

PROTECTING AFFORDABLE COVERAGE FOR EMPLOYEES

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS FIRST SESSION

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PROTECTING AFFORDABLE COVERAGE FOR EMPLOYEES

WEDNESDAY, SEPTEMBER 9, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:17 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Barton, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Schakowsky, Butterfield, Sarbanes, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Noelle Clemente, Press Secretary; Andy Duberstein, Deputy Press Secretary; Graham Pittman, Legislative Clerk; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Professional Staff Member, Health; Gregory Watson, Staff Assistant; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Meredith Jones, Democratic Director of Communications, Member Services and Outreach; Samantha Satchell, Democratic Policy Analyst; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. Good morning, ladies and gentlemen. The subcommittee will come to order, and the chairman will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's legislative hearing will consider a bipartisan bill authored by distinguished members of this subcommittee Vice Chairman Guthrie and Mr. Cárdenas, along with Representatives Mullin and Sinema.

H.R. 1624 is a bill to amend the Patient Protection and Affordable Care Act and the Public Health Service Act to revise the definition of small employer. This bill would allow the States to continue defining the small group health insurance market as employers with 1 to 50 employees.

Section 1304 of the Patient Protection and Affordable Care Act changed the Federal definition of the small group market to include employers with 1 to 100 employees. The States, however,

have been allowed to continue defining the small group market as employers with 1 to 50 employees until January 1, 2016. So, beginning on or after January 1, 2016, plans sold or renewed for employers with 51 to 100 employees will be subject to the various small group health plan regulations established by the PPACA. These more restrictive rating rules will increase health insurance premiums for these employers and reduce flexibility in benefit design. The new requirements could also lead some employers with 51 to 100 employees to self-insure to avoid higher premiums. If that happens, this could result in adverse selection in the small group pool and higher premiums for employers with 1 to 50 employees. Unless this current law is reversed, the disruption in the marketplace will be significant. For example, it is estimated that under current law, more than 3 million employees will experience a double-digit percent increase in their health care premiums. Ultimately, cost increases for small employers will change their choices regarding offering coverage, could change their business model, and will ultimately be felt by millions of workers.

Because the impact of current law will vary by State, defining the small group market should be left to the States, which is a policy envisioned in H.R. 1624. I am pleased to say there is considerable support for this legislation in the House and the Senate. The flexibility that would be given to States with immediate passage of H.R. 1624 would help ensure stable small group health insurance markets that reflect the unique characteristics in each of the States. If Congress passes H.R. 1624, premiums will be lower and millions of employees and employers by letting them keep the plan they have and like. And this is a commonsense policy that deserves our bipartisan support.

[H.R. 1624 appears at the conclusion of the hearing.]

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Today's legislative hearing will consider a bipartisan bill authored by distinguished members of this subcommittee Vice Chairman Guthrie (KY) and Mr. Cardenas (CA), along with Reps. Mullin (OK) and Sinema (AZ).

H.R. 1624 is a bill to amend the Patient Protection and Affordable Care Act (ACA) and the Public Health Service Act to revise the definition of small employer. This bill would allow the States to continue defining the small group health insurance market as employers with 1–50 employees.

Section 1304 of the Patient Protection and Affordable Care Act (PPACA) changed the Federal definition of the small group market to include employers with 1–100 employees. The States, however, have been allowed to continue defining the small group market as employers with 1–50 employees until January 1, 2016.

So, beginning on or after January 1, 2016, plans sold or renewed for employers with 51–100 employees will be subject to the various small group health plan regulations established by the PPACA. These more restrictive rating rules will increase health insurance premiums for these employers and reduce flexibility in benefit design.

The new requirements could also lead some employers with 51–100 employees to self-insure to avoid higher premiums. If that happens, this could result in adverse selection in the small group pool and higher premiums for employers with 1–50 employees.

Unless this current law is reversed, the disruption in the marketplace will be significant. For example, it is estimated that under current law, more than 3 million employees will experience a double-digit percent increase in their health care premiums. Ultimately, cost increases for small employers will change their choices regarding offering coverage, could change their business model, and will ultimately be felt by millions of workers.

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With that, I yield the remainder of my time to the vice chairman of the Health Subcommittee, Mr. Guthrie.

Mr. PITTS. With that, I yield the remainder of my time to the vice chairman of the Health Subcommittee, Mr. Guthrie.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you, Mr. Chairman. I appreciate the committee holding this hearing on such an important issue.

On January 1, 2016, the definition of the small group market is set to change, and with that, millions of employers will see dramatic changes to their insurance coverage. Employers with 51 to 100 people will be suddenly thrust into a new insurance category with dramatically different mandates and benefit requirements, and would not be able to continue to offer their current plans. Not only would these hard-working employees no longer be able to keep their current coverage, but the new plans that would be offered are likely to be significantly more expensive.

In response to this looming threat, Congressmen Cárdenas, Mullin, and Congresswoman Sinema and I joined forces to introduce the PACE Act, which would stop the expansion of the small group definition. Our bill has the support of leading business organizations which represent thousands of companies, many of which are family-owned, and millions of hard-working Americans from every congressional district. Our bill will allow States to determine their own group market size, just as they do today. This is a commonsense solution to a real and serious problem. Business owners face many challenges today, and this bill provides an opportunity to eliminate one major cause of uncertainty.

H.R. 1624 has quickly picked up momentum. Today, we have more than $\frac{1}{2}$ the House as cosponsors and nearly $\frac{1}{3}$ of the Senate. Support is wide ranging and highlights that this is something we can all agree needs to be addressed. This bill is a chance to offer a solution, and I look forward to discussing this important issue today.

I want to thank subcommittee chairman Mr. Pitts for bringing this important legislation before the subcommittee, and I would like to thank my coauthors for their help and to advance this crucial legislation, and believe me, they have put a lot of work into this in getting the cosponsors we have, and I appreciate it.

I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the ranking member, Mr. Green, 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. Good morning, and thank all of you for being here today, and our witnesses particularly. I want to particularly thank a former colleague of ours, now commission, Mike Kreidler, who he and I started our service in Congress together a few years ago when we both had dark hair. But again, welcome to all our panel, and particularly to our former colleague.

Five years ago, Congress acted upon the principle that in America, health care is not a privilege for a few, but a right for all. Since then, the Affordable Care Act has been implemented and reforms have taken place, and there are dramatic successes and some challenges, but no doubt the law is working. It has changed and even saved American lives. It has set this country on a smarter, stronger path. Since the ACA was enacted, over 16.4 million Americans gained Affordable Healthcare Act, 129 million Americans who now have—could have been denied coverage prior to the ACA's passage now have access. The uninsured rate is at a historic low. For the first time in 50 years, rising healthcare prices have been slowed. Savings on healthcare costs of \$12 billion resulted from 2010 and 2013. Both of the number of hospital-acquired conditions and patient harms have notably dropped since 2010. In short, access to affordable insurance is up, the uninsured rate is down, and the quality of care continues to improve. The ACA is working.

It is true the ACA continues to achieve positive outcomes, but it is also true there is no such thing as a perfect law. There are many opportunities for us to come together and constructively build on the ACA's successes. After more than 50 votes to repeal or weaken the law, multiple politically motivated challenges before the Supreme Court, I am pleased to be here with my colleagues working in a bipartisan basis to improve the law.

One opportunity for improvement is the subject of today's hearing; the small group market. For too long, the small group health insurance market has been volatile, subject to increasing financial strain. Between 2000 and 2010, the percentage of small firms that provided health insurance plans to their employees dropped from 43 percent to 33 percent. In response to this trend, the ACA addressed the small group insurance market to extend consumer protections to even more Americans, and to provide long-term stability in a historically broken marketplace. The ACA helped small business insurance be more affordable, and created a small business health options program called SHOP Marketplaces. SHOP was designed to improve the employee choice and plan offerings and grow risk pools.

We have seen steady improvements in our small employer market since the enactment of the ACA, and enrollment is increasing, more firms are entering the market, and employees have new choices and consumer protections.

Small group health insurance markets have traditionally been defined as firms with 50 or fewer employees. Beginning next year, the definition will expand to companies with up to 100 employees. However, while the small group market is shrinking, the SHOP Marketplaces remain in their infancy and are still evolving. Given their state of maturity, some States would prefer this marketplace

to achieve greater stability, be more fully understood before expanding it to midsized employers. The shift in rate-setting policy adds an additional source of uncertainty with the changing definition of small employers in 2016.

Protecting Affordable Coverage for Employees Act, introduced by Representative Tony Cárdenas and Brett Guthrie, will permanently change the definition of small group employers to those with up to 50 employees. Under this legislation, the States would be allowed to choose to expand their small group markets, but the default would be to remain at 50 or fewer employees.

I appreciate that a great deal of uncertainty remains in the smaller group market. More time before expanding the definition is warranted so that the effect of midsized employers joining the small group market can be better understood. A 2-year delay would likely have allowed the SHOP Marketplaces to stabilize, and give insurance 2 years of data and experience with new premium rating rules. The legislation we are discussing today has broad partisan support.

I look forward to hearing from our witnesses about the legislation, and also the impact of the ACA on the smaller group market. The ACA is not an abstract law; it is a set of fair rules and tougher protections that have made health care in America more affordable and more attainable for millions of hardworking Americans. The time to move part partisanship is long overdue, and I look forward to turning the page and working together to improve the law. It is what the American people deserve. And I want to thank our chairman for this hearing today, and look forward to hearing from our witnesses.

And thank you, and I yield back.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN

Good morning, and thank you all for being here today.

Five years ago, Congress acted upon the principle that—in America—health care is not a privilege for a few, but a right for all.

Since then, as the Affordable Care Act has been implemented and reforms have taken effect, there have been dramatic successes and some challenges.

But there is no doubt this law is working.

It has changed, and even saved, American lives.

It has set this country on a smarter, stronger path.

Since the ACA was enacted, over 16.4 million Americans gained affordable health care.

One hundred twenty-nine million Americans who could have been denied coverage prior to the ACA's passage now have access.

The uninsured rate is at a historic low.

For the first time in 50 years, rising health care prices have slowed.

Savings on health care costs of \$12 billion resulted between 2010 and 2013.

Both the number of hospital-acquired conditions and patient harms has notably dropped since 2010.

In short, access to affordable insurance is up, the uninsured rate is down, and the quality of care continues to improve.

The ACA is working.

It is true that the ACA continues to achieve many positive outcomes.

It is also true that there is no such thing as a perfect law.

There are many opportunities for us to come together constructively to build on the ACA's successes.

After more than 50 votes to repeal or weaken this law, multiple politically motivated challenges before the Supreme Court—I am pleased to be here with my colleagues, working in a bipartisan basis to improve the law.

One opportunity for improvement is the subject of today's hearing—the small group market.

For too long, the small group health insurance market has been volatile, and subject to increasing financial strain.

Between 2000 and 2010, the percentage of small firms that provided health insurance plans to their employees dropped from 43 percent to 33 percent.

In response to this trend, the ACA addressed the small group insurance market to extend consumer protections to even more Americans, and to provide long-term stability in a historically broken marketplace.

The ACA helped make small group insurance more affordable, and created the Small Business Health Options Program (SHOP) marketplaces.

SHOP was designed to improve employee choice in plan offerings and grow risk pools.

We have seen steady improvements in our small employer market since the enactment of the ACA.

Enrollment is increasing, more firms are entering the market, and employees have new choices and consumer protections.

Small group health insurance markets have traditionally been defined as firms with 50 or fewer employees.

Beginning next year, this definition will expand to companies with up to 100 employees.

However, while the small group market is strengthening, the SHOP marketplaces remain in their infancy, and are still evolving.

Given their state of maturity, some States would prefer for this marketplace to achieve greater stability and be more fully understood before expanding it to include mid-size employers.

The shift in rate-setting policy adds an additional source of uncertainty with changing the definition of small employers in 2016.

The Protecting Affordable Coverage for Employees Act, introduced by Representatives Tony Cardenas and Brett Guthrie, would permanently change the definition of small group employers to those with up to 50 employees.

Under this legislation, States would be allowed to choose to expand their small group markets, but the default would be to remain at 50 or fewer employees.

I appreciate that a great deal of uncertainty remains in the small group marketplace.

More time before expanding the definition is warranted so that the effect of mid-size employers joining the small group market can be better understood.

A 2-year delay would likely have allowed the SHOP marketplaces to stabilize and give insurers 2 years of data and experience with the new premium rating rules.

The legislation we are discussing today has broad bi-partisan support.

I look forward to hearing from our witnesses about the legislation, and also the impact of the ACA on the small group market in general.

The ACA is not an abstract law.

It is set of fairer rules and tougher protections that have made health care in America more affordable and more attainable for millions of hard-working Americans.

The time to move past partisanship is overdue, and I look forward to turning the page and working together to improve the law.

It is what the American people deserve.

I want thank the chairman for having this hearing today, and look forward to hearing from our witnesses.

Thank you, and I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes the vice chair of the full committee, Mrs. Blackburn, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. I want to thank you for the hearing today. And I think it is so timely because we have all been back in our districts and we have heard from so many employers and, you know, it didn't matter if they had 8 or 85 employees, or like some others, 114, 120, 200; the uncertainty

around health insurance and how you provide that, and what the rules are, this is something that has become such a fluid and uncertain environment that it is very difficult for employers to know that what they have is going to last. It does have an effect on small business, it is a damper on hiring and on jobs retention, and certainly on business growth. So taking an action is important for us to do. As a couple of the employers told me, they said, you know, every time we go to one of these seminars on how you provide the health insurance now and meet the mandates, we are told these are the rules for now. It is all subject to change due to the rule-making, but you should be expecting premium increases because the worst is yet to come, and that arrives in 2016. So, Mr. Chairman, I thank you for the hearing, and Mr. Guthrie for—and the others for their work on the legislation.

And I yield back the balance of my time.

Mr. PITTS. All right, is anybody else seeking her yielded time? No. The Chair thanks the gentlelady.

Now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and I welcome today's hearing on the Affordable Care Act's required expansion of the small group insurance market and H.R. 1624, which instead aims to give States the option to expand.

As everyone knows, I am a strong supporter of the Affordable Care Act, and for good reason. Since its passage, 17 million Americans have gained health insurance coverage, and as a result, we have seen the largest reduction in the uninsured in 4 decades. The ACA has increased access and reduced financial barriers to important preventative services such as cancer screenings and well women visits by requiring their coverage with no cost sharing. The law also stopped insurers from discriminating based on pre-existing conditions, or placing annual limits on how much health care they will cover. Fewer Americans are struggling to pay their medical bills, and fewer are forgoing—are forgoing care because they can't afford it.

