because each application can potentially include multiple persons (such as spouses or dependents). A total of 516,248 persons (34 percent of the combined SBM-FFM total) have applied for coverage through the SBMs, and

993,635 persons (66 percent of the combined SBM-FFM total) have applied for coverage through the FFM.

Number of Persons Determined or Assessed Eligible to Enroll in Coverage Through the Marketplace – Overall, the Marketplaces have processed eligibility determinations for 98 percent (1,477,853) of the 1,509,883 total persons who have applied for coverage through the Marketplaces. Of these, 1,081,592 persons have been determined eligible to enroll in a plan through the Marketplace, representing 72 percent of the total persons who have applied for coverage through the Marketplaces as a whole, and 396,261 persons have been determined or assessed eligible for Medicaid or the Children's Health Insurance Program (CHIP), representing 26 percent of the total persons who have applied for coverage through the Marketplaces as a whole. Additionally, approximately 30 percent of the 1,081,592 total persons who have been determined eligible to enroll in a plan through the Marketplace have also been determined eligible to enroll in a plan with financial assistance (326,130, representing 22 percent of the total persons who have applied for coverage through the Marketplaces as a whole, and 22 percent of the total eligibility determinations / assessments that have been processed). The remaining 755,462 other Marketplace plan eligible persons includes individuals who: didn't apply for financial assistance; applied for financial assistance and were found ineligible; applied for financial assistance and their applications are pending.

- ***Number of Persons Determined Eligible to Enroll in Coverage by the SBMs*** – The SBMs have processed eligibility determinations for 591,838 persons who have applied for coverage through the SBMs; however, this percentage varies by state due to differences in processing times. Within the SBMs, 378,973 persons have been determined eligible to enroll in a Marketplace plan, and 212,865 persons have been determined eligible for Medicaid or CHIP using MAGI determination criteria. Additionally, approximately 23 percent (88,953) of the 378,973 total Marketplace plan eligible persons in the SBMs have also been determined eligible to enroll in a plan with financial assistance.[7]

- ***Number of Persons Determined or Assessed Eligible to Enroll in Coverage by the FFM*** – The FFM has processed eligibility determinations for 89 percent (886,015) of the 993,635 persons who have applied for coverage through the FFM. Within the FFM, 702,619 persons have been determined eligible to enroll in a Marketplace plan (representing 71 percent of the total persons who have applied for coverage through the FFM), and 183,396 persons have been determined or assessed eligible for Medicaid or CHIP under MAGI determination criteria (representing 18 percent of the total persons who have applied for coverage through the FFM). Additionally, approximately 34 percent (237,177) of the 702,619 total Marketplace plan eligible persons in the FFM have also been determined eligible to enroll in a plan with financial assistance[8] (also representing 24 percent of the total persons who have applied for coverage through the

[7] SBM data on the number of persons with processed eligibility determinations or assessments do not add to the total number of persons applying for coverage in completed applications due to missing data.

[8] Represents the total number of individuals determined to be eligible for plan enrollment through the Marketplace, who qualify for advance premium tax credits (APTC).

FFM).

An additional 201,137 persons who applied for coverage through the Marketplaces (including approximately 93,245 in SBMs, and 107,892 in the FFM) have eligibility determinations in the Pending/Other category, including those who: 1) have a pending eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage; 2) have a processed eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace coverage.

Number of Persons Who Have Selected a Marketplace plan – Overall an estimated 106,185 (10 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan (including both those who have paid the first month's premium and those who have not yet paid the first month's premium). An additional 975,407 persons who have been determined eligible have not yet selected a plan through the Marketplace.

- ***Number of Persons Who Have Selected a Marketplace plan in SBMs*** – Within the SBMs, 79,391 (21 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan through the SBM (including both those who have paid the first month's premium and those who have not yet paid the first month's premium).

- ***Number of Persons Who Have Selected a Marketplace plan in the FFM*** – Within the FFM, overall 26,794 (4 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan through the FFM (including both those who have paid the first month's premium and those who have not yet paid the first month's premium).

Highlights of Marketplace Customer Service and Outreach

Customer Service – Based on available data, there have been a total of 26,876,527 unique visitors on the Marketplace websites, and a total of 3,158,436 calls to the SBM and FFM Marketplace call centers.

- ***Customer Service (Website and Call Center Utilization) in SBMs*** – Based on available data, there have been a total of 7,376,527 unique visitors on the SBM websites, and a total of 923,170 calls to the SBM call centers.

- ***Customer Service (Website and Call Center Utilization) in the FFM*** – Based on available data, there have been a total of approximately 19,500,000 unique visitors on the FFM website, and a total of 2,235,266 calls to the FFM call center.

Outreach Several types of marketplace assisters help people navigate the new system. As of November 1, 2013, over 18,000 assisters have been trained in the states that are a part of the Federally-facilitated Marketplace. These assisters have informally reported that they have conducted over 2,800 education and outreach events that have reached over 450,000 consumers

in their states.

Maximizing Marketplace Enrollment: SBM Experiences

CA: California has conducted extensive public outreach efforts across the state, spending $94 million dollars to help community groups, local health clinics, and labor unions reach residents and sign them up for coverage. California has used radio and television commercials, highway billboard advertisements, and a number of Twitter and Facebook posts to spread awareness of Covered California throughout the state. To reach its Latino population, California has established partnerships with Univision, Telemundo, La Opinion and impreMedia to implement Spanish-language media campaigns through TV, radio, print, and digital media. Outreach workers who speak Spanish, Tagalog, Cambodian, Mandarin and Cantonese are attending local community events such as county fairs, farmers markets, street festivals and back-to-school nights across the state.

