

**PATIENT PROTECTION AND AFFORDABLE CARE  
ACT: IMPLEMENTATION IN THE WAKE OF  
ADMINISTRATIVE DELAY**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND  
INVESTIGATIONS  
OF THE  
COMMITTEE ON ENERGY AND  
COMMERCE  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS  
FIRST SESSION

—————  
JULY 18, 2013  
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**Serial No. 113-72**



Printed for the use of the Committee on Energy and Commerce  
*energycommerce.house.gov*

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U.S. GOVERNMENT PRINTING OFFICE

86-396

WASHINGTON : 2014

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## CONTENTS

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	Page
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement .....	1
Prepared statement .....	3
Hon. Diana DeGette, a Representative in Congress from the state of Colorado, opening statement .....	4
Hon. Fred Upton, a Representative in Congress from the state of Michigan, opening statement .....	6
Prepared statement .....	7
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, prepared statement .....	8
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement .....	9
Hon. Gregg Harper, a Representative in Congress from the State of Mississippi, opening statement .....	54
WITNESSES	
J. Mark Iwry, Senior Advisor to the Secretary, Deputy Assistant Secretary for Retirement and Health Policy, U.S. Department of Treasury .....	11
Prepared statement .....	14
Answers to submitted questions .....	101
SUBMITTED MATERIAL	
Report, Majority staff, submitted by Mr. Murphy .....	55
Report, Urban Institute Analysis, submitted by Ms. DeGette .....	58
Report, Democratic Staff of Committees on Energy and Commerce, Ways and Means, and Education and the Workforce, submitted by Mr. Waxman ..	64
Report, Department of Health and Human Services, submitted by Mr. Waxman .....	89



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CARE ACT: IMPLEMENTATION IN THE WAKE  
OF ADMINISTRATIVE DELAY**

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**THURSDAY, JULY 18, 2013**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 2:34 p.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Burgess, Blackburn, Gingrey, Scalise, Harper, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Barton, Upton (ex officio), DeGette, Schakowsky, Butterfield, Castor, Tonko, Green, and Waxman (ex officio).

Staff present: Mike Bloomquist, General Counsel; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Andrew Powlenny, Deputy Press Secretary; John Stone, Counsel, Oversight; Tom Wilbur, Digital Media Advisor; Brian Cohen, Democratic Subcommittee Staff Director, Senior Policy Advisor; Hanna Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Assistant Press Secretary; Stephen Salsbury, Democratic Special Assistant; and Matthew Siegler, Democratic Counsel.

**OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. MURPHY. Good afternoon. I convene this hearing of the Subcommittee on Oversight and Investigations.

We are here today to discuss the Administration's recent decision to delay a substantial portion of the health care law, the requirement that businesses with over 50 employees provide coverage to their employees. This decision was announced quietly, just before the July 4 holiday, through a blog post.

Valerie Jarrett, one of the President's top advisors, stated that the Administration had delayed the employer mandate tax because

it was “listening” to employers who had complained about the law’s burdens and costs.

In the 3 years since the President’s health care law was enacted, this committee has also been listening and we have heard this Administration repeatedly tell us that “all is well.” The exchanges would be ready to go live in October. Never once did the Administration officials suggest that a key underpinning of the law, the requirement that employers report offer federally-approved health benefits and pay extra taxes if they didn’t, would be delayed.

As soon as the Treasury Department announced this decision in a blog post, the committee sent a letter asking for some basic information to understand how and why this decision was made. The Executive Branch, the President, has a constitutional duty to faithfully execute laws passed by Congress.

Both the Treasury Department and White House have said the decision to delay the employer mandate was made after engaging in a discussion with employers. Yet, in a July 9 letter to our committee, the Treasury Department did not answer the committee’s questions about who they spoke with to reach this decision. Why did the Administration give businesses a waiver from the law for a full year, but force families to comply with the law now or pay a new tax? Where is the waiver for America’s families?

This delay in the employer mandate tax is not the first clue that implementation of the Affordable Care Act is becoming a massive failure. In April 2011, more than 1,400 organizations and employers providing health insurance to 3.1 million Americans were granted waivers from the ACA’s mandates for one year. By January 2012, those 1,400 waivers were automatically extended for 2 more years, and now, every employer in America gets a waiver from the employer mandate tax. The American people, however, get no waivers from the mandates, the taxes, and burdens of this law.

It is interesting that the Treasury Department chose to explain that the employer mandate was delayed for two reasons: First, it will allow the Administration to find ways to simplify the reporting requirements in the law. Second, this provides time to adapt reporting systems. These same reasons support a delay for the individual mandate.

Treasury’s position that a delay is necessary because additional time is needed to adapt reporting systems sends a troubling signal about how the Administration’s lack of progress is affecting implementation of the law. How the exchanges will operate next year appears now to be a far cry from what the law envisioned. It also raises questions about another recent delay by the Administration, also announced over the July 4 holiday: Health and Human Services’ decision to scrap the income and coverage verification requirements for 2014.

I am sure today we will also hear a great deal about the news that New York’s premiums may be lower. This isn’t surprising: New York has the most heavily regulated and often the most expensive health care market in the country, so of course when you force every American to buy that expensive product, the cost may go down. I certainly am not going to be heading home to my district and saying congratulations, you now get to pay Manhattan prices in Pennsylvania.

Enrollment in the exchanges will begin in just over 70 days. It is important that every American understands how this system will work. So testifying before the committee today is J. Mark Iwry, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy at the U.S. Department of the Treasury. So I welcome you, Mr. Iwry, and I hope that you can provide specific answers to the committee members' questions about Treasury's decision and whether we can expect additional delays.

Now yesterday the House of Representatives voted to do two things. First, the House voted to codify the President's ability to delay the employer mandate, and second, it voted to offer this same option, the one given to America's businesses, to American families. Whether or not you agree on this policy, as an oversight subcommittee, we need to understand the basis for the Administration's decisions to delay or postpone the Act's requirements. As reports mount that the exchanges and states are not prepared to fully implement this law, it seems likely that the Administration will again find itself in the position of wanting to grant additional delays of the law's requirements. Examining the basis for these decisions, and how they will be made, is the job of this subcommittee, and that is the reason for having this hearing today.

I only have a few seconds left, but I yield to the vice chairman, if he has any—

[The prepared statement of Mr. Murphy follows:]

#### PREPARED STATEMENT OF HON. TIM MURPHY

We are here today to discuss the administration's recent decision to delay a substantial portion of the healthcare law—the requirement that businesses with over 50 employees provide coverage to their employees. This decision was announced quietly, just before the July 4th holiday, through a blog post. Valerie Jarrett, one of the president's top advisors, stated that the administration had delayed the employer mandate tax because it was "listening" to employers who had complained about the law's burdens and costs.

In the three years since the president's health care law was enacted, this committee has also been listening and we've heard this administration repeatedly tell us that "all is well." That exchanges would be ready to go live in October.

Never once did administration officials suggest that a key underpinning of the law—the requirement that employers report offer federally-approved health benefits and pay extra taxes if they didn't—would be delayed.

As soon as the Treasury Department announced this decision in a blog post, the committee sent a letter asking for some basic information to understand how and why this decision was made. The executive branch—the president—has a constitutional duty to faithfully execute laws passed by Congress.

Both the Treasury Department and White House have said the decision to delay the employer mandate was made after engaging in a discussion with employers. Yet, in a July 9th letter to our committee, the Treasury department did not answer the committee's question about who officials spoke with to reach this decision. Why did the administration give businesses a waiver from the law for a full year, but force individual Americans to comply with the law NOW or pay a new tax?

Where is the waiver for the American people?

This delay in the employer mandate tax is not the first clue that implementation of the Affordable Care Act is becoming a massive failure.

In April 2011, more than 1,400 organizations and employers providing health insurance to 3.1 million Americans were granted waivers from the ACA's mandates for one year.

By January 2012, those 1,400 waivers were automatically extended for two more years.

And now, every employer in America gets a waiver from the employer mandate tax.

The American people, however, get no waiver from the mandates, the taxes, and burdens of this law.

It is interesting that the Treasury Department chose to explain that the employer mandate was delayed for two reasons: First, it will allow the administration to find ways to simplify the reporting requirements in the law. Second, this provides time to adapt reporting systems. These same reasons support a delay in the individual mandate.

Treasury's position that a delay is necessary because additional time is needed to adapt reporting systems sends a troubling signal about the administration's lack of progress in implementing the law. How the exchanges will operate next year appears now to be a far cry from what the law envisioned. It also raises questions about another recent delay by the administration, also announced over the July 4 holiday: HHS' decision to scrap the income and coverage verification requirements for 2014.

I'm sure today we will also hear a great deal about the news that New York's premiums may be lower. This isn't surprising: New York has the most heavily regulated and often most expensive health care market in the country, so of course when you force every American to buy that expensive product, the cost may go down. I certainly am not going to be heading home to my district and saying: "Congratulations, you now get to pay Manhattan prices in Pennsylvania."

Enrollment in the exchanges will begin in just over 70 days. It is important that every American understands how this system will work. Testifying before the committee today is J. Mark Iwry, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy at the U.S. Department of the Treasury. Welcome, Mr. Iwry. I hope that you can provide specific answers to the committee members' questions about Treasury's decision and whether we can expect additional delays.

Yesterday the House of Representatives voted to do two things. First, the House voted to codify the President's ability to delay the employer mandate, and second, it voted to offer this same option—the one given to America's businesses—to American families. Whether or not you agree on this policy, as an oversight subcommittee, we need to understand the basis for the administration's decisions to delay or postpone the Act's requirements. As reports mount that the exchanges and states are not prepared to fully implement this law, it seems likely that the administration will again find itself in the position of wanting to grant additional delays of the law's requirements. Examining the basis for these decisions, and how they were made, is the job of this subcommittee. That is the reason for having this hearing today.

# # #

Mr. BURGESS. I will submit them.

Mr. MURPHY. He will submit them for the record.

All right, I now recognize the ranking member for 5 minutes.

**OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I am very pleased that we have started having oversight hearings on the implementation of the Affordable Care Act. I think it is an important role for the committee to play, and I also think as we go forward, it would be really constructive for us to begin having hearings on not just overall should we have the ACA or not, but rather, to drill down into some of the particular issues like we did a couple of weeks ago, when we did have small businesses come in here to this committee to talk to us about some of the challenges that they were facing.

I wish, though, that we were pursuing some of this oversight in a less hyperbolic fashion, as we just heard. Frankly, when the Administration announced a couple of weeks ago that they were de-

laying the employer mandate, it took many of us on this side of the Aisle by surprise, as well as on your side of the Aisle. But frankly, thinking about that panel of small businesspeople that we had here, one might argue that the Administration was just listening to some businesses about some very real issues that they had. Not that I would expect anybody on your side of the Aisle to give the Administration any credit for that.

I do think, though, that we should put all of this into context, because while this one particular part of the law has been delayed for a year, there is a lot more that is going to be going on in implementation and a lot that will help the American public. I would like to talk a little bit about that.

First of all, the delay of the employer mandate does not impact the 95 percent of large employers that are already offering insurance to their employees. Let me say that again. Ninety-five percent of large employers are already offering coverage to their employees, and that will continue to happen. Also, the delay of the employer mandate does not impact the millions of low income, uninsured Americans who will be newly eligible for the Medicaid program, at least in the states where the governors have not turned down the opportunity to provide fully funded coverage to their citizens. And the delay won't impact the state or federal exchanges, the heart of the health care law. Beginning in October, millions of Americans will be able to go to the exchanges, shop for the best insurance coverage for themselves and their family in a transparent, competitive market, and be protected from the worst abuses of the insurance industry. They won't have to worry about rescissions or denial of coverage if they become ill or injured, or if they have a preexisting condition.

And this is really key when you talk about should we delay this for a year for individuals. Those people, people who want insurance who can now go to the exchanges and get that insurance, will be eligible for billions of dollars in premium subsidies and tax credits to help make that health insurance affordable. So I would say, why would we delay that for people who really want to get affordable insurance, not just in New York, but in Pennsylvania and Colorado and all around this country?

The benefits of the law will be real and significant. The reports released by the democratic staff show yesterday that in Colorado, for example—or I am sorry, in my district, in the 1st District of Colorado, over 120,000 people who don't have health insurance now will have access to quality, affordable coverage without fear of discrimination or higher rates. And if it wasn't so important, I would have almost had to laugh yesterday when the response to the Administration's announcement was to vote yet again to repeal the Affordable Care Act. The main talking point seemed to be relief, but in fact, the public needs to get insurance and it needs to get it affordable. I don't think that relief means taking health care coverage away from millions of Americans. I don't think that it means eliminating billions of dollars in tax credits and subsidies. I don't think that it means leaving millions of American children and adults with preexisting conditions at the tender mercies of the insurance companies. And I don't think that it means eliminating or

delaying provisions of the law that are helping to keep costs under control.

Now, you can pooh-pooh this article about the rates—the premium rates in New York State, and maybe you could if that was the only state in which the premiums were going down. But in fact, we have seen across the country that as these preliminary rates come in, they are lower, and in fact, in some cases, the insurance companies are actually asking to rebid in the exchanges. And so I think we need to continue to try to tune this up. I read an article today when the Republican majority passed the Part D Medicare provisions about 10 years ago, there was a lot of confusion. All of us worked together to make those work. It was rocky at first, but it worked, and now over 90 percent of seniors love those protections. That is what we should be striving for in a bipartisan way today.

I want to thank you for having the hearing, but I think we need to move on from this, and I yield back. Thank you.

Mr. MURPHY. Gentlelady yields back. Now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

**OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. UPTON. Thank you, Mr. Chairman.

Yesterday the House voted to give to every American the same option the Administration gave to the business community: The ability to delay the impact of the health care law on their family for a year.

It is the right thing to do. Individuals, like businesses, are subject to reporting requirements, costs, penalties under the Affordable Care Act. We believe that individuals left to suffer in the looming rate shock deserve the same treatment that the Administration awarded to businesses, and I am glad the House voted in a bipartisan manner to do it yesterday and I hope the Senate will follow.

As a committee with jurisdiction over this law, and its implementation, we have a duty to hold the Administration accountable for its decisions and to make sure that they are transparent in the process which has sadly been missing throughout the writing, passage, and implementation of the health care law.

A great deal of uncertainty surrounds the law. Americans don't yet know how much their insurance will cost. Reports indicate that the exchanges are behind schedule. Deadlines have been delayed and missed entirely.

Today we are going to hear from Mr. Mark Iwry of the Treasury Department on its decision to delay the mandate for employers. I hope we will hear the complete story from the witness today on how this decision was made, who made it, what the record was before Treasury that prompted it to take the action 2 weeks ago. Previous hearings before this committee, Administration witnesses have looked us square in the eye and assured us that the implementation of the Affordable Care Act was, in fact, on track. Treasury's decision to delay the employer mandate confirms that this is not the case. And yesterday we learned the decision was made in June and the Administration had been considering the delay "for a while." Why did the "most transparent Administration in history"

mislead Congress and try to deceive the public? Because it knew that the law perhaps is bad for business and also bad for jobs.

We now know that the Administration shamelessly waited for July 4 fireworks to provide a smokescreen for their employer mandate bombshell. So we need to get a full accounting of this decision, in the full light of day, so we will be prepared for what comes our way once enrollment begins on October 1.

One other point that I want to make. I see a lot of public reports about those that support the Affordable Care Act making the comparisons to Part D, the Prescription Drug Program, comparisons that show that it is now rated very favorable among those people that participate. I would remind my colleagues that Part D is still a voluntary, not mandatory, program where folks can change their plans literally every year, have dozens of choices to make, and yes, there is no financial penalty for failure to participate.

I yield now to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

#### PREPARED STATEMENT OF HON. FRED UPTON

Yesterday the House voted to give to every American the same option the administration gave to the business community: The ability to delay the impact of the health care law on their family for one year.

This is the right thing to do. Individuals, like businesses, are subject to reporting requirements, costs, and penalties under the Affordable Care Act. We believe individuals left to suffer the looming rate shock deserve the same treatment that the administration awarded to businesses. I'm glad the House voted in a bipartisan manner to do this yesterday and I hope the Senate follows suit.

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I hope we will hear the complete story from the witness today on how this decision was made, who made it, what the record was before Treasury that prompted it to take this action two weeks ago. In previous hearings before this committee, administration witnesses have looked us square in the eye and assured us that implementation of the Affordable Care Act was on track. Treasury's decision to delay the employer mandate confirms that this is not the case.

And yesterday we learned the decision was made in June and the administration had been considering the delay "for a while." Why did the "most transparent administration in history" mislead Congress and try to deceive the public? Because it knew that the law is bad for business and bad for jobs.

We now know the administration shamelessly waited for July 4th fireworks to provide a smokescreen for their employer mandate bombshell.

We need to get a full accounting of this decision, in the full light of day, so we can all be prepared for what is coming our way once enrollment begins on October 1—or for whatever rewrite the administration makes next.

This is about fairness.

###

Mr. BURGESS. And I thank the gentleman for yielding.

It is of concern that on the evening of July 2, this provision was suddenly repealed—or delayed. It became especially of concern to me after hearing from Administration officials here in this sub-

committee that they would definitely be ready to go with the Affordable Care Act on time and without delay.

The questions are who discussed this delay? Were there memos circulating within the departments? Were there secret meetings with the White House? When did the Administration start thinking about delaying the reporting provisions? And what about the individuals that still must comply with the mandate to purchase their health care coverage? Do they get a delay as well?

The White House, the Treasury, Health and Human Services continue to say all systems are go. No problems here, nothing to look at. Move on. But actually, their actions belie their words. And unfortunately, it is the American people who will be left hanging in the balance.

If the gentleman from Texas would like time, I will yield to Mr. Barton.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you Mr. Chairman,

Since ACA was signed into law 3 years ago, we have only seen the law's failure to deliver on its promises.

Two weeks ago, the Obama administration announced it would delay implementation and reporting requirements for the mandate in the Affordable Care Act which requires employers to provide insurance or pay a penalty.

While the Administration attempted to bury their announcement in the midst of the July 4th holiday, they have only further proved that the President's signature law is not ready for primetime.

This announcement simply adds to a long list of provisions in the law that the Administration has delayed or postponed. Not to mention the provisions that have been so onerous and burdensome for business and consumers that Congress has already stepped in and repealed them altogether.

Not only is the law filled with broken promises, but the July 4th announcement directly contradicts statements that Administration officials have made before this Committee.

I have been told, time and time again, by officials from the agencies in charge of implementing the Affordable Care Act, that it would "definitely" be ready to go live on October 1, 2013.

So—where was the disconnect?

When did the Administration start thinking about delaying the reporting provisions?

Who discussed this delay? Were memos circulated within the departments? Were there secret meetings with the White House?

OR—is this just an attempt by the Administration to use perverse incentives to boost enrollment in their exchanges?

Furthermore, within the Administration's embarrassing admission of delay, they acknowledge the difficulty of getting verification systems up and running. So instead, the administration will rely on an honor system for reporting.

So what happens if they get it wrong?

The Administration has given a break to big business—allowing them to delay reporting compliance with the law.

What about the individuals that still must comply with the mandate to purchase health coverage? Do they get a delay?

While the White House, Treasury, and HHS continue to report that "everything is working like it's supposed to" and "they will definitely be ready", the American people are left hanging in the balance.

Thank you and I yield back.

Mr. BARTON. Well, I appreciate that.

My concern is that we have an Obama—presidential administration and President Obama that is constitutionally required to implement all the laws, and in this case, apparently chose to not im-

plement a part of the very law that it was so strongly for. So I am going to be asking questions, where in the Constitution does it give the President and the Treasury Department the ability to choose to implement this part of a law but not that part of a law, and if you only going to implement part, how can you be expected to implement the rest of it?

I have also got some questions and concerns about this decision to allow for self-attestation of income to comply with some of the subsidies. Is the Treasury Department now going to do away with the W-2 and W-4 forms and let the entire country self-attest what our income is for purposes of the income tax code? That is another question that I might have, Mr. Chairman, but I do appreciate the time and I appreciate the Treasury Department being here to participate in this hearing.

Mr. MURPHY. I thank the gentleman. The gentleman's time has expired, and now I will go to the ranking member of the full committee, Mr. Waxman, for 5 minutes.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Thank you, Mr. Chairman.

The Constitution says a law is something that is passed by the Congress and signed by the President. And my colleague just talked about the constitutional responsibility of the President to uphold the law. What about the constitutional responsibility of the Congress to make sure that the laws work?

I was shocked when we had the debate on the House Floor yesterday. A member stood up and said, "I despise the Affordable Care Act." What passion. What passion. What is it they despise so much? It is the law. If they want to change some of it, let's change it. But it just raises real concerns about—in my mind about where this Republican party is going. It is a state of mind that talks about taking things away from people that they desperately want for what purpose? Why should a state headed by a Republican governor want to deny their poor people 100 percent funding for Medicaid and leave them with no coverage at all? You know they have the hospitals and doctors say why not cover these people? I don't care. We are going to punish them because we want to punish President Obama. But they are punishing a lot of people that did nothing to deserve this kind of treatment.

Something has gone fundamentally wrong when a political party tries to deny health insurance to millions of American families just to advance its narrow partisan interest.

This law is going to go fully into effect. Millions of Americans are already benefitting from its protections. Millions more will, for the first time, have access to quality, affordable health coverage.

Yesterday, my staff released a series of reports on the benefits of this law in each congressional district in this country. I have these reports, Mr. Chairman, for each member of this subcommittee, and I would like to ask that they be made part of the hearing record. Mr. Chairman?

Mr. MURPHY. Without objection. I understand you have those things, I just want to add something, but I will mention it at the end of your time.

Mr. WAXMAN. Well I have asked unanimous consent.

Mr. MURPHY. Well let me just say I am not going to object to the unanimous consent. I do add that I will note that this report does not include information about expected costs and insurance price increases—

Mr. WAXMAN. You can put your critique of it in the record—

Mr. MURPHY. No, I just want to ask unanimous consent that we can put our Majority staff report from me on the expected premium increases.

Mr. WAXMAN. I have no problem with that.

Mr. MURPHY. Thank you.

[The information appears at the conclusion of the hearing.]

Mr. WAXMAN. Today, the Department of Health and Human Services released a new report finding that in contrast to the rate shock predictions from Republicans, health insurance plans under the Affordable Care Act will cost 18 percent less than predicted. Small businesses can almost save 20 percent over what they otherwise would have been paying for coverage. I would like to ask that this report also be made part of the hearing record. I will reserve that, because—

Mr. MURPHY. Thank you. No, we will give you time because I would like to find out what that report is.

Mr. WAXMAN. OK. The fact sheets and the HHS report document that the incredible amount of good this law is already doing. But rather than acknowledging this and trying to improve on any flaws, Republicans on this committee and in the House have launched an unrelenting effort to destroy the Affordable Care Act. Political analyst Chuck Todd said House Republicans are “trying to sabotage the law.” Where does the Constitution say that members of Congress are supposed to sabotage a law that they didn’t vote for?

USA Today described the actions of Republicans in the following way: “Having lost in Congress and in court, they are now using the most cynical of tactics: trying to make the law fail. Never mind the public inconvenience and human misery that will result.”

Yesterday, Republicans voted for the 38th time to repeal or delay key parts of the health care law. Republican governors around the country are refusing to take 100 percent for their low income people for Medicaid. The same governors are making implementation more difficult by refusing to take the option of setting up health exchanges. Republicans in the Congress have refused to provide a dime for implementation of this law, and now they are attempting to intimidate those who had worked with the Administration or the non-profit group Enroll America to help educate the public about the new benefits for which they are eligible under the Obamacare. And I say that in a positive, not a pejorative, way.

It does not have to be this way. When the Bush Administration passed and implemented Medicare Part D, Democrats and Republicans made sure the Administration had adequate funding to implement the law. I voted against Medicare Part D. We could have done a much better job to provide prescription drugs. I didn’t pre-

vail. The law was passed. We worked to spread the word about the new Medicare benefits that included a \$300 million public relations campaign and a bus tour by Administration officials that stopped in 100 cities.

The goal of this hearing is not to improve the law; the goal is to sabotage the law, regardless of the damage inflicted on the health care system or the millions of American people who, for the first time, will be able to receive affordable health insurance coverage. I think that is the wrong approach, Mr. Chairman. The Affordable Care Act is providing important benefits. I know Republicans said they want to repeal it, and then replace it. They have never given us a decent replacement. They are not talking about anything constructive—

Mr. MURPHY. I think the gentleman's time is expired.

Mr. WAXMAN [continuing]. It is all negative.

Mr. MURPHY. Thank you.

Mr. WAXMAN. I yield back the balance of my time.

Mr. MURPHY. I would now like to introduce our witness for today's hearing. The Honorable Mark Iwry is a senior advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy at The United States Department of Treasury. In this capacity, he is the reporting authority for the Office of the Benefits Tax Counsel and provides advice and counsel to the Secretary and the Assistant Secretary regarding tax issues related to retirement savings, health care, and employee benefits.

I will now swear in Mr. Iwry. You are aware that this committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Mr. IWRY. No, Mr. Chairman.

Mr. MURPHY. The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Mr. IWRY. No, sir.

Mr. MURPHY. In that case, if you would please rise and raise your right hand? I will swear you in.

[Witness sworn in.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement.

**TESTIMONY OF J. MARK IWRY, SENIOR ADVISOR TO THE SECRETARY, DEPUTY ASSISTANT SECRETARY FOR RETIREMENT AND HEALTH POLICY, U.S. DEPARTMENT OF TREASURY**

Mr. IWRY. Thank you, Chairman Murphy, Ranking Member DeGette, members of the subcommittee. Good afternoon. I am pleased to appear before you today.

As you know, on July 2, the Treasury Department announced that it would provide a 1-year transition relief period for 2014 with respect to three provisions of the Affordable Care Act that the Act added to the internal revenue code.

First, information reporting requirements for self-insuring employers, insurance companies, and other entities that provide

health coverage. Second, information reporting requirements for employers that are subject to the employer shared responsibility provisions, and third, the employer shared responsibility provisions.

On July 9, we published formal guidance, Notice 2013–45, describing and providing this transition relief. Treasury is providing the transition relief after reviewing comments on reporting requirements and related discussions, and comments with employers and other stakeholders. Employers and their representatives requested transition relief for 2014 because of concerns about the difficulty or cost of complying with the reporting requirements, the desire that reporting be simplified, and the lead times necessary to adapt information gathering and reporting systems and implement reporting effectively.

We recognize that the vast majority of employers that will need to do this reporting already provide health coverage to their workers, and we want to make sure employers will be able to comply with reporting effectively and efficiently.