In 2015, nearly 80 percent of individuals shopping for coverage on Healthcare.gov could purchase coverage for \$100 or less after tax credits. With all of the ACA's reforms, from its passage to its implementation, we have heard predictions that the sky was falling, yet it has not. Premiums have stabilized and millions of Americans are no longer one accident, injury, or diagnosis away from financial ruin.

That said, of course, no law is perfect and there is always room for improvement. Historically, Congress has been able to pass technical fixes and improvements after major legislation. A perfect example of this is Medicare, which has continually evolved over the course of the last 50 years. Since 1965, we have expanded Medicare coverage to include mammograms and hospice care. We have learned lessons that convinced us to move away from fee-for-service to alternative payment models. The ACA will need improvements

as well, and it is critical we ensure that the ACA works for everyone.

That is why I am glad that my Republican colleagues are ready to put politics aside and look to strengthen the law. While I commend the bill's sponsors, Representatives Cárdenas and Guthrie, for their leadership on this important issue, I don't necessarily agree this is the right approach. The small group health insurance market is in the midst of several reforms as a result of the ACA. The SHOP Marketplaces are still in their infancy. With these—while these reforms are still underway, experts will tell us that expanding the definition of small employers now would add significant uncertainty into our small group market. However, a few-year transitional delay would provide us with more appropriate research and actuarial data to make a smart decision at the appropriate time. I believe the benefits of an expanded small group market such as added consumer protections and increased stability for small employers are important and achievable goals. So I am concerned that H.R. 1624 is premature. But I am also mindful of the uncertainty that comes with moving forward with the expansion. That is why I am pleased to view today as a turning point. As opposed to using the ACA as a political football to repeated futile attempts to repeal or defund the law, Republicans and Democrats have come together in a bipartisan fashion to improve and strengthen the ACA, and I am hopeful this spirit can continue.

I yield the remainder of my time to Mr. Cárdenas.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you Chairman Pitts. I welcome today's hearing on the Affordable Care Act's required expansion of the small group insurance market and H.R. 1624, which instead aims to give States the option to expand.

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With all of ACA's reforms, from its passage to its implementation, we have heard predictions that the sky was falling, yet it has not. Premiums have stabilized and millions of Americans are no longer one accident, injury, or diagnosis away from financial ruin.

That said, of course, no law is perfect and there is always room for improvement. Historically, Congress has been able to pass technical fixes and improvements after major legislation. A perfect example of this is Medicare, which has continually evolved over the course of the last 50 years. Since 1965, we have expanded Medicare coverage to include mammograms and hospice care. We have learned lessons that convinced us to move away from fee-for-service towards alternative payment models. The ACA will need improvements as well, and it's critical we ensure that the ACA works for everyone.

That is why, I'm glad that my Republican colleagues are ready to put politics aside and look to strengthen the law. While I commend the bill's sponsors—Reps. Cárdenas and Guthrie for their leadership on this important issue—I don't necessarily agree this is the right approach.

The small-group health insurance market is in the midst of several reforms as a result of the ACA. The SHOP Marketplaces are still in their infancy. While these reforms are still underway, experts will tell us that expanding the definition of small employers now would add significant uncertainty into our small-group market. However, a few-year transitional delay would provide us with more appropriate research and actuarial data to make a smart decision at the appropriate time. I believe the benefits of an expanded small-group market such as added consumer protections and increased stability for small employers are important and achievable goals. So, I am concerned that H.R. 1624 is premature.

But I am mindful of the uncertainty that comes with moving forward with the expansion. That is why I am pleased to view today as a turning point. As opposed to using the ACA as a political football through repeated, futile attempts to repeal or defund the law, Republicans and Democrats have come together today in a bipartisan fashion to improve and strengthen the ACA. I am hopeful this spirit can continue.

Thank you, and I yield the remainder of my time to Mr. Cárdenas.

Mr. CÁRDENAS. Thank you very much. Thank you, Chairman and Ranking Member, for holding today's hearing. I truly appreciate the committee's willingness to work on the bipartisan bill that would impact so many small businesses. And also I would, once again, thank subcommittee chairman Mr. Pitts and also subcommittee ranking member Mr. Green.

H.R. 1624, the Protecting Affordable Coverage for Employees Act, introduced by my colleagues, Mr. Guthrie, Mr. Mullin, Ms. Sinema, and myself, would stop potential health insurance rate shock by allowing States to choose the size of their small group market for themselves. That would be an improvement on this legislation.

As a former small business owner myself, I recognize the struggle there is to live out and provide for the American dream for our employees. I know how difficult it can be when a specific sector of small business is affected by bills and laws created by local, State, and Federal governments. I am grateful for all the benefits that the Affordable Care Act has provided since its implementation began, however, no law is perfect. When it was first created, Social Security didn't cover agricultural and domestic workers. Medicaid didn't begin to cover mammograms until 1991. Even with these fundamental programs of our Nation's safety net, laws and improvements and compromise was necessary to lead to more perfect protection for Americans.

I appreciate the committee's willingness to hold today's hearing. I look forward to advancing the PACE Act, and continuing to build the committee's record of working successfully in a bipartisan fashion.

I have been married for 23 years, and I am reminded every day by my wife how imperfect I am. I have been an elected official for 19 years, and I am reminded every single day by my constituents how more perfect we need to make our laws. But like my marriage, I wouldn't want to have it any other way. Our imperfect democracy is beautiful and awesome, especially when we work in a bipartisan fashion.

Once again, I want to thank all of my colleagues on both sides of the aisle for all of your participation. Thank you.

Mr. PITTS. The gentleman yields back. The Chair thanks the gentleman.

That concludes the opening statement. As usual, all members' opening statements that are written will be made a part of the record, including our chairman, who is at another hearing.

We have one panel today. Let me introduce the panel in the order of their presentation.

First of all, we have Monica Lindeen, Montana Commissioner of Securities and Insurance and State Auditor, President of the National Association of Insurance Commissioners. Welcome. Then Kurt Giesa, FSA MAAA, Partner, Oliver Wyman. And Mike Kreidler, Washington State Insurance Commissioner. Your written statements will be made a part of the record, and you will be each given 5 minutes to summarize.

And we will, at this time, begin testimony, and I recognize Ms. Lindeen, 5 minutes for her summary.

STATEMENTS OF MONICA LINDEEN, COMMISSIONER OF SECURITIES AND INSURANCE, STATE OF MONTANA, AND PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; KURT GIESA, PARTNER, OLIVER WYMAN; AND MIKE KREIDLER, WASHINGTON STATE INSURANCE COMMISSIONER

STATEMENT OF MONICA LINDEEN

Ms. LINDEEN. Good morning, Chairman Pitts, Ranking Member Green, and distinguished members of the subcommittee. As you said, my name is Monica Lindeen. I am the elected Commissioner of Securities and Insurance for the State of Montana, and President of the National Association of Insurance Commissioners, and I want to thank you for holding this hearing on the Protecting Affordable Coverage for Employers, PACE, Act, which Vice Chair Guthrie, along with Congressman Cárdenas, introduced earlier this year.

The NAIC represents the chief insurance regulators of the 50 States, the District of Columbia, and 5 U.S. territories, whose primary roles are protecting consumers, and promoting vibrant and competitive insurance markets. As such, I come before you this morning to urge the immediate passage of the PACE Act which, as you know, would return the Federal definition of small group employers to 1 to 50 employers.

The ACA changed the Federal definition of the small group market to include employers with 1 to 100 employees but allowed the States to continue defining the small group market as employers with 1 to 50 employees until January 1 of 2016. Beginning on or after this date, plans sold or renewed for employers with 51 to 100 employees would be subject to the various small group regulations established by the ACA, such as essential health benefits, different rating pools, actuarial value requirements, different medical loss ratio requirements, adjusted community rating rules, and others.

The NAIC has endorsed the PACE Act because it would retain State flexibility to set the appropriate limits for the small group market, and ensure stable small group markets that reflect the unique characteristics and dynamics the play in each of the States.

If this legislation is not signed into law, a series of market disruptions could occur. And before I enumerate, I want to be clear

that the impact will vary by State, which is why defining the small group market should be left to the States, especially since the legislation does not prevent them from changing the definition to include all employers with 1 to 100 employees as they see fit.

First, failure to pass the Act would subject employers with 51 to 100 employees, or midsized employers, to new rating restrictions which could result in significant premium increases for some groups. Second, employers with 51 to 100 employees would face additional benefit requirements and cost-sharing restrictions, which would reduce benefit flexibility and could increase out-of-pocket spending. Midsized employers have typically had greater flexibility in rates and benefit options to choose from. Without this flexibility, midsized employers will have to seek out new plans that meet the essential health benefit benchmark and actuarial value requirements, which could also increase premiums. Lastly, these regulations could lead some employers with younger and/or healthier employees to self-insure as a way of avoiding higher premiums and limited coverage options, which could result in adverse selection in the small group pool. This, in turn, could increase premiums for employers with 1 to 50 employees.

As you know, the U.S. Department of Health and Human Services has offered a transition option, by publishing guidance that they will not enforce certain small group market regulations for existing health plans provided by employers with 51 to 100 employees if the plan is renewed on or before October 1 of 2016, effectively staving off the new regulations until October 1 of 2017.

The NAIC surveyed all 50 States and the District of Columbia, and most responded that they will be utilizing this transition option. Nevertheless, we believe a more comprehensive fix provided by this legislation is necessary in order to preserve coverage options for existing and new purchasers, and ensure stability for the future.

The NAIC encourages Congress to act quickly. Most midsized employers shop for coverage annually to ensure the best price for themselves and their employees, but they need final rates and product information by late September in order to make these decisions and carry on with the preparing of employee communications, open enrollment materials, and the actual conducting of open enrollment in advance of the effective date. Those employers who may be new entrants into the market in 2016 also need to know what options will be available to them, so quick action would avoid unnecessary confusion and disruption as we move into 2016.

For all the reasons I have articulated this morning, the NAIC strongly supports immediate passage of the Act, and thank you, and I would be happy to answer any questions.

[The prepared statement of Ms. Lindeen follows:]

**Testimony of
Commissioner Monica Lindeen on behalf of
The National Association of Insurance Commissioners**

**Before the
U.S. House Committee on Energy and Commerce's Subcommittee on Health**

**Regarding:
H.R. 1624 – Protecting Affordable Coverage for Employees Act**

**September 9, 2015
2322 Rayburn House Office Building**

Introduction

Good morning Chairman Pitts, Ranking Member Green, and distinguished members of the subcommittee. My name is Monica Lindeen, and I am the elected Commissioner of Securities and Insurance for the State of Montana, currently serving my second term, and the president of the National Association of Insurance Commissioners (NAIC). I want to thank you for holding this hearing on the Protecting Affordable Coverage for Employees (PACE) Act, H.R. 1624, which Vice-Chair Guthrie, along with Congressman Cardenás, introduced earlier this year.

Summarizing the PACE Act

The NAIC represents the chief insurance regulators of the 50 states, the District of Columbia, and five U.S. territories, whose primary roles are protecting consumers and promoting vibrant and competitive insurance markets. As such, I come before you this morning to urge the immediate passage of the PACE Act, which, as you know, would return the federal definition of “small group” to employers with 1-50 employees. The Affordable Care Act (ACA) changed the federal definition of the small group market to include employers with 1-100 employees, but allowed the states to continue defining the small group market as employers with 1-50 employees until January 1, 2016. Beginning on or after this date, plans sold or renewed for employers with 51-100 employees will be subject to the various small group health plan regulations established by the ACA, such as essential health benefits, different rating pools, actuarial value requirements, different medical loss ratio requirements, adjusted community rating rules, and others.

Assessing the Potential Impact

The NAIC has endorsed the PACE Act because it would retain state flexibility to set the appropriate limits for the small group health insurance market and ensure stable small group markets that reflect the unique characteristics and dynamics at play in each of the states. If this legislation is not signed into law, a series of market disruptions could occur. Before I enumerate, I want to be clear that the impact will vary by state, which is why defining the small group market should be left to the states, especially since the legislation does not prevent them from changing the definition to include all employers with 1-100 employees as they see fit and a few states have already made the change.

First, failure to pass the PACE Act would subject employers with 51-100 employees, or mid-size employers, to new rating restrictions, which could result in significant premium increases for some groups. For example, by compressing premiums due to the age-rating restrictions established by the ACA for the small group market, the premiums for mid-size employers with a younger population would go up significantly.

Second, employers with 51-100 employees would face additional benefit requirements and cost-sharing restrictions, which would reduce benefit flexibility and could increase out-of-pocket spending. When employers with 1-50 employees were first subjected to these requirements beginning in 2014, the impact was minimal because groups of this size were already subject to certain rating restrictions. Mid-size employers, however, have typically had greater flexibility in rates and benefit options to choose from. Without this flexibility, mid-size employers will have

to seek out new plans that meet essential health benefit benchmark and actuarial value requirements, which could also increase premiums.

Lastly, these regulations could lead some employers with younger and/or healthier employees to self-insure as a way of avoiding higher premiums and limited coverage options, which could result in adverse selection in the small group pool. This, in turn, could increase premiums for employers with 1-50 employees.

As you know, the U.S. Department of Health and Human Services has offered a transition option by publishing guidance that they will not enforce certain small group market regulations for existing health plans provided by employers with 51-100 employees if the plan is renewed on or before October 1, 2016, effectively staving off the new regulations until October 1, 2017. The NAIC surveyed the 50 states and the District of Columbia, and most responded that they will be utilizing this transition option. Nevertheless, we believe a more comprehensive fix provided by this legislation is necessary to preserve coverage options for existing and new purchasers and ensure stability for the future.

The Reasons for Urgency

The NAIC encourages Congress to act quickly. Most mid-size employers shop for coverage annually to ensure the best price for themselves and their employees, but they need final rates and product information by late September in order to make these decisions and carry on with the preparing of employee communications and open enrollment materials and the actual conducting of open enrollment in advance of the effective date. Those employers who may be

new entrants into the market in 2016 also need to know what options will be available to them. Quick action would avoid unnecessary confusion and disruption as we move into 2016.

Conclusion

For all of the reasons I have articulated this morning, the NAIC strongly supports immediate passage of the PACE Act. Thank you and I would be happy to answer any questions.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mr. Giesa, 5 minutes for your summary.

STATEMENT OF KURT GIESA

Mr. GIESA. Thank you, Congressman Pitts, Ranking Member Green, and distinguished members of the subcommittee for allowing me to speak with you today regarding the impact that changing the definition of small employer may have on the market for health insurance.