KY: Kentucky reports tens of thousands of enrollees in its Marketplace, with high rates of enrollment by young adults under 35 years old (40 percent) and women (59 percent). The Kentucky Health Benefit Exchange has awarded nearly $6.5 million in contracts to navigator programs throughout the state to ensure that Kentuckians have assisters to help them determine their health plan needs and assist them in choosing appropriate plans. The state also has 3,400 certified insurance agents trained to explain the multiple offerings available.

NY: New York State of Health (NYSOH) Marketplace officials report that nearly 174,000 New Yorkers had completed the full application process and were determined eligible for coverage as of October 23, 2013. The fast pace of New York's enrollment uptake indicates that many New Yorkers are seeking affordable health coverage. NYSOH's customer service operators have assisted more than 77,000 New Yorkers. Another potential factor in New York's success is the reduced rates in the individual market. NYSOH reports a 53 percent reduction compared to the previous year's rates.

APPENDIX A

TOTAL MARKETPLACE APPLICATIONS, ELIGIBILITY DETERMINATIONS, AND MARKETPLACE PLAN SELECTIONS BY MARKETPLACE TYPE AND STATE, 10-1-2013 TO 11-2-2013

Total Marketplace Applications, Eligibility Determinations, and							
State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
States Implementing Their Own Marketplaces (SBMs)							
California (9)	105,782	192,489	93,663	N/A	79,519	19,307	35,364
Colorado (10)	20,492	45,575	36,335	8,742	N/A	9,240	3,736
Connecticut	12,337	18,815	12,325	6,807	6,490	0	4,418
District Of Columbia (11)	2,541	N/A	N/A	N/A	N/A	N/A	N/A
Hawaii (12)	1,754	2,379	1,156	N/A	N/A	1,223	N/A
Kentucky	50,279	76,294	39,207	13,201	28,676	8,411	5,586
Maryland	10,917	N/A	3,498	2,638	5,923	N/A	1,284
Massachusetts (13)	14,413	N/A	N/A	N/A	N/A	N/A	N/A
Minnesota (14)	15,268	31,447	21,532	6,759	9,166	749	1,774
Nevada	9,186	14,819	N/A	N/A	5,710	9,109	1,217
New York	N/A	N/A	134,897	34,267	23,902	N/A	16,404
Oregon (15)	8,752	N/A	190	N/A	425	N/A	N/A
Rhode Island	6,670	9,581	3,326	2,086	3,447	2,808	1,192
Vermont	3,242	5,540	3,341	1,078	1,411	788	1,325
Washington (16)	64,990	119,309	29,503	13,375	48,196	41,610	7,091
SBM Subtotal	**326,623**	**516,248**	**378,973**	**88,953**	**212,865**	**93,245**	**79,391**
States With Marketplaces that are Supported by or Fully-Run by HHS (FFM)							
Idaho (17)	4,753	10,573	7,733	3,305	1,597	1,243	338
New Mexico (17,18)	4,055	7,529	4,249	1,549	3,552	N/A	172
Alabama	10,573	20,840	14,696	4,910	2,262	3,882	624
Alaska	1,253	2,203	1,606	598	368	229	53
Arizona	17,220	32,897	20,741	7,156	11,339	817	739
Arkansas	7,294	14,059	6,123	2,279	7,430	506	250

Total Marketplace Applications, Eligibility Determinations, and							
State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
Delaware	1,897	3,491	2,204	674	1,200	87	97
Florida	67,366	123,870	93,456	29,637	12,887	17,527	3,571
Georgia	28,642	56,783	41,426	12,757	7,709	7,648	1,390
Illinois	30,901	56,636	35,802	11,603	19,447	1,387	1,370
Indiana	15,982	31,979	19,093	7,890	11,305	1,581	701
Iowa	5,547	10,884	6,104	2,079	4,490	290	136
Kansas	6,061	12,205	9,087	3,009	1,718	1,400	371
Louisiana	7,702	14,163	10,294	3,277	1,460	2,409	387
Maine	3,550	6,497	5,061	2,116	623	813	271
Michigan	23,987	44,025	34,197	12,468	4,978	4,850	1,329
Mississippi	4,339	8,204	5,822	1,662	925	1,457	148
Missouri	14,131	27,911	20,121	7,111	4,157	3,633	751
Montana	2,683	5,205	3,815	1,711	457	933	212
Nebraska	4,947	9,973	7,453	2,967	2,295	225	338
New Hampshire	4,006	7,817	5,767	2,016	1,643	407	269
New Jersey	23,021	42,372	23,985	8,082	17,460	927	741
North Carolina	29,547	57,653	42,110	15,051	7,404	8,139	1,662
North Dakota	969	1,845	1,180	370	585	80	42
Ohio	24,050	45,128	34,374	11,866	7,535	3,219	1,150
Oklahoma	6,905	14,169	9,952	1,432	2,412	1,805	346
Pennsylvania	31,827	57,674	43,966	15,497	3,788	9,920	2,207
South Carolina	11,249	20,980	15,257	4,973	3,112	2,611	572
South Dakota	1,491	3,081	2,279	822	525	277	58
Tennessee	17,598	33,230	24,334	8,573	4,089	4,807	992
Texas	53,904	108,410	80,960	25,520	11,682	15,768	2,991
Utah	6,186	14,580	9,318	3,883	4,816	446	357
Virginia	21,667	42,341	32,534	9,333	4,088	5,719	1,023
West Virginia	3,807	7,096	3,442	1,268	3,103	551	174
Wisconsin	19,098	34,678	22,038	8,911	10,736	1,904	877
Wyoming	1,353	2,654	2,040	822	219	395	85
FFM Subtotal	**519,561**	**993,635**	**702,619**	**237,177**	**183,396**	**107,892**	**26,794**

Total Marketplace Applications, Eligibility Determinations, and Marketplace Plan Selections By Marketplace Type and State (1)
10-1-2013 to 11-2-2013

State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
MARKETPLACE TOTAL, All States	**846,184**	**1,509,883**	**1,081,592**	**326,130**	**396,261**	**201,137**	**106,185**

Notes:
"N/A" means that the data for the respective metric is not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 10/1/13 to 11/2/13.