To address these concerns, Treasury announced that 2014, an additional year, would be provided before the reporting requirements began. This is designed to meet two primary concerns raised by stakeholders. First, it allows for an additional dialogue and consideration of ways to simplify the new reporting process, consistent with effective implementation of the law. Second, it gives employers more time, which many have requested, to adapt health coverage and reporting systems as they move toward making coverage affordable and accessible for their employees. Once reporting rules have been issued, employers, insurers, other reporting entities are encouraged to report voluntarily for 2014. Allowing time for real world testing of reporting systems for 2014 will contribute to a smoother transition to full implementation in 2015.

Employer reporting is integral to administration of the employer shared responsibility provisions. Because of the 2014 transition relief, it generally will not be possible for the IRS to match up the information from employers with the information about individuals claiming a premium tax credit for 2014. As a result, as further explained in my written statement, the transition relief for reporting will make it impractical to determine which employers owe shared responsibility payments for 2014. Accordingly, we have extended the transition relief to the employer shared responsibility provisions so that no such payment will be assessed in 2014.

In preparation, though, for the application of the reporting and employer responsibility provisions in 2015, employers and others are encouraged to report voluntarily for 2014 and maintain or expand health coverage in 2014.

The transition relief provided in this notice is an exercise of the Treasury's longstanding administrative authority under the tax code. This authority has been used to provide transition relief for taxpayers seeking to comply with new legislation and to provide a wide range of other guidance. In particular, on a number of prior occasions across administrations, this authority has been used to postpone the application of new legislation when immediate application would have subjected taxpayers to unreasonable administrative burdens or costs.

Finally, the transition relief does not affect employees or other individuals' access to the premium tax credits available beginning in 2014; nor does this transition relief affect the effective date of other ACA provisions, including the individual responsibility provisions and the insurance market reforms.

While the 2014 transition relief for employer reporting would make it impractical to implement the employer responsibility provisions, it would not have a comparable impact on implementation of the individual responsibility provisions, which as a practical matter, are necessary for implementing the ACA's insurance market reforms that guarantee access to affordable insurance for individuals.

As you know, the Affordable Care Act is projected to provide coverage for tens of millions of Americans. Together with the other departments involved, Treasury is implementing this Act to build on the progress already made toward better and more affordable coverage. We welcome the opportunity to further work with the committee to achieve these objectives, and I look forward to answering your questions.

[The prepared statement of Mr. Iwry follows:]

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

**Written Testimony of J. Mark Iwry**  
**Senior Advisor to the Secretary and**  
**Deputy Assistant Secretary for Retirement and Health Policy**  
**U.S. Department of the Treasury**  
**Before the House Energy and Commerce Subcommittee on Oversight and Investigations**  
**July 18, 2013**

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee, I appreciate the opportunity to testify on the recent decision to provide transition relief with respect to certain requirements of the Affordable Care Act (“ACA”).

On July 2, 2013, the Treasury Department announced that it would provide one-year transition relief (for 2014) with respect to three provisions of the ACA: (i) the information reporting requirements that apply to insurance companies, self-insuring employers, and certain other entities that provide minimum essential health coverage under section 6055 of the Internal Revenue Code (the “Code”); (ii) the information reporting requirements that apply to applicable large employers under section 6056 of the Code, and (iii) the employer shared responsibility provisions under section 4980H of the Code. On July 9, 2013, we published formal guidance describing this transition relief. A copy of that guidance, Notice 2013-45, is attached.

**Background**

Section 6055 requires annual information reporting by health insurers, self-insuring employers, government agencies, and other providers of health coverage. Section 6056 requires annual

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

information reporting by applicable large employers relating to the health insurance that the employer offers (or does not offer) to its full-time employees. Section 4980H(a) imposes an assessable payment on an applicable large employer that fails to offer minimum essential coverage to its full-time employees (and their dependents) under an eligible employer-sponsored plan if at least one full-time employee enrolls in a qualified health plan for which a premium tax credit is paid with respect to the employee. Section 4980H(b) imposes an assessable payment on an applicable large employer that offers minimum essential coverage to its full-time employees (and their dependents) under an eligible employer-sponsored plan but has one or more full-time employees who enroll in a qualified health plan for which a premium tax credit is paid with respect to the employee (for example, if the coverage offered either does not provide minimum value or is not affordable to that full-time employee).

#### **Information Reporting**

The Treasury Department is providing this transition relief after reviewing written comments addressing the employer and insurer information reporting requirements and discussions with stakeholders (including employers, governmental entities, and others) regarding the requirements. Employers and their representatives requested transition relief for 2014 because of concerns about the difficulty or cost of complying with the reporting requirements, the desire that reporting be simplified and the lead times necessary to adapt information gathering and reporting systems and implement the reporting requirements effectively. We recognize that the vast majority of employers that will need to do this reporting already provide health coverage to their workers, and we want to make sure employers will be able to comply with the reporting requirements effectively and efficiently.

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

To address these concerns, the Treasury Department announced that an additional year – 2014 – will be provided before the ACA mandatory employer and insurer reporting requirements begin. This is designed to meet two primary concerns expressed in stakeholder comments and discussions. First, it allows for additional dialogue on and consideration of ways to simplify the new reporting requirements consistent with effective implementation of the law. Second, it gives employers additional time, which many have requested, to adapt health coverage and reporting systems as they move toward making health coverage affordable and accessible for their employees. Once reporting rules have been issued, employers, insurers, and other reporting entities are encouraged to voluntarily implement information reporting in 2014, in preparation for the application of the provisions in 2015. Real-world testing of reporting systems in 2014 will contribute to a smoother transition to full implementation in 2015.

#### **Employer Shared Responsibility**

We recognize that this transition relief for reporting will make it impractical to determine which employers owe shared responsibility payments for 2014. Accordingly, we have extended this transition relief to the employer shared responsibility payments.

A brief explanation may be helpful in understanding how providing a transition year for employer reporting affects implementation of the employer shared responsibility provisions. Under those provisions, an applicable large employer generally must offer affordable, minimum value health coverage to its full-time employees or an “assessable payment” under the employer responsibility provisions may apply if one or more of its full-time employees qualifies for and receives a premium tax credit with respect to health insurance coverage purchased on a Health

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

Insurance Marketplace (Marketplace). The employer information reporting is integral to the administration of the employer shared responsibility provisions.

Because an employer typically will not know whether a full-time employee received a premium tax credit, the employer generally will not have all of the information needed to determine whether it owes an assessable payment under the employer responsibility provisions.

Recognizing that employers generally will not have all of the necessary information, the statute does not require the employer to calculate an assessable payment or file returns submitting such a payment. To implement these provisions, after receiving the information returns filed by applicable large employers and the information about employees claiming the premium tax credit for any given calendar year, the Internal Revenue Service will determine whether any of the employer's full-time employees received the premium tax credit and, if so, whether an assessable payment may be due. If the IRS concludes that an employer may owe such an assessable payment, it will contact the employer, and the employer will have an opportunity to respond to the information the IRS provides before a payment is assessed.

Because of the transition relief for employer reporting for 2014, it generally will not be possible to match up the information from employers with the information about individuals claiming a premium tax credit for 2014. As a result, the 2014 transition relief for employer reporting will make it impractical to determine which employers owe assessable payments for 2014.

Accordingly, no such payments will be assessed for 2014. However, in preparation for the application of the reporting requirements and employer responsibility provisions beginning in 2015, employers and other affected entities are encouraged to voluntarily comply with the

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

reporting provisions for 2014, as noted earlier, and employers are encouraged to maintain or expand health coverage in 2014.

**Authority to Grant Transition Relief**

Notice 2013-45 is an exercise of the Treasury Department's longstanding administrative authority under section 7805(a) of the Internal Revenue Code.

This administrative authority has been used to provide transition relief for taxpayers seeking to comply with new legislation, and to provide a wide range of other guidance. In particular, on a number of prior occasions across Administrations, this authority has been used to postpone the application of new legislation when immediate application would have subjected taxpayers to unreasonable administrative burdens or costs. For example, the Small Business and Work Opportunity Act of 2007 made changes to the standards return preparers must follow to avoid penalties. The amendments were effective May 25, 2007. On June 11, 2007, the Treasury Department released Notice 2007-54 providing that the IRS would follow the standards in prior law in determining whether to assert penalties for returns due on or before December 31, 2007. Similarly, the Airport and Airway Extension Act, Part IV (signed August 5, 2011) reinstated the air transportation and aviation fuels excise taxes retroactively to July 23, 2011, when they had expired. On September 9, 2011, the Treasury Department released Notice 2011-69 providing that the excise taxes would not be imposed on purchases of air transportation services made after July 22, 2011 and before August 8, 2011.<sup>1</sup>

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<sup>1</sup> See also, e.g., Notice 2000-5 (waiving corporate penalties for certain estimated taxes due December 15, 1999, which were affected by the retroactive amendment of section 6655 by the Tax Relief Extension Act of 1999); Notices 2005-29, 2006-2, and 2007-4 (postponing the statutory effective date of the section 470 loss disallowance rules applicable to certain pass-through entities); Notices 2005-94, 2006-100, 2007-89, and 2008-115 (waiving

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

#### **Effect on Other ACA Provisions**

Finally, it is important to note that this transition relief does not affect employees' or other individuals' access to the premium tax credits available under the ACA beginning in 2014. Individuals will continue to be eligible for a premium tax credit by enrolling in a qualified health plan through the Marketplaces if their household income is within a specified range and they are not eligible for other minimum essential coverage, including an eligible employer-sponsored plan that is affordable and provides minimum value. Nor does this transition relief affect the effective date of other ACA provisions, including the individual responsibility provisions, the insurance market reforms, and the various revenue provisions. While the 2014 transition relief for employer reporting would make it impractical, as noted earlier, to implement the employer responsibility provisions, it would not have a comparable impact on implementation of the individual responsibility provisions, which, as a practical matter, are necessary for implementing the ACA's insurance market reforms that guarantee access to affordable insurance for individuals.

#### **Conclusion**

As you know, the Affordable Care Act is projected to provide health coverage for nearly 30 million additional Americans. Together with the other departments involved, we are implementing the ACA to build on the progress already made toward better and more affordable

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reporting of certain deferred compensation under section 409A for 2005 through 2008 and, subsequently, until the year after final regulations are published); Announcement 95-48, Notice 96-64, and Notice 99-40 (postponing the effective date of various statutory changes in qualification rules affecting governmental plans by deeming these plans to satisfy those requirements until a later date); Notice 2010-91 (postponing the statutory effective date for 3% withholding on contractors under section 3402(t)); Notice 2011-88 (postponing the effective date for required backup withholding payments made in settlement of payment card and third-party network transactions, as enacted by the Housing Assistance Tax Act of 2008); Notice 2012-34 (postponing the statutory effective date for amendments to the cost basis reporting regime enacted by the Energy Improvement and Extension Act of 2008); and Notice 2013-14 (extending the statutory deadline for submitting a pre-screening notice to claim the Work Opportunity Tax Credit).

EMBARGOED UNTIL 10:00 A.M. July 18, 2013

coverage. We welcome the opportunity to further work with the Committee to achieve these objectives. Thank you, and I look forward to answering your questions.

Mr. MURPHY. Thank you, Mr. Iwry. I will recognize myself now for 5 minutes.

In your public posts in this law and in the information submitted to this committee, you claim that you have administrative authority to grant relief under the Internal Revenue Code. Do you have the ability to utilize this transition relief for the individual mandate?

Mr. IWRY. Mr. Chairman, we have not—

Mr. MURPHY. It is a yes or no.

Mr. IWRY. Mr. Chairman, we have given a lot of consideration to our authority—

Mr. MURPHY. You do have the authority or not?

Mr. IWRY. We have not considered that question whether we would have the authority to provide similar transition relief with respect to the individual responsibility.

Mr. MURPHY. Well wait, so is it your position that there are limits on the authority that prevent Treasury from delaying the individual mandate, and if so, I mean, is there any limits at all? Are you able to do anything with the individual mandate?

Mr. IWRY. There certainly are limits, Mr. Chairman, to the Treasury's authority to provide this kind of transition relief, and the limit—

Mr. MURPHY. Do you have information there about some of the burdens and costs involved with the individual mandate or the business mandate? Do you have information in front of you that you are referring to about some of those burdens and costs for businesses and individuals?

Mr. IWRY. Mr. Chairman, we have considered the burdens—

Mr. MURPHY. Do you have information in front of you on the burdens and costs for individuals and businesses? That is a yes or no. Do you have information in front of you on the burdens and costs— I am going to yield myself more time, because you are not answering my question. Do you have information in front of you on the burdens and costs for individuals and businesses? That is a simple yes or no. I just want to know.

Mr. IWRY. Yes, qualitative information.

Mr. MURPHY. I would like you to submit that to the committee so that both sides have a chance to review that. I am going to order that.

I am going to continue on here. So when you are looking at individual costs in business, who looked at this authority for Treasury to be able to make this decision that you can waive these things for the individual? Who in your department did that?

Mr. IWRY. Mr. Chairman, the Office of Tax Policy—

Mr. MURPHY. Who? Were you involved in those discussions?

Mr. IWRY. I was only tangentially involved, mainly.

Mr. MURPHY. So communications were related to you about those? Communications were made to you about the content of those meetings, those discussions?

Mr. IWRY. That is correct, Mr. Chairman.

Mr. MURPHY. We would like to see the notes, emails, and things from those communications, because we would like to find out about how this decision was made. Can you provide that for the committee?

Mr. IWRY. I don't recall, Mr. Chairman, that there were—whether there were written communications about that, but the Treasury Office of Tax Policy has for decades—

Mr. MURPHY. We will cover history another time, sir. I want you to focus on our questions. Things will go smooth if that happens.

Before the announcement of the delay of the employer mandate, did you do an analysis of the constitutionality of the delay?

Mr. IWRY. I did not.

Mr. MURPHY. Did anyone that you communicated with do an analysis of constitutionality of the delay? For example, have you reviewed any memoranda or participated in any discussions at all about the authority to delay these provisions in the Affordable Care Act?

Mr. IWRY. Yes, Mr. Chairman. The—

Mr. MURPHY. What I would like you to do is submit for the record information from those discussions.

I want to ask you, too, as long as we are on the topic of waivers. I got a letter here from the International Brotherhood of Electrical Workers, the Electrical Workers Union, and it says that we cannot afford to sit on the sidelines as this law imposes increased benefit costs, fees, and new taxes. If these concerns are not addressed, it is likely that the majority of multi-employer health plans will dissolve and that 26 million covered individuals will lose their plans. They also managed to put a full-page ad—I think this was in roll call—also addressed these issues to Congress and to the President. This begs the question, do you agree that implementation of the Affordable Care Act is jeopardizing multi-employer plans and the individuals they cover? I might add, Mr. Jimmy Hoffa also published something in this, too. Do you agree that multi-employer plans are in jeopardy here too for these 26 million Americans?

Mr. IWRY. Mr. Chairman, the multi-employer plans are going to be able, we believe, to comply with this law in a way that does not jeopardize coverage for—

Mr. MURPHY. Well, Jimmy Hoffa from the Teamsters and IBW and the National Electrical Contractors Association are saying it does not, so will you be reviewing about giving them a waiver as well?

Mr. IWRY. Mr. Chairman, there have been requests—

Mr. MURPHY. Let me ask this. Do you have the authority to offer that waiver?

Mr. IWRY. We have not—what sort of waiver are you referring to, Mr. Chairman, if I may ask?

Mr. MURPHY. The kind of waivers you have been offering other people. The kind of waivers you are offering other people. I just want to know. I would like an answer to this question, without being desultory here. So if they like the coverage 26 million Americans have through the unions, can they keep it? Do you have the authority to waive that?

Mr. IWRY. Mr. Chairman, the coverage that members of the plans sponsored by the multi-employer unions have is coverage that they can keep.

Mr. MURPHY. Mr. Iwry, Jimmy Hoffa, the Teamsters, IBW, and other groups are saying they do not, and I would like you to submit an answer for the record of A) if you have the authority to offer

them waivers, and B) what they will be. I know I am over time here, but I am sure the members will follow up. I yield to Ms. DeGette for 5 minutes.

Ms. DEGETTE. Now Mr. Iwry, the Treasury delayed the employer mandate, is that correct, by 1 year, correct?

Mr. IWRY. Ms. DeGette, the Treasury provided transition relief with respect to the—

Ms. DEGETTE. And delayed the—

Mr. IWRY [continuing]. Employer responsibilities.

Ms. DEGETTE. Correct?

Mr. IWRY. Correct.

Ms. DEGETTE. And what section of the Internal Revenue Code did they do that under?

Mr. IWRY. The transition relief is an exercise of the Treasury Department's administrative authority under Section 7805(a).

Ms. DEGETTE. And what exactly does Section 7508—I am sorry, 7805(a) say?

Mr. IWRY. Section 7805(a) of the Internal Revenue Code provides that the Secretary shall prescribe all needful rules and regulations for the enforcement of this title, including all rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue.

Now what that means in this context, Congresswoman, is not that it gives Treasury authority to ignore the statute or parts of the statute, but rather that it allows us to implement the law more effectively, specifically—

Ms. DEGETTE. OK, let me stop you right there, and let me ask you, to your knowledge, does Treasury intend to take any other steps under Section 7805(a) to delay any other provisions of the Affordable Healthcare Act? Are you contemplating using what you view your authority under the Act to delay any other provisions of the ACA? I think that is what the chairman was trying to get at.

Mr. IWRY. Congresswoman, we do not have—first of all, let me make clear, this transition relief does not have any impact on any other—

Ms. DEGETTE. That is correct.

Mr. IWRY [continuing]. Expected date—

Ms. DEGETTE. Is it the intention of the Agency—

Mr. IWRY [continuing]. Under the Act.

Ms. DEGETTE [continuing]. To use Section 7805(a) to delay any other provisions of the ACA? That is a pretty easy question.

Mr. IWRY. Right. Consistent with our normal process in implementing new legislation—

Ms. DEGETTE. Yes.

Mr. IWRY [continuing]. We will evaluate the need for any other possible transition relief on a case-by-case basis if there is a reason sufficiently compelling circumstances to—

Ms. DEGETTE. To your knowledge, does the Agency intend—at this point, do you know of any other delays?

Mr. IWRY. We don't have any specific provision that we have identified for which we would—

Ms. DEGETTE. Thank you. And if further requests come in, you will evaluate those? That is what you are trying to tell me?

Mr. IWRY. I am sorry?

Ms. DEGETTE. If further requests come in like came in from the business community, what you are saying is you will evaluate those within the Agency's authority. Is that correct?

Mr. IWRY. That is correct.

Ms. DEGETTE. OK. Now has Treasury ever used this authority before to delay or modify other tax rules?

Mr. IWRY. Yes, Congresswoman—

Ms. DEGETTE. Could you describe maybe one or two examples, very briefly?

Mr. IWRY. Yes. Treasury has traditionally interpreted this authority to allow implementation of statutes in a manner that is best designed to give effect to their terms, including transition relief, as appropriate in connection with situations where the law has changed.

Ms. DEGETTE. OK, do you have an example of that?

Mr. IWRY. Right. My written testimony contains a whole series of specific examples, as you suggest, Congresswoman, in the tax law. Let me mention one or two of them here.

Ms. DEGETTE. How about one? We have got 53 seconds left.

Mr. IWRY. Sure.

Ms. DEGETTE. Thank you.

Mr. IWRY. Basis reporting rules for investment securities were enacted in 2008. Treasury and IRS issued proposed regulations on those for debt instruments and options. The statutory effective date was January 1, 2013, as reflected in the regulations, and after numerous comments from taxpayers that this proposed effective date did not give them enough time to program their information systems, Treasury and the IRS issued a notice postponing the effective date to January 1, 2014.

Ms. DEGETTE. OK. Let me ask you a question, because I am running out of time. So I know you think the authority is clear. You are saying that you could do it here. You are going to look at any other situations that come up, but you know, we have institutional prerogatives, too, and when we write a law, we expect that it will go into effect. I can't tell whether my friends on the other side of the Aisle object to this delay or think everything else should be delayed, but what I am hearing you say is it is not the intention of your agency to indefinitely delay this mandate or to ignore it completely or to do this wholesale with the rest of the ACA, is that correct?

Mr. IWRY. That is—

Ms. DEGETTE. Yes or no would be good, since I am out of time.

Mr. IWRY. That is correct.

Ms. DEGETTE. Thank you very much.

Mr. MURPHY. And the gentlelady's time is expired. Now recognize the vice chair of the committee—full chair of the committee Mr. Upton is not here, so we will go to Ms. Blackburn, vice chair, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and Mr. Iwry, thank you so much—I am over here—for your time to be with us. I want to go right back to what the chairman of the full committee—the subcommittee was talking with you about is where you got this authority and what you think gives you this authority. So this is a really simple yes or no. Does Treasury have the authority

to delay the individual mandate under the healthcare law? Yes or no?

Mr. IWRY. Congresswoman, as I mentioned, Treasury has not yet had occasion to consider whether it would have authority to delay or to give transition relief with respect to individual—

Mrs. BLACKBURN. So your presumptiveness on the request from the business community that this thing is half-baked and not ready for primetime, you chose to delay the employer mandate. So what you are saying is you do not know if you do or do not have authority to delay the individual mandate?

Mr. IWRY. Congresswoman, we have not had occasion because we have not found that the individual mandate presented the kinds of administrative difficulties for individuals—

Mrs. BLACKBURN. Well let me just interject right here, because we can show you plenty of surveys and evidence that it is causing tremendous disruption in the healthcare community and in the individual health insurance marketplace.

I will try this another way. Why is it possible to delay the requirements on business but not on individuals?

Mr. IWRY. Congresswoman, when we considered whether to provide this transition relief, we were motivated by the concerns that were raised with us and with Congress by those who would be providing coverage and continuing to provide coverage that the reporting requirements under the employer responsibility conditions—

Mrs. BLACKBURN. So then what you are telling me is that this is too cumbersome for our business community to comply with? Would that be a statement that matched what you found? It is too cumbersome?

Mr. IWRY. Congresswoman, what we found was that the business concerns—

Mrs. BLACKBURN. OK, you are running the time—

Mr. IWRY. That they needed more time.

Mrs. BLACKBURN. Yes, well, you are running my time out. You are running my time out by trying to talk as slow as I talk and I don't appreciate it, quite frankly.

Let me tell you what I am finding, and it shows that you have great sympathy for big business and that you are trying to cater to big business, but not to hardworking taxpayers and small business people that are fighting every single day against this law. Because it is redefining—I tell you, I agree with what the unions wrote to the Democrat leadership. This is redefining the 40-hour work week in this country, and I think you agree with that because of the actions that you took. It is redefining what benefits are for individuals. This is wrecking what employers are providing for individuals because you all want to put this out there that is going to destroy the healthcare marketplace and destroy the doctor-patient relationship. And you are saying—you are making this that you are motivated by concerns. Well let me tell you what concerns I am motivated by, and it is men and women who are going to work every single day and are seeking to do the best for their families. They want the ability to make these decisions. They do not trust bureaucrats in Washington, D.C. to make these decisions, and quite frankly, I don't think they appreciate some of the attitudes when you come in and you are unprepared and unwilling to answer

a simple yes or no. What gives you the authority and do you have the authority, and if you do have the authority or think you do, and you think it was a constitutional act, then for heaven's sake, why would you favor big business and then vote against hardworking men and women with the actions that you took?

I yield back.

Mr. MURPHY. Gentlelady yields back. Recognize the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Well thank you, Mr. Chairman.

Boy, I have a different view. I think the Affordable Care Act is working for families and it is certainly working for small businesses, and we have a ways to go. So I would hope that now that it is law, the Supreme Court has ruled. We are moving into significant areas of implementation. We can begin to all work together to ensure that it works for families across America and on all businesses, small and large.

I would like to highlight what Chairman Waxman said early on. There are some new statistics out, and it is helpful because they are broken down by congressional district, that demonstrates how the law is helping families. And just a few great statistics from my own community—and keep in mind that a congressional district, the population now is estimated to be about 700,000. So what I learned yesterday is in my own congressional district, under the Affordable Care Act, almost 10,000 young adults in my district now have health insurance because they have been able to stay on their parents' plan. Almost 6,000 seniors in my district have received prescription drug discounts worth \$8.2 million. That is an average of \$610 per person in 2011, \$690 in 2012, and \$840 in 2013. You better believe my seniors can use a few extra dollars in their pockets. My Medicare neighbors, they now have access to free preventative services that they didn't have before without paying a co-pay. Children are no longer barred from getting insurance because they have a preexisting condition, like childhood cancer or asthma. These are very important consumer protections that the ACA has provided. And now the rebates are coming in. We expect another round of rebates. In the entire Tampa Bay area alone so far, my families have gotten \$47 million back from insurance companies. And then the President announced that the White House says that there is another round coming this summer. We anticipate in the State of Florida alone we are—consumers, families are going to get back another \$54 million, because under the law, we say most of the co-pays and premiums that people work hard to pay will go to actual healthcare and not to exorbitant salaries or profits. So this is good news and I hope we can all work together.

Now Mr. Iwry, thank you for being here. I want to ask you about the extent to which the decision to implement a business transition relief period to those—some of those businesses is going to work. Now as of today, most large employers in America already offer coverage to their employees, correct?

Mr. IWRY. Congresswoman, the vast majority of larger employers already offer coverage.

Ms. CASTOR. In fact, it is about 160 million Americans today already receive health insurance through their employers. And when

we talk about the larger employers, we are talking about employers that have 50 or more employees, is that correct?

Mr. IWRY. For this purpose, yes, Congresswoman.

Ms. CASTOR. And I know this might not be your area of expertise, but why do employers, why do businesses provide health insurance to their employees?

Mr. IWRY. Congresswoman—

Ms. CASTOR. Kind of the way the unique American health system has grown up over the decades. Your health insurance is tied to your job, but why do businesses provide health insurance?

Mr. IWRY. Congresswoman, I think there are several reasons. One is that businesses find that offering important key benefits like health insurance makes it easier to recruit valuable employees.

Ms. CASTOR. I think that is right. I think if you were—if you had two jobs in front of you and you had one that offered health coverage for you or your family, and the other that did not, that makes it more attractive to go work for that employer, and that is why over time most employers do that. It gives them an advantage.

Now is there anything in your purview that changes the calculus here for the way that works?

Mr. IWRY. Well that is, of course, still the case as well as to retain valued employees as they grow older, and—

Ms. CASTOR. Right.

Mr. IWRY [continuing]. Prior to this—

Ms. CASTOR. And nothing changes that. Now there is another part of the ACA—and I take umbrage at what my colleague from Tennessee said—this law is going to provide substantial tax credits to our small businesses at home. In fact, over 360,000 small businesses across America have already taken advantage of those new tax credits. We anticipate this to grow. Mr. Iwry, did Treasury's recent decision impact the small business tax credits provided under the ACA?