My name is Kurt Giesa. I am a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and a partner at Oliver Wyman Actuarial Consulting.

Starting in 2016, the Affordable Care Act expands the definition of small employer to include midsized employers. Historically, no State, nor the District of Columbia, nor the Federal Government, has adopted a definition of small employer for the purposes of health insurance, which includes employers with more than 50 employees. The ACA permitted States in 2014 and 2015 to expand the definition of the small group market to include midsized employers. States considered this possibility but no State elected to do so. States have recognized that the health insurance market for midsized employers has generally functioned well, and also that expanding the definition of small group could be harmful to the market where small employers currently purchase health coverage. Expanding the definition of small employer will mean that issuers will have to apply the rules and regulations that apply to small groups to midsized employers as well, including those related to benefits, actuarial value, and most importantly premiums.

Currently, issuers are allowed to set premiums for midsized employers based on actuarial considerations, matching premiums to expected costs. Under the ACA, health plans must use modified community rating with limited adjustments in setting premiums for small employers. These rules mean that younger, healthier midsized groups will be asked to pay more for health insurance than they had been paying, and that groups that are older and less healthier will pay less. In addition, starting with the 2016 plan year, the claims experience of small and midsized employers will be pooled in developing premiums. It is important to note that these rules only apply to fully insured plans. Self-funded employers are not subject to these requirements. I expect the number of midsized groups that self-fund will increase if the definition is expanded, which, in turn, would lead to premium increases in the expanded market.

To better understand this dynamic, I performed an analysis on behalf of the Blue Cross Blue Shield Association using data from health insurance issuers that I consider to be representative in the way they set premiums for midsized employers. Specifically, I compared the premium rates these issuers were charging their midsized employers to the premium rates they will have to charge in 2016. I found that 64 percent of midsized group members would see their premiums increase, and the average premium increase would be 18 percent as a result of the ACA's rating rules. Midsized employers group with the highest increases, that is, the youngest

and healthiest groups, are those most likely to exit the market, either by dropping coverage entirely or by self-funding.

It is not possible to predict exactly which groups are likely to leave, but one reasonable assumption is the groups facing an increase of 10 percent or more would leave the fully insured market. That would mean that about 40 percent of individuals who currently obtain their insurance through a mid-sized employer would no longer be part of the fully insured group market.

After the healthiest mid-sized groups leave the market, the new combined market will be composed of the current small groups, and older, sicker mid-sized groups. We estimate that this could result in premium increases for small employers in the 3 to 5 percent range. In other words, rather than lowering prices by pooling small and mid-sized firms, this expansion could increase the average cost of insurance for small firms. These estimates are first-year estimates and likely to worsen over time as costs increase, and more small and mid-sized firms drop coverage.

Affordability and stability are the central challenges in the health insurance market today. As healthcare costs continue to outpace inflation, small firms have found it more and more difficult to provide coverage. Congress could avoid adding to these costs, and could provide stability to mid-sized employer groups by allowing States to define what constitutes a small employer for the purpose of providing health insurance. But in order for this to be effective, this change would have to be made relatively quickly. One third of mid-sized groups renew their coverage January 1, and these groups are in the process of planning for 2016. They will soon have to begin selecting a funding vehicle, developing communications, setting contribution rates, and conducting open enrollments, so time is very tight.

Thank you, and I look forward to answering your questions.

[The prepared statement of Mr. Giesa follows:]



**Testimony before the Energy and Commerce Committee, Subcommittee on Health
September 9, 2015**

Kurt Giesa, FSA, MAAA

**The Effect of Expanding the Definition of Small Employer to Include Employers with 51
to 100 Employees**

Introduction

Chairman Pitts and distinguished members of the Committee, thank you for allowing me to present this written testimony to you regarding the potential impact of changing the definition of the small employer as it relates to health insurance markets. My name is Kurt Giesa. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and a Partner in the firm of Oliver Wyman Actuarial Consulting.

Summary of Findings

We have undertaken an analysis of the impact of expanding the definition of "small employer" to include employers with 51 to 100 employees (mid-sized employers or groups) in the small employer market in 2016. This analysis is based on actual underwriting data from a number of health insurance issuers. While we show results in aggregate across these issuers, the results for each issuer on its own are similar to the results across the issuers. In total, we believe these data are representative of the market at large, but actual results will be different for particular issuers or in a particular state, depending on a number of factors, such as prevailing benefit levels and the availability of self-funded products, and the impact of transitional policies.

Our primary findings are that expanding the definition of small group to include mid-sized groups would increase average premiums in the expanded small group market, primarily by discouraging young, healthy groups from purchasing health insurance. Specifically:

- Roughly two-thirds (64%) of members in mid-sized groups would receive a premium increase in 2016 as a result of changes in rating rules and expanding the market, with these groups receiving an 18% increase on average. We expect that many of the groups receiving such sizeable increases would elect to drop their health insurance coverage and either self-fund or not offer any coverage at all. The departure of relatively healthy groups would increase the average expected health costs of the single risk pool, leading to premium increases to cover the costs of the remaining, older and less healthy groups.
- Application of Essential Health Benefit (EHB) requirements and the requirement to offer coverage at the metals would increase premiums by 3% to 5% for mid-sized groups on top of the impact from changes in rating rules and expanding the market.
- Premiums in the expanded market (1-100 employees) would increase. Premiums would increase by as much as 5% in 2016 in states that allowed the transitional policy.

- Cumulative rate increases over time could be much higher as a result of adverse selection. As rates increase, more mid-sized and small groups may drop coverage or self-fund, and this, in turn could lead to a rate assessment spiral in the 1-100 market.

Background

Beginning in 2016, the definition of small employer will be expanded to include employers with one to 100 employees. This will subject groups with 51 to 100 employees to the insurance rules that are currently in place for ACA-compliant small group policies, where premiums may vary only according to the following factors:

- age, according to a 3:1 rate schedule for adults,
- the number of covered members, subject to the restriction that no more than three dependent children under age 21 may be counted in developing the premium for a given subscriber,
- rating area,
- tobacco use, and
- benefit plan.

Issuers will not be allowed to reflect the group's actual claims experience in setting premiums, to vary administrative expenses or risk charges based on group size, participation rates or industry, or make any of the other adjustments to a given group's premium rate that

are currently used in the mid-sized group market. In addition, policies sold to mid-sized employers will have to include the EHB package, which includes providing benefits that meet one of the metal actuarial values.

There are at least four ways the change in the definition of small employer will impact rates for mid-sized groups:

- The restriction on age rating will mean that groups with older covered members will see premiums decrease, and groups with younger members will see premiums increase, all else equal.
- The elimination of adjustment for claims experience or otherwise adjusting a group's premiums to reflect expected costs will mean that those with lower expected claims will see premiums increase, while those with higher expected claims will see premiums decrease, again, all else equal.
- Premium increases in the expanded market will likely lead some of the mid-sized groups to leave the market, either dropping coverage entirely, self-insuring, or taking advantage of the transitional policy discussed below.
- Covering the EHB package, which requires providing coverage with an actuarial value consistent with the metals, will mean that some mid-sized employers will have to increase both the scope and level of the benefits they are currently providing to their employees. We estimate that this could increase the average premiums that mid-sized groups will pay in 2016 by 3% to 5%, though this will vary considerably by group.

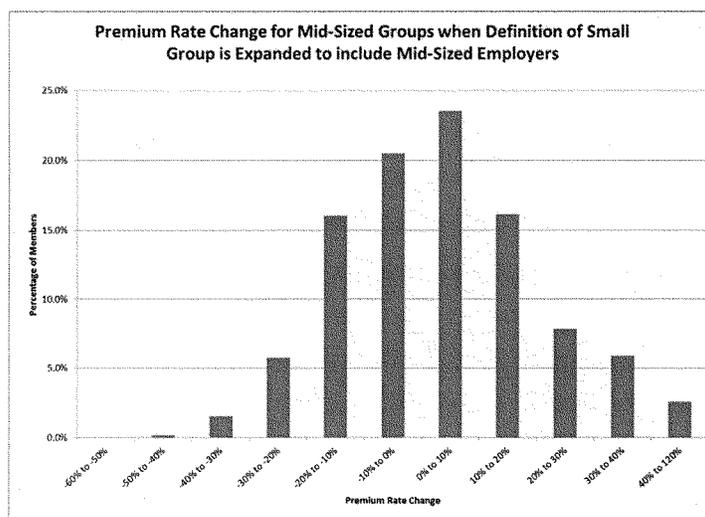
Change in Premiums for Mid-Sized Groups under Modified Community Rating

In order to understand the impact of these factors on the premiums mid-sized employers will pay, we undertook a study on behalf of the BlueCross BlueShield Association. We analyzed actual underwriting decisions from several health insurance issuers. Our starting point was the premiums the mid-sized groups were paying, and we compared those premiums to premiums that will result once the ACA's modified community rating standards are implemented.

Currently, demographic factors used to rate mid-sized groups are based on actuarial considerations, matching cost to risk. When the definition of small group is expanded to include mid-sized groups, issuers will be required to use a modified community rating approach to determine premiums for mid-sized employers. Issuers will no longer be allowed to use rating factors that are predictive of the cost of providing coverage to a group.

Absent the adverse selection that may occur as a result of the ACA rating requirements being imposed on the mid-sized group market, our data shows that roughly 30% of the new small group market membership in 2016 would be composed of what had been consider mid-sized groups. Further, in our data, the premium for current small groups is roughly 5% higher than premiums for mid-sized groups after adjusting for benefit and other differences. Again, absent adverse selection, combining the two markets will result in about a 3.5% increase for mid-sized group members and a 1.4% decrease for small group members.

In the following chart, we illustrate the range of premium changes that mid-sized groups will experience when their premiums are determined in compliance with the ACA's small group rating rules and the risk pools are merged. Note that the changes we illustrate are before medical trend or other factors that could lead to premium increases such as the wear-off of the transitional reinsurance program. In addition, the changes we illustrate assume no net change in the total premium collected from mid-sized groups, other than the 3.5% discussed above that is required to cover the increased cost of merging the two markets.



Sixty-four percent of members are in groups that would receive a premium increase, and the average increase would be 18%. Roughly 40% of members would receive premium increases averaging 10% or more, and the average increase for these members is 25%.

The Potential for Adverse Selection

Small and mid-sized groups will have options for obtaining coverage in 2016. They may choose fully insured, ACA-compliant products either on or off the exchanges and so become part of the expanded, single risk pool. They may offer employees and their dependents health benefits on a self-insured basis, purchasing reinsurance to mitigate the risk of self-insuring. All other things equal, self-funding may provide a group a cost advantage of roughly 6% to 8% relative to being fully insured by avoiding health insurer taxes and the requirement to provide EHBs. This is in addition to the potential advantage of avoiding the new rating rules. As the small group market is expanded to include mid-sized groups, we expect to see an increase in the number of mid-sized groups choosing to self-insure, particularly among those groups that would otherwise see a large increase in costs from purchasing adjusted community rated, ACA-compliant coverage.

Finally, small and mid-sized groups may choose to stop offering health benefits.

We expect that this range of available options will result in adverse selection in the expanded single risk pool in 2016 and beyond.

This dynamic, where small and mid-sized groups forum shop for the best price for coverage will lead to adverse selection that health plans will incorporate into their small group pricing for 2016, and the addition of mid-sized groups into the mix may exacerbate this problem.

Premium Rate Change Considering the Effects of Adverse Selection

The impact of adverse selection by mid-sized groups on the expanded market depends primarily on the size of the small group market relative to the mid-sized group market, and also on the morbidity of the small group market relative to the mid-sized group market. Among the companies whose data we are using for this analysis, the mid-sized group market represented roughly 30% of the total of the small group and mid-sized group markets, combined. However, there are indications that this is changing, that the relative size of the small group market is shrinking as small groups drop coverage to allow employees access to premium subsidies.^{1,2}

We illustrate the effect of adverse selection among mid-sized groups on the expanded market by postulating that at some level of rate increase, mid-sized groups will choose one of the following: to self-fund, to take advantage of the transitional policy, if allowed, or to stop offering coverage, and so remain outside of the expanded single risk pool, and that groups

¹ <http://kaiserhealthnews.org/news/small-businesses-drop-coverage-as-health-law-offers-alternatives/>

² <http://www.jsonline.com/business/more-small-businesses-dropping-insurance-helping-workers-buy-health-plans-b99358644z1-277383331.html>

with smaller increases, or rate decreases, will choose to purchase ACA-compliant coverage in the expanded single risk pool.

In Table 1, below, we show the consequences of this adverse selection on the premiums for mid-sized groups.

Table 1
Impact of Adverse Selection on Mid-Sized Groups Lapsing
Results for 2016

Rate Increase above Which Mid- Sized Group Lapse	Percentage of Mid- Sized Group Members Lapsing	Increase in Mid- Sized Group Premiums as a Result of Lapses
0%	64%	18%
10%	41%	12%
20%	23%	8%
30%	12%	6%

Table 1 shows, for example, that if all mid-sized groups that will receive a rate increase as a result of the ACA rating rules were to lapse (the first line of the table), this would mean that 64% of the mid-sized group members would leave the fully insured market, and this would require an 18% increase in premiums for those mid-sized groups remaining in the market. If only those mid-sized groups receiving more than a 10% rate increase as a result of the merging of markets were to lapse, 41% of mid-sized group members would lapse, and the premium increase for the remaining members would be 12%. Again, this analysis ignores the

impact of the requirement that mid-sized groups provide EHBs, which could add 3% to 5% to the average premiums mid-sized employers will pay in 2016. These increases would be in addition to medical trend.

Table 1 reflects the results for 2016 only. Increases like the 18% rate increase we illustrate in Table 1 would likely result in additional relatively low-cost, mid-sized and small groups leaving the single risk pool for self-funding or dropping coverage in 2017 and later, potentially leading to a rate assessment spiral in the single risk pool.

The impact of this adverse selection on the expanded single risk pool will depend, in part, on the extent to which the selection can be spread over the small group market. As we noted, small employers comprised roughly 70% of what would be the expanded market if all fully insured small and mid-sized employers were in the expanded market. However, in some states where the transitional policy was implemented, rather than 70% of the potential expanded single risk pool being made up of small employers, one-half or less of the potential expanded single risk pool could be comprised of small group employers in 2016.