(2) "Completed Applications" represents the total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if the applicant applied for insurance affordability programs, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, as well as to begin eligibility assessments or determinations for Medicaid and CHIP. In the case of Medicaid and CHIP, the Marketplace may perform eligibility assessments instead of determinations, at state option. Additionally, for electronic applications, Completed Applications include only those applications for which the applicant has hit the "submit" button and the application has been accepted for further processing. In addition to these applications, the FFM also has 259,107 additional paper and call center applications that are not included in this total. Note: a single Completed Application may include multiple individuals who are applying for coverage.

(3) "Individuals Applying for Coverage in Completed Applications" represents the total number of individuals included in Completed Applications that were submitted to the Marketplace during the applicable reference period. This number does not include individuals applying through the SHOP. Note: SBM data on the number of Individuals Determined Eligible to Enroll in a plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to missing data and differences in process flows for Marketplace Plans and Medicaid/CHIP eligibility determinations / assessments.

(4) "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace" (i.e., a Marketplace plan) represents the total number of individuals for whom a Completed Application has been received and who are determined to be eligible for plan enrollment through the Marketplace during the reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in coverage by the end of the reference period. Individuals who have been determined or assessed eligible for Medicaid or CHIP are not included.

(5) "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance" represents the total number of individuals determined by the Marketplace to be eligible for enrollment through the Marketplace, who qualify for an advance premium tax credit (APTC). This number includes individuals who were

determined eligible for Marketplace plan enrollment with only an APTC, as well as individuals who were determined eligible for enrollment into a plan with both an APTC and a cost-sharing reduction (CSR).

(6) "Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace" represents the number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP, based on modified adjusted gross income (MAGI). In some states, Completed Applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In other states, the Marketplace has been delegated the final Medicaid/CHIP determination responsibility for these individuals. Thus, this data element includes all Medicaid MAGI assessments, regardless of the state Medicaid/CHIP agency's final eligibility determination. Note: this data element does not include eligibility determinations made by State Medicaid/CHIP agencies based on applications originally submitted to the State agency or other Medicaid/CHIP assessments or determinations. Additionally, this column may vary slightly from accounts transferred to states by the FFM.

(7) "Pending / Other": A derived estimate for individuals who have a completed and processed application, who either: 1) have a pending eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage; 2) have a completed eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace plan coverage.

(8) "Individuals Who Have Selected a Marketplace plan" represents the total number of "Individuals Determined Eligible to Enroll in a plan Through the Marketplace" who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period. This is also known as pre-effectuated enrollment.

(9) For California, the total includes individuals who have been fully determined as well as those that are "pending" and also those that are "contingent."

(10) Because the Colorado Marketplace does not have an eligibility system that is integrated with its state Medicaid department, the data for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time.

(11) The total of completed applications for the District of Columbia reflects online applications only. Data are currently not available for the District of Columbia on the number of individuals deemed eligible for or enrolled in Marketplace plan, or eligible or enrolled in Medicaid/CHIP because the District of Columbia's information systems record data by accounts rather than number of individuals or covered lives. In many instances, the accounts reflect two or more individuals. Thus, the District of Columbia has reported that between October 1, 2013 and November 2, 2013, 572 plans were selected, which could represent 1,000 or more individuals selecting a plan.

(12) Because the Hawaii Marketplace does not have an eligibility system that is integrated with its state Medicaid department, the data for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time.

(13) Due to Massachusetts's system constraints, cumulative values for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time. Additionally, data for the total number of applications completed for Massachusetts represents time period 10/01/13 through 11/01/13

(14) Minnesota's cumulative data for "Individuals Determined Eligible to Enroll in a Marketplace plan," "Individuals Determined Eligible to Enroll in a Marketplace plan with Financial Assistance," and "Individuals Who Have Selected a Marketplace plan" do not include adults between 133% and 200% of the Federal Poverty Level (FPL) because these individuals are enrolled in the MinnesotaCare program. In addition, children up to 275% FPL are covered through the Medicaid program. Please note that when comparing Minnesota's cumulative data for these indicators with other State-Based Marketplaces, the number of individuals (2,505) determined eligible for MinnesotaCare should be included in the calculation.

(15) Cumulative data for Oregon represents best available data as of 11/04/13.

(16) Cumulative data for Washington represents time period 10/01/13 through10/31/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being

redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.

(17) Idaho and New Mexico are Federally supported SBMs for 2014; they are using the FFM platform for 2014.

(18) New Mexico data on the number of Individuals Determined Eligible to Enroll in a Marketplace plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

Source: Centers for Medicare & Medicaid Services, as of 11-12-2013.

APPENDIX B: METHODOLOGY AND TECHNICAL NOTES

The data that are reported in this issue brief have been generated by the information systems of the Centers for Medicare & Medicaid Services, based on information reported to CMS by SBMs, and information collected by the FFM for states with HHS- supported or fully run Marketplaces (including those run in partnership with states).