Mr. IWRY. Congresswoman, it did not impact the small business tax credits or the premium tax credits worth several hundred billion dollars for individuals, which are central to the whole legislation here, nor did it affect the marketplaces.

Mr. MURPHY. Thank you. Gentlelady's time is expired. Now recognize the chairman emeritus of the committee, Mr. Barton, for 5 minutes.

Mr. BARTON. Thank you, Mr. Chairman. On July the 9th, the Assistant Secretary for Tax Policy, Mark Mazur, replied to a letter that myself and I think almost every Republican on this subcommittee had sent to the Treasury Secretary, asking for—why this particular part of the law was delayed and what the authority was from it. In that letter, on page two, it says that the legal authority to delay was based on the administrative authority under Section 7805(a) of the Internal Revenue Code. Well, I have Section 7805(a) of the Code, and I am not an attorney, nor am I a tax expert, but what Section 7805 of the Revenue Code says is that unless explicitly authorized somewhere else so that some other official has the authority, the Secretary of the Treasury shall prescribe all needful rules and regulations for the enforcement of this title, including all rules and regulations as may be necessary by reason or any alteration of the law in relation to Internal Revenue. It says

nothing about giving authority to not implement, and in the Affordable Care Act, as Congresswoman Blackburn pointed out, there is not an opt-out clause. There is not a you shall do this unless you decide it can't be implemented, in this case, you can delay. The law was passed on March 23 or signed into law on March 23, 2010. That is over 3 years ago. So we are now getting to the point where you actually have to implement it, and lo and behold, the Secretary of the Treasury has decided to pick and choose which parts of the law to implement. Other than this Section 7805, is there any other authority anywhere else that gives the Secretary of the Treasury, and I would assume in consultation with the President of the United States, to pick and choose which parts of which laws that he or she implements?

Mr. IWRY. Mr. Chairman, Section 7805(a) is, in our view, sufficient authority and in the view of previous Treasury Departments across various administrations, to, in an appropriate case, implement statutes in a way that is best designed to give effect to their terms, including providing transition relief, as appropriate when there is what the provision refers to an alteration of the law—

Mr. BARTON. Well, 3 ½ years from the law's passage, it is pretty weak to say this is transition relief. And it is explicit in the law that it shall be implemented in the Affordable Care Act, and it is explicit in this Section 7805 that you are supposed to prescribe—the Secretary, that is—needful rules and regulations for the enforcement, not for the non-enforcement. I am not an attorney but I don't believe you have got the legal authority, the Secretary of the Treasury, to do what you all just did.

I do have a question. This decision to delay implementation, was it done in consultation with the White House, upon the direction of the White House, or without any input from the White House?

Mr. IWRY. Mr. Chairman, it was—this decision to provide transition relief with respect to the reporting provisions for employers—

Mr. BARTON. To delay implementation, I don't consider that transition relief. The decision to not implement one of the key components of the Affordable Care Act, did the Secretary of the Treasury, with advice from people like you who are senior advisors to the Secretary, did you all do this on your own or did you do it at the direction and consultation or with input from the White House?

Mr. IWRY. Mr. Chairman, the Treasury Department did not do this without coordination with the White House. It was not at the direction, but it was with—

Mr. BARTON. So the President knew about this?

Mr. IWRY [continuing]. Coordination and consultation—

Mr. BARTON. The President knew about this before it was announced?

Mr. IWRY. Mr. Chairman, I don't personally have a basis for knowing what the President knew at what point in time, but certainly to answer your question fairly, the White House was involved. The Treasury kept—

Mr. BARTON. Normally intelligent people can assume the President knew about this before the fact, was friendly towards it, probably, I would assume, directed it, but at least was strongly supportive of it. It wasn't done against his opposition.

Mr. IWRY. Mr. Chairman, I have no reason to think that it was or would have been done had he been opposed to it.

Mr. BARTON. My time is expired. I appreciate your candor. I will yield back.

Mr. MURPHY. Gentleman's time is expired. Now to the gentleman from North Carolina, Mr. Butterfield, for 5 minutes.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, and thank you for your testimony today. You know, Mr. Barton, I would stipulate that the President was aware of this change in policy, and he would be derelict if he was not aware of the change. And so I certainly believe that he was, and thank him for making this important administrative decision.

The President's decision to delay the employer mandate I think has gotten too much attention. I think we need to be using this energy and this time to try to find ways to make the Affordable Care Act work, and I am trying to listen very carefully at the debate today to try to figure out if my friends on the other side of the Aisle feel that the employer responsibility delay should be repealed or whether the individual mandate should be delayed. I can't quite figure out where you are going with this. I have always looked at you as my friends over on the other side as being friends of business, and now today you seem to be really championing the rights of individuals. I am glad to see that progress. I wish you would join me in North Carolina to try to champion individuals who are poor people in North Carolina who are not going to be able to benefit from the Medicaid expansion. And so I just want to talk about the business aspect of this and try to get some answers on the record.

Sir, correct me if I am wrong. Firms with fewer than 50 full-time equivalent employees are not subject to the employer responsibility provisions of the Act. Is that correct?

Mr. IWRY. Congressman, firms with fewer than 50 full-time employees or full-time equivalent employees—

Mr. BUTTERFIELD. It doesn't apply to them at all.

Mr. IWRY [continuing]. Are not subject to the employer responsibility provisions of the Act.

Mr. BUTTERFIELD. Now or in the future, the foreseeable future, is that right?

Mr. IWRY. The statute, Congressman, does not provide at all for businesses smaller than 50 to be subject to that requirement.

Mr. BUTTERFIELD. Am I correct, then, that the vast majority of U.S. businesses have fewer than 50 employees? That is the impression that I get.

Mr. IWRY. Congressman, it is generally been estimated that roughly 95 percent of employers in the United States would be below that threshold.

Mr. BUTTERFIELD. Well, am I correct that the vast majority of employers with more than 50 full-time employees already offer coverage to their employees?

Mr. IWRY. Congressman, that is also correct. Roughly a similar percentage that is about 95 percent of employers above 50 in size have been estimated—it has been estimated that those employers do provide coverage currently to their employees.

Mr. BUTTERFIELD. The number of businesses that we are talking about seems to be getting smaller and smaller and smaller. So

many of the employers that would have been affected by the employer mandate already offer coverage that meets the standards in the law. So what we are really talking about is a limited—a very limited number of companies that are affected by the mandate and the delay. And so for all the sound and fury over the mandate delay, the core of the law remains reform of the individual insurance market. That is what this thing is all about. Where people buy coverage when they do not get it through their jobs, and I can tell you, I represent a district in North Carolina. I don't know about my friends who are in other seats in this committee, but the vast majority of the people that I represent are ready for implementation, full implementation of the Affordable Care Act.

And so I want to thank you, sir, for your testimony today. I think my friend on the other side who criticized your method of speaking owes you an apology, because your response to my questions was equal in tone and pace and cadence as it was to the other members of this committee. I think without knowing your personality and knowing the way you express yourself that you are owed an apology. I yield back.

Mr. MURPHY. Gentleman yields back. I now recognize the gentleman from Texas, Mr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Iwry. Thank you for being here.

I want to pick up where Mr. Barton left off. I have got about three areas that I want to cover, so I apologize if it seems like we are going to go fast. And then I have got some other questions I am going to submit for a written response.

When did you know that the mandate for the businesses was going to be delayed? That is not a yes or no question, but it is a calendar day. When did you know?

Mr. IWRY. Mr. Burgess, I knew that this transition relief would be granted sometime last month, the month of June.

Mr. BURGESS. June 25, June 27? Do you have a date? Would there be a meeting that took place? Would there be a phone call? Would there be a record of some type that you could provide to this committee?

Mr. IWRY. Congressman, I don't recall any specific meeting or phone call.

Mr. BURGESS. May I ask that you look at your logs and your records and see if you can refresh your memory and provide that to the staff of this committee?

Let's move on, because I got a lot of stuff to do and we have already discussed how slow I talk. Who made the decision to delay the employer mandate? Was that made exclusively at Treasury, Health and Human Services? Did they have any role at all, or was it also the White House that was involved? You told Mr. Barton that the White House was aware. Were they actually involved, actively involved in the decision-making process?

Mr. IWRY. Congressman, policy decisions under this legislation, in particular under the Affordable Care Act, policy decisions generally that are made by the Treasury Department are coordinated with the White House—

Mr. BURGESS. So who did you talk to? Who did you discuss this with? Who did you coordinate with in the White House?

Mr. IWRY. I was not—Congressman, I was not privy to all the conversations.

Mr. BURGESS. Well let me just ask you a question. This was odd the way this happened at 6:00 p.m. Eastern time on July the 2nd. I think it caught a lot of us by surprise. Valerie Jarrett put it out in a blog post. Was there any discussion with you and Valerie Jarrett prior to her posting this on the blog site?

Mr. IWRY. Congressman, I don't recall having had any discussion with Ms. Jarrett about this, and indeed, I am a policy person, not someone who deals with communications or media relations, or congressional relations, so—

Mr. BURGESS. But sir, this was a big deal and it was rolled out at an odd time. Once again, will you review your logs and your email? Were you copied on any email or was Valerie Jarrett copied on any email to you? Can you provide that to this committee, because I think it is important to our understanding of this process.

Mr. IWRY. Congressman, I am not the person at Treasury to respond to the question—

Mr. BURGESS. Well then who is that?

Mr. IWRY [continuing]. What we can—sorry.

Mr. BURGESS. Well fine. We can subpoena all of your records if that is what you would prefer.

Mr. IWRY. Congressman, we are happy to cooperate with the committee.

Mr. BURGESS. Thank you.

Mr. IWRY. And I will refer this to the people at Treasury who would be dealing with this.

Mr. BURGESS. Thank you. The reason this is important is we had Secretary Sebelius and Mr. Cohen from Center for Communications Insurance Oversight here at this committee at the very end of April. From them, no delay, we will be ready, it will be on time. I specifically asked Mr. Cohen about contingency plans. I specifically asked Mr. Cohen are you planning on any delay? Are you planning on narrowing the scope of what is provided, and even after I reminded him that he was under oath, he replied no. So somehow between April 30 and June 25, that all changed in a big way. And what we are trying to understand in this committee is how did that happen? What was the process? What was the trigger that occurred that caused such a massive change from no delay, we will be ready, to wait a year. Do you understand the concern?

Mr. IWRY. Congressman, I understand your question, yes, and I would be happy to try to address that now, if I might.

Mr. BURGESS. Well let me ask you this. What does a deadline mean? Are you aware of the phrase "deadline"?

Mr. IWRY. Congressman, we try our best at the Treasury Department to comply with the statutory timeframes and deadlines. We had a request here from—many requests from the plan sponsor committee—

Mr. BURGESS. Well let me ask you this. I mean, a lot of times we are accused of writing gobbledygook in our laws, but this is pretty straightforward. The amendments made in this section shall apply to the months beginning after December 31, 2013. That is pretty clear, isn't it?

Mr. MURPHY. Gentleman's time is expired.

Mr. BURGESS. And it sounds like a deadline, and I would appreciate a response from your office in writing what deadline means to you and your office. I will yield back.

Mr. MURPHY. Gentleman's time is expired. Now recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair.

Mr. Iwry, before I ask you some questions, I just wanted to highlight some of the profile in my congressional district with the ACA. I have more than 12,000 seniors in the district receiving prescription drug discounts worth some \$16 million, an average discount of \$610 per person in 2011, and \$650 in 2012, and some 124,000 seniors in the district now eligible for Medicare preventative services without paying any co-pays, co-insurance, or deductible. And up to 27,000 children in the district with preexisting health conditions no longer being denied coverage by health insurers. And I just wanted to highlight that for the record, because it is part of the strength of the ACA.

Again, Mr. Iwry, one concern raised by critics of the Treasury decision is that it will impact the verification process for individuals on the exchanges. I want to read you a quote from Uval Levin, a conservative critic of the law, and he says, and I quote, "The most serious problem for the Administration with this delay of the employer mandate is the effect on the liability of the exchanges. Under the law, eligibility for exchange subsidies depends on an individual not receiving an affordable offer of qualified insurance from an employer. If employers will now not be required to report on their insurance offerings in 2014, I don't see how the government will be able to determine eligibility for subsidies and therefore how the exchanges will be able to function."

Mr. Iwry, is this a legitimate concern?

Mr. IWRY. Congressman, the impact of the transition relief with respect to employer and insurer reporting on the functioning of the marketplaces and the ability to verify is something that was considered carefully as part of the decision-making process, together with many other factors, including the potential impacts of the decision on coverage and cost. And the conclusion was that the administration of the individual responsibility provisions could go forward without being unduly hampered by the lack of employer reporting partly for a year, except to the extent employers report voluntarily, which they are encouraged to do. Partly because the individual in going to the exchange would receive an employer form that provides information about their coverage, the individual would normally know during the open season with the employer through the summary of benefits and coverage that employers would be providing to employees, whether they had coverage or not, and therefore would be able to go to the exchange and know whether they are potentially entitled to apply for a premium tax credit at the exchange if their income otherwise permits. So the individual has the wherewithal to apply, determine whether he or she is entitled to apply for a premium tax credit to help them pay for this coverage, regardless of that employer report, and indeed, the employer report is something that the exchange provides to ultimately—information about employer coverage is something that the exchange also provides to the IRS when the IRS then does a

second check of the individual's eligibility for the tax credit on reconciliation, after the individual files the return. The IRS gets information from the exchange about what the employer provided as a result of what the employer provides, information the employer reports to the individual. The individual can fill out their 1040, knowing whether they have coverage or not, knowing whether they are exempt from individual responsibility or not, and in the very few cases, the small percentage of cases where a person is expected to owe a payment, they will have the tools on their 1040 to make the payment.

Mr. TONKO. Thank you. Thank you very much for the clarification, and with that, I yield back.

Mr. MURPHY. Gentleman's time is expired, and I now recognize the gentleman from Texas, Mr. Olson, for 5 minutes.

Mr. OLSON. I thank the chair, and I thank Mr. Iwry for appearing to explain how the Administration decided to delay Obamacare's employer mandate.

I didn't think it was possible, sir, but the Administration's actions created more uncertainty back home in Texas 22 over Obamacare's impacts on their families and businesses. The employer mandate was a low murmur compared to the full repeal war I heard after March 23 of 2010 when Obamacare was passed, but that changed when the employer mandate was delayed. That became a full-on war back home in Texas 22. And that war is locked on two questions. One, how can I plan for the future prosperity of my family? How can I plan for the future prosperity of my business? The second question, what change is coming next?

Sir, under the Constitution of the United States, it is my job, my sacred duty to get answers to those questions for these 700,000 people, Texans who live in Texas 22. Sir, I need, I demand the cooperation to get those answers.

And now the facts. It seems this delay was ready for primetime by June 24 of this year. I say that because CMS Administrator Marilyn Tavenner testified yesterday that she was made aware of the delayed employer mandate that was being considered on June 24 of this year. Yesterday. In your testimony in front of the Ways and Means Subcommittee and right here just about 10 minutes ago, you stated that Treasury's final decision to postpone the Affordable Care Act's employer mandate was made "sometime in June." It was considered in a very careful way for a while. My question, sir, who in Treasury took part in the careful consideration in the month of June? I need names and positions, please.

Mr. IWRY. Congressman, would you like me to start with your last question or your first one?

Mr. OLSON. I need names and positions to my question. Who took part in this careful consideration in the month of June? Names and positions, please.

Mr. IWRY. Congressman, the authority to make a tax policy regulatory decision resides in the Assistant Secretary—this is the position—the Assistant Secretary for Tax Policy within the Department—

Mr. OLSON. Names, please, sir. Names and positions, please. That is all I am asking. I worked in the Senate for 8 years. I know

what a filibuster looks like. Please, names and positions. Please help me. I have a duty to 700,000 people to get these answers.

Mr. IWRY. Congressman, respectfully I am trying to answer your question fully. So the position is the Assistant Secretary for Tax Policy, and that authority is delegated to the Assistant Secretary by the Secretary of the Treasury. The name of the individual who is Assistant Secretary for Tax Policy is Mark Mazur. He is the author of that blog post.

Mr. OLSON. OK, got that from Chairman Barton before, Chairman Emeritus Barton.

One more question, sir. Your lack of details doesn't support your repeated considerations that you had careful considerations, your repeated contentions. As you might have done some research on my life, I am a former Naval—U.S. Naval aviator. Careful, to me, means knowing that your plane, your route of flight, and the obstacles en route. If Treasury's actions were applied to flying aircraft, you would have been on autopilot, asleep for over 3 years, only waking up when the collision avoidance system is going pull up, pull up, pull up. You pulled up, woke up, and avoided crashing the plane.

I will give you one more chance to help me out, sir. Considering that at least seven components of the Affordable Care Act, the class act, the 1009, small business changes, mandate employers, data hub, income verification, employer insurance verification, have been repealed late in the past 3 years, what is coming in the future? Anything that Treasury is looking at that I can tell my people back home, get ready for this?

Mr. IWRY. Congressman, we are continuing to implement the Affordable Care Act, and we have no specific provision at Treasury that I am aware of in mind that would call for, in our view, further transition relief. However, if it does develop that there is a legitimate need and one that is within our authority, which we take seriously, sir, and we very much begin with respect for the law and for the statute that Congress passed and the language of the statute, but if we need to exercise the longstanding authority which has been exercised across different Administrations under the 7805(a) section of the Tax Code, with respect to another provision of the tax law, we would do that. There are many examples in the past where that has been done—

Mr. MURPHY. Gentleman's time is expired.

Mr. OLSON. My interpretation of your comments, sir, is we can expect a Labor Day, a Halloween, or Thanksgiving, or Christmas surprise again. I yield back the balance of my time.

Mr. MURPHY. Gentleman's time is expired. Now recognize Mr. Green of Texas for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Welcome, Mr. Iwry. The issue of the delay of the employer mandate, I think, has been bogged down and whether the Department of Treasury had the authority to do so. Transitional relief is not objectionable. Has the authority to provide transition relief been used by other Administrations in the past?

Mr. IWRY. Congressman, the authority that I have referred to under Section 7805(a) of the Tax Code to provide interpretations and in this case, transition relief, with respect to Tax Code provi-

sions has been used in the past on a whole number of occasions. Information reporting is a particular area where transition relief has been found to be necessary on prior occasions, and the decisions to provide transition relief on occasion have been made, to my knowledge, in the exercise of the professional, legal judgment of the Treasury Department, without regard to political affiliation across different Administrations. There is a tradition at Treasury of very professional and serious dedication to the law and respect for the law and respect for tax policy, and there is an effort made consistently to keep that up, regardless of what Administration is in office.

Mr. GREEN. OK, and so this has been used by other Administrations—

Mr. IWRY. Correct.

Mr. GREEN [continuing]. In Department of Treasury and other Administrations. The bigger issue for me is what the future holds for the law that is so important to so many Americans. I know that we are how few people will be affected by this delay, however, I represent a very urban district in Houston. Currently our district has the highest percentage of people who have jobs, but no health insurance, either through their job or because they make too much to be qualified for Medicaid. And of course, our State of Texas unfortunately is not expanding Medicaid. So this delay deals my constituents a hard blow.

The other issue, anyone who is employed and makes between 100 and 130 percent of the federal poverty rate and doesn't have insurance through their job still cannot afford it because their employers aren't required to provide it, and they won't receive the subsidies to purchase coverage through the exchange. Do you think there is some way that Treasury could look at that and maybe have a transition so those folks who are left waiting for that mandate for their employers, is there some way the Administration can deal with that, to where those people who are not qualified now because that would be able to have some type of transition purchase coverage with the subsidies through the exchange? That may not be your area. Probably not. Treasury is your jurisdiction, but that is one of the concerns. What are we going to do with these folks because of this decision their employers are not covering them? This delay creates significant uncertainty about the time and the implementation of the rest of the Affordable Care Act, and I have a number of questions that should require simply very short answers. Can you provide the necessary certainty to this committee, to the employers, and employees that in 2015 the employer mandate will not be delayed again?

Mr. IWRY. Congressman, this transition relief is a 1-year grant of transition relief for 2014. There is every intention to have the implementation of these specific provisions go into effect at the beginning of 2015 of the expressed terms—

Mr. GREEN. OK. I only have about 40 seconds. Do you know if the Treasury is preparing to delay the implementation of any other provisions of the Affordable Care Act within its jurisdiction?

Mr. IWRY. Congressman, as I have said, the administrative authority that we have used to provide transition relief for these employer provisions is authority that could, in appropriate cases, po-

tentially be used as it has been in the past with respect to other provisions, but as we implement—continue to complete the implementation of the Affordable Care Act, we don't currently have on our radar screen any particular provision—

Mr. GREEN. OK. Well one of my concerns—and I know my Republican colleagues might not share it, but I think I have been in every meeting we have had, not only on the committee but also through the Democratic caucus with Health and Human Services employees, Administration employees, granted, none from Treasury, and this was never even came up. Nobody knew about it until the day before the 4th of July. So I would hope some of us who really support this law and want it to work, that we will not give fodder to the folks who don't want it to work.

Thank you, Mr. Chairman, for your time—the time.

Mr. MURPHY. Gentleman's time is expired. Now to the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate it very much.

Following up on that, you said that there was nothing on your radar screen at this time. We have heard the decision or some kind of decision was made sometime in June, but they wanted to contemplate it—and I know I may not be using the exact words you used—and that is why it didn't come out until July 2. I would ask you, if there is nothing on your radar screen now, when did this one pop up on your radar screen, because as Congressman Green said, nobody ever heard anything about it in numerous hearings or meetings.

Mr. IWRY. Congressman, the requests for transition relief from plan sponsors, which started the process of thinking about it, were ones that were made over the course of the past year or so.

Mr. GRIFFITH. Past year or so, because here is what is really instructive. On July 1, as a result of part of this process, the Commonwealth of Virginia shifted its part-time employees from what they regularly would have to a 29-hour workweek because of what is going on. I am sure a lot of those folks would have liked transition relief, and if it has been talked about for some time, they would have liked to have had it before the law was changed back during the legislative session and it went into effect on July 1, your announcement not coming out until July 2.

Further, I would submit to you that this creates a huge confusion and area of concern for the American people, because if something can be, you know percolating out there, there are all kinds of concerns—we have heard about union concerns and so forth—for a great deal of time and then all of a sudden it pops up and a decision is made, you know, late one month and 2 weeks later it is announced. That means anything can happen if you interpret the code this way before January 1 comes around or maybe even October 1. Do you believe you have the authority to delay the implementation of the exchanges? Yes or no?

Mr. IWRY. Congressman, we—

Mr. GRIFFITH. Yes or no. I have got only limited time. Either you have the authority or you don't. I am not asking you if you are doing it, I am asking you if you have the authority.

Mr. IWRY. That is—the exchanges are established pursuant to provisions which are—

Mr. GRIFFITH. Are not part of the Internal Revenue Code, but you don't have authority.

Mr. IWRY [continuing]. By and large—

Mr. GRIFFITH. Thank you. No answer. You know, that is real simple. Just no, we don't have that authority.

Mr. IWRY. Congressman—

Mr. GRIFFITH. In regard to that—hang on, I only have limited amount of time. You talk about this transition relief and you rely on the Section 7805(a). I have read 7805(a) and the rest of 7805. I don't see the words transition relief anywhere in there, and in fact, I would point out to you that the section deals with regulations predominantly, although it does reference the Internal Revenue Code on three occasions, it references regulations 35 times and it is talking about, you know, delaying a regulation. This is not a regulation. This is a law that was put into effect by the United States Congress, and I would ask you, just because other Administrations have done it—you are a lawyer by training, I believe.

Mr. IWRY. That is correct.

Mr. GRIFFITH. That is correct. Just because other Administrations have done it doesn't necessarily make it right, and am I not correct that there has been no court opinion that has ever said that changing the law by unelected bureaucrats under that particular code section is, in fact, lawful? I am correct, there is no court case saying that, yes or no?

Mr. IWRY. Congressman, we have not exercised this authority because other Administrations have done it. We have exercised this authority because we believe in good conscience—

Mr. GRIFFITH. This law cannot be enforced the way it was written. I understand that, but the bottom line I am asking you is there is no court opinion. You have referenced other Administrations to say this is where we get our authority from, but there is no court opinion saying this is a lawful act. Isn't that correct? Yes or no?

Mr. IWRY. No court opinion addressing this transition—this branch of transition relief—

Mr. GRIFFITH. Any transition relief granted by this code section that you are referencing, 7805(a) of the Internal Revenue Code? I am correct, there is no opinion referencing that, am I not? No court opinion that says it is lawful, yes or no? It is real simple. You all are making a huge decision on the United States of America and you can't answer the question? It is yes or no. It is simple.

Mr. IWRY. Congressman, there are court opinions referencing Section 7805(a) of the Internal Revenue Code—

Mr. GRIFFITH. In changing a law passed by Congress? It is mostly regulation, am I not correct? Is there any case that references a time when the Treasury Department used this section to stop the implementation of a section of the law and a court has said oh yes, you got that authority? Can't cite me one, can you?

Mr. IWRY. Congressman, we will be happy to respond to you after the hearing.

Mr. GRIFFITH. And I appreciate that, but I would think if you were coming to a hearing where you are going to testify under oath

and you are changing the law of the United States of America by—of the executive and by the administrative branch, I think you would have your court cases lined up. I don't believe you got it, but I would be glad to see it if you do.

Thank you. I yield back.

Mr. MURPHY. Gentleman's time is expired. Now recognize Mr. Johnson of Ohio for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Iwry, I certainly am not happy that we are here today. I am sure you are not either. You know, the Administration has had 3 years to work on this, and it is just now getting worried about the timeframe. Was there ever a comprehensive plan in place, or was too much of the 2,000 page healthcare law waiting to be written into 20,000 pages of regulations that have slowly leaked out of HHS and the IRS? Because oh, that is right, we had to pass the bill to find out what was in it. That was what we all heard. Turns out that deceiving the American people with a law largely written by bureaucrats after it was already signed into law wasn't such a good thing for the President after all. Because now that we have got those 20,000 pages of regulations, the law supporters are finding out just how unworkable it is, something that we have been saying all along.

Today, 78 percent of Americans lack awareness about the law, and four in ten don't even know the law takes effect 5 months from now. We are 3 years in here, folks, and issues like this are exactly why the Administration should be delaying the individual mandate, too. And if things have gone the way they have and are going is any indication of what is to come, this law will never be workable. So it probably doesn't come as a surprise to you, but let me ask you once again, does the IRS, does your department have the authority to delay the individual mandate? Because I thought I just heard you tell my colleague on the other side there that after analysis and under certain circumstances, you do have the authority. That is what you said, correct?