In Table 2, we show estimates of the impact of this selection assuming the small groups comprise 50% of the potential expanded single risk pool, roughly representative of states where the transitional policy was implemented and again, assuming small groups comprise 70% of the expanded single risk pool, roughly representative of states where the transitional policy was not implemented. We further vary the impact based on the assumption that mid-

sized groups with rate increases over a certain amount choose not to participate in the expanded market.

Table 2
Impact of Selection on Premiums in the Expanded Market

Rate Increase at which Mid-Sized Groups Lapse	Small Employer Share of the Potential Expanded Market	
	50%	70%
0%	5%	3%
10%	4%	2%
20%	2%	1%
30%	1%	1%

Table 2 shows, for example, that assuming mid-sized groups would lapse if they see any rate increase as a result of the imposition of the ACA rating rules, and if small groups comprise 50% of the potential expanded market, then premiums for the expanded market as a whole would increase by 5% if the small and mid-sized markets are combined and the sort of adverse selection we anticipate were to occur. Similarly, if mid-sized groups only lapse if premiums increase by more than 30% as a result of the ACA rating rule, and small employers make up 70% of the potential expanded market, then the rate increase due to adverse selection among mid-sized groups would cause premiums for the market as a whole to increase by 1%. Again, these increases would be in addition to medical trend.

I welcome the opportunity to address any questions you may have related to this analysis.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Kreidler, 5 minutes for your summary.

STATEMENT OF MIKE KREIDLER

Mr. KREIDLER. Good morning, Mr. Chairman and Ranking Member Green, and other members of the subcommittee. Thank you for the opportunity to talk about the impact H.R. 1624 will have on Washington State's small business health insurance market.

My name is Mike Kreidler. I am the elected Insurance Commissioner for the State of Washington. I am also the longest-serving insurance commissioner in the country.

I am here today on behalf of the people of the State of Washington. I am pleased to report that the Affordable Care Act is working in our State. Before the Affordable Care Act, we had almost 1 million people without health insurance. Today, that is down from—and now we are at 14 percent. Today, it is down to 8.5 percent; almost a 40 percent drop going back and the lowest point that we can go back and find measurements for.

Steady improvements are also taking place in our small employer market. Enrollment is increasing. More insurers are entering the market. Rates are going down. We had 8 insurers in our small employer market in 2012. Today, we have 12; a 50 percent increase. Enrollment in our small group market has grown from 108,000 people in 2013 to 125,000 today. All but one health insurer that came for submission for rates for 2016 asked for decreases rather than increases. Our largest insurer, Regence Blue Shield, asked for a 13.8 percent decrease for 2016. A big part of that decrease is the anticipation of the employer size expanding to 100. Insurers are counting on better risks joining the market.

Making a change, as 1624 proposes, so late in the game will be very disruptive to the market in the State of Washington. Insurers have already filed for 2016, so they would have to modify their plans and rates. Even though they can do it on a quarterly, it means an adjustment in midyear after they received a promise, and most likely, it would be going up.

Employers and their employees would lose access to the essential health benefits guaranteed under the Affordable Care Act. In other words, they get better coverage. Older employees would not be protected from rating disparities.

I understand that Washington State may be further along than other States in the implementation of reforms and that our experience may be different than others, but I know that we all share a common goal of improving health insurance market for small business. For too long in our State, we have seen a death spiral for the small group market. Now, we are seeing improvements. Increasing competition, lower rates, growing enrollment are signs of market reforms can work.

Nearly 70 percent of our small businesses are in the 1 to 50 employer group. They will benefit by bringing in larger employers.

Some States may need more time to implement these reforms, but this bill is not the solution. If it had been started a year ago, it would have been much less disruptive. If we delay, it would even be better, but certainly not this approach. It puts the burden back on the States to implement change that is already in motion, and

would significantly harm the market that is just starting to improve. The Affordable Care Act is working, and we are beginning to see real improvement for small employers. Changing course now would undermine our progress and significantly disrupt our market.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Kreidler follows:]

**Testimony of Washington State Insurance Commissioner, Mike Kreidler
On H.R. 1624 – Protecting Affordable Coverage for Employees**

**Before the U.S. House Energy and Commerce Committee
Subcommittee on Health**

**September 9, 2015
10:15 AM**

Good morning Chairman Pitts, Ranking Member Green, and members of the Subcommittee.

Thank you for the opportunity to testify today about the small employer market in Washington state and the impact H.R. 1624 would have on our market and consumers.

My name is Mike Kreidler, and I am the statewide-elected Insurance Commissioner for the state of Washington, the longest-serving insurance commissioner in the country, and a former member of Congress – serving on this subcommittee from 1993-1994. I am testifying today on behalf of the people of Washington state.

I've spent most of my career in the health care field – either as a provider, elected policymaker or health administrator.

I have worked to reform our health care system for many years. Now, as insurance commissioner for the state of Washington, I am on the front lines.

At the end of 2013, before the federal Affordable Care Act took effect, Washington state had almost a million uninsured people. That's 14 percent of our state's population.

Today, I'm happy to report that our state's uninsured rate is at 8.5 percent – representing a drop of almost 40 percent since the Affordable Care Act took effect and the lowest rate of uninsured we have seen since 1987.

People now have access to meaningful coverage that provides critical services when and if they need them.

We've also seen steady improvements in our small employer market.

Our enrollment is increasing, more companies are entering the market and rate increases are going down.

In 2012, we had eight insurers in our small group market. Today we have 12.

At end of 2013, our small group enrollment was at 108,000 and today it's grown to more than 125,000 people.

This year, most of the health insurers in our small group market have requested rate *decreases*, including an *average rate decrease of 13.8%* from our largest insurer in this market, Regence Blue Shield.

The decreases are based, in large part, on the anticipation that the group size would expand to 100 and carriers would see better risks join the market.

To make a change at this late date would create substantial upheaval to our market.

Insurers would have to re-file their plans and there simply is not time to do this before Jan. 1, 2016. Doing so *after* the plans took effect would create chaos for our brokers and our small business community would most likely see rates go up.

Consumers who have been promised better benefits would lose access to the essential health benefits guaranteed under the Affordable Care Act and older enrollees would not be protected from rating disparities.

I understand that my state of Washington may be further along in implementing many of the reforms than other states, and that our experience may be different from others.

But I know we all share the common goal of improving the health insurance market for small businesses.

For too long, the small group market has been in a death spiral. Our market had the added complexity of a large association health plan market that attracted the healthier, better risks and we have paid a price for that market instability. However, we are beginning to see real improvements.

Increased competition, lower rates and growing enrollment are signs that market reforms can work. We are leveling the playing field for small businesses that want to

compete with larger employers for valuable employees. We are stabilizing rates for everyone and we are guaranteeing better coverage.

The proponents of HR 1624 predict that unless this bill passes, rates will rise and more businesses will self-insure or drop health coverage altogether. I disagree. By bringing in better risk to the small employer market we will see rates stabilize – as we're seeing now. Nearly 70 percent of our small businesses in Washington state have 1-50 employees and will benefit from bringing in the larger employers.

Our small businesses also want to do what's right by their employees and offer them meaningful, affordable coverage. The small employer market has been volatile, but we're making real progress.

The Affordable Care Act gave states flexibility to implement these market reforms, and I understand that some states may need more time, but this bill is not the solution. It puts the burden back on states to implement a change that is already in motion and would do significant harm to a market that is just starting to improve.

The Affordable Care Act is working and we are beginning to see real improvements for small employers. A change in course at this late date would undermine our progress and significantly disrupt our market.

Thank you.

Mr. PITTS. The Chair thanks the gentleman.

That concludes the opening statements. We will begin questioning.

I will begin the questioning. Recognize myself 5 minutes for that purpose.

Commissioner Lindeen, the bill we are discussing today, H.R. 1624, would reverse a policy in current law and allow the States to continue defining the small group health insurance market as employers with 1 to 50 employees. Would you please explain how many employers and employees across the country could face higher premium costs if this bill were not passed by Congress in the coming weeks?

Ms. LINDEEN. Mr. Chairman, thank you for the question, but I would have to tell you that I do not have that answer for you today—

Mr. PITTS. All right.

Ms. LINDEEN [continuing]. And, in fact, I am not even sure that I can give you an answer to that question.

Mr. PITTS. Mr. Giesa, do you have any response to that?

Mr. GIESA. I think I can help a bit. The best information we have on these questions you are asking comes from the insurance component of the MEP Survey, and MEPS shows that we have about 1.8 million establishments, not firms but establishments, the difference being physical location versus legal entity, 1.8 million establishments that would be affected by this legislation, and about 12 million employees and—including dependents, you would essentially double that, so about 24 million people we would be talking about being impacted by this legislation.

Mr. PITTS. OK, thank you.

Commissioner Lindeen, would you please explain the practical effect of what would happen in your State of Montana if this bill were not passed by Congress in the coming weeks? What types of cost increases would Montanans face?

Ms. LINDEEN. Thank you again, Mr. Chairman. Certainly, if this piece of legislation were not passed, we are very concerned in Montana that we would see some adverse selection occur in the small group market, which would obviously then increase costs to those employers with employees between 1 and 50. Certainly, with the increased regulatory burdens on those groups between 51 and 100, we really do see that there would be more of those employers in that midsized group who would, especially if they had healthier, younger employees, look for other options. And one of the options that is certainly much easier to obtain these days is self-insurance, as a result of the stop loss coverage. So definitely, we would see adverse selection to the smaller group, and increased costs for those folks.

Mr. PITTS. Do you believe that if H.R. 1624 passed Congress and was signed by the President, that consumers would have fewer meaningful protections than they do today?

Ms. LINDEEN. I am sorry, could you please repeat that?

Mr. PITTS. Do you believe that if this passed Congress, was signed by the President—

Ms. LINDEEN. Um-hum.

Mr. PITTS [continuing]. That consumers would have fewer meaningful protections than they do today?

Ms. LINDEEN. No.

Mr. PITTS. No. Would you please explain why the National Association of Insurance Commissioners has been so supportive of this bill when you have some State insurance commissioners suggesting there is no need for the bill in their State?

Ms. LINDEEN. Mr. Chairman, I certainly respect the opinions of all the commissioners in every single State, and my colleague from Washington is no exception. Just let me say that the States have all different markets, and we understand that what works in Montana does not necessarily work in Washington, and vice versa, and that is why it is really important that we have the flexibility to make those decisions at the State level.

Mr. PITTS. OK, I think you and I thank Mr. Giesa said, under current law, the premiums for midsized employers with a younger population would go up significantly, and this troubles me since this could be viewed as a disincentive for offering coverage to younger workers. Would you care to comment on the types of premium increases younger workers could anticipate? Either, or Mr. Giesa.

Mr. GIESA. Well, based on—

VOICE. Put your mike on.

Mr. GIESA. As I said, in our work we saw that 64 percent of employees would be members of groups that would see an average rate increase of about 20 percent. And if you think about employees that see, essentially, 40 percent of employees would be in groups that would see increases 10 percent or more, and those would average well over 20 percent.

Mr. PITTS. Just talk briefly, I don't have any time left, why it is important for Congress to act quickly, and also why there is time left.

Mr. GIESA. Well, the important thing here is small employer—or midsized employers right now are in the process of planning their 2016 benefit year. A third of the small employers renew their coverage January 1. And these employers right now are in the process of deciding on their funding vehicle, they are thinking about what kind of communication materials they will have to put together, what the contribution rates will be, and not only that, but the carriers need time to get all these types of materials in place as well.

Mr. PITTS. Thank you. My time has expired.

The Chair recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. And again, welcome to our panel.

Historically, after passing any large piece of legislation, Congress has worked together to enact technical fixes and improvements because no law is perfect. And, in fact, I often say if you want perfection, you don't come to a legislative body, simply because we do things that can boggle our mind. Although following—Congressman Cárdenas is not here, but we know the only thing—perfect thing we can do is when we got married, for our wives. But—and I hope my wife is watching.

The Affordable Care Act has been an exception to this tradition and serving as a political football for the last 5 years. And we haven't done the meaningful tweaks and changes that we should do, but today, it seems like it is a starting point, and we are here to adjust one small but important aspect of the law. Clearly, the small group market is an area where Congress can do a great deal to help small businesses, employers, and employees who work for them.

Commissioner Kreidler, in your testimony you stated that the small group market has been in a death spiral. Can you describe the challenges small business owners have been facing in purchase—purchasing health insurance for their employees, and that larger employers do not face?

Mr. KREIDLER. Thank you, Representative Green. The big difference here is that, for a small employer before the ACA, you were having adverse selection from the standpoint that they more likely were going to have sicker people inside the community-rated small group market, and as a result of that, the cost for that insurance continued to rise. Outside, and with a large employer that was self-insured, you found that they offered broader benefits. Now, that was a real disadvantage then for small business to be able to compete with larger employers because they had a richer package with the large employer than what they could afford to offer, even in comparison to what that—on a per capita basis what that large employer would have. So it presented some real challenges going forward. And we are starting to see some real relief to that now by having this larger group come in, 51 to 100, you are making it a much more compatible community-rated pool that is going to have the wealth of experience from some larger midsized, along with the small. It is going to be good for small business.

Mr. GREEN. OK. We just heard from Commissioner Lindeen talk about the impact of the law—this law—or bill in Montana. Can you talk about the impact you think it would have in Washington State?

Mr. KREIDLER. Well, I certainly can. One aspect of it is the—are the filings that we received for 2016 all have to be compliant with the—to the 1 to 100. So we have the large group—midsized group being melded with the small group market right now. And we are seeing, out of the 12 insurers in the market, all but 1 of them came and made a request—made the request, I haven't made a decision yet, but made a request to have lower rates, as much as 16 percent. So we are seeing a significant decrease in the market, largely based on these midsized employers which offer some—make it a much more stable small group market by virtue of their size, and already the insurers are responding and saying we think we can offer insurance at a better price, more comprehensive coverage than what they have seen in the past.

Mr. GREEN. Can you describe some of the provisions of the ACA that aim to reduce the burdens on small businesses? Anything the ACA has done to help the small businesses.

Mr. KREIDLER. You know, I think that the major thing here is, by having a common set of benefits, that is the essential health benefits and how they are applied, by virtue of having that in place, it has really meant that you have been successful in starting

to develop a much more level playing field. And we are finding that for small employers, for the first time, now they are going to be in a position to be much more competitive with large employers, both for attracting and retaining employees, but also that the costs to them are being mitigated to the point where it is not a marked disadvantage for the small employer up against the big, self-insured employer.

Mr. GREEN. OK. My last question. Given that the small group market is still evolving, some States have expressed concern that expanding to include larger employers, as the ACA requires, is premature and could create turmoil in the market. How would you respond to those concerns about the expansion?