Unless otherwise noted, the data in this issue brief represent cumulative Marketplace enrollment-related activity for the 10-1-13 to 11-2-13 reporting period, with information available as of 11-12-13. Data for certain metrics are not yet available for some states due to information system issues. We anticipate that more comprehensive data will be available in future monthly enrollment-related reports as system issues are resolved.

We believe that the information contained in this issue brief provides the most systematic "snapshot" of enrollment-related activity in the Marketplaces to date because the data for the various metrics are counted using comparable definitions for data elements across states, and between the SBMs and FFM (see table below). **It is important to note that the SBM enrollment-related data that are reported in this issue brief represent state data that have been reported to CMS, and may differ from comparable data that have previously been publicly reported on SBM websites or in media reports because that data may be based on different time periods or metric definitions from those used in this report.**

Summary of Marketplace Monthly Enrollment-Related Information By Marketplace Type (10-1-13 to 11-2-13)	Marketplaces Total (SBMs and FFMs)		States Implementing Their Own Marketplaces (SBMs)		States With Marketplaces that are Supported by or Fully-Run by HHS (FFM)	
	Number	% of Total*	Number	% of Total*	Number	% of Total*
Completed Applications	846,184	n/a	326,623	n/a	519,561	n/a
Number of Individuals Applying for Coverage in Completed Applications	1,509,883	100.0%	516,248	***	993,635	100.0%
Number of Individuals With Processed Eligibility Determinations or Assessments	1,477,853	97.9%	591,838	***	886,015	89.2%
Eligible for Marketplace plan Enrollment	1,081,592	71.6%	378,973	***	702,619	70.7%
Eligible for Marketplace plan with APTC *(non-add)*	326,130	21.6%	88,953	***	237,177	23.9%
Other Marketplace plan-Eligible Individuals *(non-add)*	755,462	50.0%	290,020	***	465,442	46.8%
Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace	396,261	26.2%	212,865	***	183,396	18.5%
Pending / Other	201,137	**	93,245	***	107,892	10.9%
Total Individuals Eligible to Enroll in a Marketplace plan	1,081,592	100.0%	378,973	100.0%	702,619	100.0%
Marketplace Eligible Individuals Who Have Selected a Marketplace plan	106,185	9.8%	79,391	20.9%	26,794	3.8%
Marketplace plan Eligible Individuals Who Have Not Yet Selected a Marketplace plan	975,407	90.2%	299,582	79.1%	675,825	96.2%

* Percent of total represents the percent of total individuals applying for coverage in completed applications, or the percent of total individuals eligible to enroll in a Marketplace plan who have selected a Marketplace plan.

** Pending/Other does not sum to 100 percent due to missing SBM data.

*** Total SBM data on the number of persons with processed eligibility determinations or assessments do not add to the total number of persons applying for coverage in completed applications due to missing data and differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

Source: Centers for Medicare & Medicaid Services, as of 11-12-2013.

While this issue brief includes some data for all states, data for certain metrics are not available for certain states. For example, CMS did not receive data on the number of individuals applying for coverage in completed applications, the number of processed eligibility determinations and assessments, or the number of individuals eligible for plan enrollment through the Marketplace who have selected a Marketplace plan from two states (Hawaii and Massachusetts) and the District of Columbia.

In the table in Appendix A, which shows the state-level data, "N/A" means that the data for the respective metric is not yet available for a given state.

Definitions of Enrollment-Related Data Terms

- **Reference Period:** Unless elsewhere noted, the reference period for which data are reported is from 10-1-13 to 11-2-13.

  Oct 1- Nov 2 most closely represents the first month of operations since state based Marketplaces generally compile enrollment-related metrics on a weekly basis.

- **Completed Applications:** The total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if the applicant applied for insurance affordability programs, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, as well as to begin eligibility assessments or determinations for Medicaid and CHIP. In the case of Medicaid and CHIP, the Marketplace may perform eligibility assessments instead of determinations, at state option. Additionally, for electronic applications, Completed Applications include only those applications for which the applicant has hit the "submit" button and the application has been accepted for further processing. It is important to note that a single Completed Application can include multiple individuals who are applying for coverage.

  These data represent completed applications that were reported as submitted across all channels by the SBMs and FFM during the reporting period. Applications can be submitted electronically (online) or on paper, by the applicant or on behalf of the applicant by an assister (navigator, in-person assister, agent/broker), or through the call center. The data on paper applications that are included in this total are likely to be undercounted because of a lag time between mailing and receiving the applications.

  Applications submitted through the mail are included in the paper category. Applications submitted through the call center or in-person are included in the electronic or paper

categories, as appropriate.

The FFM data on completed applications does not include paper applications or call center applications. An additional 259,107 applications were filed by paper and through call centers during this Oct. 1- Nov. 2 reporting period that are not included in this total.

- **Individuals Applying for Coverage in Completed Applications:** The total number of individuals included in Completed Applications that were submitted to the Marketplace during the applicable reference period. This number does not include individuals applying through the Small Business Health Options Program (SHOP).

  Note: SBM data on the number of Individuals Determined Eligible to Enroll in a plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to missing data.

- **Individuals Determined Eligible to Enroll in a Plan Through the Marketplace** (i.e., a Marketplace plan)**:** The total number of individuals for whom a Completed Application has been received and who are determined to be eligible for Marketplace plan enrollment through the Marketplace during the reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in a plan through the Marketplace by the end of the reference period. Individuals who have been determined or assessed as eligible for Medicaid or CHIP are not included.