Mr. IWRY. That is not, Congressman, what I—

Mr. JOHNSON. No, that is exactly what you said.

Mr. IWRY [continuing]. Was saying with respect to—

Mr. JOHNSON. No, that is exactly what you said, Mr. Iwry. You said that under certain conditions, based on the analysis, that you would be able to apply the same section of the IRS code to waive this and other future law mandates under that provision in the IRS code. That is what you said to the colleague before, so are you now changing that answer?

Mr. IWRY. Congressman—

Mr. JOHNSON. Do you have the authority? If you were to conduct the analysis, do you have the authority to change it? If the analysis were to give you the same level of concern that the employer mandate did, would you have the authority under the IRS code to change and give the transition relief?

Mr. IWRY. Congressman, the individual responsibility provision does not present—

Mr. JOHNSON. No, I am asking you if you have the authority. I am not asking you will you; I am not asking you if you have conducted the analysis. I am asking you if the analysis were con-

ducted, do you have the authority under the IRS code to provide that transition relief? That is a yes or no, Mr. Iwry.

Mr. IWRY. Congressman, we have not performed—

Mr. JOHNSON. I know you haven't. I know you haven't. I am not asking you have you. You are not answering the question that I am asking you. You are very calm and poised. You have been very skilled at this, so I commend you on that. I have noticed. What is the IRS prepared to do if the analysis were to indicate the same level of concern over the individual mandate as the employer mandate? Does the code allow you to use this provision to delay the individual mandate?

Mr. IWRY. Congressman, it is not based on the level of concern by stakeholders—

Mr. JOHNSON. But you just said it was. You said it was in an earlier statement—you are under oath. Do you remember what you said about 5 minutes ago, 10 minutes ago?

Mr. IWRY. Respectfully, Congressman, what I am saying is—

Mr. JOHNSON. Well respectfully answer the question. If you want to be respectful, Mr. Iwry, to the voice of the American people, then answer the questions that you are being asked and stop dancing around the issue. Does the IRS have the authority to delay the individual mandate under the same IRS provision that they delayed the employer mandate?

Mr. IWRY. Congressman, we have not considered—

Mr. JOHNSON. You are not going to answer the question.

Mr. IWRY. We have not—

Mr. JOHNSON. You said earlier in your testimony—

Ms. DEGETTE. Mr. Chairman, I respectfully ask the witness be allowed to answer the question.

Mr. MURPHY. Gentleman has the time.

Mr. JOHNSON. This is my time, Mr. Chairman.

You said in your testimony earlier that your decisions were based on concerns from stakeholders. Who were the stakeholders? Who did you talk—who did the IRS talk to before they made this decision?

Mr. IWRY. Congressman, the stakeholders who expressed these concerns—

Mr. JOHNSON. Yes, who were they? Specifically, who were they?

Mr. IWRY [continuing]. Included the National Restaurant Association, the National Retail Federation, the Retail Industry Leaders Association, the Employers for Flexibility in Healthcare.

Mr. JOHNSON. Did you talk to any individual companies, the businesses that were going to be impacted?

Mr. MURPHY. Gentleman's time is expired.

Mr. JOHNSON. I thank you, Mr. Chairman. I yield back.

Mr. MURPHY. Chair recognizes the gentleman from Missouri, Mr. Long, for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman, and thank you, Mr. Iwry, for being here today on kind of a hot topic, I think as we all know.

Mr. Johnson kind of took one of my questions. I guess he is over here looking at my notes, but these different companies that you talked to in making this decision or your agency made in delaying the employer mandate, can you name three companies? I mean, the top three companies that pop in your head, hey, we talked to John

Deere, we talked to General Motors, we talked to this one, we talked to that one. Can you name me three companies just real quickly that you talked to about it?

Mr. IWRY. Congressman, we talked to many and heard from many company representatives, as well as various individual companies. What I am—

Mr. LONG. That, to me, is the company. If you talked to the representative, then—you are kind of representing Treasury here today so I think I am talking to Treasury. So if I was talking to somebody that represented John Deere, then I would think I was talking to John Deere, so can you just—three names that pop in your head of companies that you talked to about this, how onerous it was going to be on them or why you made this decision?

Mr. IWRY. I am sorry, Congressman, I wasn't being clear. What I meant was associations representing hundreds of companies.

Mr. LONG. Right, well you named the National Restaurant, but that is not what I am looking for. I am looking for KFC. I am looking for Darden. I look for a lot of restaurants, if you haven't noticed, but—

Mr. IWRY. Congressman, we spoke to Darden. We have spoken to the Gap. We have spoken to numerous companies, and I would be happy to think of them. What I am not coming up with right now and I would like to do that to be helpful and responsive to your question, is sorting out my recollection—

Mr. LONG. If you can, I would appreciate it.

Mr. IWRY. Yes, sir.

Mr. LONG. OK. Let me move on. I will tell you one company. I heard earlier one of the Congressmen said we each represent about 700,000 people. I represent, I think, 751,000. We lost a Congressman due to the Census last time in Missouri, so I have 751,000 constituents. But I don't want to talk about 750,999 of them, I want to talk about two of them. One of them is an employer in my area that came to me, the CEO came to me and said I want to tell you how bad this Affordable Care Act is going to be on our company. This is a company that started out with one store in Springfield, Missouri. They now have 56,000 employees. Obviously, they have stores all around the country now. He said we provide a great healthcare insurance for our people. They loved it. It was affordable for our company. We cannot provide that insurance for them next year. The requirements of the Affordable Care Act are going to be so onerous on us that we cannot do that. We are going to tell our part-time employees—and I think they already have, at this point—that we are not going to provide healthcare for the part-time employee that they were providing for before, and the best we can figure, we are going to have to cut people down to 29 hours a week. Well that is not doable. That is not—people can't go to work somewhere 29 hours a week and then pick up a few more hours somewhere else. So those are the types of people that I am concerned about. An employer in my area, again, started out—the great American success story. Started out with one company, now they have 56,000 employees. And this bill is so onerous on them that they cannot provide that coverage.

So you stated earlier that the vast majority already receive this coverage, because they work for a company like this that has

56,000, but even when this 1-year mandate runs out, then they are not going to be able to provide the same healthcare at the same affordable cost that they are now. So they can't keep it next year when this runs out.

You said that the White House was involved. Were there any talks about the individual mandate? I mean, to me, you have done a good thing. I don't know that it is constitutionally legal. I can't imagine the President just willy-nilly arbitrarily saying I am going to change a law because we want to change the law. I don't know that that is constitutional, but let's say—let's assume that it is. But I think you have done a good thing in shutting the barn door before the horse was out on the mandate on employers. The individual mandate, that horse is still in the barn. Did you talk about shutting the door before that horse gets out of the barn? Did you have those discussions about delaying the individual mandate?

Mr. IWRY. Congressman, we collectively as a lot of people—I can just speak to you about the discussions I was in, which I assume is what you are asking me about. But in the discussions that I have been involved in, which are part of the total discussions, we did not consider delaying or giving transition relief with respect to the individual mandate because we did not identify similar reasons for doing so, a comparable impact.

Mr. LONG. OK. So you didn't think that the individuals would want and need this same relief that the employers would need, correct?

Mr. IWRY. That is correct, Congressman. I would be happy to explain why.

Mr. LONG. OK. I am about out of time here. For the record, I just want to state that we do things in Congress—I have a lot of friends on the other side of the Aisle. I have a few on this side, but I have a lot of friends that I really, really try and reach out and get along with people. I am kind of a people person, and I think that we need to work together. It just seems like on all of these issues—I don't care what the topic is—that when we want to do something, the other side is violently opposed to it, and if they on our side and their side, too, once in a while could reach out with an olive branch and say hey, you know, the White House got in on this and we are not going to do the employer mandate, and we say hey, why not for the individuals, too? If they would come back and say that is fine on immigration reform, they want to—they don't want to touch—we want the borders tightened. We can talk about immigration and get something done on immigration, but if they would once in a while come together, I think it would be better for all of us. Thank you.

Mr. MURPHY. Gentleman would have more friends if he sticks to the time limit. I thank the gentleman. Now turn to the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman.

Mr. Iwry, I have a couple questions for you regarding the employer mandate. You know, the Affordable Care Act, or Obamacare, was put in place March 2010, is that correct? Yes or no?

Mr. IWRY. That is correct, Congresswoman.

Mrs. ELLMERS. OK. When was the employer mandate actually put in place? When was the finalization of the actual language to what employers would have to adhere to put in place?

Mr. IWRY. The language was part of the law that was enacted in March.

Mrs. ELLMERS. So it was in the initial part of the law back in 2010. OK. May I remind you it is now July 18, 2013. There have been businesses across this country and individuals and American families who have been dreading this terrible piece of legislation going into place. This is the worst piece of legislation that has ever affected American families.

Now here we are, July 2, week of 4th of July, and we get this message put out that we are now going to delay the employer mandate, the employer mandate forcing businesses to have to give insurance and incur the cost. What was the tipping point at this point when we are so close to the implementation in 2014? What was it? Was it the cost to businesses? Was it the affordability? Was it the fact that jobs were going to be lost? Was it going to be the hours? What was it that you heard from these associations that changed your mind or urged you to make this decision?

Mr. IWRY. Congresswoman, the associations and the individual companies—

Mrs. ELLMERS. What did they say the issue was?

Mr. IWRY. The associations and the individual companies said that the issue was two-fold.

Mrs. ELLMERS. And it was?

Mr. IWRY. One, that they needed more time to implement the reporting requirements—

Mrs. ELLMERS. OK.

Mr. IWRY [continuing]. But because their systems needed to be adapted, both for collecting—

Mrs. ELLMERS. OK, but this—so when did you start getting this information? When did you start sitting down with these associations?

Mr. IWRY. We started sitting down with the associations and individual businesses shortly after enactment of the law.

Mrs. ELLMERS. So that was back in 2010—

Mr. IWRY. 2010 or—

Mrs. ELLMERS. And you now, 3 years later, have made this decision.

Mr. IWRY. Or 2011.

Mrs. ELLMERS. OK. Well this is the issue. Do you have a business background?

Mr. IWRY. Congresswoman, I have spent more years counseling businesses in the private sector—

Mrs. ELLMERS. OK, so you are very familiar with business. Time is money. When it costs a business to have to adhere to onerous regulations, that is money. So basically what you are telling me, yes or no, is that it really boils down to the cost and the fact that businesses would have to fire employees. Is that correct?

Mr. IWRY. Congresswoman, that is not how the businesses that have expressed these concerns that the reporting be—

Mrs. ELLMERS. So what is going to change in a year?

Mr. IWRY. Congresswoman, businesses have asked us if we can simplify or streamline—

Mrs. ELLMERS. OK, so you are going to simplify the system. Three years later—knowing the requirements have always been there, now 3 years later we are going to simplify. OK, that is fine. That is fine. I don't have a problem with that. It is totally inadequate, but I will accept it.

Let me move on to the individual mandate. Now you say that you don't see any problem with individuals being able to report?

Mr. IWRY. Congresswoman, the impact of the reporting conditions—

Mrs. ELLMERS. Have you actually reached out to individuals to get comments, to find out what the individuals feel about this? Because I have, because I represent 700,000 of them and they are all very concerned about this. What input have you received?

Mr. IWRY. The Administration has worked with many individuals—

Mrs. ELLMERS. The Administration or—OK. So what is your impact? So the individuals you are talking to are saying this is just perfect, it is wonderful, this is the best thing that has ever happened?

Mr. IWRY. The individuals process for navigating—

Mrs. ELLMERS. OK. Let's just move on, because see, interestingly enough, HHS put out a 606-page rule now saying that individuals who are going to the exchanges in the 16 States where they are up and running or will be that they won't have to report any type of income verification or employer-based insurance for these exchanges. Now why would that happen at the same time?

Mr. IWRY. I believe that is not correct, Congresswoman.

Mrs. ELLMERS. What is your version, then, and has the Treasury had any input there?

Mr. IWRY. My understanding from Ms. Tavenner—

Mrs. ELLMERS. I have 2 seconds.

Mr. IWRY [continuing]. And from CMS HHS is that that verification change that they announced in that regulation—

Mrs. ELLMERS. Yes.

Mr. IWRY [continuing]. Was much more limited in its application.

Mrs. ELLMERS. Well, 606 pages. However, there is an issue here because there is no time limit on that. We are not just giving someone a year to learn how to report; we are just removing it. Am I not correct in that? We are just now saying that individuals do not have to report their asset verification, is that not correct?

Mr. IWRY. That is not my understanding, Congresswoman. I am not an expert on the HHS requirements, but that is different from the myths and facts statement that they—that Ms. Tavenner at CMS posted—

Mrs. ELLMERS. Well my time has expired, but I find it amazingly coincidental. Thank you.

Mr. MURPHY. Gentledady's time is expired. Now turn to the gentleman from Louisiana, Mr. Scalise, for 5 minutes.

Mr. SCALISE. Thank you, Mr. Chairman. I appreciate you holding this hearing. It is very important that we have this hearing. Mr. Iwry, I appreciate you being here.

We have had a number of hearings in this committee exploring the ramifications of the President's healthcare law, and when we have had Administration officials in the last few months come and testify, we have been hearing horror stories from people in our districts. You know, I represent southeast Louisiana. I hear from businesses all the time that have been talking about the devastating impacts this is having on their business, on their ability to hire new employees. Many businesses are being forced to reduce the number of hours that employees work because of the healthcare law. In fact, our State study had just come out that said our State, Louisiana, would see a 56 percent increase in individual healthcare premiums on families. Fifty-six percent increase because of the President's healthcare law, so we are seeing all of this. And then when we have had hearings with Administration officials, they have all said everything is going fine. Everything is looking great. We have recently had hearings where those things were being said and we present them with this information, things that we are seeing and hearing on the ground in our districts back home.

So I think when you come here and say that sometime in June you all made a decision that you could just ignore part of the law, there are a lot of real serious questions that come about. How long have you all known about this? How long has your agency known about it, and what other agencies within the Obama Administration have known?

I want to first ask you, when you started coming up with this understanding as you are meeting with businesses and they are telling you we have got serious problems, and then ultimately you decided you think you can delay a part of the law, did you have any talks with HHS, to have the same conversation that you all had internally with HHS who was moving forward with implementation?

Mr. IWRY. There is a lot of coordination between Treasury and HHS—

Mr. SCALISE. On this decision? On the decision to delay the employer mandate, did you have conversations with HHS about the decision that you made? It is a yes or no question.

Mr. IWRY. Personally I did not have conversations, Congressman, with HHS that I can recall before the decision was made—

Mr. SCALISE. How about Mr. Mazur, the person that you said at Treasury made this decision? Do you know if he had any conversations with HHS about this?

Mr. IWRY. Congressman, I do not know whether Mr. Mazur—

Mr. SCALISE. All right, then let me—he is not here, you are. I want to ask you, can you get the committee that information? Can you get the committee the names of anybody at Treasury that consulted with HHS, if those consultations happened along the way, that you all were going to delay this mandate, and when—because they were testifying that everything was fine, while you all were sitting in a room somewhere behind closed doors making a decision that it wasn't going fine, so much so that you thought you can just ignore the law. And so can you get us that information?

Mr. IWRY. Congressman, does that—does your request include—so I understand your request—

Mr. SCALISE. I am asking you to get the names of people at Treasury that had any conversations with HHS about the delay of the employer mandate, and then the dates and times when those conversations occurred. Can you get that to us? It should be pretty easy.

Mr. IWRY. The conversations that coordinate between Treasury and HHS—

Mr. SCALISE. Yes. Can you get that?

Mr. IWRY [continuing]. Often go through—

Mr. SCALISE. Answers. Can you get us that? The clock is running. I don't have all day. I appreciate your time and I hope you respect mine. Can you get us that information?

Mr. IWRY. Congressman, the conversations are coordinated by—

Mr. SCALISE. Can you get us that information?

Mr. IWRY [continuing]. OMB in many cases, or the White House.

Mr. SCALISE. Can you get us that information, yes or no?

Mr. IWRY. We will be happy to—I would be happy to ask the appropriate people at Treasury to pursue your question and—

Mr. SCALISE. And get us that. Because I am looking at the law here, and this is the law—I was on the committee. I just got on right when the President's healthcare law was coming through. We had hearings for months and months, hours and hours at a time, and I had more concerns about this bill as it was going through. Every day they were worse. And unfortunately, they have all come to fruition and then some.

But when I look at the section we are talking about, large employers, Section 605 says "large employers required to report on health insurance coverage effective date, the amendments made by this section shall apply to periods beginning after December 31, 2013." Now did the President get out some kind of magical pen and change this to 2014? Did the President change this law? This is the law right here. You are talking about something you all did on a blog post in a secret room behind closed doors. This is the law. Did this law change? Because yesterday we had a bill on the House Floor to actually change this law, to delay this by a year. I want to repeal the whole thing. Every American, the more they see about it—look, the unions, of all people, the labor unions who actually helped pass this law—James Hoffa wrote a letter saying "the law as it stands will hurt millions of Americans, including the members of our respective unions," and actually went on to say it would not only harm their hard-earned health benefits, but destroy the foundation of the 40-hour workweek that is the backbone of the American middle class. That is the unions who helped pushed this bill through that are saying that.

And so when the Secretary of HHS is out shaking down companies recently, trying to get them to give money, companies she oversees and regulates, I think it is corrupt for her to do it. She is shaking down companies, trying to get money, to get them to promote the law. She is going to the NFL and NBA trying to get them to promote the law, and then somebody else behind closed doors in the same Obama Administration is saying this thing is so unworkable we got to delay it.

And so what I am asking you is who is talking to who in the Obama Administration? It is Sebelius out there on one hand, shaking down companies, saying help us promote this lemon, while you all are out there in a room going you know, this thing is so unworkable we better delay the damn thing. Can you get us that information, those answers to those questions?

Mr. IWRY. I would be happy to respond now.

Mr. SCALISE. The floor is yours.

Mr. MURPHY. Gentleman—the time has gone over so I am going to have to hold to that, but there are some questions we want—we will submit and you will respond in a timely fashion.

Mr. SCALISE. Thank you. I yield back the balance of my time.

Mr. MURPHY. I would now recognize Mr. Gardner from Colorado for 5 minutes.

Mr. GARDNER. Thank you, Mr. Chairman, and thank you, Mr. Iwry, for your time before this committee.

Just a couple of questions for you. You are the senior advisor to the Secretary, is that correct?

Mr. IWRY. I am a senior advisor.

Mr. GARDNER. A senior advisor, OK. So in terms of the advice you would give to the Secretary on the question that Mr. Johnson was asking you, do you have the authority under the same tax provision to provide a delay in the implementation for the individual? What would your advice be to the Secretary?

Mr. IWRY. Congressman, I would have to participate with the appropriate people—

Mr. GARDNER. OK.

Mr. IWRY [continuing]. At Treasury.

Mr. GARDNER. So your answer is that you would look into it, and so the answer is not no. You would have the authority to do that.

Mr. IWRY. Congressman, if that question were asked, I would have to research or—

Mr. GARDNER. And you haven't researched that?

Mr. IWRY [continuing]. Or participate with others or have—

Mr. GARDNER. Have you researched that point?

Mr. IWRY [continuing]. Others research the question whether we would have authority to—

Mr. GARDNER. Have others researched that point?

Mr. IWRY. Whether we would have authority to—

Mr. GARDNER. Correct, under the same provision of law.

Mr. IWRY [continuing]. Provide transition relief with respect to individual—

Mr. GARDNER. To delay the mandate for individuals. Have you researched it, have others researched it?

Mr. IWRY. We have not researched that particular request—

Mr. GARDNER. So you delayed the business mandate without understanding its full implication on what it would mean for individuals?

Mr. IWRY. Congressman, no, that is not what we did. If I may explain—

Mr. GARDNER. You did—I have some other questions for you. How many—when was the President made aware of your decision to delay implementation of the business healthcare rules?

Mr. IWRY. Congressman, may I just finish my response to your prior question?

Mr. GARDNER. If you would like to submit it for the record, that would be great. When was the President made aware of your decision to delay the business provisions?

Mr. IWRY. I don't know—

Mr. GARDNER. You don't know when the President was made aware?

Mr. IWRY. I don't know what communications there were with the President on this matter. I was not involved.

Mr. GARDNER. You weren't a part of the decisions to inform the President of the United States about the decision to delay what is arguably a major provision of his marquee piece of legislation?

Mr. IWRY. Congressman, we coordinate with the White House. The Treasury did coordinate with the White House—

Mr. GARDNER. Who spoke to the President about this?

Mr. IWRY. Congressman, I don't know who, whether at the White House or at Treasury, spoke to the President about this. If I assume you have—people here have assumed that the President was told, I don't have—

Mr. GARDNER. Would you assume that the President was told? How are decisions made with this White House?

Mr. IWRY. I would not be surprised at all if the President was advised of this, Congressman.

Mr. GARDNER. Well I wouldn't be surprised either. I would just like to know when.

Mr. IWRY. I simply have no personal knowledge.

Mr. GARDNER. Would you please get back to me on when the President was made aware of these decisions?

How many IRS agents right now are working with you on implementation of the healthcare bill?

Mr. IWRY. Congressman, I don't know the exact number as I sit here of IRS personnel who are working on implementation, but we would be happy to check on that—

Mr. GARDNER. Could you get back and tell me how many IRS personnel are working on the healthcare bill at this moment? Would you please get back to me with that number?

Mr. IWRY. We would be happy to—I assume that that is something that we would be able to do, so—

Mr. GARDNER. I will take that last question and if you could report it for the record, that would be great.

How much money have businesses spent to this point, are you aware, to try to comply with the healthcare rules?

Mr. IWRY. How much money businesses have spent to date?

Mr. GARDNER. Yes, how much does it cost American businesses to try to comply with the healthcare law?

Mr. IWRY. Congressman, I am not sure I know the—I don't know the answer to that question.

Mr. GARDNER. Could you get back to me with the estimate that Treasury has and what it will cost American businesses to comply with the healthcare law?

Mr. IWRY. Congressman, businesses are benefitting as well from the healthcare provisions—

Mr. GARDNER. Do you agree that it costs businesses to fill out their tax code, fill out their tax forms? It costs businesses to hire accountants? Do you agree with that?

Mr. IWRY. Congressman, of course.

Mr. GARDNER. So it will cost businesses to try to comply with a new regulation and new law. I would like to know Treasury's estimation of how much it has cost American businesses to comply with the healthcare law.

Mr. IWRY. I will be happy to inquire of my colleagues whether the economists at Treasury have that kind of information.

Mr. GARDNER. Isn't that something the Treasury Department should have, is how much it is costing the American businesses?

Mr. IWRY. The cost issues with respect to the Affordable Care Act are certainly something that Treasury has been taking into account in a very serious way, and weighing them against the benefit—

Mr. GARDNER. Who advises the Treasury Secretary or the President on how much it will cost to comply with the regulation?

Mr. IWRY. The Assistant Secretary for Tax Policy is the individual who would be delegated the authority to make those regulatory decisions, and therefore if the question was asked how much does this—would this cost—

Mr. GARDNER. Would you mind getting back to me with that information?

Mr. IWRY. That would be at least one individual within Treasury, not necessarily the only official within Treasury who would be responsible for developing that.

Mr. GARDNER. I think we would all be interested in that information. I have other questions for the record. Thank you. I yield back.

Mr. MURPHY. Gentleman yields back. I now recognize the gentleman from Georgia, Mr. Gingrey—Dr. Gingrey, for 5 minutes.

Mr. GINGREY. I thank the chairman, and I came in a little bit late, but I am looking at the witness's bio and of course, in the name tag, Honorable Iwry, Senior Advisor to the Secretary of the Treasury, Deputy Assistant Secretary for Retirement and Health Policy of the United States Department of Treasury. Obviously haven't earned that title of honorary, and I am just astounded at the lack of ability to answer the questions, Honorary Iwry.

In your capacity at the Treasury Department, have you heard either in meetings or by public comments about concerns from businesses that the employer mandate will cause employers to reconsider or even halt plans to expand? Have you heard that concern?

Mr. IWRY. Congressman, we have heard some people express that concern, as well as many who have said that it would not have that effect on their businesses.

Mr. GINGREY. Well, I can tell you this, Honorary. I have certainly heard that concern in my district. When I talk to small businesses back home in Georgia, I often hear that the 50-employee threshold has repeatedly forced different hiring practices. I learned that Heatco, a company that specializes in the design and manufacture of world-class hearing solutions located in Bartow County, Georgia, has looked into expanding. The thing is, they currently have, you guessed it, 49 employees, and to expand by adding additional employees will cost more than automatizing some of their processes due to the added Obamacare costs. It seems to me that your delay

is directly influenced by examples such as this one, and not due to the purported reporting requirements, for God's sake, that have had 3- $\frac{1}{4}$  years to figure that one out.

In your response to the committee, you stated that the delay occurred after "having engaged in a dialogue with stakeholders and reviewing written comments about the employer and insurer reporting requirements." Did any of these comments mention the effect the mandate could have on their expansion plans?

Mr. IWRY. Congressman, I am confident that while I can't recall specifics now, that at least some of those comments probably did. At least some probably did mention concerns such as those. Those were not what drove our decision, and indeed, the concerns that were expressed about the reporting and about the employer responsibilities were not ones that we gave credit to automatically or lightly.

Mr. GINGREY. I want to interrupt you just for a second, because it seems to me you are kind of running out the clock, and that is—I thought that Harvard-educated lawyers could talk a little bit faster than Georgians.

But look, would you please tell the committee some of these employer stakeholders who weighed in? Name two or three.

Mr. IWRY. Well, the Business Roundtable representing numerous major companies—

Mr. GINGREY. That is a trade association. That is not a company.

Mr. IWRY [continuing]. Weighed in. Oh, yes, sir. There were—we would be happy to get back to you with—

Mr. GINGREY. Well, I thank you for that. You should get back to me. That will be fine.

Now it seems to me that this unconstitutional delay by the Executive Branch, by this President, was in direct response to the drag on the economy, higher unemployment, needing more time to develop reporting requirements was an economic political decision. I don't deny that or have any particular problem with that. In that light, though, in that light, would you please answer the following questions as our distinguished chairman emeritus, Mr. Dingell, would often say with yes or no answers regarding the raw Senate politics of this decision that was dumped on us on the July the 2nd.

Did you hear during the stakeholder process, Honorable Iwry, did you hear either directly or indirectly from Senator Mark Pryor?

Mr. IWRY. From Senator—

Mr. GINGREY. Mark Pryor of Arkansas.