Mr. KREIDLER. Well, every State is different, and you have certainly heard that from Monica Lindeen, and I am not going to second-guess their position on that from other States. I understand it is very different. I am familiar with one State, and that is my own State. In our State we are ready, and we are going to go forward and we are going to be able to make significant changes.

I would suggest that, without hampering my ability and the State of Washington to bring in the 51 to 100 being added, at least offer a delay for 2 years. That would make a lot more sense, and I think there has been broad support for that, to have a delay rather than eliminating that option. I think in the long run, by virtue of the 51 to 100, whether it is a couple of years out or whether it is today, it is going to have a marked improvement for small business, that it only advantages them.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the vice chairman, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Mr. Kreidler, I have to tell you, if you were going with me in my district, people would not be agreeing with you. They don't see this as an advantage, they see it as a burden, and more regulation and more interference, and they are just really not happy with what they are being left to deal with.

Mr. Giesa, I want to come to you on something. Commissioner Lindeen mentioned, when the chairman asked her what people would do if they are booted out of the marketplace, she said they will self-insure. So let's go back and let's look at some of this, because you have some proponents of the small group expansion, that market expansion, saying that is going to help to moderate the cost, and then you have the report that came from the Academy of Actuaries, I think is—yes, that said the premiums will increase because of the less attractive risk that comes in. So I would like to get your take on that. What do you think is actually going to be what finally hits the market? What is the impact that we are going to see?

Mr. GIESA. Congresswoman, thank you for the question. And recognizing the fact that Commissioner Kreidler knows his market much better than I do, I can't speak to a given market, but what I can say is in my experience across—

Mrs. BLACKBURN. Yes, I am asking for a general overview.

Mr. GIESA [continuing]. Across most States is that we will see, as a result of the rate increases, that the young, healthy mid-sized employers will see—when the ACA rating rules are put in place, we will see a number of employers choose to self-fund. It is an option that self-employer—that mid-sized employers do have now, and it is one that they will have much more incentive to pursue when the ACA rate restrictions are put in place.

Mrs. BLACKBURN. And when you are looking at that mid-sized market, do you think that this is going to make them more or less competitive? What is going to be the end result for them?

Mr. GIESA. I don't think it will have a major impact on the—

Mrs. BLACKBURN. OK.

Mr. GIESA [continuing]. Competitiveness of—

Mrs. BLACKBURN. OK.

Mr. GIESA [continuing]. Groups.

Mrs. BLACKBURN. OK. Commissioner Lindeen, you want to weigh-in on either of those questions?

Ms. LINDEEN. Well, definitely, I would concur that those employers who do have the younger, healthier groups are going to look at the option of self-insuring. It really has become much more attractive and easier for these employers in that range to look at self-insurance because the stop loss insurers have made it easier. They have lowered those attachment points to a point where there is minimal risk for the employer, they don't have to have a large amount of money or cash upfront in order to self-insure, and so for that reason it is definitely something that is more attractive. If they are allowed to continue as they are, I think you will see them continue to purchase in the way that they have been because, certainly, it has been working for them. We haven't gotten a lot of Complaint.

Mrs. BLACKBURN. All right. Let me ask you—

Ms. LINDEEN. Um-hum.

Mrs. BLACKBURN [continuing]. One other question before my time runs out. When you were talking to employers in your State, and they are discussing the uncertainty that is embedded, and some of the points that you made in your remarks, what is the number one thing that employers complain about when they come in? Is it cost, is it access, is it uncertainty, is—what are the variables, and what do they complain about?

Ms. LINDEEN. Congresswoman, thank you for the question. I think that uncertainty is the biggest concern that most employers have. I think that once we all know what the rules are and can play by those rules, it makes it much easier to make decisions moving forward.

Mrs. BLACKBURN. Great, thank you.

Mr. PITTS. The gentlelady yields back. The Chair recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask my questions of Commissioner Kreidler. Good to see you again. In addition to the many reasons I mentioned in my opening statement, I support the Affordable Care Act because of its positive impact on small businesses. Before the ACA, I heard from small businesses in my district that they were on their own, they

wanted to provide health insurance for their employees but it was too risky or too expensive, or too difficult to administer. Now, the SHOP Marketplaces created in the ACA would give small businesses a new tool that lets them research and compare the health insurance options in one place, and administer their employees' health care through the Web site. And the ACA gave small business owners more peace of mind because, by joining a much bigger risk pool, they would no longer be vulnerable to sharp swings in their rates based on the health of a few employees. And that is why I was concerned about the rocky start to the SHOP Marketplace, but it also why I believe we should give the small group market a chance to stabilize and then expand to groups of 100 or fewer employees.

So, Commissioner, is it safe to say that one of the goals of the new definition of small group insurance in the ACA was to expand consumer protections of the small group market to additional Americans?

Mr. KREIDLER. Thank you, Congressman. Definitely, that is one of the goals is to expand protections, both for the employer, but also for their employees. And the Affordable Care Act, with the essential health benefits, provides that in 51 to 100 by being melded into the community-rated pool for small business of 1 to 100.

Mr. PALLONE. Now, would adding more larger employers to the small group marketplace help with the sustainability of the SHOP Marketplaces?

Mr. KREIDLER. From my perspective, definitely. I mean that is—we have looked at the filings that have come in, and like I say, we have had double digit rate increases from the largest insurer in that market. The—what are the reasons. We take a look at their actuarial assumptions, and their assumptions are largely hedged on the concept here that by bringing in 51 to 100 to the community-rated small group market of 1 to 50, that you improve the vitality of that overall market. So, yes, it improves the health.

Mr. PALLONE. OK. And as we know, before the ACA, insurers in the small group market were not required to offer essential health benefits. Has requiring these insurers to offer essential health benefits, such as emergency room visits, prescription drug coverage, has that caused turmoil in the small group market thus far?

Mr. KREIDLER. Speaking for the State of Washington, no, it has not, Congressman, presented a challenge for those small employers. In fact, we saw that the carriers had already started to move aggressively toward the merger of 51 to 100 in—that size to the plans that they were offering. They were already taking on many of the aspects of what they were going to be required to have as of January 1, of 51 to 100. So it was already starting to take effect so it was not that disruptive. It is relatively smooth in the State of Washington. Can't speak for other States and other markets. State of Washington, it was one where they were prepared in moving forward successfully.

Mr. PALLONE. Thank you. You mentioned that most of the health insurers in Washington State's small group market have actually requested rate decreases. Can you describe Washington's experience implementing the small group insurance reform thus far?

Mr. KREIDLER. So far, we work with stakeholders before we made the decision. We could have postponed this until October of '16, but working with stakeholders, we made a decision not to do that. So we are looking—after working with them, I think it is one where, working with the stakeholders, we were prepared to do it, particularly the insurers. And again, we have 12 insurers now in the State of Washington in the small group market, which is a very strong indication, a 50 percent increase with the start of the Affordable Care Act, that there is real interest in that market and there is opportunity, and that is good for small business.

Mr. PALLONE. Now, you mentioned 12 insurers offering coverage, how many of them filed to increase rates?

Mr. KREIDLER. One.

Mr. PALLONE. Just one? And what effect do you think the expansion of the small group market will have on these rate filings?

Mr. KREIDLER. I think what most likely would happen, Congressman, is this, that if this legislation passed, these carriers would need to come back and adjust their rates, and if not their forms, which are the policy language itself, and do so after the first quarter. We have never allowed first quarter. We like to tell small business that this is the price you are going to have for a full year, so we have never done it on a quarterly basis, but this would be the—we would be prepared to do that, but inevitably, what it would mean is a price increase for them. And I don't want to be the one they point to and say how come you allowed this price increase to go through, and I says, well, after Congress passed 1624, I had no other choice but to allow you to raise your rates because you didn't have the benefits of 51 to 100 to help hold down the rates.

Mr. PALLONE. All right, thank you so much.

Mr. PITTS. The gentleman yields back.

The Chair recognizes the chair emeritus of the full committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. Thank you. Thank you, Mr. Chairman. Thanks for this hearing.

As I understand it, if you have, under current law or old law, 50 employees or less, you don't have all the mandates and you basically set your insurance—health insurance for your employees based on what you can afford and what you think the market is, but under the redefinition, if you define small business from 100— from 50 and go up to 100, then there are all these mandates that kick in. Is that correct, Ms. Lindeen? Do I understand that correctly?

Ms. LINDEEN. Congressman, I would say that if this proposed legislation is not passed and the existing law kicks in, you will see additional regulatory requests or burdens put on the small businesses.

Mr. BARTON. But I am correct in that, under the old system, 50 employees or less, you basically—if you decided to have a health insurance plan for your employees, it was one that you developed in conjunction with the employees and whatever insurance company you happened to pick.

Ms. LINDEEN. Yes, I would say that they definitely do work with the insurance provider to negotiate the plan and the product. Yes.

Mr. BARTON. And under the Affordable Care Act, the definition changes, small business to 100, but you also get a lot of mandates that you don't currently have. Is that not correct?

Ms. LINDEEN. Yes.

Mr. BARTON. Now, Mr.—is it Kridler or Kreidler, or—

Mr. KREIDLER. Kreidler.

Mr. BARTON. Kreidler. I am sorry, Mr. Kreidler.

Mr. KREIDLER. Yes. Not at all.

Mr. BARTON. In Washington State, there is nothing that would preclude a small business from trying to join a larger group plan, is there? I mean, absent the mandate, if you felt it was in your best interest of your employees to go into a pool with larger employers, there is nothing that precludes that.

Mr. KREIDLER. That is true. We do see some employers that wind up doing that, in fact, Congressman.

Mr. BARTON. OK. So the fact that—I mean, the law has changed and the implementation date is 2016, and in your State, it sounds like you all have done a very good job of trying to fast forward the new law, and it appears that it is providing some benefits because, apparently, they are getting better rates because you are spreading the risk amongst a larger number of workers. Is that not correct?

Mr. KREIDLER. Congressman, that is correct. It becomes a larger pool—community-rated pool—and, therefore, you have the benefits of having more insured, and much less subject to having price increases—

Mr. BARTON. Right.

Mr. KREIDLER [continuing]. Just because some people get sick.

Mr. BARTON. So it would seem to me that if we pass Congressman Guthrie's legislation that kept the definition at 50, you would have the best of both worlds. You would let employers that felt like their current plans were as much as they could afford, they could keep it, but you would also let employees and employers who felt like, well, we will get a better deal if we go into these risk pools that have more people, they could still do that, but they wouldn't have to do it. They wouldn't have to comply with the mandates that go with moving up. So I don't know why we wouldn't pass the bill to let the market operate and let people choose. What is wrong with that?

Mr. KREIDLER. Congressman, I would say that 51 to 100, that it heightens their protections from the standpoint of the Affordable Care Act, particularly when it comes to age discrimination. You can have an employer with a much younger workforce that can offer health insurance at a much better price. If you go into a community pool, you have that all aggregated, you help to protect the more—

Mr. BARTON. I understand that.

Mr. KREIDLER [continuing]. Older workers, which is really very much to their advantage, otherwise you have—

Mr. BARTON. There are—what you say is true. I am not arguing what you are saying is not true, but what I say is also true. If you let the market operate, you can get the benefits of larger pools if—but it should be done on a case-by-case basis because in many cases, the mandates in the Affordable Care Act do cost more money. There is no question about that. If you go from a plan that

doesn't have all the coverage requirements to a plan that has more, it is going to cost more and you are going to pay more. Now, there may be anomalies and there may be cases like Washington State where just the local situation is such that the benefits of consolidation or accumulation, or aggregation, whatever you want to call it, overcome the increase in cost in the mandates. But I would postulate, and in my State, like Texas, probably it is going to cost more overall. So I am supportive of the bill, and I hope, Mr. Chairman, that at some point in time we move the bill.

And my time has expired, so I yield back.

Thank you for your answers.

Mr. PITTS. The Chair thanks the gentleman.

The Chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for his questions.

Mr. SCHRADER. Thank you, Mr. Chairman. I appreciate it. And actually, I appreciate having the hearing on this bill. A good bipartisan bill that I think there is honest discussion about the pros and cons for the employer groups of 51 to 100, and then those groups underneath it, and how best to hopefully drive down costs and provide better health care for Americans, both the employers, employees, and writ large. So it is a good hearing. I am here to learn, actually.

And to that end, I guess just to get us some basic facts, I think that one of you were talking about there is 1.8 million employers in that 51 to 100 range, I think. Is that correct?

Mr. GIESA. Right. There is 1.8 million employers in that 51 to—

Mr. SCHRADER. Establishments.

Mr. GIESA [continuing]. 100 range that are—right, establishments, that are providing health insurance right now.

Mr. SCHRADER. And then so how many would—employers would there be below that, in other words, 50—to up 50 employees, the—what is the number there? I would assume be in the 40 million range, right, because most employers are small employers?

Mr. GIESA. Did you say employers—

Mr. SCHRADER. Yes.

Mr. GIESA [continuing]. You are asking for?

Mr. SCHRADER. Yes.

Mr. GIESA. Yes, that is almost 90 percent of employers are in that—

Mr. SCHRADER. Right.

Mr. GIESA [continuing]. 1 to 50.

Mr. SCHRADER. Right. So then the question for us, I guess, a little bit would be, you know, to the point of we expand the risk pool writ large, it would sound like those smaller businesses might get some decrease, obviously, in premiums, and, obviously, the guys that haven't had to play with the rate—the rating issues and some of the others would see some slight increases. And I guess the debate for us is, is that enough of a critical mass to reduce things significantly for the one group to offset the slight increases perhaps for the other group.

A lot of my experience has been, like Washington, I come from Oregon, most—certainly, the individual market, we had all of the essential health benefits already required and, you know, a lot of

the small groups are already going that way. And we also had most of our insurers come in asking for rate decreases. It is controversial whether it is good to do that right now from the standpoint of making sure the business market is active and engaged. So there are a number of States, I guess, for my colleagues' benefit that are, you know, seeing some of the same things that Washington State is seeing also.

And I just want to—Mr. Kreidler, will you agree everyone seems to be pretty on target here, that the accepted definition of a small group market employer was under 50 employees? Would you agree with that?

Mr. KREIDLER. Correct.

Mr. SCHRADER. OK. So the ACA arbitrarily changed that, is—make a fair statement. And I won't ask you guys that, but—

Mr. KREIDLER. Right.

Mr. SCHRADER. And I assume that the reason for that was to make sure that there was enough critical—well, I will make this statement and you guys react to it. A critical mass to keep the insurance rates as reasonable as possible for smaller-type employers, realizing there would be some adverse selection. Mr. Kreidler first, if I could.