- **Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance:** The total number of individuals determined by the Marketplace to be eligible for plan enrollment through the Marketplace, who qualify for advance premium tax credits (APTC). This number includes persons who were determined eligible for plan enrollment with only APTC, as well as persons who were determined eligible for enrollment into a Marketplace plan with both APTC and cost-sharing reductions (CSR).

  This number does not include Marketplace plan eligible individuals who: didn't apply for financial assistance; applied for financial assistance and were found ineligible; or applied for financial assistance and their applications are pending.

- **Individuals Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace:** The number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP, based on modified adjusted gross income (MAGI) eligibility criteria. In some states, Completed Applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In other states, the Marketplace has been delegated the final Medicaid/CHIP determination responsibility for these individuals. Thus, this data element includes all

Medicaid/CHIP MAGI assessments by the Marketplace, regardless of the state agency's final eligibility determination. This data element does not include eligibility determinations made by state Medicaid/CHIP agencies based on applications originally submitted to the state agency or other Medicaid/CHIP assessments or determinations. Additionally, this column may vary slightly from accounts transferred to states by the FFM.

- **Pending/Other:** A derived estimate of the total number of individuals for whom a Completed Application has been received, who either: 1) have a pending eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage; 2) have a processed eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace plan coverage.

  The data represented in the "Pending/Other" column are only an approximation; because they are not strict subsets of one another, the sum of "Individuals Eligible to Enroll in a Marketplace plan", "Individuals Assessed Eligible for Medicaid/CHIP", and "Pending/Other" does not necessarily equal the "Total Individuals Applying for Coverage in Completed Applications." Given process flows, it is sometimes very difficult to separate individuals who are assessed eligible for Medicaid [MAGI] and those determined eligible for Marketplace plans.

  Pending/Other does not sum to 100 percent of total Individuals Applying for Coverage in Completed Applications due to missing SBM data.

- **Individuals Who Have Selected a Marketplace plan:** The total number of "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace" who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period, whether or not they are eligible to receive an Advanced Premium Tax Credit or cost-sharing reduction.

Additional Technical Notes for SBM Data

- For California, the total includes individuals who have been fully determined as well as those that are "pending" and also those that are "contingent."

- Because the Colorado Marketplace does not have an eligibility system that is integrated with its State Medicaid/CHIP agency, data for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time.

- The total of completed applications for the District of Columbia reflects online applications only. Data are currently not available for the District of Columbia on the number of individuals deemed eligible for or enrolled in Marketplace plans, or eligible or enrolled in Medicaid/CHIP because the District of Columbia's information systems record data by accounts rather than number of individuals or covered lives. In many instances, the accounts reflect two or more individuals. Thus, the District of Columbia has reported that between October 1, 2013 and November 2, 2013, 572 plans were

selected, which could represent 1,000 or more individuals selecting a plan.

- Because the Hawaii Marketplace does not have an eligibility system that is integrated with its State Medicaid/CHIP agency, data for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time.

- Due to Massachusetts's system constraints, cumulative values for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time; additionally, data for the total number of applications completed for Massachusetts represents time period 10/01/13 through 11/01/13.

- Minnesota's cumulative data for "Individuals Determined Eligible to Enroll in a Marketplace plan," "Individuals Determined Eligible to Enroll in a Marketplace plan with Financial Assistance," and "Individuals Who Have Selected a Marketplace plan" do not include adults between 133% and 200% of the Federal Poverty Level (FPL) because these individuals are enrolled in the MinnesotaCare program. In addition, children up to 275% FPL are covered through the Medicaid program. Please note that when comparing Minnesota's cumulative data for these indicators with other State-Based Marketplaces, the number of individuals (2,505) determined eligible for MinnesotaCare should be included in the calculation.

- Cumulative data for Oregon represents best available data as of 11/04/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.

- Cumulative data for Washington represents time period 10/01/13 through10/31/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.

Additional Technical Notes for FFM Data

For the data on eligibility:

- An individual found eligible with an inconsistency counts as an eligible person.

- Counts for potentially eligible for Medicaid/CHIP include FFM Assessments as well as FFM Determinations as directed by the states.

- The business logic for conducting Medicaid and CHIP eligibility assessments and determinations are based on the FFM's interpretation of each state's Medicaid and CHIP eligibility rules, and are subject to revision.

For the data on Marketplace plan selection:

- The "Selection of a Marketplace plan" metric reflects unique consumers who have

enrolled in either a Marketplace plan or a Dental Plan. If a consumer selects both a Marketplace plan and a Dental Plan, they are counted as 1 plan selection. If a consumer enrolls in a Marketplace plan only, they are counted as 1 plan selection. If a consumer selects a Dental Plan only, they are counted as 1 plan selection. Any plan selection is counted at the moment the consumer hits the "Submit" button in Plan Compare. These are "active" polices.

- These data were pulled for an "As of" date of 11-2-2013, with the following logic:
  - If a policy is created in October and cancelled in October, that policy, and the individuals on it, are NOT included in October counts.
  - If a policy is created in October and cancelled after November 2, 2013 that policy, and the individuals on it, WOULD be included in October counts.

- During an enrollment-related transaction, if a consumer clicks either the "Enroll" or the "Cancel" button more than once, the system may improperly generate multiple transactions. In addition, duplicate transactions have been sent concerning the same person due to minor name differences. Until these technical issues are corrected, the number of transactions may underestimate or overestimate the number of people who will ultimately be actively enrolled.