Mr. IWRY. I don't recall having heard from Senator Pryor.

Mr. GINGREY. How about Senator Mary Landrieu from Louisiana?

Mr. IWRY. Congressman, I don't recall having heard from—

Mr. GINGREY. Struggling a little bit, Honorable. How about Senator Mark Begich from Alaska? How about Senator Kay Hagan from North Carolina?

Mr. IWRY. Congressman, what I am referring to by stakeholders are companies, associations of companies, other organizations in the private sector—

Mr. GINGREY. Yes, what you are referring to as stakeholders and what I am referring to as stakeholders are two different animals, and I am trying to ask you if these Senators up for reelection in

2014 in States that Mitt Romney carried overwhelmingly came to you, Honorable, and I am sure you were in the room if they did, if you had heard any concerns that they have about their reelection potential process in regard to this bill, which is a train wreck, as retiring Senator Baucus described to the Secretary of Health and Human Services—

Mr. MURPHY. Gentleman's time is expired.

Mr. IWRY. Congressman—

Mr. MURPHY. Gentleman's time is expired. Here is how we are going to handle this in talking with the Minority here. So what we are going to do is give each side 5 additional minutes to ask some questions. I have a question or two, and if members from my side want to ask a question, let me know.

All right, Ms. DeGette, 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I really appreciate you coming over here, Mr. Iwry. I know it is sometimes frustrating and difficult to answer questions to which you have no answer, but I do think it is important for us to understand the decision that was made, and also to understand the scope of Treasury's ability to make these decisions regarding implementation of the Affordable Care Act. So thank you for coming. Some of the questions where folks asked you to submit written responses, you may not be able to respond to those questions because they were, you know, they were big, but if that is the case, please let us know that, too, so that we can help make sure that we get the information we need.

Mr. Chairman, I just—I think finally Mr. Johnson's question did get answered and I appreciate my colleague from Colorado, Mr. Gardner, for getting that answer because I thought it was very useful about the agency's scope of ability to be able to delay the individual mandate. And I believe what you had said, Mr. Iwry, is the agency has not really considered delaying the individual mandate, and therefore, the agency has not done an analysis to determine whether or not they do have that ability under Section 7805(a). Is that correct? Yes or no would be—

Mr. IWRY. Congresswoman, that is correct.

Ms. DEGETTE. OK, thank you. I just want to point one last thing out, Mr. Chairman, which is we keep talking about this Administration decision to delay the reporting requirements under Section 7805(a) for the employers, and then we keep talking about delaying the individual mandate as if it were a comparable decision, but in fact, it is really apples and oranges because the employer reporting is simply an IRS reporting that the employers have to make. And in fact, the Urban Institute did an analysis—and I will submit this for the record. They did an analysis after the Administration's decision figuring out how many more people would be uninsured if you had the ACA, even without the employer mandate, not just the 1-year delay, but without it, and it turned out to be very minimal. The reason is because over 90 percent of Americans who work for companies already have insurance, and that is not going to change with just the 1-year delay.

But the Urban Institute analysis also showed, though, if you delayed the individual mandate by a year, that is a totally different thing and the reason is the individual mandate encourages people

to go out and buy insurance. It is not simply a tax reporting, but when they go out and buy this insurance then, they get the subsidies, they get the tax relief, they get all of the other benefits that people are going to get. And what the Urban Institute analysis found out was that if you did not have the individual mandate, the Affordable Care Act without the individual mandate, then 13 million people would be without coverage. So in fact—and you know, it is just two ways of looking at different sides of the coin is you delay the business mandate for a year, which is something that all the businesses sat in this room and said they wanted and everybody on both sides of the Aisle seemed to think might be a good idea. You delay that for a year, well swell, but then if you delay the individual mandate for a year, what will happen is many, many millions of Americans, people with preexisting conditions and others, won't be able to get affordable health insurance through these exchanges.

So I think it is kind of a little different, and I myself intend to continue to try to help all of my constituents in the 1st Congressional District of Colorado get enrolled so that they can get these benefits and so that we can bend the cost curve. And those are my two cents, Mr. Chairman. I would ask unanimous consent to put this Urban Institute analysis into the record.

Mr. MURPHY. Without objection.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Mr. MURPHY. Gentlelady yields back?

Ms. DEGETTE. I yield back.

Mr. MURPHY. Thank you. I am just going to ask a couple questions here, and then yield to Dr. Burgess.

What are the costs to American businesses of complying with the reporting requirements? Do you have this number, the cost to American businesses of complying with the reporting requirements? I am assuming that is part of the record the Treasury is considering as a basis for your decision, their costs.

Mr. IWRY. Mr. Chairman, the fact that there are costs is certainly something that is relevant.

Mr. MURPHY. I know it is relevant. Is it—do we have a number of how much it is going to cost American businesses to comply?

Mr. IWRY. I would be happy to take that back and see whether we—

Mr. MURPHY. Is there a memorandum or any other information that was reviewed by you or other people with regard to the costs?

Mr. IWRY. Businesses and their representatives provided information about the fact that it was costly. If I—

Mr. MURPHY. So you will provide us with those memorandums or communications regarding the costs?

Mr. IWRY. I am sorry, sir?

Mr. MURPHY. You will provide us with information regarding the costs?

Mr. IWRY. We will be happy to look back and see whether they provided information—

Mr. MURPHY. It was only a week ago you decided this, so I was hoping you would remember. It was only 2 weeks ago that you de-

cided to delay this, so I was hoping you would remember how much the costs were.

Mr. IWRY. Mr. Chairman, I don't remember a particular figure that—

Mr. MURPHY. Did Treasury do an analysis of the costs?

Mr. IWRY. Treasury considered the cost as part of the analysis—

Mr. MURPHY. And the number is?

Mr. IWRY [continuing]. Taking it into account, but I don't know whether there is a separate number that was broken out. I will be happy—

Mr. MURPHY. Add that up and please get that to us.

You also mentioned that Treasury carefully considered the rule. Do you know what other agencies reviewed the announcement with regard to delay? Did other departments, other than Treasury, review this before the announcement came out? For example, did you ask HHS to review?

Mr. IWRY. Mr. Chairman, OMB or other White House offices coordinate typically between the various departments that are involved in implementing—

Mr. MURPHY. Did you seek review from anyone else? Did Treasury seek review from any other agencies?

Mr. IWRY. I personally did not, don't recall talking to the other—

Mr. MURPHY. Did you see any memos or hear of any communications where other people within Treasury were reviewing this with any other agencies, any other departments?

Mr. IWRY. I do recall discussions in which this was reviewed by and there were consultations—

Mr. MURPHY. Other agencies, other departments?

Mr. IWRY [continuing]. With other organizations within the government, but I don't recall such with respect to the other departments, as opposed to OMB or—

Mr. MURPHY. Let me broaden that. Any government agency, entity, department, division, person, desk, cubicle, group where two or more are gathered, we would like to know, all right?

Is there any evidence or data before Treasury about the burdens of costs on the individual? You had mentioned before that you reviewed this for businesses but not necessarily for individuals. Did you hear from any individual groups? Did you seek information or do you plan to seek any information from individuals with regard to individual concerns and burdens?

Mr. IWRY. I think the Administration has heard from individuals, Mr. Chairman—

Mr. MURPHY. Treasury. I am pausing the clock.

Mr. IWRY. I would have to check. Certainly Treasury has weighed the impact on—

Mr. MURPHY. Let me ask this. If Americans want to let you know what their concerns are as individuals, what address can they send their concerns to?

Mr. IWRY. There are—

Mr. MURPHY. Just yours. I want them to write to you. Do you have an address at Department of Treasury?

Mr. IWRY. Mr. Chairman, yes, there are specific addresses that have been provided for the public.

Mr. MURPHY. We are asking you because you are involved with this decision and implementation, and you said you haven't heard from individuals. So I would like—if there are some people that have concerns out there, I would like them to be able to write to you. So we can have them write to you at Department of Treasury, care of the Department of Treasury?

Mr. IWRY. Mr. Chairman, I would be happy to hear from them.

Mr. MURPHY. Thank you. I am now going to yield to Dr. Burgess for a question.

Mr. BURGESS. Thank you, Mr. Chairman.

Let me just ask, did you get any feedback from the Department of Health and Human Services as to making this announcement on July 2?

Mr. IWRY. I don't recall, Mr. Burgess, hearing any feedback from HHS regarding this July 2 announcement.

Mr. BURGESS. Did they provide you an analysis of what this delay meant?

Mr. IWRY. Whether they provided an analysis to the White House or to OMB or to someone else at Treasury, some other office at Treasury, I don't know. I had not—I don't recall receiving any analysis from HHS.

Mr. BURGESS. I just find that extremely odd that a department that had worked on this so diligently and then you provide this delay, and there is no consultation.

Did Treasury consult CMS directly on the question of whether a delay would harm the integrity of the employer verification system, and shouldn't this question have been discussed, given that the Exchange Subsidy Program will cost taxpayers a trillion dollars over the next decade?

Mr. IWRY. Congressman, there are discussions which I am not privy to between CMS and IRS personnel about verification and reporting coordination between the marketplaces or exchanges and the tax system that go on on a, I believe, a continual basis and I am not involved generally in those conversations, so I don't know.

Mr. BURGESS. Mr. Chairman, it is apparent that the witness does not want to answer the question. I am going to respectfully request that this committee follow up with an aggressive document request from the Department of Treasury and the Department of Health and Human Services, and I expect a document request to be fulfilled. I will yield back to the chairman.

Mr. MURPHY. Thank you. We are—our time is expired. I just want to—with regard to your welcoming comments from individual citizens across the country, so I am assuming if they write to you, Mr. Iwry, at Office of the Deputy Assistant Secretary for Retirement Health Policy at the U.S. Treasury Department, letters should get to you. Am I correct?

Mr. IWRY. Mr. Chairman, we would be happy to provide an appropriate address or a recipient for those letters.

Mr. MURPHY. Can you tell me—I am just asking your address. You have got to be able to answer that question. You told us you haven't heard from people. I am just trying to help America. I am just trying to clear this up. So is it OK if people write to you at

Deputy Assistant Secretary for Retirement Health Policy at the U.S. Department of Treasury?

Mr. IWRY. Mr. Chairman, we have heard from individuals, but on this particular issue—

Mr. MURPHY. On this issue. This is what we would like to know.

Mr. IWRY. I am not aware that whether we have heard from individuals on this particular issue.

Mr. MURPHY. OK, thank you. Well with regard to this, I ask unanimous consent that the written opening statements of other members be introduced into the record, and so without objection, documents will be entered into the record.

And in conclusion, I would like to thank you for being here today and participating in this hearing. I remind members that they have 10 business days to submit the questions for the record. Mr. Iwry, I ask that you respond to them promptly with answers.

Thank you very much. This hearing is adjourned.

[Whereupon, at 5:03 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

#### PREPARED STATEMENT OF HON. GREGG HARPER

Mister Chairman,

Thank you, Mr. Chairman, for facilitating today's discussion on two issues that are of major concern to Mississippians.

Once again, we see that the "Affordable Care Act" is nothing short of politics above economics.

I've argued that this law was bad for employers from the start. And it seems now that the administration would agree. But if the federal government is going to exempt billion-dollar corporations from this burdensome law, why wouldn't we give average citizens the same relief?

This law is broken. And it can't be fixed by handpicking some provisions to enforce and others to conveniently ignore.

Let's repeal all of this health care law.

Let's consider fair health care reforms.

And only then will Americans receive the care that they need, from the doctors that they choose, at a cost that they can afford.

Thank you, and I yield back.

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Estimated 2014 Premium Rate Changes due to PPACA

PPACA Item	INDIVIDUAL BUSINESS	
	New Business	Existing Non-Grandfathered Business
Essential Health Benefits (EHBs) and Cost-Sharing Rules	15.0%	15.0%
Minimum Bronze Level	10.0%	8.0%
Guarantee Issue, Removal of Underwriting Actions	65.0%	10.0%
Insurer Fees	2.3%	2.3%
Reinsurance Recovery*	-10.0%	-10.0%
Risk Adjustment Transfer Payment **	0.0%	35.0%
Reinsurance, Risk Adjustment Fees (\$5.33 ppm)	2.6%	1.8%
Secondary Effect - Small Employer Market Dropout	n/a	n/a
Average Starting Premium Per Member (w/ 2009)	\$ 158	\$ 179
+ Essential Health Benefits (EHBs) and Cost-Sharing Rules	\$ 182	\$ 206
+ Minimum Bronze Level	\$ 200	\$ 222
+ Guarantee Issue, Removal of Underwriting Actions	\$ 330	\$ 245
+ Insurer Fees	\$ 337	\$ 250
+ Reinsurance Recovery*	\$ 304	\$ 235
+ Risk Adjustment Transfer Payment **	\$ 304	\$ 304
+ Reinsurance, Risk Adjustment Fees (\$5.33 ppm)	\$ 309	\$ 309
+ Secondary Effect - Small Employer Market Dropout	\$ 309	\$ 309
<b>Total Average Change Due to 2014 PPACA-Related Impacts</b>	<b>96%</b>	<b>73%</b>
<b>Potential Rate Change Ranges*** due to:</b>		
(1) Age	Low -25%	47%
	High 52%	197%
(2) Minimum Bronze Plan	Low 0%	78%
	High 90%	238%
Both (1) & (2)	Low -25%	33%
	High 169%	413%

How much could Obamacare cost YOU?

96% MORE  
for those getting a new plan

73% MORE  
for those keeping their insurance

as much as  
413% MORE  
based on age and Obamacare plan mandates

\* Reinsurance recoveries could range from 5% - 15%, with larger variances at the state level based on the block size.  
 \*\* Risk adjustment transfer payment is based on internal data comparisons. While 35% is shown for existing business impact, actual transfer will differ. Additional analysis pending. We expect the risk adjustment transfer to be a payment from Existing Non-Grandfathered Business, since the existing business is largely an underwritten block with lower average morbidity.  
 \*\*\* Ranges do not account for additional variation due to Area Factor and Underwriting Rating changes.  
 \*\*\*\* Premium for individual book of business is not directly comparable to premium for Small Group book of business in this example due to different inherent benefit levels, geographic mix, and other factors

**Small Group 2014  
Likely Rate Increase Distribution**

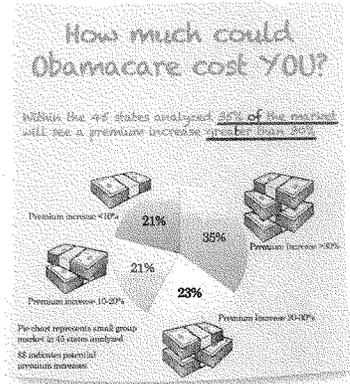
Likely Rate Increase	Community-Rated States	States with Moderate Rating Bands (1-25% or less)	States with Wide Rating Bands (over 25%)	Total Small Group Block
State*	CO, CT, MD, MA, NJ, RI, VT, WA	CA, FL, NY, OR, AL, AR, GA, IL, IA, KS, MN, MS, MT, NE, NC, ND, NM, OK, SC, TX	AZ, DC, DE, ID, IN, LA, MI, MO, NV, OH, PA, TN, UT, VA, WY, WI, WY	
<10%	16%	21%	24%	21%
10-20%	38%	18%	15%	21%
20-30%	32%	25%	17%	23%
>30%	14%	38%	44%	38%

Excludes VT, AK, HI, ME, NH, SD

**Includes:** Medical Trend and Demographic Impact (+10%), Insurer Fee & Reinsurance Assessment (3.5%), Product Changes, Risk Selection Movement (-2%) and Impact of Adjusted Community Rating (includes impact of rating age, removing gender, industry, group size, and other prohibited adjustments)

**Excludes:** Impact of risk adjustment (varies by state), impact of re-sloping (revenue neutral but varies by group), and SHOP user fee/assessments.

Model provided to the U.S. House of Representatives Committee on Energy and Commerce in response to 05/14/13 request. The analysis was not a comprehensive review of all PHS/ACA-related premium impacts. Thank you to other sources that assisted with this analysis.



## How much could Obamacare cost YOU?

### Examples of actual premium increases projected in the individual and small group markets

One national insurer predicts a 96 percent average increase for new customers in the individual market; Another predicts that small businesses in "nearly all states will see premium increases" in the small group market

**Arizona:** Potential premium increases range from 54 - 88 percent in the individual market and 50 percent in the small group market

**California:** Potential premium increases from 33 - 66 percent in the individual market and 37 percent in the small group market

**Colorado:** Potential premium increases from 22 - 25 percent in the individual market and 17 percent in the small group market

**Connecticut:** Potential premium increases of 26 percent in the small group market

**Florida:** In the individual market, example of 21-year-old male and female currently enrolled in less comprehensive plans could see increases of 120 and 103 percent, respectively, in the small group market, estimated increases ranged from 18 - 75 percent

**Georgia:** Potential premium increases from 48 - 63 percent in the individual market and 55 percent in the small group market

**Idaho:** While no overall average was provided, one provider suggested 60 percent of existing customers in the small group market would face premium increases

**Indiana:** One example provided by an insurer showed a 101 percent increase in the small group market

**Illinois:** Potential premium increases from 27 - 61 percent in the individual market and 35 percent in the small group market

**Maine:** Potential premium increases of 55 percent in the small group market

**Maryland:** Potential premium increases of 18 percent in the small group market

**Michigan:** Potential premium increases from 25 - 30 percent for males in the individual market, with premiums to vary greatly throughout the state; in the small group market, an estimated 44 percent of plans seeing a decrease and 58 percent seeing an increase

**Nevada:** Potential premium increases of 31 percent in the small group market

**New Jersey:** Example of young male and older male in the individual market, premiums could range from 19 and 8 percent increase to 26 and 23 percent decrease, respectively; in the small group market, potential premium increases of 16 percent

**Ohio:** Potential premium increases from 14 - 20 percent in the individual market and 53 percent in the small group market

**Oregon:** For one insurer, >35% of existing customers in the small group market will see either no change or an increase of up to 10 percent

**Pennsylvania:** An average increase of 30 percent in the individual market and 27 percent in the small group market

**Tennessee:** Potential premium\* increases from 27 - 54 percent in the individual market and 35 percent in the small group market

**Texas:** Potential premium increases from 9 - 43 percent in the individual market and 28 percent in the small group market

**Utah:** For one insurer, ~50% of existing customers in the small group market will see increases from 0 - 45 percent

**Virginia:** Potential premium increases of 33 percent in the small group market

**Washington:** For one insurer, >70% of existing customers in the small group market will see either no change or an increase of up to 10 percent; 20% will see an increase from 10 - 20 percent

## It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate

### Timely Analysis of Immediate Health Policy Issues

July 2013

Linda J. Blumberg, John Holahan, and Matthew Buertgens

#### Summary

There will be a one-year delay in the implementation of employer penalties for large employers (50 or more workers) who do not offer affordable coverage to their full-time workers (30 or more hours per week) under the Affordable Care Act (ACA). Some viewed the employer responsibility requirement as a key part of the ACA and the penalties as being an important tool for securing employer based insurance coverage once other reforms to the nongroup market are implemented. However, our analysis shows otherwise. In addition, some have suggested that it is unfair to leave the individual mandate in place while delaying the employer mandate. Our analysis shows that the different requirements have dramatically different implications for cost and coverage under reform.

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a state-of-the-art microsimulation model for estimating the cost and coverage implications of an array of changes to the health care system. The analysis compares the distribution of coverage under the full ACA, the ACA without an employer mandate, and the ACA without an individual mandate. We show that the employer mandate delay has almost no effect on overall coverage under the ACA or the distribution of that coverage across public and private sources of coverage. Eliminating the individual mandate, however, would significantly increase the number of uninsured compared to full implementation of the ACA, decreasing employer coverage as well. These findings are consistent with the evidence in Massachusetts, where coverage reforms were implemented beginning in 2006. The delay of the employer mandate also has little effect on government spending on subsidies or Medicaid, but does result in a slight reduction in government revenue.

While a delay of one year in the implementation of the employer mandate will not have a discernible effect on coverage or government spending on insurance, delaying the individual mandate would undermine a critical component of the coverage expansion in the ACA. Combined with the Medicaid expansion, insurance market reforms, and subsidies to assist those with modest incomes to purchase private insurance through the health insurance exchanges, the ACA's individual responsibility requirement provides stability to insurance pools and financial access to adequate coverage for a broad swath of the population disadvantaged by the prior system.

#### Introduction

On July 2, the Obama administration announced a one-year delay in the implementation of employer penalties for large employers (50 or more workers) who do not offer affordable coverage to their full-time workers (30 or more hours per week) under the Affordable Care Act (ACA).<sup>1</sup> Under the law, a penalty is imposed on larger employers if at least one of their full-time employees purchases coverage through one of the new nongroup health insurance exchanges (or marketplaces) and uses a federal subsidy to do so. The announcement of the delay was met with some suggesting that the employer penalties amounted to a key component

of the ACA and, as such, inferring that the delay was further evidence that the law was unworkable.<sup>2</sup> Some members of Congress and some health policy analysts expressed their feelings that it was "unfair" to delay the penalty on employers but to leave the penalty on individuals in place, indicating that the individual responsibility requirement ought to be delayed as well.<sup>3</sup>

In contrast, our analysis compares the effectiveness of the two policies and shows that the employer responsibility requirement is not central to expanding insurance coverage and does not have substantial effects on the public and

private costs associated with the coverage expansion. That is, the ACA can achieve all its major objectives without the employer responsibility provisions. On the other hand, the individual mandate is clearly a central component of the law and its anticipated coverage expansion.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we show that the employer mandate delay has almost no effect on overall coverage under the ACA or the distribution of that coverage across public and private sources of coverage. Eliminating the individual mandate,

Support for this report was provided by a grant from the Robert Wood Johnson Foundation.

**Table 1: Health Insurance Coverage Distribution of the Nonelderly, With and Without Reform**

	No ACA		ACA		ACA Without Employer Mandate		ACA Without Individual Mandate	
	N	%	N	%	N	%	N	%
<b>Insured</b>	<b>224,255,000</b>	<b>80.8%</b>	<b>249,541,000</b>	<b>89.9%*</b>	<b>249,206,000</b>	<b>89.8%</b>	<b>235,500,000</b>	<b>84.9%</b>
Employer (Non-Exchange)	153,914,000	55.5%	148,203,000	53.4%	147,303,000	53.1%	142,839,000	51.5%
Employer (Exchange)	0	0.0%	10,112,000	3.6%	10,925,000	3.9%	9,009,000	3.2%
<b>Employer Total</b>	<b>153,914,000</b>	<b>55.5%</b>	<b>158,315,000</b>	<b>57.1%</b>	<b>158,228,000</b>	<b>57.0%</b>	<b>151,848,000</b>	<b>54.7%</b>
<b>Nongroup (Non-Exchange)</b>	<b>15,218,000</b>	<b>5.5%</b>	<b>2,660,000</b>	<b>1.0%</b>	<b>2,658,000</b>	<b>1.0%</b>	<b>2,043,000</b>	<b>0.7%</b>
Nongroup (Exchange)	0	0.0%	15,881,000	5.7%	15,671,000	5.6%	11,483,000	4.1%
<b>Nongroup Total</b>	<b>15,218,000</b>	<b>5.5%</b>	<b>18,541,000</b>	<b>6.7%</b>	<b>18,329,000</b>	<b>6.6%</b>	<b>13,526,000</b>	<b>4.9%</b>
<b>Medicaid/CHIP</b>	<b>48,317,000</b>	<b>16.7%</b>	<b>63,879,000</b>	<b>23.0%</b>	<b>63,843,000</b>	<b>23.0%</b>	<b>61,320,000</b>	<b>22.1%</b>
<b>Other (including Medicare)</b>	<b>8,807,000</b>	<b>3.2%</b>	<b>8,807,000</b>	<b>3.2%</b>	<b>8,807,000</b>	<b>3.2%</b>	<b>8,807,000</b>	<b>3.2%</b>
<b>Uninsured</b>	<b>53,214,000</b>	<b>19.2%</b>	<b>27,526,000</b>	<b>10.1%</b>	<b>28,264,000</b>	<b>10.2%</b>	<b>41,989,000</b>	<b>15.1%</b>
<b>Total</b>	<b>277,469,000</b>	<b>100.0%</b>	<b>277,469,000</b>	<b>100.0%</b>	<b>277,469,000</b>	<b>100.0%</b>	<b>277,469,000</b>	<b>100.0%</b>

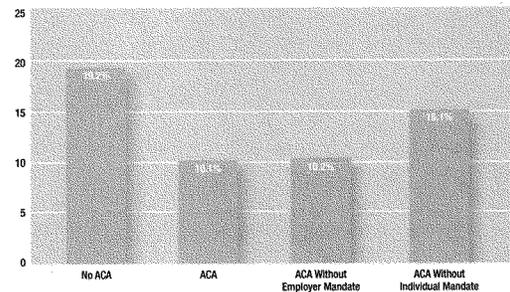
Source: Urban Institute analysis, HIPSIM 2013  
 Note: The ACA simulated as if fully implemented in 2013.

however, would significantly increase the number of uninsured compared to full implementation of the ACA, decreasing employer coverage as well. These findings are consistent with the evidence in Massachusetts, where coverage reforms were implemented beginning in 2006. The delay of the employer mandate also has little effect on government spending on subsidies or Medicaid, but does result in a slight reduction in government revenue.

**Approach**

We use the Urban Institute's HIPSIM to estimate the effects of health reform among the nonelderly population.<sup>2</sup> The Urban Institute has more than 10 years of experience using detailed microsimulation models to simulate the effects of changes in health policy, including analysis of Massachusetts' landmark health reform law. HIPSIM is our latest model, and it has been used in more than 40 publications and research reports since its launch in 2009. National ACA results using HIPSIM are generally comparable to those of other commonly used models, such as that used by the Congressional Budget Office (CBO). HIPSIM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model estimates changes

**Figure 1: Share of the Non-Elderly Who are Uninsured Today Compared with Reform**



Source: Urban Institute analysis, HIPSIM 2013  
 Note: The ACA simulated as if fully implemented in 2013.

in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully phased in today (2013).<sup>5</sup> Individuals age 65 and over eligible for Medicare are excluded from the analysis. Results are simulated as if each state eventually chooses to participate in the Medicaid expansion; this assumption has no effect on the relative differences across the policy options examined here.

We provide coverage and spending simulation results under four scenarios:

- No ACA;
- Full implementation of all the ACA's policies;
- ACA with no employer mandate (individual mandate and all other coverage-related reforms in place); and
- ACA with no individual mandate (employer mandate and all other coverage-related reforms in place).