Mr. KREIDLER. Absolutely. That was the purpose. I think the real question is, is the timing. Don't remove the requirement. Maybe postpone it for a couple of years, but—to give some States more of a time to kind of gear up for this, and their insurers to gear-up for that market. But from the standpoint of some States that are prepared to do it today, don't take that away from them, essentially throwing us back to the legislature to try to get approval. If we want to be successful with reforms, you need to have these kind of changes going into effect. Some States can do it sooner, like the State of Washington and the State of Oregon, but other States are going to want to buy more time before they make the jump. But the jump is a good one for healthcare reform and for the small group market.

Mr. SCHRADER. How about Mr. Giesa and Ms. Lindeen?

Ms. LINDEEN. Congressman, if I could, I mean I—theoretically, expanding the risk pool should drive down rates—

Mr. SCHRADER. Right.

Ms. LINDEEN [continuing]. But in this case, that is not necessarily true because when you take the 51 to 100 employers who have healthier, younger employees, and they leave that group and then instead leave older, less healthy employees, then they are going to have adverse risk, which is not going to lower rates—

Mr. SCHRADER. Well, that would—

Ms. LINDEEN [continuing]. But it is actually—

Mr. SCHRADER. That would be true in any size business, including—

Ms. LINDEEN. Correct.

Mr. SCHRADER [continuing]. The small businesses. And as I am saying, I haven't seen that in my State, and it is not like we are seeing that in Washington, either. But I can see where it would vary State-by-State.

Ms. LINDEEN. Right.

Mr. SCHRADER. You know, one of the big variables is the essential health benefits that our States primarily—I guess another basic question from me would be, Why do you think large group employers and self-insurers were left out of the essential health benefits package? Why were they not required to have the same essential health benefits? I have my ideas, but you would be more informed than I.

Ms. LINDEEN. Well, it is my—I don't believe it was actually needed—

Mr. SCHRADER. OK.

Ms. LINDEEN [continuing]. And that is why.

Mr. SCHRADER. That makes sense.

Mr. GIESA. I would concur with that.

Mr. SCHRADER. Yes. Mr. Kreidler, same thing.

Mr. KREIDLER. I think you have to move eventually to having them included. It is just going to be a process over time. Part of it right now is going 51 to 100, for some States that are ready, delay it but don't eliminate the requirement. Give a couple more years for the markets to mature and be able to handle the kind of change. We are ready in the State of Washington. Oregon is in a comparable position. Other States are ready to go right now. But I think for the sake of the country, don't eliminate it but postpone it so that you can still have the benefits here of giving more people the better protections that helping to bring down the cost, particularly in this case for small business.

Mr. SCHRADER. Thank you all.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. And before I begin, I would like to ask unanimous consent to enter into the record the following letters of support for H.R. 1624: 50 to 100 Coalition, America's Health Insurance Plans, NFIB, National Small Business Association, National Association of Insurance and Financial Advisors, National Association of Professional Insurance Agents, Council for Affordable Healthcare Coverage, Blue Cross Blue Shield Association, Delta Dental, Kentucky Chamber of Commerce, and U.S. Chamber of Commerce.

Mr. PITTS. Without objection, so ordered.

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

Mr. PITTS. Let me add to that list letters from the American Academy of Actuaries, National Association of Insurance Commissioners, the Center for Insurance Policy and Research, talking points from the Council for Affordable Health Coverage, and issue briefs from Third Way, the American Academy of Actuaries, and the National Institute of Healthcare Management.

VOICE. And this HHS Data.

Mr. PITTS. And the HHS HRQ MEPS Data.

VOICE. For Washington State.

Mr. PITTS. For Washington State.

OK, without objection, so ordered.

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

Mr. GUTHRIE. OK, thank you. Thank you so much, and thank you all for being here. I am the main sponsor of the bill, and with the bill, some of the things that—maybe some of the criticisms of the bill I think have been addressed. Working with my good friend, Mr. Cárdenas from California, Kyrsten Sinema, working with Markwayne Mullin, and we have looked at that. Some States are ready. So there is a provision in the bill for States to move forward if they so choose to move forward. And so that seems to take care of one of the concerns. The other one is just delay it. And I spent—like my friend from Tennessee, I spent a lot of time in my district back in August meeting businesses, and every time you go into a business it is not just insurance, it is the way we seem to be governing here; everything is on an extension, a delay, a waiver. I think one you suggested there, say we are just not going to enforce the regs if you move forward. The regs are on the books, we are just not going to enforce them. And that is not a good way to do business. And people plan more than year-to-year on investment and growing their business. And so, you know, putting this into place, I think what's critical is to get rid of the uncertainty. And also one of the—I guess I will ask Mr. Giesa this: So if you are a fully ACA-compliant plan, rate restrictions, essential health benefits, community rating, minimum actuarial values, your price is going to be higher—it will be a high price. And so if you go before the Insurance Commissioner and you are saying you are going to get all these new businesses on, you probably—I mean I think it makes sense that your rate is not going to go up or increase, because you are looking at new customers mandated by the law. But if you are in that 51 to 100 where we are trying to address, if you are in that and you are offering a health benefit plan that you like, you know, the President said if you like it you can keep it, your employees like, it is moving forward, you are going to—because the high rate of insurance didn't go up doesn't mean your premium is not going to—and cost is not just going to go up because you are having to buy up to a higher plan, and that is what we are trying to address in this bill. Could you comment on that? So it is not different from what we are hearing from Washington State, I don't think, but it still disrupts 51 to 100 employers.

Mr. GIESA. Well, I think there are a number of employers, and this will vary by State and by employer, but employers who will see their premiums go up for no other reason than additional benefits. They will have to meet a medal value that is a little bit higher than they would like, and so they will see premiums go up, or they will have to provide benefits that they weren't providing, that they will be required to. But I think the real dynamic, the thing that most concerns me, is this issue of the midsized employers will be given 2 options; they can either self-insure or they can go into the fully insured small group market, and they will choose the one that yields them the lowest cost. And that dynamic will force premiums in that small group market up as the—those—

Mr. GUTHRIE. So it is counterintuitive of what you would think because people—like at the market. And with self-insuring, it is usually larger employees that self-insure because of the bigger risk pool, the more—your—the bigger—you know, if you have 100 employers, you usually have more cash, more ability to—employees

ability to do that. And so even when you are talking about people leaving, if we leave it 51 to 100, you are talking about probably people in the 85, 90, close to 100 employees, not necessarily the one with 51 employees, 52 employees, although some people that small can self-insure. I am not going to say they can't, but it is more difficult the smaller you are. So really not only getting an adverse selection of younger people, you are probably getting at the higher end of the—of 90 to 100 employees probably self-insuring. Is that a fair—

Mr. GIESA. That is a fair statement, but I would like to make the point that actually Commissioner Lindeen had made—

Mr. GUTHRIE. Um-hum.

Mr. GIESA [continuing]. It is becoming easier and easier for groups to self-insure, and if you go out and look, say, Google, level funding, small employer, you will get all kinds of hits now from benefits consultants and insurance companies who are bringing products to market to encourage this kind of selection that we are talking about. So it is becoming much easier for groups to access self-insurance than it had been. They are understanding this dynamic we are describing right now.

Mr. GUTHRIE. Well, people are saying—people who choose to self-insure, they are saying I can have a known cost and know what my risk is buying full insurance plans, and based on that price, they say, or I can take risk if I have the cash to—and—to accept that risk and not put my business at stake. And you are right, as the price grows to fully insure, you are willing to take more risk to self-insure. And so your—also argument is there are other tools, financial tools, out there even if you don't have cash in the bank to help cover your out-of-pocket—it is essentially a high deductible plan is what self-insurance is. So there are other opportunities to finance the high deductible than just cash out of your business, is that what you are saying is developing?

Mr. GIESA. Exactly right, yes.

Mr. GUTHRIE. And they are developing because they know this market is going forward.

Mr. GIESA. Exactly right.

Mr. GUTHRIE. So I was like—even though we are hearing success in Washington State and others, it is, you know, the people with 51 to 100, that is who this bill specifically designed who are being disrupted, and so I think giving States the flexibility to stay in, given the opportunities for people to continue to provide the health insurance if they want to provide, I think is a good way to go, and I am glad it has been bipartisan and very carefully put together.

Thank you. I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you. While we are on the topic of self-insurance, we have heard a lot of concerns that increasingly the small market definition would increase the possibility of adverse selection, and that they—the companies would go to self-insurance, but today, only 14 percent of these midsized companies—these midsized employers are able to self-insure, and even among firms

between 100 and 999 employees, only 33 percent self-insure right now.

So I wanted to ask Mr. Kreidler, can you describe the reasons why these small firms self-insure at much lower rates than larger companies? Actually, anyone could answer that.

Mr. KREIDLER. Thank you, Congresswoman. I look at they are making that choice largely based on the fact that they probably have younger, healthier employees and, therefore, they say, you know, if I self-insure, I get a better rate. But the reason you don't see a lot of them jumping for it is because there are risks that are involved in making that decision. I think it is imperative because insurance, by its very nature, is a law of large numbers. You want to get a large pool, a large group, and that helps to hold down costs. It doesn't guarantee that everybody is a winner. There are going to be some that are losers in that proposition, but it is building that common base, but it offers protections that going forward you can't have if you have a fragmented market. And hopefully, that is one of those areas where we spend some time taking a look at what it does to the market as to whether that is an appropriate step. The kind of refinements that Ranking Member Green spoke to, which is the changes that have always followed major legislation that haven't been possible as kind of midcourse corrections.

Ms. SCHAKOWSKY. Yes. Before I ask the others if you want to comment on that, I wanted to—Ms. Lindeen, when the chairman asked you whether or not consumers would lose any benefits of this extension and you said, oh, no. But the fact of the matter is, right now, under the—on the small group, there is the essential health benefits required, you said it is not necessary to require it for larger companies. There is premium protection regardless of industry for the small groups, regardless of coworkers' health, regardless of personal health status. There are caps on premium increases based on age. There is—prevents premium discrimination based on sex. So how could you say that there is no loss, that benefits wouldn't be increased for people between 51 and 100?

Ms. LINDEEN. Congresswoman, thank you. Certainly, if there was a move to the small group market from 1 to 100, there would be additional benefit requirements placed on those employers who are at—now currently at 51 to 100, absolutely. What I am saying is that there hasn't really been any real complaints and issues with that group, and so they—there hasn't been a real need that we have been aware of for that to occur.

Ms. SCHAKOWSKY. Among the employers, there hasn't been?

Ms. LINDEEN. Well, I can just tell you what I know personally, that we haven't had problems with the employees complaining either. Certainly, those employers are negotiating the best product design possible, with the best rate design possible for their group.

Ms. SCHAKOWSKY. I just want to say that we are looking at this, mainly so far—

Ms. LINDEEN. Um-hum.

Ms. SCHAKOWSKY [continuing]. As I can hear, from an employer standpoint. The purpose of the Affordable Care Act is we have so many individuals who are either uninsured or underinsured, and the goal here is to have a healthier society, and a standard that we set for all Americans. Basic things. Lack of gender discrimina-

tion, reducing the age discrimination that make it hard for people. So I just think that it is important to acknowledge that, and that one of our goals has been to make sure that the kinds of standards—I don't have time, I would have like to have asked Mr. Kreidler what ready means, when a State is ready, but I think we passed the bill in 2010, and I realize that there was an extension made, was it last year, for larger businesses. It seems time to get ready to provide quality health care for all of our citizens.

Thank you. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman. Good morning to the distinguished panel.

To Commissioner Lindeen, I have never been in Montana. I hope to have the opportunity to visit your beautiful State, and I have heard many wonderful things about it.

I have heard from a number of my constituents that if current law is not changed, many employers will either choose to self-insure rather than purchase a small group plan, or choose to drop coverage rather than purchase coverage in the small group market, and thus, pay the employer mandate penalty. Commissioner, can you explain in a little more detail from your perspective, and you have a great deal of advice, given your responsibilities statewide in Montana, the incentives and the trade-offs that employers would face in that case?

Ms. LINDEEN. Thank you, Congressman. Certainly, the employers are going to have to make a decision, as I think Mr. Giesa pointed out, in terms of looking for coverage in the expanded small group market, or looking at potentially self-insuring. And the one thing that I think also, which we haven't really touched on today, is in terms of potential market disruption as even carriers leaving the small group market. For example, we have a carrier in Montana who withdrew from the small group market in 2013. Under law, they cannot return for 5 years unless they get permission from the commissioner, which certainly, we would consider. However, some of those insurers may decide that they don't want to do it, for a host of business reasons, and so they may withdraw completely which means then those who they have been covering under the 51 to 100, they would give up. And in some cases, that could actually cause serious financial distress to the company as well.

Mr. LANCE. I am interested, you said that there is a provision of not re-entry for 5 years. Is that State law in Montana, and is that true in other States as well?

Ms. LINDEEN. Yes. It is Federal, I think HIPAA.

Mr. LANCE. It is Federal law.

Ms. LINDEEN. Um-hum.

Mr. LANCE. So that this would apply across the board, but do State agencies such as yours, do you have the ability to override that?

Ms. LINDEEN. We would have the ability to say to the company, if they wanted to continue in the small—or come back to the small group market, to let them in. But then certainly, they would have to refile all their forms and rates and so forth.

Mr. LANCE. And given your expertise in Montana, do you think other companies might choose not to continue in the small group market?

Ms. LINDEEN. Well, certainly, every company has got that decision to make. I mean if they see the small group market is not being as desirable, for whatever reason, they could make that decision.

Mr. LANCE. I would image that small group markets might not be as profitable a line as larger. I speculate here, but certainly, some might leave.

Other distinguished members of the panel, do you have an opinion on what I have asked? Congressman?

Mr. KREIDLER. You know, my impression is that, once you are out for 5 years, you can't come back in unless you are totally restructured coming back. So once you are out, you are out, and that is Federal law that requires that under HIPAA. But my experience has been I didn't have companies that dropped out. I had some companies that talked about it, not in this market but the small group market—or individual market, I should say—and we explained to them if you drop out, you are gone for 5 years, and they said, well, maybe we can figure out a way. And every one of them wound up finding a way to stay in the market so they didn't face that particular penalty. But in the case of the small group market, like I said, we have had a 50 percent increase in the number of carriers in the small group market since 2012.

Mr. LANCE. Thank you. Your position, sir?