New Mexico data on the number of Individuals Determined Eligible to Enroll in a Marketplace plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

APPENDIX C: PAST EXPERIENCES IN HEALTH COVERAGE ENROLLMENT

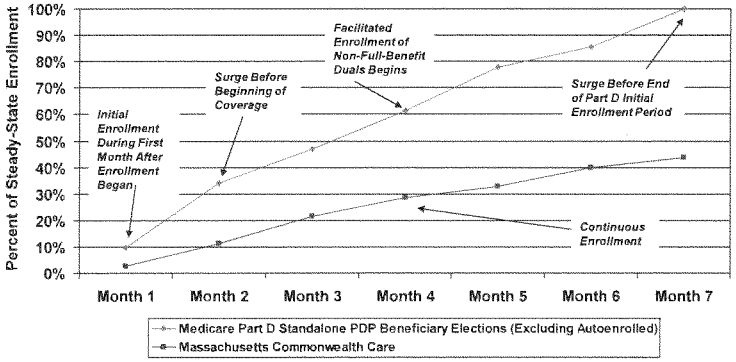
Past enrollment experiences from other health coverage programs inform the Department's expectations for enrollment in the new Marketplace. Based on the experience of the Federal Employees Health Benefits Program (FEHB), Medicare Part D, Massachusetts' Commonwealth Care, and the Children's Health Insurance Program (CHIP), we have learned that several factors drive enrollment rates, particularly in the early months of program operation.

1. "Action-forcing" events — such as the end date of an open enrollment period or the start date for benefits — often result in a spike in enrollment activity.
2. The length of a program's pre-benefit period (i.e., the period between sign-up/enrollment and the receipt of benefits) affects rates of initial enrollment. Shorter pre-benefit periods (e.g., 1 month) tend to generate higher initial enrollment rates than longer pre-benefit periods, during which the consumer may perceive little advantage to signing up or enrolling early.
3. A requirement to pay the initial premium to complete enrollment creates a financial disincentive to enroll early. Consumers are generally required to pay their first month's premium prior to the first day of coverage. This can result in last-minute enrollment activity by consumers to minimize the lag time between payment and access to benefits. Marketplace enrollees must pay premiums by December (even if they enroll in October) for coverage to begin January 1, this fact may affect enrollment in October and November.
4. The use of "auto" or "passive" enrollment, where a group of consumers is enrolled in coverage without any action on the consumers' part, results in higher enrollment rates.
5. Public education campaigns and outreach efforts tied to deadlines that correspond to benefits coverage build consumer awareness and encourage enrollment.

Graphs included in this Appendix illustrate initial enrollment in Medicare Part D, Massachusetts Commonwealth Care, and CHIP, plus enrollment from the FEHB's annual open season for 2012. Each program differs in terms of pre-benefit periods, length of the open enrollment period, and the use of auto-enrollment, which in turn affected enrollment rates during initial months of operation. For example, Medicare Part D experienced faster rates of enrollment compared to Massachusetts Commonwealth Care due to a six-month open enrollment period.

Comparison of Early Part D and Massachusetts Commonwealth Care Enrollment Experience

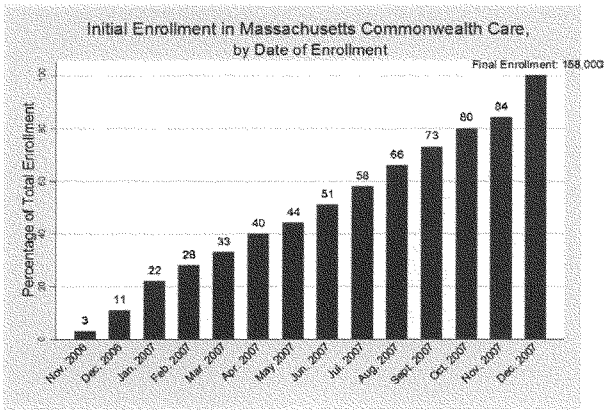
Part D experienced faster rates of enrollment due to a six-month open enrollment period



Notes: Medicare Part D Standalone PDP (Prescription Drug Plan) Beneficiary Elections represents beneficiaries who submitted applications to enroll in a Standalone PDP (excluding Medicare/Medicaid full-benefit dual eligible beneficiaries who were initially autoenrolled into a PDP (including those who subsequently switched plans) and including beneficiaries qualifying for the low income subsidy who received facilitated enrollment); Part D had a 6-month initial open enrollment period. Massachusetts Commonwealth Care represents total enrollees (including auto-enrolled individuals from the state's uncompensated care pool; the program has continuous enrollment, allowing people to sign up at any time during the year.

Source: CMS and HHS Part D Enrollment Press Releases, 12/22/2005 – 6/14/2006; CMS Administrative Data (Facilitated Enrollments). Data on initial Commonwealth Care enrollment, available at http://www.mass.gov/chia/docs/r/pubs/09/key-indicators-02-09.pdf and http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm

Massachusetts Commonwealth Care. Commonwealth Care is a means-tested subsidized insurance program for uninsured individuals who do not qualify for Medicaid (MassHealth) and is part of the Massachusetts Health Connector. Enrollment and benefits for subsidized coverage in Commonwealth Care began January 1, 2007, although Massachusetts auto-enrolled a large number of individuals from the state's uncompensated care pool beginning October 1, 2006. Commonwealth Care enrollment appears to have reached a steady state a year after coverage began.[9] By December 2007, 158,000 people had enrolled in Commonwealth Care.