**Table 2: Health Care Spending of Government and Employers, With and Without Reform (in millions)**

	no ACA	ACA	ACA Without Individual Mandate	U.S. Government
<b>Government Spending</b>				
Medicaid/CHIP*	\$284,253	\$344,105	\$344,276	\$337,955
Federal Share	\$162,984	\$224,464	\$224,694	\$220,325
State Share	\$121,269	\$119,642	\$119,582	\$117,630
Premium Subsidies	\$0	\$37,473	\$37,036	\$31,808
Cost-Sharing Subsidies	\$0	\$4,166	\$4,161	\$3,328
Employer Subsidies	\$0	\$4,368	\$4,343	\$4,035
Individual Mandate Penalties	\$0	-\$3,540	-\$3,552	\$0
Employer Mandate Penalties	\$0	-\$3,717	\$0	-\$6,108
<b>Net Government Spending</b>	<b>\$284,253</b>	<b>\$382,856</b>	<b>\$386,263</b>	<b>\$371,018</b>
<b>Employer Spending</b>				
ESI Premiums	\$597,669	\$612,743	\$613,138	\$571,039
Employer Mandate Penalties	\$0	\$3,717	\$0	\$6,108
Employer Subsidies	\$0	-\$4,368	-\$4,343	-\$4,035
<b>Net Employer Spending</b>	<b>\$597,669</b>	<b>\$612,092</b>	<b>\$608,795</b>	<b>\$573,112</b>

Source: Urban Institute analysis, HPSM 2013

Note: The ACA simulated as if fully implemented in 2013.

\* Spending on acute care costs for the nonelderly.

## Results

**Coverage.** Table 1 shows the distribution of insurance coverage for each of the four policy scenarios: no ACA, full ACA, ACA without the employer mandate, and ACA without the individual mandate. The share of the population uninsured under each policy scenario is also shown graphically in Figure 1. Under the full implementation of the ACA, the share of the nonelderly population uninsured is estimated to decline from 19.2 percent absent any reform to 10.1 percent. Nongroup and employer coverage both increase, but the reason for more than half of the decline in the uninsured is the increase in Medicaid coverage, under our assumption that all states participate.<sup>6</sup> This impact on overall coverage is essentially unchanged if the employer mandate is removed from the rest of the ACA's reforms; the share uninsured falls to 10.2 percent instead of 10.1 percent under the full reform.

Eliminating the employer mandate has very little effect on the distribution of coverage; it remains virtually identical to the case when the full ACA is in effect.<sup>7</sup> In particular, there is no large movement from employer-based coverage to the nongroup exchanges. Most employers offer coverage today, when they face no penalty, and they

will, by and large, continue to do so under the ACA.<sup>8</sup> The bottom line: most workers' firms will be dominated by workers who will receive better benefits and, through the tax system, better subsidies through the tax exclusion for employer-provided coverage than for coverage purchased through newly created insurance exchanges. If employers were to drop coverage, over time they inevitably would make their most valued workers worse off. If those workers sought employment elsewhere as a result, then the firm would be worse off as well. Thus, under the ACA, the employer penalty is not what keeps employers offering coverage; it is the preferences of their workers, the same reason large employers are very likely to offer coverage even before implementation of health care reform.<sup>9</sup>

Eliminating the individual mandate has a much greater impact, with insurance coverage declining significantly. Without the individual mandate, the share of the nonelderly population uninsured would only fall to 15.1 percent of the population. In contrast, under the full ACA, the uninsured falls to 10.1 percent of the population. This difference in coverage means that an extra 13.7 million people would be uninsured under the ACA without an individual mandate compared to the situation with no

employer mandate. Even without an individual mandate, insurance coverage remains above the levels with no reform at all, since some individuals will take advantage of increased eligibility for Medicaid and subsidized insurance coverage in the nongroup exchange even without a requirement to do so.<sup>10</sup>

In the absence of an individual mandate, the rate of employer-sponsored insurance coverage (exchange and nonexchange combined) would be lower than under the full ACA: 54.7 percent of the nonelderly compared to 57.1 percent of the nonelderly. Nongroup coverage and Medicaid/CHIP coverage would be lower as well.

Our earlier analysis<sup>11</sup> showed that the individual mandate combined with income-related financial assistance for the purchase of nongroup coverage, even in the absence of an employer mandate, increases employer-based insurance coverage. This microsimulation finding was since confirmed by survey results following implementation of comprehensive health reform in Massachusetts.<sup>12,13</sup> Once the individual requirement to have coverage is in place, uninsured individuals identify the best source for obtaining that coverage. For a significant number of them, their best option will be to purchase coverage through

their employer. As a result, some workers will take up offers they had previously declined, and some employers will begin to offer coverage for the first time, knowing that their employees are newly willing to trade off some of their wages in order to receive some of their compensation as health insurance.

**Government and Employer Spending.**

Eliminating the employer mandate from the ACA has very little effect on government spending (table 2). Medicaid and spending on exchange-based premium and cost-sharing subsidies remain largely unchanged between the full-ACA and no-employer-mandate scenarios. There is about a 1 percent decrease in premium and cost-sharing subsidies paid through the exchanges, which parallels a roughly 1 percent decline in exchange-based coverage. Overall, these findings reflect the results discussed previously that there is almost no difference in the distribution of insurance coverage.

The only noticeable difference when the employer mandate is dropped is that the federal government loses the \$3.7 billion in revenue that it would otherwise receive from employer penalties, a finding comparable to that of CBO.<sup>14</sup> Likewise, there is virtually no change in employer spending on premiums, since employer coverage stays quite constant.<sup>15</sup> Employers do save, however, by not paying penalties.

By contrast, eliminating the individual mandate but leaving the employer mandate in place does lead to significant differences in spending. Medicaid spending is \$6.2 billion lower due to fewer individuals enrolling in the program absent the individual mandate. As has been seen in Massachusetts, even those groups who would not be directly subject to an individual mandate penalty—due, for example, to exemptions for being low

income—increase their take-up of Medicaid in the presence of an individual mandate. This may stem from misunderstanding their exempt status or from changes in social expectations of coverage in the presence of a general requirement affecting others. As a result, without the individual mandate, even the number of individuals covered by Medicaid will be lower, as will spending on the program.

As a consequence of lower demand for employer-based coverage absent an individual mandate, small employers are less likely to offer coverage to their workers, lowering federal spending on small employer subsidies by about \$300 million. Individual mandate penalties are eliminated in this scenario, decreasing federal revenue by about \$3.5 billion relative to the full ACA case.

If the individual mandate is eliminated but the employer mandate is kept in place, employer penalties are significantly higher; federal revenues mount to \$6.1 billion compared to \$3.7 billion under the full ACA implementation. This results from a smaller number of workers in firms of 50 or more being offered coverage without an individual mandate. Some of these workers purchase insurance through exchanges and receive subsidies, leading to their firms being assessed penalties. Without the individual mandate, the demand for health insurance among some workers falls, and some employers no longer offer it. We estimate that about 2 million fewer workers in large firms would receive offers without an individual mandate (data not shown), and thus more large employers are subject to employer mandate penalties.<sup>16</sup>

Employer premium spending in the absence of the individual mandate is lower than under the full ACA, as fewer workers and dependents are covered. Large employers' spending on penalties is higher

and small employer subsidies are modestly lower, as was already discussed.

**Discussion**

Microsimulation results using HIPSM show that the ACA's individual mandate has a significant effect on health insurance coverage and spending by government and employers, but the employer mandate does not. Delaying or eliminating the individual mandate would significantly decrease insurance coverage relative to the full ACA's implementation, whereas delaying or eliminating the employer mandate will have essentially no effect on coverage or program costs.

The employer mandate is not central to the coverage goals of the ACA, though it does play a very modest financing role. Some have argued that the employer mandate will dissuade employers that currently offer coverage to their workers from stopping doing so once the rest of the reforms are in place. However, the analytic evidence and the experience in Massachusetts does not support the need for employer penalties for that purpose. Thus, a delay of one year in its implementation will not have a discernible effect in that regard.

The individual mandate, in contrast, is a critical component of the coverage expansion in the ACA. Combined with the Medicaid expansion, insurance market reforms, and subsidies to assist those with modest incomes to purchase private insurance through the health insurance exchanges, the ACA's individual responsibility requirement provides stability to insurance pools and financial access to adequate coverage for a broad swath of the population disadvantaged by the prior system. The principal objectives of the law can be met without the employer requirement, and implementation of the law should be made considerably easier without it.

## Endnotes

- <sup>1</sup> Mazur MJ. "Continuing to Implement the ACA in a Careful, Thoughtful Manner." *Treasury Notes*, July 2, 2013. <http://www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner.aspx>. On July 5, 2013, the Department of Health and Human Services (HHS) announced a new rule, which included changes to the subsidy eligibility verification process for state-based exchanges. This rule includes a narrow exception for 2014 related to verification of affordable offers of employer insurance. The federal government had originally intended to conduct random sample checks of cases of individuals reporting whether they have job-based insurance, but that federal assistance will not be available until 2015. HHS is allowing the 16 states running their own exchanges to accept individuals' reports without doing sampling until HHS can begin doing it in 2015. Workers are still required, however, to provide information from their employers on coverage offered in the workplace. Judy Solomon provides a clear explanation of the verification delays at her blog, <http://www.offthechartblog.org/author/solomon/>.
- <sup>2</sup> See, for example, Calmes J and Pear R, "Critical Rule Is Delayed a Year for Obama's Health Law," *New York Times*, July 2, 2013, <http://www.nytimes.com/2013/07/03/us/politics/obama-administration-to-delay-health-law-requirement-until-2015.html?ref=politics>; Kliff S, "White House Delays Employer Mandate Requirement until 2015," *Washington Post*, July 2, 2013, <http://www.washingtonpost.com/blogs/monkeyblog/wp/2013/07/02/white-house-delays-employer-mandate-requirement-until-2015/>; and Miller Z, "Obama Administration Delays Health Care Law Employer Penalty until 2015," *TIME*, July 2, 2013, <http://swampland.time.com/2013/07/02/obama-administration-delays-health-care-law-employer-penalty-until-2015/>.
- <sup>3</sup> See for example: Weisman J, "Seeing Opening, House GOP Pushes Delay on Individual Mandate in Health Law," *New York Times*, July 9, 2013, [http://www.nytimes.com/2013/07/10/us/politics/house-gop-pushes-delay-on-individual-mandate-in-health-law.html?\\_r=1&\\_ga=2.188.188.1370912320.1370912320.1370912320.1370912320.1370912320.1370912320](http://www.nytimes.com/2013/07/10/us/politics/house-gop-pushes-delay-on-individual-mandate-in-health-law.html?_r=1&_ga=2.188.188.1370912320.1370912320.1370912320.1370912320.1370912320.1370912320); Calmes J, "Postponing Health Rules Emboldens Republicans," *New York Times*, July 3, 2013, [http://www.nytimes.com/2013/07/04/us/politics/postponing-health-rules-emboldens-republicans.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/07/04/us/politics/postponing-health-rules-emboldens-republicans.html?pagewanted=all&_r=0); "GOP to White House: ObamaCare Delay for Businesses Unfair to Everyone Else," *Fox News*, July 9, 2013, <http://www.foxnews.com/politics/2013/07/09/gop-to-white-house-obamacare-delay-for-businesses-unfair-to-everyone-else/>; and Morgan D "Could Obama Administration Delay the Individual Mandate?" *Denver Post*, July 5, 2013, [http://www.denverpost.com/breakingnews/cj\\_23603893/could-obama-administration-delay-individual-mandate](http://www.denverpost.com/breakingnews/cj_23603893/could-obama-administration-delay-individual-mandate).
- <sup>4</sup> For more about HIPSMS's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," <http://www.urban.org/publications/412434.html>. A more technical description of the construction of the model can be found at <http://www.urban.org/publications/412471.html>.
- <sup>5</sup> Ideally, we would simulate reform in a future year, such as 2017, when the ACA and the associated behavioral changes of employers and individuals would be fully phased-in. Doing so requires an array of assumptions about the growth in health care expenditures, changes in employment and incomes, and other factors. For simplicity, here we simulate the reforms fully phased-in in the current year, and the comparisons across policy options are not affected by the choice of year.
- <sup>6</sup> Ten percent of the population is estimated to remain uninsured for various reasons: some are exempt from the individual mandate because they do not have an affordable coverage option available to them, some are undocumented immigrants ineligible for new coverage options or financial assistance, and others have affordable coverage options available to them but choose not to enroll. See Buettgens M and Hall M. "Who Will Be Uninsured After Health Insurance Reform?" Washington: The Urban Institute, 2011, available at <http://www.urban.org/UploadedPDF/10115201Uninsured-After-Health-Insurance-Reform.pdf>.
- <sup>7</sup> One noticeable exception is that a slightly larger share of employer coverage is expected to be purchased through the small group exchanges without the employer mandate. This occurs due to changes in source of coverage for a small number of families with one working spouse in a large firm and one in a small firm. In the absence of the employer mandate, a slightly smaller share of large-firm workers will have offers of coverage from their employer; consequently, if their spouse has an offer through a small employer, the family is more likely to obtain their coverage that way. There is also a very slight decrease in nongroup coverage through the exchange of about 1 percent. When the number of workers offered declines by even a very small number, families change coverage decisions in both the group and nongroup markets, which have very small secondary effects on premiums in those markets, which lead small numbers of other individuals and families to change their coverage decisions. Microsimulation models capture these interactions and secondary effects, but they are very small and not meaningful.
- <sup>8</sup> Blumberg L, Buettgens M, Feder J and Holahan J. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." *Timely Analysis of Immediate Health Policy Issues*. Washington: The Urban Institute, 2011, available at <http://www.urban.org/publications/412428.html>.
- <sup>9</sup> The ACA with employer penalties in place may, however, provide incentives for employers to reduce premium contributions for their lowest income workers if that is necessary to avoid penalties. If so, some employers could decrease overall premiums by modifying the plans they offer by increasing deductibles or other cost-sharing responsibilities. We do not model such potential changes to employer/worker premium divisions and cost-sharing structure of plans.
- <sup>10</sup> Absent an individual mandate, some individuals otherwise excluded from the nongroup market will enter it, and others will leave that market due to the broader sharing of health care risk through modified community rating and other changes to insurance market rules, ultimately leaving nongroup coverage at a lower level than the case without any reforms.
- <sup>11</sup> Blumberg LJ, Holahan J, Wei A, et al. "Toward Universal Coverage in Massachusetts." *Inquiry*, 43(2): 102-21, June 2006.
- <sup>12</sup> Long SK, Stockley K and No'dahl KW. "Coverage, Access, and Affordability under Health Reform: Learning from the Massachusetts Model." *Inquiry*, 49(4): 303-16, Winter 2012/2013.
- <sup>13</sup> Employers of 11 or more workers who do not make a "fair and reasonable contribution" toward their workers' health insurance can be assessed a penalty of up to \$295 per worker per year. This nominal assessment is small enough to be roughly equivalent to an example of comprehensive reform with an individual mandate but not an employer mandate. Our microsimulation analysis prior to the passage of the state's 2006 reforms compared a scenario with an individual mandate and a "play or pay" employer mandate to an identical reform that excluded the employer mandate.
- <sup>14</sup> Reports indicate that the CBO estimates lost revenue from elimination of the employer penalties at \$4 billion in 2014. See Kennedy K, "Delay of Employer Penalties Could Have Unintended Effects," *USA Today*, July 7, 2013, <http://www.usatoday.com/story/news/politics/2013/07/03/how-hc-delay-will-affect-budget/2486499/>.
- <sup>15</sup> Our results show aggregate employer spending on premiums of roughly .06 percent higher without the employer mandate than with it. This aggregate increase is a result of average employer premiums increasing by less than 1 percent without the employer mandate, due to very modest changes in the risk pool of insured workers. That premium increase is barely noticeable, but in aggregate it leads to slightly higher overall employer spending on premiums as shown in table 2.
- <sup>16</sup> Without an employer mandate, roughly 1 million fewer workers in large firms would have an employer offer of coverage through their own job (data not shown).

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*The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.*

**About the Authors and Acknowledgments**

Linda Blumberg is a Senior Fellow, John Holahan is an Institute Fellow, and Matthew Buettgens is a Senior Research Associate in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors are grateful for research assistance by Chris Hildebrand and the comments and suggestions made by Steve Zuckerman and Katherine Baicker.

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July 2013

## Benefits of the Health Care Reform Law in the 33rd Congressional District of California

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Waxman's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,000 seniors** in the district received prescription drug discounts worth **\$17.5 million**, an average discount of **\$650 per person in 2011, \$740 in 2012, and \$550 thus far in 2013.**
- **126,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **236,000 individuals** in the district – including **48,000 children** and **99,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **324,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **48,400 consumers** in the district received approximately **\$3.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$71 per family in 2012 and \$65 per family in 2011.**
- **Up to 31,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **329,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **63,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **128,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 1st Congressional District of Colorado

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. DeGette's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,900 seniors** in the district received prescription drug discounts worth **\$9.3 million**, an average discount of **\$570 per person in 2011, \$660 in 2012, and \$1,120 thus far in 2013**.
- **110,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **192,000 individuals** in the district – including **36,000 children** and **80,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **201,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **27,900 consumers** in the district received approximately **\$5.2 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$134 per family in 2012 and \$227 per family in 2011**.
- **Up to 37,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **247,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **121,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **55,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 1st Congressional District of Iowa

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Braley's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,100 seniors** in the district received prescription drug discounts worth **\$12.5 million**, an average discount of **\$610 per person in 2011, \$680 in 2012, and \$790 thus far in 2013.**
- **129,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **238,000 individuals** in the district – including **51,000 children** and **95,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **179,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **7,100 consumers** in the district received approximately **\$400,000 in insurance company rebates** in 2012 and 2011 – an average rebate of **\$111 per family in 2012 and \$100 per family in 2011.**
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **278,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **61,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **50,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

**Benefits of the Health Care Reform Law in the  
3rd Congressional District of New Mexico****Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report**

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Lujan's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,700 young adults** in the district now have health insurance through their parents plan.
- **More than 5,600 seniors** in the district received prescription drug discounts worth **\$7.3 million**, an average discount of **\$480 per person in 2011, \$810 in 2012, and \$880 thus far in 2013**.
- **105,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **147,000 individuals** in the district – including **32,000 children** and **60,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **122,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead.
- Up to **43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **163,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **147,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **33,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 9th Congressional District of Illinois

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Schakowsky's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,700 seniors** in the district received prescription drug discounts worth **\$13.8 million**, an average discount of **\$730 per person in 2011, \$800 in 2012, and \$750 thus far in 2013**.
- **102,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **201,000 individuals** in the district – including **39,000 children** and **84,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **188,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **17,300 consumers** in the district received approximately **\$3.9 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$52 per family in 2012 and \$380 per family in 2011**.
- **Up to 36,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **251,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **99,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **42,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 1st Congressional District of North Carolina

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Butterfield's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,300 seniors** in the district received prescription drug discounts worth **\$9.7 million**, an average discount of **\$600 per person in 2011, \$680 in 2012, and \$1,110 thus far in 2013**.
- **130,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **150,000 individuals** in the district – including **25,000 children** and **71,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **138,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 13,200 consumers** in the district received approximately **\$1.7 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$87 per family in 2012 and \$158 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **155,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 137,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **33,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 14th Congressional District of Florida

Committees on Energy and Commerce, Ways and Means, and Education and  
the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Castor's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,900 seniors** in the district received prescription drug discounts worth **\$8.2 million**, an average discount of **\$610 per person in 2011, \$690 in 2012, and \$840 thus far in 2013**.
- **87,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **152,000 individuals** in the district – including **29,000 children** and **65,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **134,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 43,000 consumers** in the district received approximately **\$6.1 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$132 per family in 2012 and \$168 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **181,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 156,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in Vermont

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in the State of Vermont, which Rep. Welch represents. As a result of the law:

- **5,000 young adults** in state now have health insurance through their parents' plan.
- **More than 6,100 seniors** in the state received prescription drug discounts worth **\$9.4 million**, an average discount of **\$720 per person in 2011, \$780 in 2012, and \$1,000 thus far in 2013.**
- **118,000 seniors** in the state are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **175,000 individuals** in the state -- including **30,000 children** and **75,000 women** -- now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **163,000 individuals** in the state are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **5,200 consumers** in the state received approximately **\$2.5 million in insurance company rebates** in 2012 and 2011--an average rebate of **\$58 per family in 2012 and \$807 per family in 2011.**
- **Up to 31,000 children** in the state with preexisting health conditions can no longer be denied coverage by health insurers.
- **201,000 individuals** in the state now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **41,000 individuals** in the state who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **32,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 20th Congressional District of New York

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Tonko's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,100 seniors** in the district received prescription drug discounts worth **\$16 million**, an average discount of **\$610 per person in 2011, \$650 in 2012, and \$290 thus far in 2013**.
- **124,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **223,000 individuals** in the district – including **42,000 children** and **95,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **227,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **43,600 consumers** in the district received approximately **\$5.1 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$92 per family in 2012 and \$138 per family in 2011**.
- **Up to 37,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **262,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **49,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 29th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Green's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **11,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 3,000 seniors** in the district received prescription drug discounts worth **\$3.6 million**, an average discount of **\$530 per person in 2011, \$570 in 2012, and \$1,090 thus far in 2013**.
- **58,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **96,000 individuals** in the district – including **22,000 children** and **36,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **89,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 24,600 consumers** in the district received approximately **\$3.5 million in insurance company rebates** in 2011 and 2012 – an average rebate of **\$95 per family in 2012 and \$187 per family in 2011**.
- **Up to 55,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **121,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 261,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **12,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 12th Congressional District of Michigan

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Dingell's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,200 seniors** in the district received prescription drug discounts worth **\$7.9 million**, an average discount of **\$580 per person in 2011, \$750 in 2012, and \$540 thus far in 2013**.
- **107,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **206,000 individuals** in the district – including **40,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **183,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,700 consumers** in the district received approximately **\$2.5 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$138 per family in 2012 and \$214 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **252,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 75,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 6th Congressional District of Michigan

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Upton's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,700 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,100 seniors** in the district received prescription drug discounts worth **\$11.4 million**, an average discount of **\$590 per person in 2011, \$740 in 2012, and \$850 thus far in 2013**.
- **131,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **197,000 individuals** in the district – including **43,000 children** and **80,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **163,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,000 consumers** in the district received approximately **\$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$138 per family in 2012 and \$214 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **223,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 84,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **36,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 18th Congressional District of Pennsylvania

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Murphy's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **3,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 15,300 seniors** in the district received prescription drug discounts worth **\$23.1 million**, an average discount of **\$620 per person in 2011, \$800 in 2012, and \$730 thus far in 2013**.
- **133,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **230,000 individuals** in the district – including **45,000 children** and **97,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **181,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 35,800 consumers** in the district received approximately **\$3.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$77 per family in 2012 and \$165 per family in 2011**.
- **Up to 35,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **266,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 49,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 26th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Burgess's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 4,900 seniors** in the district received prescription drug discounts worth **\$7 million**, an average discount of **\$650 per person in 2011, \$720 in 2012, and \$850 thus far in 2013**.
- **55,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **232,000 individuals** in the district – including **66,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **230,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 59,300 consumers** in the district received approximately **\$8.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$95 per family in 2012 and \$187 per family in 2011**.
- Up to **48,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **305,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- Up to **90,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **44,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 7th Congressional District of Tennessee

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Blackburn's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,000 seniors** in the district received prescription drug discounts worth **\$10 million**, an average discount of **\$580 per person in 2011, \$610 in 2012, and \$960 thus far in 2013**.
- **116,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **191,000 individuals** in the district – including **50,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **181,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 27,900 consumers** in the district received approximately **\$4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$69 per family in 2012 and \$201 per family in 2011**.
- **Up to 44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **208,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 91,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **39,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 11th Congressional District of Georgia

Committees on Energy and Commerce, Ways and Means, and Education and  
the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Gingrey's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,300 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,800 seniors** in the district received prescription drug discounts worth **\$12.6 million**, an average discount of **\$620 per person in 2011, \$760 in 2012, and \$900 thus far in 2013**.
- **86,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **195,000 individuals** in the district – including **47,000 children** and **78,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **169,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 19,900 consumers** in the district received approximately **\$2.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$82 per family in 2012 and \$134 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **248,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 129,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **45,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 1st Congressional District of Louisiana

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Scalise's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 13,600 seniors** in the district received prescription drug discounts worth **\$17 million**, an average discount of **\$570 per person in 2011, \$650 in 2012, and \$740 thus far in 2013**.
- **125,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **200,000 individuals** in the district – including **43,000 children** and **82,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **175,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 15,100 consumers** in the district received approximately **\$1.2 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$50 per family in 2012 and \$94 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **239,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 112,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **51,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 3rd Congressional District of Mississippi

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Harper's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,000 seniors** in the district received prescription drug discounts worth **\$11.7 million**, an average discount of **\$610 per person in 2011, \$650 in 2012, and \$890 thus far in 2013**.
- **132,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **184,000 individuals** in the district – including **40,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **153,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,400 consumers** in the district received approximately **\$4.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$140 per family in 2012 and \$329 per family in 2011**.
- **Up to 44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **217,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 114,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **44,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 22nd Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Olson's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,500 seniors** in the district received prescription drug discounts worth **\$8 million**, an average discount of **\$680 per person in 2011**, **\$730 in 2012**, and **\$660 thus far in 2013**.
- **65,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **212,000 individuals** in the district – including **61,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **208,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 54,100 consumers** in the district received approximately **\$7.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$95 per family in 2012** and **\$187 per family in 2011**.
- **Up to 49,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **279,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 127,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **35,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 4th Congressional District of Colorado

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Gardner's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 4,700 seniors** in the district received prescription drug discounts worth **\$6.3 million**, an average discount of **\$600 per person in 2011, \$660 in 2012, and \$990 thus far in 2013**.
- **81,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **206,000 individuals** in the district – including **53,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **215,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **30,000 consumers** in the district received approximately **\$5.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$134 per family in 2012** and **\$227 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **265,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **100,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **58,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.