Mr. GIESA. Well, in the near term, I can see a couple of competitive dynamics in play. One is, not all the companies that are operating in the midsized group market now will have the administrative capabilities to take on the small group market, so when the markets are combined those companies may withdraw. The other thing that could happen is if we do see this sort of rate spiral happening, we could see companies exit the market. We have seen that happen in the past.

Mr. LANCE. Thank you very much. And I yield back 24 seconds.

Mr. PITTS. The Chair thanks the gentleman, and now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. This is a fascinating discussion, and my head is kind of exploding listening to it a little bit.

I am trying to understand, Mr. Giesa, I mean you and Mr. Kreidler are projecting fundamentally different scenarios as to what will happen. Mr. Kreidler's prediction seems to be based on information he already has in-hand in terms of the insurers' reaction to what will happen in January of 2016. Yours is a little more tenuous, I guess, but can you try to explain why you think, even though you are projecting premium hikes as high as 20 percent because these midsized employers who have the ability to go self-insure will choose to do that and pull themselves out of this pool, why you are projecting 20 percent increases based on that assumption, whereas insurers have actually come in in Washington State and are submitting requests for premium reductions in all but one case, as I understand it, and as high of a reduction, I think you said, as 16

percent in one instance. So maybe you all could have a little colloquy just to try to help me understand why there is such a disconnect there.

Mr. GIESA. Well, I will start. And first, I am not an expert in the Washington market, but I think there are some uniquenesses in the Washington market about the way the market is structured that don't apply to a majority of States. And then I will acknowledge the fact that, you know, the little bit of the work that I have done is kind of tenuous, but those rate increases I was illustrating, the 64 percent seeing 18 percent, that is real, that is based on real data. I had underwriting decisions that companies made and I said, well, those underwriting decisions will have to change under the ACA. So that is really what is going to happen to 64 percent of the issuers that I considered representative.

Mr. SARBANES. Right.

Mr. GIESA. The other part of this calculation though is, who withdraws and what does that have on the rest of the market, the impact of those who remain, and that is the part that is a little tenuous, subject to speculation, but I want to be clear that the rate increases that I was saying would happen in the mid-sized group—

Mr. SARBANES. OK, that is fair.

Mr. GIESA [continuing]. Those are real.

Mr. SARBANES. Mr. Kreidler, do you have some anxiety that, even though the insurers who submitted rate proposals seem to be assuming that the effect that you anticipate will actually take hold, that there could be a number of employers in that mid-sized range that would select themselves out and self-insure, and it could have the impact that is being talked about there with, I guess, the potential for them to come in midyear based on that activity and then reverse and seek what would then be a significant—by comparison, significant rate increase, to try to address that situation?

Mr. KREIDLER. Congressman, I will be honest with you, I really don't stay awake worrying about it as a major factor. I think that there are going to be some employers that are mid-sized that are going to see rate increases. Whether that is enough to—for them to want to take the risks of going to the self-insured market. All of these businesses, for practical purposes, are not in the business of health insurance, they are in the business of whatever commercial activity they have. And they want to be able to go out and buy a product that is going to be able to provide the kind of incentives for their employees, to retain employees, to attract employees, so that is why they offer it and that is what really matters to them. And I think that is going to vary somewhat from State to State. In the State of Washington, we already saw those mid-sized moving toward the ACA standards even before the requirement went into effect. So they are already stepping up to it. One protection that it offers right now are certainly for older employees, that they don't wind up being biased, paying multiple times what a younger employee would have to pay. They have the 3-to-1 protection. That is good for the older employee. Not so good for maybe with a younger workforce, but you have other protections and limitations of out-of-pocket expense that really play to that small employer, so there are benefits even if they wind up paying more. And again, there are

always winners and losers when you wind up pulling markets together. You can't make everybody a winner. You wind up doing the best you can, and you see the improvement in the overall health in the small group market for employers. That is the positive. You want to see that happen. In the long run, it is one of those where there are added protections that certainly enhance for that small employer, protections, even if they wind up paying more initially. But we are seeing very little of that in the State of Washington.

Mr. SARBANES. Thank you all for your testimony.

Mr. PITTS. The Chair thanks the gentleman, and now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. And thank you for your testimony.

Commissioner Lindeen and Mr. Giesa, I hope I pronounced that right, the small business health options plans, or SHOPS, have not been a popular option for employers. They have not offered much difference from the outside small group market. In my district, there are only 2 companies that offer coverage in the SHOP, and you can only choose from 3 plans in silver and gold. Would the SHOP be more successful if it allowed employers to provide a defining contribution, and allowed employees to choose a plan, a metal tier, and benefit design that best fits their needs, and shouldn't there be greater diversity of carriers and benefits designed to truly drive competition?

Mr. GIESA. Congressman, that is a wonderful question, and I think it is certainly worthy of consideration, but it is not something that, right now, I am in a position to comment on.

Mr. BILIRAKIS. OK, can you get back to me on that? I would appreciate that.

And then, Commissioner Lindeen?

Ms. LINDEEN. Well, Congressman, I certainly understand that the more options that we can provide the better, but certainly, I can get back to you on a response as well.

Mr. BILIRAKIS. Please do.

Ms. LINDEEN. Thank you.

Mr. BILIRAKIS. Please do. All right, second question. Commissioner Lindeen and Mr. Giesa, according to the CBO, "Plans being offered through exchanges in 2014 appear to have in general, lower payment rates for providers, narrower networks of providers, and tighter management of their subscribers use of health care than employment-based plans do." Less than half of the plans available on the Exchange have the Moffitt Cancer Center, the only NCI-designated Cancer Center in Florida, within their network. And those that do have Moffitt in-network, the coverage may be conditional based on where you live. If we push midsized businesses into the small business market, will these workers have more options or fewer options for health insurance? Will the employees of midsized businesses be stuck in narrower networks with fewer providers if the small group market is expanded? And again, the question is for Commissioner Lindeen and Mr. Giesa.

Ms. LINDEEN. Congressman, I really do want to apologize, I don't have a specific answer for you. Certainly, each one of the employers is negotiating with the insurer for the best product possible, and I am sure that they are looking at the networks to ensure that they

are hopefully the best network possible for their employees because insurance companies contract locally and regionally for the providers in those networks, and I am sure that the companies and the employees are looking very closely at those networks.

Mr. BILIRAKIS. Mr. Giesa?

Mr. GIESA. Yes. Again, thanks for the question. That is an excellent one. And they will have fewer employers if the midsized employer is forced into the small group market, they will have fewer options with respect to benefits. Right now, they can design benefits that best fit their needs. In the small group market there is really just a, you know, a group of benefits they will have to select from.

And then on your question of networks, I think that does deserve consideration. The small group plans, the networks are fixed and there is really no negotiation as far as what benefits or what providers the employees could see. The only way around that would be to self-fund. And so it is conceivable that these midsized groups might say, you know, to get access to the employers we want—or the providers we want, we need to self-fund.

Mr. BILIRAKIS. Thank you. Third question, again for Commissioner Lindeen and Mr. Giesa. Again, I apologize if I mispronounce your names. There appears to be evidence that the small group market is shrinking as small businesses drop coverage to allow employees access to premium subsidies. Is it better for taxpayers to have employers pay for health insurance or for the Government to pay for subsidies?

Ms. LINDEEN. Congressman, that is a difficult question. Certainly, we have in Montana seen a drop in the small group market and folks moving to the individual marketplace for that purpose. But at the same time, I can tell you that, at least in Montana, I can talk to that experience, in Montana we had about 20 percent of our population that was uninsured. We have actually seen a drop to 15 percent uninsured, and so we are seeing more and more folks becoming insured, which I guess for societal purposes, and then for the employer, whoever that may be, small or large, that is a good thing, and that is a good economic impact for the employer and Montana's economy.

Mr. BILIRAKIS. Sir?

Mr. GIESA. Congressman, this is another question that I would like the opportunity to get back to you on. I am really not in a position to answer that definitively right now.

Mr. BILIRAKIS. Please get back to me. I would appreciate that very much.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. Now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. And the first question I have is for Mr. Kreidler on the issue that you are here and your concerns, I am just wondering how much you have taken into consideration that Washington State has the ability to opt out and continue on without being affected by this if this bill, 1624, actually goes into effect. Are you aware of that?

Mr. KREIDLER. Yes, I am—

Mrs. ELLMERS. OK.

Mr. KREIDLER [continuing]. Congresswoman, aware of it.

Mrs. ELLMERS. I guess that brings me to the next question, then, which is, if you are aware of that then I don't understand why you have the issue, because you are presenting to us that this is something that is working very well in Washington State and that you see this moving forward, and hope that our bill that we are discussing today does not go into effect.

Mr. KREIDLER. There are a couple of problems that I see right now. Number 1 is they have already submitted their plans, their rates and their forms with me, so this is already in progress for going from—with the 51 to 100 being included with the—into the small—

Mrs. ELLMERS. Um-hum.

Mr. KREIDLER [continuing]. Group market. That would have to be adjusted and rolled back. Most likely, that is going to mean in the State of Washington that that is going to be a rate increase for small employers—

Mrs. ELLMERS. OK, stopping there though—

Mr. KREIDLER. OK.

Mrs. ELLMERS [continuing]. Washington, again, has the ability to not accept this bill, correct? And so, therefore, all of those plans that you are moving forward on in Washington would remain in place with the Affordable Care Act.

Mr. KREIDLER. In the State of Washington, Congresswoman, I do not have that option because State law would effectively be reverted to, with the passage of this law, that State law says 1 to 50. Therefore, 51 to 100 is not an option for me. The State would have that option, but—

Mrs. ELLMERS. Right, the State would have that option.

Mr. KREIDLER. But I would still have to go to the legislature to get their approval, and they are well underway with already making the implementations. And I can tell you right now, the chances of having that pass in the State legislature are probably zero to none. So as a consequence, the benefits that would occur to the small group—

Mrs. ELLMERS. Why—

Mr. KREIDLER [continuing]. Markets—

Mrs. ELLMERS. Why would it be zero to none if—I mean, I don't want to—because I have some other questions, but I don't understand. You are presenting today that this is working in Washington, that it is moving forward, that you feel very confidently that it is playing out as is, but yet you believe that the option for it passing the legislature in Washington would be zero to none?

Mr. KREIDLER. Congresswoman, I think it is pretty much the same dynamics that you have in Congress itself. There are differences of opinion about the Affordable Care Act and any modification to it.

Mrs. ELLMERS. So what you are saying is your opinion is not necessarily that of the rest of Washington's opinion.

Mr. KREIDLER. No, I think the rest of Washington would agree with me, but on this issue, obviously, it is going to be very difficult to get favorable action on the part of the legislature, certainly and do it in a timely fashion.

Mrs. ELLMERS. OK. Well, thank you for clarifying that for me.

I do want to ask Ms. Lindeen and Mr. Giesa. The NFIB Research Foundation showed that 40 percent of small businesses with fewer than 100 employees offered health insurance in 2014. So that is 40 percent, which is a 6 percent drop from 2013. According to HHS, only 32 percent of businesses with fewer than 50 employees offered group coverage in 2014, which is a 3 percent drop from 2013. Showing that trend, or looking at those numbers, what is the overall picture, and I know we are talking in generalities and I know that is difficult for you because you are coming from your own position, but what is going to happen with these rates? If we are already seeing that fewer businesses are dealing in this way, and we have seen that over the last year or 2, how is this going to affect these small group rates if this is the trend moving forward?

Ms. LINDEEN. Congresswoman, if I may, that is a really good question. I think it really could—should bring us back to the fact that we are still in this transition period—

Mrs. ELLMERS. Right.

Ms. LINDEEN [continuing]. With the market being—

Mrs. ELLMERS. Yes.

Ms. LINDEEN [continuing]. Influx. At the same time, I think that the markets are beginning to adjust and make sense of what happened—

Mrs. ELLMERS. Um-hum.

Ms. LINDEEN [continuing]. And so I think that is why it is important for us to not make further changes if we don't have to—

Mrs. ELLMERS. OK.

Ms. LINDEEN [continuing]. Unless it is going to be—have a positive effect—

Mrs. ELLMERS. A positive—yes, that—

Ms. LINDEEN [continuing]. But—

Mrs. ELLMERS [continuing]. You know that there is certainty and that the—

Ms. LINDEEN. Correct.

Mrs. ELLMERS [continuing]. The outcome is going to be positive.

Ms. LINDEEN. Correct.

Mrs. ELLMERS. Mr. Giesa, would you like to comment on that?

Mr. GIESA. Yes, thanks for the question. I think, you know, and briefly, the response to your question is if we don't see this change made, if the—

Mrs. ELLMERS. Um-hum.

Mr. GIESA [continuing]. Midsized employers do move into the small group market, we will see an acceleration of the process you were describing of small groups—

Mrs. ELLMERS. Small groups basically—

Mr. GIESA [continuing]. Continuing—

Mrs. ELLMERS [continuing]. Decreasing. And so—I am running out of time, but if there was one thing that you had to ask us in Congress, moving forward, looking forward to this as this bill being a positive step forward, what would you say it is? What would you like to leave this committee with as far as your messaging that we need to know?

Ms. LINDEEN. You need to give the States the flexibility so that the markets can be more certain.

Mr. GIESA. And I would say that time is of the essence here.

Mrs. ELLMERS. Time. Time. Thank you very much. Thank you to all of you for being here. And thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentlelady. Now recognizes the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Yes, thank you, Mr. Chairman.

In a prior life, as in about 6 months ago, I was the subcommittee chair on Health and Technology for Small Business. I had hearing after hearing on the Affordable Care Act, the impact on small business, the potential impact on small business, if you went back a couple of years ago when some of this was just moving through, and I can just categorically state it was all negative. Business group after business group after business group stepped forward to say here is the devastation that is going to occur. You know, with the redefinition—I guess I—it is maybe worth reminding folks, back in the day before Affordable Care, the definition of a large business was someone over 500 employees. It was pretty universally accepted. That is a big company. HR Departments, you know, lots of folks at management levels, 500-plus. Along comes the Affordable Care Act and says, well, no, we are going to redefine a large company as anyone with over 50 employees. It is like, whoa, 500 down to 50? A lot of companies with 50 to 55 employees, they don't have an HR Department. They may or may not have a full-time bookkeeper, let alone all the infrastructure that went with the prior universally accepted definition of a large company. So the reverse of that is, obviously, a small company used to be anyone up through 499. Now it is 49, which is—with my hearings on the Small Business Committee, just turned everything upside down. The issues of, you know, do I want to grow to 55 employees.