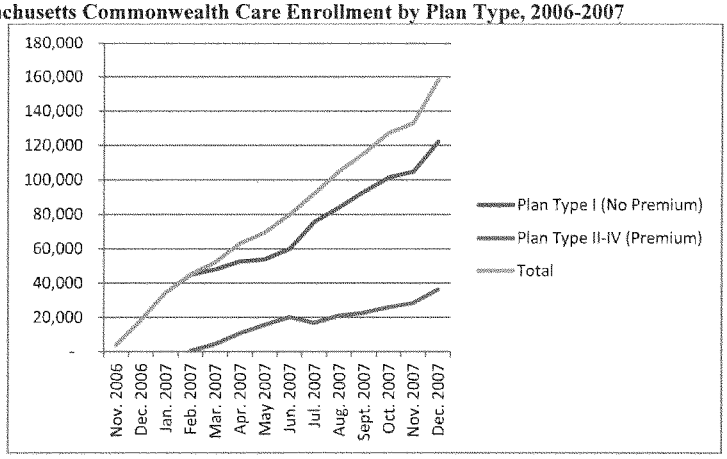


The majority of individuals who enrolled in Commonwealth Care during the first year were in "Type I" plans and not responsible for paying a premium. There were large differences in initial enrollment rates between those who qualified for plans without having to pay a premium and those who were required to pay a premium (see chart below).[10] For the plan types that may require a premium payment (Type II, III and IV), only about 4,000 individuals signed up in the first couple of months of the program.

[9] For data on initial Commonwealth Care enrollment, see http://www.mass.gov/chia/docs/r/pubs/09/key-indicators-02-09.pdf and http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm

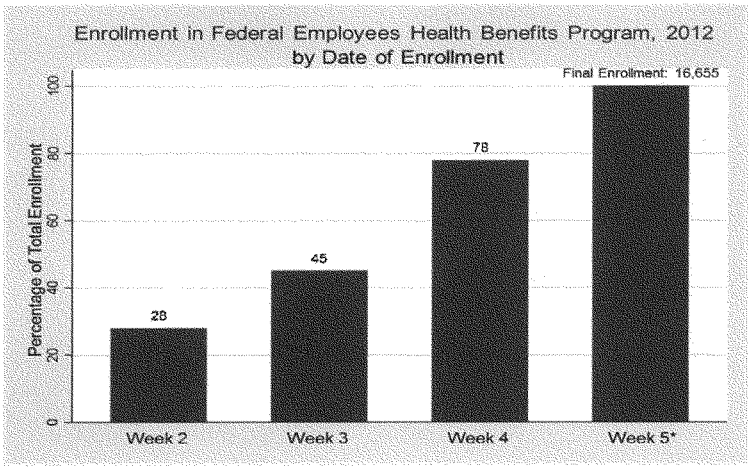
[10] Individuals who have Commonwealth Care Plan Type I (available to those with incomes below 100 percent of the FPL) do not pay premiums for coverage. Individuals who have incomes above 150 percent of the FPL and are enrolled in Plan Type II-IV (available to those with incomes 100.1 to 300 percent of the FPL) pay premiums unless their income is below 150 percent FPL. Data on enrollment by plan type through May 2007 are available here: https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%252520Us/Publications%252520and%252520Reports/2007/2007-05-10/CommCare%252520Program%252520Update.pdf

Massachusetts Commonwealth Care Enrollment by Plan Type, 2006-2007



Source: Boston Globe, October 16, 2013:
http://www.boston.com/lifestyle/health/health_stew/2013/10/how_much_aca_enrollment_is_enough.html

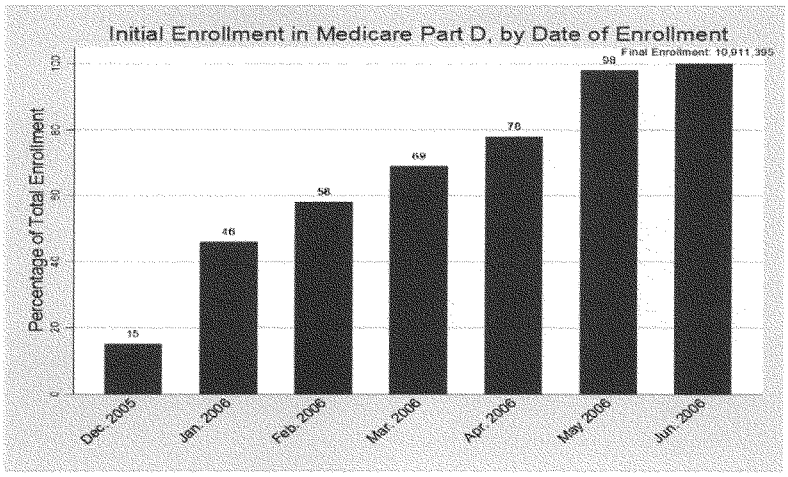
Federal Employees Health Benefits Program. The Office of Personnel Management reports that enrollment spikes in the last few days before the end of the open enrollment period. This is consistent with the experience of private employers as well. The FEHB program has an annual, month-long open season during which employees are allowed to change their insurance coverage status and switch plans. Data from the FEHB's 2012 open season shows that relatively few employees make changes to their coverage in the first couple weeks of the period. Nearly a quarter (22 percent) of those employees who changed their enrollment during the open season made their selection in the last two days before the season's deadline. In the table below, Week 5 of 2012 open season consisted of only 2 days.