July 2013

## Benefits of the Health Care Reform Law in the 9th Congressional District of Virginia

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Griffith's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,200 seniors** in the district received prescription drug discounts worth **\$17.7 million**, an average discount of **\$620 per person in 2011, \$770 in 2012, and \$840 thus far in 2013**.
- **162,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **189,000 individuals** in the district – including **32,000 children** and **81,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **168,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 18,600 OR 54,000 consumers** in the district received approximately **\$4.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$88 per family in 2012** and **\$115 per family in 2011**.
- **Up to 34,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **214,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 93,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **41,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 6th Congressional District of Ohio

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Johnson's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 15,200 seniors** in the district received prescription drug discounts worth **\$20.8 million**, an average discount of **\$510 per person in 2011, \$810 in 2012, and \$860 thus far in 2013**.
- **162,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **186,000 individuals** in the district – including **38,000 children** and **76,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **149,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 8,300 consumers** in the district received approximately **\$700,000 in insurance company rebates** in 2012 and 2011 – an average rebate of **\$133 per family in 2012** and **\$139 per family in 2011**.
- **Up to 38,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **206,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 88,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **22,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 7th Congressional District of Missouri

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Long's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 10,100 seniors** in the district received prescription drug discounts worth **\$13.7 million**, an average discount of **\$600 per person in 2011, \$680 in 2012, and \$770 thus far in 2013**.
- **141,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **194,000 individuals** in the district – including **40,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **139,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 68,900 consumers** in the district received approximately **\$9.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$72 per family in 2012 and \$173 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **225,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 126,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 2nd Congressional District of North Carolina

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Ellmers's district. It also provides the first picture of the impacts of the law in district's redrawn or newly created following the 2010 Census. As a result of the law:

- **6,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,400 seniors** in the district received prescription drug discounts worth **\$11.3 million**, an average discount of **\$600 per person in 2011, \$670 in 2012, and \$990 thus far in 2013**.
- **119,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **197,000 individuals** in the district – including **52,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **142,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 17,300 consumers** in the district received approximately **\$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$87 per family in 2012 and \$158 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **207,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 109,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **38,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



July 2013

## Benefits of the Health Care Reform Law in the 6th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and  
Education and the Workforce  
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Barton's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,400 seniors** in the district received prescription drug discounts worth **\$8.7 million**, an average discount of **\$610 per person in 2011, \$680 in 2012, and \$890 thus far in 2013**.
- **85,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **188,000 individuals** in the district – including **46,000 children** and **72,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **183,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 48,100 consumers** in the district received approximately **\$6.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **\$95 per family in 2012 and \$187 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **241,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 142,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.<sup>1</sup> In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

<sup>1</sup> Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.



# ASPE

## ISSUE BRIEF

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### Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected

By: Laura Skopec and Richard Kronick, ASPE

A goal of the Affordable Care Act is to increase competition and transparency in the markets for individual and small group insurance, leading to higher quality, more affordable products. To date, this proposition has largely been based on theory. The early market reforms, such as requirements for a minimum Medical Loss Ratio and for review of proposed rate increases of 10% or greater, have clearly created value for consumers.<sup>1</sup> Further, data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC) shows that the average premiums for employer sponsored insurance increased by only 3% from 2011 to 2012, the lowest rate of increase observed since the data series started in 1996. However, the major changes in the rules for individual and small group insurance will begin in plan year 2014.

Information on proposed premiums in the individual and small group markets has recently been made available by selected states, and it is now possible to move from theoretical arguments to data-driven analysis. This research brief analyzes proposed rates in the individual market for 2014 in the eleven states that have made information available, and compares these rates to those estimated by the Congressional Budget Office (CBO). Further, for six states, we compare the rates that will be charged to small employers under the Affordable Care Act with the average amount that small employers would have been expected to pay in 2014 for comparable coverage and a comparable population. Details about our methodology and assumptions are available in the methods section.

As shown below, we find that:

- In the eleven states for which data are available, the lowest cost silver plan in the individual market in 2014 is, on average, 18% less expensive than ASPE's estimate of 2014 individual market premiums derived from CBO publications.<sup>2</sup>

<sup>1</sup> See *Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act*. Chu R, Kronick R. February 2013. Available at: <http://aspe.hhs.gov/health/reports/2013/rateincreaseindvmt/rb.cfm>; and *80/20 Rule Delivers More Value to Consumers in 2012* Centers for Medicare and Medicaid Services. June 2013. Available at: <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf>

<sup>2</sup> Throughout this document, we refer to the ASPE-derived CBO estimate. This is an estimate derived from CBO's March 2012 estimate that the average premium for a family enrolled in the second lowest cost silver plan will be \$15,400 in 2016. See the methods section for details on how we derived a 2014 single premium from CBO's 2016 estimate.

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- Further, the lowest cost silver plan available to small employers in 2014 in the six states with available data is estimated to be 18% less expensive, on average, than the average premium that small employers would be paying for a pre-Affordable Care Act silver plan trended forward.
- These preliminary rates may be further lowered before health plans are offered in Marketplaces<sup>3</sup> this fall. Already, in a number of states (DC, OR, RI, VT), the rate review process and competition are resulting in final rates that are significantly below rates proposed earlier this spring.
- Preliminary premiums appear to be affordable even for young men – a group about which there has been concern about “rate shock.” There are approximately 750,000 young men (ages 18-34) who will not qualify for a premium tax credit who are currently enrolled in the individual market. In Los Angeles County (the county with the largest number of uninsured Americans in the nation), the lowest cost silver plan in 2014 for a 25-year-old individual costs \$174 per month without a tax credit, \$34 per month for an individual whose income is \$17,235 (or 150% of the Federal Poverty Level), and a catastrophic plan can be purchased for \$117 per month for an individual.<sup>4</sup>

While further work is needed to better understand 2014 rates, the results strongly suggest that greater competition and transparency are leading to substantial benefits for both consumers and employers in these markets.

#### Individual Market Results

From the premiums released by eleven states, the *lowest* cost silver premium in the individual market is 18% lower than the ASPE-derived CBO estimate of 2014 individual market premiums (Figure 1), and premium from the *second lowest* cost issuer is 10% lower than the ASPE-derived CBO estimate (Figure 2). As noted in the methods section, we make some assumptions about medical trend and about reinsurance parameters for the Affordable Care Act reinsurance program in order to infer a 2014 premium consistent with the 2016 CBO premium estimates, and we make assumptions about the age distribution of individual market enrollees in order to compare the proposed premiums by age group for 2014 with the average premium estimated by CBO. With that caveat, we are quite confident that the average premiums proposed by the lowest cost and second lowest cost issuers in the eleven states where data are available are substantially below the second lowest cost plan that was inferred from the CBO in its modeling.

It is theoretically possible that the eleven states for which we have data are not representative of the rest of the nation, and that when data are available from all fifty states and the District of Columbia that the national averages will be much closer to the ASPE-derived CBO estimates. However, we note that the weighted average small group premiums from MEPS-IC data in these

<sup>3</sup> “Marketplaces” are also known as “American Health Benefit Exchanges” or “Exchanges” as defined by and established in Section 1311 of the Affordable Care Act. In addition, Marketplaces may be established and operated by a state (State-based Marketplaces or “SBMs”), by the federal government (Federally-facilitated Marketplaces or “FFMs”), or by the federal government with state participation (State Partnership Marketplaces or “SPMs”).

<sup>4</sup> Tax credits can not be used for the purchase of catastrophic plans.

eleven states is close to the national average, and that data on per capita health spending in these eleven states from the CMS Office of the Actuary's National Health Accounts also shows the weighted average per capita spending in these states are close to the national average. Thus, it seems unlikely that data from all states will be much different. For individual states, however, it is possible that the state-level premiums could be closer to ASPE-derived CBO estimates, while national or multi-state averages remain below ASPE-derived CBO estimates.

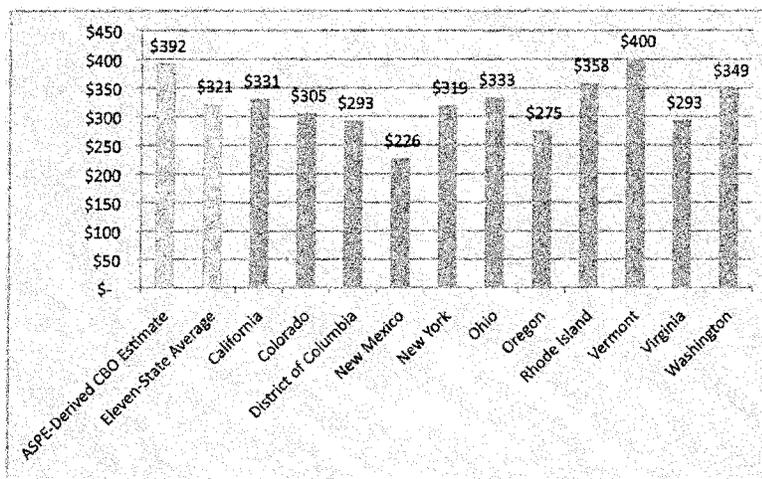
Although there are many hypotheses that might account for the finding that actual premiums appear to be substantially below ASPE-derived CBO estimates, a likely explanation is that greater competition and greater transparency are driving down prices in the Marketplace.

We note that, although the ASPE-derived CBO estimate of 2014 premiums is higher than the actual 2014 premium costs seen to date, the ASPE-derived CBO estimate was still much closer to actual 2014 premiums than those of many other analysts. For example, in a 2009 report, Oliver Wyman estimated that the average premium for an individual purchasing coverage in the individual market would be \$4,561 (or \$380 per month) in 2009 dollars due to the Affordable Care Act reforms, and that this would represent a 54% premium increase over the status quo.<sup>5</sup> It is not clear from the report what actuarial value (AV) level the Oliver Wyman analysis assumed, but it seems likely that the assumption was for an AV no greater than a silver level, and, probably, less. We trended forward the 2009 estimate to 2014 dollars using CMS Office of the Actuary trends in private health insurance per person, which is almost certainly a substantial underestimate of the rate of increase in individual market premiums. This yields a 2014 estimated premium of \$5,400 annually, or \$450 per month.<sup>6</sup> Even using this low estimate of trend, and assuming the average individual market actuarial value is in the silver range (which is likely an overestimate), the Oliver Wyman predictions are clearly far above the reality of 2014 premiums. In the eleven states with available data 2014 premiums average \$321 per month for the lowest cost silver plan, and \$352 per month for the second lowest cost issuer.

<sup>5</sup> *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small Employer Health Insurance Markets*. Oliver Wyman. December 2009. Available at [http://www.oliverwyman.com/media/YBS009-11-28\\_PPACA120309.pdf](http://www.oliverwyman.com/media/YBS009-11-28_PPACA120309.pdf)

<sup>6</sup> We trended forward to 2014 using estimates of per enrollee private health insurance spending increases from 2012 to 2013 and 2013 to 2014 from the Office of the Actuary described in footnote 8, as well as 2009-2010 and 2010-2011 estimates from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>. The 2011-2012 estimate, also from the Office of the Actuary, was 2.9%. Many people would expect that actual trend will be higher than these estimates, particularly for individual market premium growth. To the extent that actual trend is higher, our analysis is conservative – that is, true savings are likely higher than those estimated here.

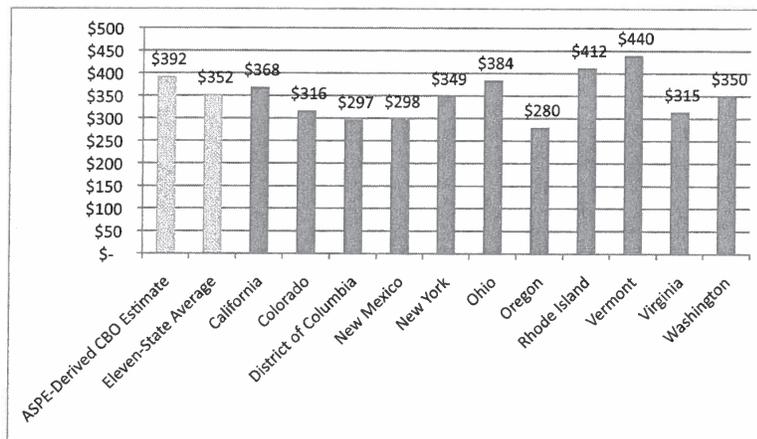
**Figure 1: Comparison of ASPE-Derived CBO 2014 Premium Estimate to Individual Market Lowest Cost Silver Premium, Weighted by Expected 2014 Individual Market Age Distribution**



*Note: Ohio and Virginia have not yet posted premiums for all issuers; the numbers presented here may be higher than the lowest cost 2014 silver premiums when all filings are posted.*

*Sources: Congressional Budget Office estimate derived as described in footnote 19. State data from publicly available sources, weighted by RAND COMPARE estimate of enrollment by age in the individual market in 2014. US average constructed by weighting each state according to its proportion of individual market enrollees per the 2011 Medical Loss Ratio filings.*

**Figure 2: Comparison of ASPE-Derived CBO 2014 Premium Estimate to Individual Market Second Lowest Cost Issuer's Silver Premium, Weighted by Expected 2014 Individual Market Age Distribution**



Note: Ohio and Virginia have not yet posted premiums for all issuers; the numbers presented here may be higher than the lowest cost 2014 silver premiums when all filings are posted.

Sources: Congressional Budget Office estimate derived as described in footnote 19. State data from publicly available sources, weighted by RAND COMPARE estimate of enrollment by age in the individual market in 2014. US average constructed by weighting each state according to its proportion of individual market enrollees per the 2011 Medical Loss Ratio filings.

### Small Group Market Results

In the six states for which small group data is readily accessible, the *lowest* small group silver premium for single coverage, weighted by small group age distribution, is 8% to 36% lower than the estimated pre-Affordable Care Act 2014 small group average premium for single coverage,<sup>7</sup> averaging 18% lower across these six states when weighted by total small group market size. Similarly, the small group premium from the *second lowest* cost issuer for 2014 is 6% to 36% lower than the estimated pre-Affordable Care Act 2014 small group premium (Table 1), averaging 15% lower across these six states.

<sup>7</sup> The pre-Affordable Care Act average premium is based on MEPS-IC survey data. In the pre-Affordable Care Act market, most states allowed health status rating in the small group market, often restricted to a "rate band" of +/- 35% of the base rate. As of January 1, 2014, this practice is no longer allowed for new or renewing small group health plans.

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In addition, the State of New York has reported that its 2014 small group silver premiums are nearly 32% below CBO projections.<sup>8</sup>

As noted in the methods section, the data available for 2014 is different in kind from the pre-Affordable Care Act data. For pre-Affordable Care Act, we have reported average premiums in 2011. We assume, based on data from two independent sources, that the average small group enrollee with single coverage is enrolled in a silver plan, but there is some uncertainty about this assumption. In addition, there may be variations in the average actuarial value of small employer plans by state, which we do not account for here. We use the Current Population Survey to estimate the age distribution of employees covered by single policies by small employers, and the uniform age curve specified by CMS to estimate the average amount that small employers would pay in 2014.

Part of the reason that we estimate such substantial savings for small employers in 2014 is that we are comparing average premiums in the pre-Affordable Care Act environment to lowest cost and second lowest cost issuer premiums in 2014. Some employers offering silver plans in 2014 may choose more expensive silver plans than the lowest cost or second lowest cost issuer options, in part because they or their employees value the wider networks that the more expensive plans may offer. But it is clear that all small employers have the option of choosing the lower price offerings, and for small employers, on average, these lower price offerings appear to offer substantial savings below the status quo for a comparable benefit package and a comparable population.

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<sup>8</sup> *Governor Cuomo Announces Approval of 2014 Health Insurance Plan rates for New York Health Benefit Exchange*. July 2013. Available at: <http://www.healthbenefitexchange.ny.gov/news/press-release-governor-cuomo-announces-approval-2014-health-insurance-plan-rates-new-york>

**Table 1: Comparison of Pre-Affordable Care Act Small Group Average Premiums for Single Coverage to 2014 Small Group Silver Plans**

	Average Monthly Small Group Pre-Affordable Care Act Premium, Single Coverage, Inflated to 2014	Lowest Cost Silver Plan, Weighted average	Second Lowest Cost Issuer's Silver Plan, Weighted average	% Difference, 2014 Small Group Lowest Silver Weighted Average vs Status Quo Trended to 2014	% Difference, 2014 Small Group Second Lowest Cost Issuer Weighted Average vs Status Quo Trended to 2014
<b>Colorado</b>	\$474	\$391	\$412	-18%	-13%
<b>District of Columbia</b>	\$538	\$343	\$343	-36%	-36%
<b>New Mexico</b>	\$494	\$323	\$410	-35%	-17%
<b>Oregon</b>	\$458	\$362	\$369	-21%	-20%
<b>Vermont</b>	\$507	\$400	\$440	-21%	-13%
<b>Washington</b>	\$438	\$404	\$413	-8%	-6%

Sources: For average small group premiums, 2008-2011 MEPS IC trended forward to 2014. See <http://www.irs.gov/pub/irs-pdf/i8941.pdf>. For 2014 small group market, publicly available premium data, weighted using CPS age distribution of small group employees with single coverage described in footnote 24. Note: For pre-Affordable Care Act data, analysis assumes that the average Actuarial Value for small group plans was approximately 70%. It seems likely that there is state-level variation in average AV, but reliable state-level data on average AV in the small group market is not available.

#### Recent Reports on Rate Review

As described above, most of the rates that have been published to date are preliminary and proposed. States typically review their rationale and basis, and rates may be lowered before they are finalized. The 2012 Annual Rate Review Report issued by HHS found that, when issuers requested rate increases of 10% or more, the rate increase approved was lower than requested more than half of the time.<sup>9</sup> In 2014, examples of issuers lowering rates include:

- In Oregon, two issuers lowered their proposed 2014 individual market premiums within days of the State of Oregon's public release of 2014 premium information.<sup>10</sup> In addition, through the state's rate review process, the Oregon Insurance Division lowered proposed

<sup>9</sup> 2012 Annual Rate Review Report: Rate Review Saves Estimated \$1 Billion for Consumers. Centers for Medicare and Medicaid Services. September 2012. Available at: <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html>.

<sup>10</sup> Two Oregon Insurers Rethink 2014 Premiums as State Posts First-Ever Rate Comparison. The Oregonian. May 9, 2013. Available at: [http://www.oregonlive.com/health/index.ssf/2013/05/two\\_oregon\\_insurers\\_reconsider.html](http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html)

rates for individual plans by between a few percentage points to 30 percentage points. For small employers, the Oregon Insurance Division lowered rates from a few percentage points to 12 percentage points.<sup>11</sup>

- In the District of Columbia, United Healthcare submitted a 10% rate reduction for small businesses after rates were posted publicly.<sup>12</sup>
- The Green Mountain Care Board, which runs the Health Insurance Marketplace in Vermont, lowered proposed rates from Blue Cross Blue Shield of Vermont and MVP Health Care by 4.3% and 5.3%, respectively.<sup>13</sup>
- Through its rate review process, the Rhode Island Office of the Health Insurance Commissioner lowered proposed rates in the individual market by 5.2% for Blue Cross Blue Shield of Rhode Island, and by 9.6% for Neighborhood Health Plan of Rhode Island. The Office of the Health Insurance Commissioner also lowered proposed rates in the small group market by between 1% and 8.2%.<sup>14</sup>

In addition to these examples in which effective rate review caused approved rates to be below those initially proposed by insurers, it is clear that the requirement that all rate proposals of 10 percent or greater be reviewed for reasonableness created a strong sentinel effect, and reduced the number of proposals with increases above 10%. In the individual market in 2010, 75% of all rate proposals were for increases greater than 10%, a statistic that declined sharply to 34% of all rate proposals in 2012, and to 14% in partial data for 2013.<sup>15</sup> The average increase approved in 2012 and the first part of 2013 was 30% lower than the average increase approved in 2010.

#### Rates for Young Men

Evidence is also emerging that the concerns expressed that millions of young men will be priced out of coverage due to the new rating reforms may be unfounded.

First, an analysis of the individual market today shows that young men with income above tax credit eligibility (400% of FPL) comprise a small fraction of enrollees: 7 percent of the 10.8

<sup>11</sup> Oregon Department of Consumer & Business Services press release. July 10, 2013. Available at: [http://www.oregon.gov/DCBS/docs/news\\_releases/2013/july10ratedecisions.pdf](http://www.oregon.gov/DCBS/docs/news_releases/2013/july10ratedecisions.pdf).

<sup>12</sup> UnitedHealthcare Lowers Rates for the District of Columbia's Health-Insurance Exchange - A Sign Competition Is Already Cutting the Cost of Buying Insurance. DC Department of Insurance, Securities, and Banking. June 26, 2013. Available at: <http://dishb.dc.gov/node/567902>.

<sup>13</sup> Care Board Trims Rates for Vermont Health Exchange. Burlington Free Press. July 8, 2013. Available at: <http://www.burlingtonfreepress.com/article/20130708/NEWS03/307080022/Care-Board-trims-rates-Vermont-health-exchange>.

<sup>14</sup> OHIC Approves Commercial Health Insurance Contracts, Rates and Rate Factors. State of Rhode Island Office of the Health Insurance Commissioner. June 28, 2013. Available at [http://www.ohic.ri.gov/documents/2013%20Rate%20Review%20Process/2013%20Rate%20Review%20Final%20Decision/1\\_2013%20Rate%20Review%20Process%20Final%20Decision%20Press%20Release\\_FINAL.pdf](http://www.ohic.ri.gov/documents/2013%20Rate%20Review%20Process/2013%20Rate%20Review%20Final%20Decision/1_2013%20Rate%20Review%20Process%20Final%20Decision%20Press%20Release_FINAL.pdf).

<sup>15</sup> Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act. Chu R, Kronick R. February 2013. Available at <http://aspe.hhs.gov/health/reports/2013/rateincreaseIndvMkt/rb.cfm>.

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million total individual market enrollees, or about 750,000 in 2011 (See Table 2 below).<sup>16</sup> Overall, nearly 60 percent of young men ages 18-34 currently enrolled in the individual market may be eligible for tax credits or Medicaid if their state implements the Affordable Care Act's Medicaid eligibility expansion.

Second, preliminary information suggests that premiums will be affordable for this group, even without eligibility for a premium tax credit. In Los Angeles for example, for a 25 year old individual the lowest cost silver plan is \$174 per month, and the lowest cost bronze plan is \$147 per month. Premiums in Portland are very similar—\$174 per month for the lowest cost silver plan for a 25 year old individual and \$133 per month for the lowest cost bronze plan. In Albuquerque, a 25 year old could pay as little as \$143 for a silver plan.<sup>17</sup> Individuals under the age of 30 will also be eligible for catastrophic coverage, and those under the age of 26 may be eligible for coverage on parent's policy. In Los Angeles, California, the lowest cost catastrophic plan is \$117 per month for a 25-year-old individual. In Albuquerque, New Mexico, the lowest cost catastrophic plan is \$109 per month for a 25-year-old individual. In Portland, Oregon, a 25-year-old individual could pay as little as \$89 for a catastrophic plan.

Third, tax credits will help many young men in this market. To illustrate the impact, a 25 year old in California with income of \$17,235 (150% of poverty) could pay as little as \$34 per month for a silver plan in North Los Angeles, and could purchase a bronze plan for as little as \$7 per month.

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<sup>16</sup> From the 2011 submissions of Medical Loss Ratio data to the Centers for Medicare and Medicaid Services, there are 10.8 million enrollees in the individual market.

<sup>17</sup> New Mexico has not yet posted bronze rates for 2014.

**Table 2: Individual Market Enrollment by Age, Gender, and Income, 2011<sup>18</sup>**

	< 138% of the FPL		138-249% of the FPL		250-399% of the FPL		400% of the FPL		Totals by Age
	Men	Women	Men	Women	Men	Women	Men	Women	
Age 18-25	2.5%	1.9%	1.8%	1.5%	1.8%	1.9%	3.8%	2.2%	17.3%
Age 26-29	0.4%	0.6%	0.8%	0.7%	1.2%	0.8%	1.5%	1.6%	7.6%
Age 30-34	0.4%	0.5%	0.7%	0.9%	0.8%	0.7%	1.7%	1.6%	7.3%
Age 35-39	0.3%	0.3%	0.4%	0.6%	0.8%	0.8%	2.4%	1.8%	7.3%
Age 40-44	0.2%	0.2%	0.9%	0.9%	1.1%	1.5%	2.2%	2.7%	9.8%
Age 45-49	0.6%	0.9%	0.9%	0.8%	1.3%	1.1%	3.3%	2.6%	11.5%
Age 50-54	0.3%	0.5%	0.8%	0.8%	1.5%	1.3%	3.3%	3.6%	12.1%
Age 55-59	0.5%	0.6%	0.5%	1.0%	0.9%	1.8%	3.6%	3.7%	12.5%
Age 60-64	0.3%	1.1%	0.8%	1.9%	1.5%	2.2%	3.3%	3.6%	14.6%
Totals by Income	11.9%		16.8%		22.9%		48.3%		100.0%

Notes: FPL = Federal Poverty Level

Source: ASPE analysis of the 2011 National Health Interview Survey.

### Methods

Eight states have posted health insurance premiums for their state-based Marketplace, and an additional three states have posted health insurance premiums for their Federally-facilitated Marketplaces or State Partnership Marketplaces.<sup>19</sup> In each of these states, information is available on the proposed premium payments, by age, for each of the issuers that is proposing to sell plans in the individual market. In addition, information on proposed rates in the small group market is readily available for all issuers in six of these states.<sup>20</sup>

<sup>18</sup> Table 2 was developed based on internal analysis of the 2011 National Health Interview Survey. This analysis used adults only, and defined individual market coverage as those with private insurance who indicated coverage was "purchased directly," excluding those who also reported Medicare, Medicaid, military, or other public coverage.

<sup>19</sup> The states are: California, Colorado, District of Columbia, New Mexico, New York, Ohio, Oregon, Rhode Island, Vermont, Virginia, and Washington.

<sup>20</sup> These states are: Colorado, District of Columbia, New Mexico, Oregon, Vermont, and Washington. Three of the remaining five states had some small group filings available, but we do not analyze those filings due to missing premium data in some filings, inability to find filings for large issuers in the state, or lack of clarity on how to develop accurate rates by age from the filed rating factors. In New York, while small group premiums for silver

The ASPE-derived CBO premium estimate was derived from the March 2012 CBO estimate that the average family would pay \$15,400 in 2016 for coverage in the second lowest cost silver plan.<sup>21</sup> This estimate was adjusted to reflect single individual market coverage in 2014 by using a single coverage to family coverage ratio of 1:2.7, trending backward at 5.5% per year to 2014, and adjusting for higher levels of reinsurance payments in 2014, yielding an estimated 2014 single premium of \$4,700.<sup>22</sup> For comparison to proposed 2014 individual market premiums, we weighted by the expected age distribution of individual market enrollees in 2014 from the RAND COMPARE microsimulation model. To arrive at a national estimate, we weighted state-level premiums by the number of current individual market enrollees in each state from the 2011 Medical Loss Ratio data collection.