*Week 5 comprises only 2 days

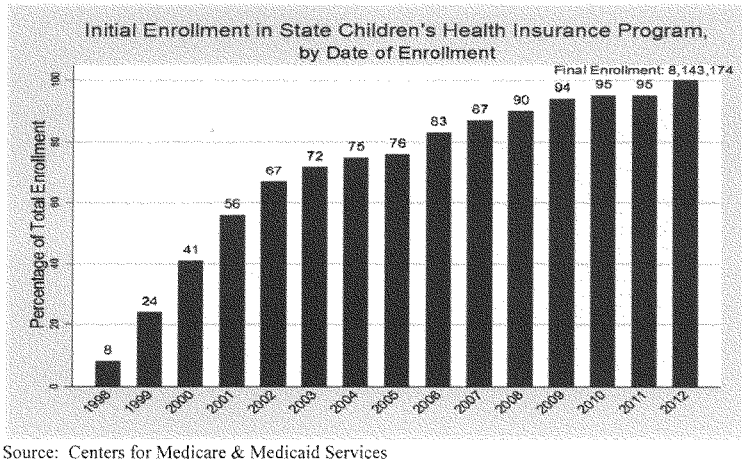
Source: Office of Personnel Management

Medicare Part D. Initial enrollment for Part D opened November 15, 2005 and closed on May 15, 2006. Coverage began January 1, 2006, approximately six weeks after the start of open enrollment. The enrollment rate was 15 percent at the end of December 2005, the end of the "pre-benefit period," and rose to 98 percent by May 2006, the end of the open enrollment period. *This data (and graph) includes only those who affirmatively enrolled and paid a premium for a standalone Medicare Part D plan.* Medicare Part D had auto-enrollment for Medicare-Medicaid dual eligibles and those in Medicare Advantage plans that added drug coverage, but we do not include those enrollees in the chart below.



Source: Centers for Medicare & Medicaid Services

Children's Health Insurance Program. CHIP experienced low enrollment rates in the early years of the program. Despite extensive outreach and streamlining of application procedures, only 60 percent of eligible children participated in CHIP fully five years after states began implementing their CHIP programs in 1998. At that point the program reached an enrollment plateau. Currently, CHIP, combined with Medicaid, reaches 86 percent of all eligible children.



Source: Centers for Medicare & Medicaid Services

Expectations for Marketplace Enrollment

Looking forward, the Department expects that Marketplace enrollment will start slowly, with peaks in December 2013 (shortly before benefits begin January 1) and March 2014 (at the end of open enrollment). There is a three-month lag between the beginning of open enrollment on October 1, 2013, and January 1, 2014 when Marketplace benefits begin. As a result, the Department anticipates the enrollment trend will start gradually, with low enrollment in the first two months of open enrollment (October 2013 and November 2013). Enrollment activity is expected to increase in December in anticipation of coverage starting January 1, 2014 and again in March as the March 31, 2014 deadline for open enrollment approaches.

APPENDIX D: CONSUMER AWARENESS OF THE MARKETPLACE

National surveys show that awareness of the Marketplaces increased over the month of October, and nearly one in five Americans who is uninsured or covered by individual market insurance has visited the Marketplace to shop for a plan.

A Commonwealth Fund survey conducted Oct. 9-27[11] polled adults (ages 19-64) who are uninsured or have individual coverage and found:

- Most (60 percent) are aware of the Marketplace.
  - 53 percent are aware that financial support is available for Marketplace coverage.
  - 17 percent have visited the Marketplace.
- Most (58 percent) said they are very likely or somewhat likely to go or go back to visit the Marketplace before the end of open enrollment on March 31, 2014 to enroll in a plan or to apply for a premium tax credit or for Medicaid.
- Of those who have visited the Marketplace, 21 percent enrolled in a plan.
  - 47 percent tried to find out if they were eligible for financial assistance (through APTCs or CSRs) or Medicaid.
  - 27 percent rated their Marketplace experience excellent or good, and 70 percent said it was fair or poor.
  - 56 percent said it was difficult, very difficult, or impossible to find a plan with the type of coverage they needed; 38 percent said it was somewhat easy or very easy.
- Of those who did not enroll in October, the most frequently cited reasons were: not being certain they could afford a plan (48 percent), still trying to decide on a plan (46 percent), and thinking deductibles and copayments were too high (42 percent).

The polling firm Gallup found in its October surveys:

- Among all uninsured adults, 18 percent have visited or attempted to visit the online Marketplace. Among uninsured adults who are planning to obtain or who have already obtained coverage through the Marketplace, 22 percent have visited or attempted to visit the online Marketplace. [12]
- The share of the uninsured who consider themselves familiar with the Marketplace was larger at the end of October (27 percent) than at the end of September (25 percent).[13]

According to a national survey by the Pew Research Center, conducted Oct. 9-13,[14] awareness of the Marketplaces is higher in states that are involved in running their Marketplaces:

[11] http://www.commonwealthfund.org/Publications/Data-Briefs/2013/Nov/Americans-Experiences-Marketplaces.aspx

[12] Poll conducted Oct. 23- Nov. 6. http://www.gallup.com/poll/165776/uninsured-americans-ignoring-health-exchange-sites.aspx

[13] The October poll was conducted Oct. 18-29, 2013. http://www.gallup.com/poll/165668/uninsured-aware-health-insurance-requirement.aspx

[14] http://www.people-press.org/2013/10/21/public-registers-bumpy-launch-of-health-care-exchange-websites/

- In the 24 states (including D.C.) with State-based Marketplaces or state-federal Partnership Marketplaces, 72 percent are aware that a Marketplace is available.
- In the 27 states that have federally-run Marketplaces, 59 percent are aware that a Marketplace is available in their state.

○