Due to data limitations, we are unable to directly compare the ASPE-derived CBO estimates to the price of the second lowest cost silver plan in 2014. Therefore, we have presented a comparison to the lowest cost silver plan as well as a comparison to the second lowest cost silver issuer. It is likely that the second lowest cost silver plan will differ very little in price from the lowest cost silver plan, as both plans will often be from the same issuer. Our estimates here can be thought of as a range that captures the second lowest cost silver plan in each state.

Data on premiums in the pre-Affordable Care Act small group market come from the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), conducted by the Agency for Healthcare Research and Quality (AHRQ). MEPS-IC surveys approximately 38,000 employers each year, and gathers information on the average premium paid. In order to increase sample size in each state, we average data from the 2008 to 2011 MEPS-IC, and trend the estimates forward to 2014 using estimates from the CMS Office of the Actuary of trends in private health insurance per person.<sup>23</sup>

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plans are available, the State notes that they are not comparable to pre-Affordable Care Act premiums. See press release referenced in footnote 6.

<sup>21</sup> *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance*. March 2012. Available at: [http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA\\_and\\_Insurance\\_2.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf).

<sup>22</sup> Single coverage to family coverage ratio derived from: *Letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act*. Congressional Budget Office. November 30, 2009. Available at: <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>. Annual increase in premiums of 5.5% from the Congressional Budget Office's March 2013 Baseline. Our inference about CBO's assumptions about reinsurance recoveries as a percentage of premium is 2% in 2016 and 10% in 2014. The reinsurance inference was derived using the following assumptions. From the March 2013 CBO baseline, we estimate there will be approximately 20 million individual market enrollees in 2014 (7 million Exchange enrollees, 13 million other individual market enrollees). This leads to a very approximate market size of \$100 billion based on an approximate average premium of \$5000, which would yield a 10% reduction in premiums due to reinsurance (10 billion/100 billion). Also from the March 2013 CBO baseline, we estimate there will be roughly 35 million individual market enrollees in 2016. This leads to a very approximate market size of roughly \$200 billion including trend, which would yield a roughly 2% reduction in premiums due to reinsurance (4 billion/200 billion).

<sup>23</sup> Data on average small group premiums used for comparison comes from tables published by the Internal Revenue Service for 2012 average premiums by state. See <http://www.irs.gov/pub/irs-pdf/i8941.pdf>. The IRS tables are based on 2008-2011 MEPS-IC data, trended forward to 2012. For comparison to the 2014 individual market premiums, we trended the IRS estimates forward to 2014 using estimates of per enrollee private health insurance spending increases from 2012 to 2013 and 2013 to 2014 from the CMS Office of the Actuary. These estimates are 3.7% for 2012-2013 and 3.4% for 2013-2014. Many people would expect that actual trend will be higher than these

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Analysis of data from the Health Intelligence Company, LLC (HIC) database that was used by HHS in the development of the Actuarial Value Calculator estimates that average AV for single coverage in the small group market is very close, on average, to silver coverage, with an average AV of 69% for single coverage in 2010.<sup>24</sup> Analysis of data from the 2012 Employer Health Benefits Survey finds that the average deductible for single coverage in small group plans is about \$1,900, the average maximum out-of-pocket is \$3,300, and the average coinsurance rate is approximately 20%.<sup>25</sup> Taking into account that about 30% of small group plans in the sample only cover generic prescription drugs, and nearly two thirds do not apply prescription drugs to the maximum out-of-pocket limit, the KFF/HRET data also supports an average small group AV in the silver range. Thus, it is appropriate to compare pre-Affordable Care Act small group premiums trended forward to proposed silver premiums in 2014.

We collected 2014 small group market silver premiums by age from the following six states: Colorado, the District of Columbia, New Mexico, Oregon, Vermont, and Washington. To create weighted average premiums that are comparable to pre-Affordable Care Act small group market average premiums, we weighted posted small group market premiums in 2014 by the age distribution of workers in small firms who have single employer-sponsored insurance coverage.<sup>26</sup> Given the changes in pricing practices and information available due to the Affordable Care Act, our comparison of pre-Affordable Care Act average small group premiums to proposed 2014 small group premiums inevitably uses different data for pre- and post-Affordable Care Act. For the 2014 proposed small group premiums, we have actual prices by age and metal level. For the pre-Affordable Care Act data, we have an average premium paid by small employers in each state. To compare these, we estimated the average AV in the current small group market, as well as the age distribution. We note that there is uncertainty about each of these assumptions, as well as variation in average small group actuarial value by state, which we have not taken into account here.

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estimates. To the extent that actual trend is higher, our analysis is conservative – that is, true savings are likely higher than those estimated here.

<sup>24</sup> From the Health Intelligence Company, LLC (HIC) database. Actuarial values are imputed based on plan characteristics.

<sup>25</sup> Estimates derived from the Kaiser Family Foundation/Health Research and Educational Trust 2012 Employer Health Benefits Survey microdata. Estimates limited to employers with fewer than 50 employees that reported a deductible, maximum-out-of-pocket, and whether the maximum-out-of-pocket was inclusive of the deductible.

<sup>26</sup> The age distribution for the current small group market was estimated using the 2012 Current Population Survey. We analyzed the average age and age distribution for individuals with ESI in their own name who report working for a small employer and have no dependents in their household with dependent ESI. The average age of small group employees covered by single coverage is approximately 45. However, the standard age curve rises steeply after age 45. As a result, the weighted average standard age factor that we use in the analysis is close to 50 – that is, we compare status quo small employer average premiums, trended forward, to the premium that would be paid by a 50 year old purchasing silver coverage in 2014.

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August 2, 2013

The Honorable Mark Iwry  
Senior Advisor to the Secretary  
Deputy Assistant Secretary for Retirement and Health Policy  
U.S. Department of Treasury  
1500 Pennsylvania Avenue, N.W.  
Washington, D.C. 20220

Dear Mr. Iwry:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, July 18, 2013, to testify at the hearing entitled "Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay."

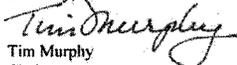
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Friday, August 16, 2013. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to [brittany.havens@mail.house.gov](mailto:brittany.havens@mail.house.gov).

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy  
Chairman  
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

*House Committee on Energy and Commerce, s/c on Oversight and Investigations  
"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"  
Questions for the Record for J Mark Iwry  
Hearing held July 18, 2013*

**The Honorable G.K. Butterfield (D-NC)**

**Question 1:**

Thank you, Deputy Assistant Secretary Iwry, for your testimony. At the June 26th hearing of this Subcommittee, we heard from business owners who unanimously agreed during questioning that they embrace the goal of the Affordable Care Act to make affordable insurance available to every single American. Those business leaders also agreed during questioning that good corporate citizens should look for responsible ways to comply with the law. What I took from that hearing is that businesses have accepted this is the law of the land and are committed to working with us to ensure that implementation of the Marketplaces and other aspects of the law go smoothly

The Treasury Department Appears to be working closely with many of these stakeholders to find the best way to ensure the law of the land is implemented effectively. The Administration's decision to provide transition relief preserves the ability of business employees and individuals to access tax credits offered by the ACA starting in 2014. And there will still be safeguards in place to prevent access to premium tax credits in error. Once the Marketplaces are up and running, more than 30 million additional Americans, including 137,000 of my constituents in eastern North Carolina who currently lack health insurance, will be able to benefit from more comprehensive and more affordable health insurance under the ACA.

The Treasury's decision to delay implementation of certain requirements under the Affordable Care Act is designed to help businesses come in compliance with the law, while enabling people to be able to participate in the Marketplaces set to begin in 2014. If I am an employee of a business in Goldsboro, North Carolina who wishes to purchase a qualified health plan from the Marketplaces and I qualify under the law for a credit, will I still be able to receive that credit regardless of transition relief? Will transition relief impact in any way the ability of individuals to access the Marketplaces and receive affordable health insurance?

The decision to provide transition relief with respect to the reporting and employer responsibility requirements under the Affordable Care Act is designed to help businesses come into compliance (as well as provide more time to develop simplified, streamlined reporting rules), without delaying people's ability to participate in the Marketplaces and obtain a premium tax credit. Individuals who wish to purchase coverage under a qualified health plan in the Marketplaces and who qualify for a premium tax credit will still be able to receive the credit starting in 2014. The transition relief provided by the Treasury Department and Internal Revenue Service in Notice 2013-45 will not impair anyone's eligibility for a premium tax credit under the Affordable Care Act. Likewise, this transition relief generally will have no impact on the ability of individuals to access the Marketplaces and receive affordable health coverage.

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

**Question 2:**

**Can you describe the safeguards and income verification steps in place that ensure an employee from a company in, for instance, Elizabeth City, North Carolina will not receive a premium credit in error? What type of penalties will be in place for individuals who try to receive credits they do not qualify for?**

Both the Marketplaces and the IRS have safeguards in place to prevent those who are not eligible for these benefits from receiving them. The Marketplaces are required by the statute and HHS regulations to verify eligibility criteria. The IRS is building systems to collect, match, and leverage available data to verify premium tax credit claims on individuals' income tax returns.

The Affordable Care Act includes penalties to address false claims for benefits by applicants. For example, individuals applying at a Marketplace submit their application under the penalty of perjury. Where appropriate, the IRS may also apply existing tax penalties and sanctions.

**Question 3:**

**The decision to move forward with transition relief for 2014 came with a great deal of outreach and communication with stakeholders. As I mentioned earlier, we recently heard from a panel of businesses before this committee who embraced the goal of the law to provide affordable health insurance to all Americans and believed good corporate citizens should make efforts to comply with the law. In Treasury's communications with these stakeholders, have you found that most businesses have accepted this law, aim to comply with it, and are interested in finding ways to provide affordable health care to their employees? Would you say that transition assistance will make it easier for businesses that embrace the goals of the ACA to comply with the law?**

Most of the stakeholders that have communicated with the Treasury Department about the Affordable Care Act have contacted us about specific issues that are of particular interest to them and have not expressed their views on the Affordable Care Act as a whole. Most of those communications and interactions, however, seem to reflect a desire to comply with the Affordable Care Act and provide affordable health care to employees.

*House Committee on Energy and Commerce, s/c on Oversight and Investigations  
"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"  
Questions for the Record for J Mark Iwry  
Hearing held July 18, 2013*

**Question 4:**

**You mentioned that employers and affected entities may voluntarily comply with reporting provisions from 2014. It is encouraging that employer who embrace the ACA are preparing to assist with the implementations of this law, even though they will not be required to for another year. Can you provide some examples of employers who are preparing to report voluntarily in 2014? Will employers who voluntarily report information in 2014 be responsible for "assessable payments"? Will employers who do voluntarily report in 2014 be rewarded for doing so?**

Reporting entities will be encouraged to voluntarily implement information reporting in 2014 (when reporting will be optional), in preparation for the full application of the reporting provisions in 2015. Real-world testing of reporting systems in 2014 will contribute to a smoother transition to full implementation in 2015. Notice 2013-45 provides that no employers will be responsible for assessable payments under Code section 4980H for 2014, including employers that voluntarily implement information reporting for that year.

**The Honorable Tim Murphy (R-PA)**

**Question 1:**

**Please submit the information you have on the burdens and costs for individuals and businesses.**

To minimize costs and administrative tasks for businesses and individuals, and to provide greater flexibility, Treasury and the IRS have sought to develop, among other things, simplified information reporting methods. For example, the preamble to the proposed regulations implementing Section 6056 information reporting states that stakeholders provided comments suggesting that, "at least for some employers, the collection, assembling and processing of the necessary data into an appropriate format for filing may not be necessary if the employer offers sufficient coverage to make it unlikely that the employer will be subject to an assessable payment under section 4980H because the employee will be ineligible for a premium tax credit. Treasury and the IRS have considered these comments in formulating the potential simplified reporting methods described in this section. If Treasury and the IRS adopt one or more of these simplified reporting methods, they would be optional alternatives to the general reporting method set forth in the proposed regulations, which could substantially reduce the data elements reported using the general method." The preamble also invites comments on "potential simplified reporting methods and on other possible simplified approaches that would benefit employers while providing sufficient and timely information to individual taxpayers and the IRS."

*House Committee on Energy and Commerce, s/c on Oversight and Investigations  
"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"  
Questions for the Record for J Mark Iwry  
Hearing held July 18, 2013*

**Question 2:**

**Please provide all notes, emails, and other related documents with respect to the communication of the Treasury Department's authority to be able to make the decision to delay the employer mandate.**

The Treasury Department's authority to be able to make the decision to provide transition relief derives from section 7805(a) of the Internal Revenue Code. This authority has been used to postpone the application of new legislation on a number of prior occasions across Administrations, including Notice 2011-69 regarding the Airport and Airway Extension Act, Part IV (signed August 5, 2011); Notice 2007-54 regarding the Small Business and Work Opportunity Act of 2007; and Notice 2000-5 regarding the Tax Relief Extension Act of 1999.

**Question 3:**

**Please submit all documents related to the discussions regarding the Treasury Department's analysis of the constitutionality of the delay.**

The authorities Congress provided under section 7805(a) of the Internal Revenue Code allowed the Treasury Department to make the decision to provide transition relief. This authority has been used to postpone the application of new legislation on a number of prior occasions across Administrations.

**Question 4:**

**Do you have the authority to offer multi-employers waivers? If so, what will they be?**

Certain multiemployer health plans have asked the Treasury Department whether the premium tax credit under the Affordable Care Act would be available to individuals who are covered by a multiemployer health plan. Under the Affordable Care Act, an individual who is covered by an eligible employer-sponsored plan is not eligible to receive a premium tax credit. The conclusion that an individual cannot benefit from both the exclusion from taxable income for employer-provided health coverage under an eligible employer-sponsored plan and the premium tax credit provided by the Affordable Care Act applies whether the individual is covered by a single-employer plan or a multiemployer plan. Similarly, the statute also would not allow an employee who was offered minimum essential coverage under an eligible employer-sponsored plan that provided minimum value and was deemed "affordable" for the employee to receive a premium tax credit, even if the employee declined the coverage.

The Administration is committed to implementing the Affordable Care Act in a manner that makes health care more effective and affordable for all Americans, including those covered by multiemployer plans. We intend to continue working with employers, labor organizations, and all other stakeholders who have ideas on how best to preserve high-quality existing coverage while new coverage is extended to those who do not have it – in all cases in accordance with the statutory terms of the Affordable Care Act.

*House Committee on Energy and Commerce, s/c on Oversight and Investigations  
"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"  
Questions for the Record for J Mark Iwry  
Hearing held July 18, 2013*

**Question 5:**

**Was there any communication between people within the Treasury Department and any other government agency regarding the delay of the employer mandate? If so, please provide any communication.**

Treasury decided to provide transition relief after receiving feedback over the course of 2012 and 2013. Treasury has been engaged in a dialogue with stakeholders, including employers, insurers, and governmental entities. Stakeholders submitted comments on the information reporting provisions of both section 6055 and section 6056. At various points in the process, Treasury has discussed the reporting provisions with others, including government offices that help coordinate the efforts of the multiple federal agencies involved in implementing the Affordable Care Act. Ultimately, Treasury decided to provide an additional year as a transition period before the Affordable Care Act employer and insurer reporting requirements would first apply. We also extended this transition relief to the employer responsibility provisions under section 4980H, which would have been impractical to implement without the reporting information.

**Question 6:**

**What are the costs to American businesses of complying with the reporting requirements?**

**a. Please provide all communication regarding the costs to American businesses.**

Treasury decided to provide transition relief after receiving feedback over the course of 2012 and 2013. Stakeholders – including the U.S. Chamber of Commerce, the Business Roundtable, the Blue Cross Blue Shield Association, Aetna, the National Association of Health Underwriters, and the American Benefits Council – submitted comments on the information reporting provisions of both section 6055 and section 6056. Particular comments expressed concern about the anticipated difficulty or cost of complying with the reporting requirements, the desire that the reporting process be made as simple as possible, and the need for adequate lead time to adapt information gathering and reporting systems to implement the reporting requirements effectively.

Treasury and the IRS have sought to develop simplified information reporting methods to minimize costs and administrative tasks for businesses. The preamble to the proposed regulations implementing Section 6056 information reporting states that stakeholders have provided comments suggesting that, "at least for some employers, the collection, assembling and processing of the necessary data into an appropriate format for filing may not be necessary if the employer offers sufficient coverage to make it unlikely that the employer will be subject to an assessable payment under section 4980H because the employee will be ineligible for a premium tax credit. Treasury and the IRS have considered these comments in formulating the potential simplified reporting methods described in this section. If Treasury and the IRS adopt one or more of these simplified reporting methods, they would be optional alternatives to the general reporting method set forth in the proposed regulations, which could substantially reduce the data elements reported using the general method." The preamble also invites comments on "potential simplified reporting methods and on other possible simplified approaches that would benefit

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

employers while providing sufficient and timely information to individual taxpayers and the IRS."

**The Honorable Michael C. Burgess (R-TX):**

**Question 1:**

**Please provide any records related to the date you found out that the mandate for businesses was going to be delayed.**

The transcript of my July testimony before the Committee documents that I knew sometime in June 2013 that transition relief would be granted with respect to the employer shared responsibility provisions.

**Question 2:**

**Please provide any documents related to communications with Valarie Jarrett related to the delay of the mandate.**

Consistent with my testimony before this committee in July, I do not recall communicating with Ms. Jarrett about Treasury's decision to provide transition relief.

**The Honorable Phil Gingrey (R-GA):**

**Question 1:**

**Please provide a list of employer stakeholders that weighed in and helped you make this decision to delay the employer mandate.**

Treasury decided to provide transition relief after receiving feedback and reviewing statements and comments from stakeholders, including employers, insurers, governmental entities and others. Particular comments expressed concern about the anticipated difficulty or cost of complying with the reporting requirements, the desire that the reporting process be made as simple as possible, and the need for adequate lead time to adapt information gathering and reporting systems to implement the reporting requirements effectively. Treasury recognized that transition relief for reporting would make it impractical to determine which employers owed employer shared responsibility payments and therefore provided transition relief with respect to the employer responsibility provisions as well. Among the entities that weighed in were the following:

- American Benefits Council
- Aetna
- America's Health Insurance Plans
- Aon Hewitt
- BlueCross BlueShield Association
- Business Roundtable

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

- Cigna
- Corporate Health Care Coalition
- Employers for Flexibility in Health Care
- Families USA
- HR Policy Association
- Information Reporting Program Advisory Committee
- National Association of Health Underwriters
- National Business Group on Health
- National Coordinating Committee for Multiemployer Plans
- National Immigration Law Center
- National Payroll Reporting Consortium
- Retail Industry Leaders Association
- State of Tennessee, Department of Finance and Administration
- UPMC Insurance Services Division
- U.S. Chamber of Commerce
- World at Work

**The Honorable Steve Scalise (R-LA):**

**Question 1:**

**Did you or Mark Mazur have any conversations with HHS about the decision to delay the employer mandate? If so, please provide any documents related to communications.**

Treasury decided to provide transition relief after receiving feedback over the course of 2012 and 2013. Treasury has been engaged in a dialogue with stakeholders, including employers, insurers, and governmental entities. Such stakeholders – including the U.S. Chamber of Commerce, the Business Roundtable, the Blue Cross Blue Shield Association, Aetna, the National Association of Health Underwriters, and the American Benefits Council – submitted comments on the information reporting provisions of both section 6055 and section 6056. At various points in the process, Treasury has discussed the reporting provisions with others, including government offices that help coordinate the efforts of the multiple federal agencies involved in implementing the Affordable Care Act. Ultimately, Treasury decided to provide an additional year as a transition period before the Affordable Care Act employer and insurer reporting requirements would first apply. We also extended this transition relief to the employer responsibility provisions under section 4980H, which would have been impractical to implement without the reporting information.

*House Committee on Energy and Commerce, s/c on Oversight and Investigations  
"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"  
Questions for the Record for J Mark Iwry  
Hearing held July 18, 2013*

**Question 2:**

**Please provide the names of all individuals who communicated with HHS and the dates and times that they communicated with HHS about delaying the employer mandate.**

Treasury decided to provide transition relief after receiving feedback over the course of 2012 and 2013. Treasury has been engaged in a dialogue with stakeholders, including employers, insurers, and governmental entities. Such stakeholders – including the U.S. Chamber of Commerce, the Business Roundtable, the Blue Cross Blue Shield Association, Aetna, the National Association of Health Underwriters, and the American Benefits Council – submitted comments on the information reporting provisions of both section 6055 and section 6056. At various points in the process, Treasury has discussed the reporting provisions with others, including government offices that help coordinate the efforts of the multiple federal agencies involved in implementing the Affordable Care Act. Ultimately, Treasury decided to provide an additional year as a transition period before the Affordable Care Act employer and insurer reporting requirements would first apply. We also extended this transition relief to the employer responsibility provisions under section 4980H, which would have been impractical to implement without the reporting information.

**The Honorable Cory Gardner (R-CO):**

**Question 1:**

**When was the President made aware of the Treasury Department's decision to delay the employer mandate?**

The President addressed the decision to provide transition relief in his remarks at an August 9, 2013 press conference. I do not have personal knowledge of when the President was made aware of the transition relief.

**Question 2:**

**How many IRS personnel are currently working with you on the implementation of this law?**

It is our understanding, based on recent information provided to us by the IRS, that the IRS has just under 700 full-time equivalent staff working on the tax law changes included in the Affordable Care Act.

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

**Question 3:**

**Please provide the Treasury Department's cost estimate on how much money it will cost American businesses to comply with this law?**

To minimize costs and administrative tasks for businesses and individuals, and to provide greater flexibility, Treasury and the IRS have sought to develop, among other things, simplified information reporting methods. For example, the preamble to the proposed regulations implementing section 6056 information reporting states that stakeholders provided comments suggesting that, "at least for some employers, the collection, assembling and processing of the necessary data into an appropriate format for filing may not be necessary if the employer offers sufficient coverage to make it unlikely that the employer will be subject to an assessable payment under section 4980H because the employee will be ineligible for a premium tax credit. Treasury and the IRS have considered these comments in formulating the potential simplified reporting methods described in this section. If Treasury and the IRS adopt one or more of these simplified reporting methods, they would be optional alternatives to the general reporting method set forth in the proposed regulations, which could substantially reduce the data elements reported using the general method." The preamble also invites comments on "potential simplified reporting methods and on other possible simplified approaches that would benefit employers while providing sufficient and timely information to individual taxpayers and the IRS."

**The Honorable Morgan Griffith (R-VA):**

**Question 1:**

**Is there any case that references a time when the Treasury Department used Section 7805(a) to stop the implementation of a section of the law and a court has said they have authority?**

The Treasury Department has exercised its administrative authority to postpone the application of new legislation on a number of prior occasions across Administrations of both parties.

For example, the Small Business and Work Opportunity Act of 2007 made changes to the standards return preparers must follow to avoid penalties. The amendments were effective May 25, 2007. On June 11, 2007, the Treasury Department released Notice 2007-54 providing that the IRS would follow the standards in prior law in determining whether to assert penalties for returns due on or before December 31, 2007.

Similarly, the Airport and Airway Extension Act, part IV (signed August 5, 2011) reinstated the air transportation and aviation fuels taxes retroactively to July 23, 2011, when they had expired. On September 9, 2011, the Treasury Department released Notice 2011-69 providing that the excise taxes would not be imposed on purchases of air transportation services made after July, 2011 and before August 8, 2011. *See also, e.g.,* Notice 2000-5 (waiving corporate penalties for certain estimated taxes due December 15, 1999, which were affected by the retroactive amendment of section 6655 by the Tax Relief Extension Act of 1999); Notices 2005-29, 2006-2,

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

and 2007-4 (postponing the statutory effective date of the section 470 loss disallowance rules applicable to certain pass-through entities); Notices 2005-94, 2006-100, 2007-89, and 2008-115 (waiving reporting of certain deferred compensation under section 409A for 2005 through 2008 and, subsequently, until the year after final regulations are published); Announcement 95-48, Notice 96-64, and Notice 99-40 (postponing the effective date of various statutory changes in qualification rules affecting governmental plans by deeming these plans to satisfy those requirements until a later date); Notice 2010-91 (postponing the statutory effective date for 3% withholding on contractors under section 3402(t)); Notice 2011-88 (postponing the effective date for required backup withholding payments made in settlement of payment card and third-party network transactions, as enacted by the Housing Assistance Tax Act of 2008); Notice 2012-34 (postponing the statutory effective date for amendments to the cost basis reporting regime enacted by the Energy Improvement and Extension Act of 2008); and Notice 2013-14 (extending the statutory deadline for submitting a pre-screening notice to claim the Work Opportunity Tax Credit).

**The Honorable Bill Johnson (R-OH):**

**Question 1:**

**If an analysis conducted by the Treasury Department revealed that there was a need to delay the individual mandate, do you have the authority to delay the individual mandate?**

While the 2014 transition relief for employer reporting would make it impractical for the IRS to administer the employer responsibility provisions of the Affordable Care Act, the IRS has determined that that transition relief will not have a comparable impact on implementation of the individual responsibility provisions. Accordingly, it is unnecessary to delay the individual responsibility provisions. Moreover, as a practical matter, the individual responsibility provisions are necessary to implement the Affordable Care Act's insurance market reforms that guarantee health security for Americans, such as prohibiting discrimination against people with preexisting conditions.

**The Honorable Billy Long (R-MO):**

**Question 1:**

**Please name companies that you have talked to that helped the Treasury Department make the decision to delay the employer mandate.**

Treasury decided to provide transition relief after receiving feedback and reviewing statements and comments from stakeholders, including employers, insurers, governmental entities and others. Particular comments expressed concern about the anticipated difficulty or cost of complying with the reporting requirements, the desire that the reporting process be made as simple as possible, and the need for adequate lead time to adapt information gathering and reporting systems to implement the reporting requirements effectively. Treasury recognized that

*House Committee on Energy and Commerce, s/c on Oversight and Investigations*  
*"Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay"*  
*Questions for the Record for J Mark Iwry*  
*Hearing held July 18, 2013*

transition relief for reporting would make it impractical to determine which employers owed shared responsibility payments and therefore provided transition relief with respect to the employer responsibility provisions as well.

Among the entities that weighed in were the following:

- American Benefits Council
- Aetna
- America's Health Insurance Plans
- Aon Hewitt
- BlueCross BlueShield Association
- Business Roundtable
- Cigna
- Corporate Health Care Coalition
- Employers for Flexibility in Health Care
- Families USA
- HR Policy Association
- Information Reporting Program Advisory Committee
- National Association of Health Underwriters
- National Business Group on Health
- National Coordinating Committee for Multiemployer Plans
- National Immigration Law Center
- National Payroll Reporting Consortium
- Retail Industry Leaders Association
- State of Tennessee, Department of Finance and Administration
- UPMC Insurance Services Division
- U.S. Chamber of Commerce
- WorldatWork