So I am bringing this up only to point out there has been a little bit of a pause for the 51 to 99. They are subject to the Affordable Care Act, the employer mandate, but at least during this time they could offer, you know, some health benefits that may have been more affordable to them. Well, now, all of a sudden, it—in pops—if we don't pass this, their costs are, by and large, going to go up. They are going to be forced to do something and make changes they may not want to do. And I guess I would like to point out, when a midsized—or when a small company, 51 to 99 for sure, has to absorb higher costs in health insurance, or anywhere else, they are generally—they have to cut someplace else. We are not talking about companies making a lot of money, even paying their owners well, and I think it is just a rhetorical comment to say if I have to increase costs here and decrease somewhere else, my cuts may be in product development, research, marketing, advertising, going to trade shows, and just continuing. What does that mean? Less growth, fewer jobs, bad for the economy, bad in every way. So I just felt like I should at least point out the overarching impact that I see on this is less job growth for those companies between 51 and 99 employees, because they are going to absorb cost increases that have to be offset. They just can't go print money or wish upon a star that they didn't have that.

So I guess, you know, Mr. Giesa, you are the actuarial expert, and maybe just some comments about—I mean I always go back—there is no free lunch. If somebody, as Mr. Kreidler says, is going

to save money, someone else is going to pay for it. You know, it is—this is what happens. You get less, I pay more. I always say it is a bad day at the office when you run out of other people's money. But—so you have kind of heard my, you know, comments here, what would you say, Mr. Giesa?

Mr. GIESA. Well, this idea of, you know, there are some real consumer protections associated with—or that come along with being part of the small group market but those benefits come at a cost, and we will be asking a group of small—or midsized employers to pay that cost. And if they choose not to do so, if they choose to sort of withdraw from that consideration and say I am going to self-fund, we will see costs go up for the small groups and those other groups that remain in the market.

Mr. COLLINS. And I think we have point out, it is amazing how competition works. There are changes going on in the self-insured market that would have been unheard of 5 years ago, but in that, small businesses can be very creative and they have to be entrepreneurial to survive and grow. And I tend to concur, we don't know what the answer is but we are incentivizing, I wouldn't even call them midsized, they are still small companies, somebody with 58, 62 employees, if that is not a small company, and that is where I have spent my life, I don't know what is, we don't know the outcome but it is going to incentivize that move. And when you take those employees out of the group market, we all know the price you pay.

So with that, thank you, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman, and now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you so much, Mr. Chairman. I do appreciate it. Mr. Kreidler, I appreciate you being here today. I have some questions for you.

You talked about increases in the small shops in the State of Washington—small shop insurance in the State of Washington. In my district, and I represent 22 counties and 7 independent cities in the rural parts of Virginia, and as a result of that, we found that many of our locations, or at least a certain number of them, we don't have but one provider for the small shop plans. And so it raises the question that I would ask you, is the city of Richmond in the Commonwealth of Virginia has lots of small shop plans, my rural counties and some of my independent cities don't—some of my rural counties don't, some of my independent cities don't, is that your experience in Washington or do you have this larger number across the State of Washington in all the counties?

Mr. KREIDLER. We have seen an increase in all of the counties for the small group market of the number of carriers that offer it. Not that many in the shop through the Exchange, but in the small group market, we have certainly seen it. But rural American is tough. It is tough in the State of Washington, and I am sure Commissioner Lindeen has it tough in Montana. It is difficult to get the same kind of competition in those rural counties that you get in the more urban counties, and I understand that.

Mr. GRIFFITH. Yes. I thought it was interesting, your testimony has been very instructive here today because I gather that you don't like this bill, but you acknowledged in some of the ques-

tioning that you did think that for some States that weren't as far along as the State of Washington was, that some type of a delay might be advisable. So you recognize that at least for some States, moving forward right away would be a problem and that we as Congress probably ought to take some kind of action. Even if you don't like this bill, you would look for us to make some action for those States that aren't as far along as the State of Washington. Is that correct?

Mr. KREIDLER. Congressman, that is correct.

Mr. GRIFFITH. Now, I am concerned, I know you come from a healthcare background, and I am sure it wasn't your intent, but as an old country lawyer, when I see what appears to be, I am sure it wasn't the intent, but appears to be a little bit of a shell game, it always makes me worry. And I noticed that you talked about one of your larger—in your testimony you talked about one of your larger insurance companies, and you referenced Regence, but it looks like, from what I can determine, it was Regence Blue Cross Blue Shield of Oregon, which only covers one of the counties that had a decrease and about 1,500 folks involved, but that the larger presence in the State had a modest—not a large increase, but it had a small increase for the Regence Blue Cross Blue Shield of Washington. And so it just makes me curious as to—I am sure that those 1,500 people think that it is very important, but I am just curious and it makes me wonder about what it going on there, but I have appreciated the rest of your testimony.

In that regard, Ms. Lindeen, let me ask you. In regard to your colleague's experience in the State of Washington, it is my understanding that might be somewhat unique because Washington actually had State law that enacted small employer health insurance changes well before the Federal law was enacted, which meant that the bump that all of my people are seeing now, the increase in the cost actually occurred before the Affordable Care Act, ObamaCare, went into effect there, and that most States are going to see that increase coming up now. Is that your understanding? In other words, they got ahead of the curve so the increases are going to be less there because—or not—or even decreases there because they were ahead of the curve in coming up with some of the requirements that ObamaCare requires our small groups now to have.

Ms. LINDEEN. Congressman, I would say that it certainly depends on the marketplace in the State. In Montana, we have seen mixed results depending on whether it is the mixed—or, excuse me, the individual market or the small group market. In fact, this year we are—or this coming year, we are going to see, unfortunately, some substantial increases in the individual market, but in the small group market those increases are very limited, between 3 and 7 percent on average.

Mr. GRIFFITH. OK. I do appreciate that. I am hearing from my constituents that they are very nervous about it, and they do make decisions, as you have heard others say, that some of those small employers are making decision, do they hire the 51st employee, do they look at expanding, do they continue to carry all of the different products, in other words, do they lay off one shift perhaps that is doing a product line that is not as successful as some of the

others and just focus on the high-profit areas. When they are on that bubble, these are all things that businesses take into account.

I appreciate Mr. Guthrie for bringing the bill, and others, and do appreciate that we need to make some kind of a resolution, even if it is not this bill, that we need to do something.

And I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman. Now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman.

Mr. Kreidler, your testimony says the State of Washington may be further along in implementing many of the reforms than other States. Why have more than $\frac{2}{3}$ of the rest of the States opted for the transition option?

Mr. KREIDLER. I think, in no small part, if you are talking about the federally facilitated Exchange through the Federal Government, is that correct, Congressman? If you are, in that situation I think politics played a lot to do with that. We had a former insurance commissioner from the State of Pennsylvania who headed the operation to assist States establishing their own exchanges. When it started, he was fully convinced that every State was going to jump to create their own exchange, rather than defer to the Federal Government, and yet, as you point out, $\frac{2}{3}$ have opted to do it otherwise. I think a lot of it had to do with the politics at the time, or the size of the State. I think most States were thinking of creating their own exchanges. In the long run, there are pluses and minuses as to whether you went with the Federal or whether you went with State—went with your own route with the State—as the State of Washington did.

Mr. LONG. Well, what you are doing may work in Washington—in the State of Washington, which Mr. Guthrie's bill allows, so I think that you could be supported, but the president of your national association there at the table with you is saying that is what caused problems in other States.

Mr. KREIDLER. Congressman, it is like the body politics, you—just because the majority party says this is our position, it isn't necessarily what you take as an individual member, and I would say the same is true as being an insurance commissioner.

Mr. LONG. OK. Commissioner Lindeen, you are testifying on behalf of all States, whereas it seems that Commissioner Kreidler is only testifying on behalf of the State of Washington. Can you talk about what you are hearing from other commissioners and consumers across the United States?

Ms. LINDEEN. Congressman, thank you for the question. And, certainly, I appreciate the diverse point of view that all of the commissioners have across the country, including my colleague from Washington, but at the same time, I believe that the overwhelming number of commissioners across the country do believe that—and do support this piece of legislation because they understand that that will give them the flexibility to do what is right for their marketplace in their individual States because of the diversity.

Mr. LONG. OK, thank you. And, Mr. Giesa, you and others have warned that the current law could lead some employers with 51 to 100 employees to self-insure to avoid higher premiums, which could result in adverse selection in the small group pool, and higher pre-

miums for employers with between 1 and 50 employees. Can you explain this adverse selection a bit more?

Mr. GIESA. Yes, Congressman. Thanks for the question again. What we will see, I think, is the midsized employers will be looking at 2 options. They will be looking at guaranteed issue access to the small group market on a community-rated basis, and they will be looking at self-funding. And in some States, there is actually a third option and that is States that have adopted the transitional policy to stay on their existing policy. So these midsized employers will be looking at 3 different options, saying which one is most financially advantageous for me. Those that choose the small group market will be the oldest and the sickest, and that will drive up premiums in that combined small group, midsized employer market.

Mr. LONG. OK, thank you. And thank you all for your testimony. And with that, Mr. Chairman, I yield back.

Mr. PITTS. The Chair will recognize the gentleman, Mr. Cárdenas, 5 minutes for questions.

Mr. CÁRDENAS. Thank you very much. I just want to say it is wonderful to—I have been here 2½ years, and this is probably the most bipartisan moment I have been working with my colleague, Republican Guthrie, on, and Sinema, and a few others. I just want to say I appreciate all the efforts of the—and the sincere efforts that everybody has put into this bill so far.

And with that, I have a question for—a couple of questions, one of them for Commissioner Lindeen. Thank you so much for testifying today. My question is, given that this legislation would allow States to determine the size of their small group market for themselves, do you anticipate any States that would make the move to include companies with 51 to 100 employees, given the new realities of the ACA?

Ms. LINDEEN. Congressman, I am sure that there will be States who would make that decision and feel that is the best for their marketplace, while others would not.

Mr. CÁRDENAS. Um-hum, but to have that option, and the hopes and expectation that each State will evaluate it based on the needs and their understanding of their constituencies and their businesses, or what have you, do you see that it could possibly provide—should this come—law go into effect, it would provide that kind of result that we would hope for?

Ms. LINDEEN. Absolutely.

Mr. CÁRDENAS. OK. Also, Mr. Kreidler, do you oppose a—different States from determining what works best for their small group markets?

Mr. KREIDLER. Congressman, I would have to say, you know, there are places where choice is certainly something that is preferred. There are other places where it is not. Before healthcare reform, the States had a great deal of latitude to do healthcare reform and yet we saw a growing problem of the number of uninsured in this country continuing to rise, and we saw the amount of spending in the healthcare system that was not collected, it was shifted to other payers. It is one of those things where we are clearly seeing we needed to have improvement, we needed to do it on a national basis, and having a national standard is something that

really works well. And that is why I would be the first to admit that offering to some States the opportunity for a couple-of-year delay before this went into effect, but don't hamper a State like mine that is ready to step up and make the changes right now. But to essentially suspend this activity and defer it back to the State is a move against healthcare reform in the sense of helping to create the kind of large markets, large groups of self—or the community-rated pool that you have with the small group market that advantages small business. I don't want to deny small business those advantages.

Mr. CÁRDENAS. OK. Commissioner Lindeen, having heard that, do you have any comments?

Ms. LINDEEN. Congressman, I think that it is important not to deny the small businesses that are currently utilizing a product that works for them—

Mr. CÁRDENAS. Um-hum.

Ms. LINDEEN [continuing]. To be able to continue to do that.

Mr. CÁRDENAS. Um-hum.

Ms. LINDEEN. And so I think that this piece of legislation which you are coauthoring is a good thing for those small businesses and for their employees, and so I would encourage passage.

Mr. CÁRDENAS. OK. The reason why I ask is because, to me, what this legislation would do, which affects an incredibly larger piece of legislation, would allow an opportunity where, hopefully, very responsible legislators, Governors, et cetera, will actually responsibly evaluate this additional tool and then use it responsibly. And I feel if they do so, then what would happen is, overall, we will get the benefit of those States that perhaps choose that they are not going to go to the 100 model and—because of what is best for their constituency, and those that choose to go to the 100 model, they will do so because they are—they have the best interest of their businesses and their constituents, the workers and their families in mind. So, to me, this is a bill that actually enhances the opportunity for responsible individuals to go ahead and say this is better—this is going to be a better environment, and as a result, hopefully, we will have better results.

Thank you very much, and I yield back my time.

Mr. GUTHRIE [presiding]. I thank my friend for yielding back.

And seeing no further questions, I appreciate the comments, and it has truly been a bipartisan effort and carefully crafted bill.

And I want to remind the members they have 10 business days to submit questions for the record, and ask the witnesses to respond to these questions promptly. Members should submit their questions by the close of business Wednesday, September 23.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we will examine H.R. 1624, the Protecting Affordable Coverage for Employers Act, authored by Subcommittee Vice Chairman Brett Guthrie. This important bill would provide relief for many employers who are on track to face higher health coverage costs in coming months if we do not act soon.

Currently, health insurance offered in the small group market must meet certain requirements that do not apply to the large group market. Because of a requirement

in the president's health law, beginning next year businesses with between 51 and 100 employees will be forced to offer health insurance coverage that currently applies only in the small group market.

These new mandates and requirements will ultimately lead to higher premiums for employees. The new plans are also expected to have less flexibility with respect to plan design as compared to the current plans. Employers with 50 or fewer employees also may face disruption under current law, facing higher costs and fewer choices over time.

One of our witnesses today has estimated that roughly two-thirds of businesses offering coverage to their 51–100 employees could face an 18 percent increase in premiums. Additionally, the American Academy of Actuaries has projected more than 150,000 establishments with over 3 million workers could be negatively impacted if we do not act.

I know many employers in my home State of Michigan have already seen their health care costs increase, and many more are worried about what 2016 may bring.

According to nonpartisan analysis, enactment of H.R. 1624 would yield notably lower premiums than currently projected, encourage continued health coverage, discourage employers from dropping coverage, and help encourage market stabilization. Under this bill, businesses and their employees will be able to keep their current health care plans and avoid higher premiums for coverage with more prescriptive benefit mandates and rating restrictions.

This bill enjoys strong bipartisan support. H.R. 1624 has more than 200 cosponsors, and a similar bill in the Senate enjoys the support of nearly one-third of the Senate.



114TH CONGRESS
1ST SESSION

H. R. 1624

To amend title I of the Patient Protection and Affordable Care Act and title XXVII of the Public Health Service Act to revise the definition of small employer.

IN THE HOUSE OF REPRESENTATIVES

MARCH 25, 2015

Mr. GUTHRIE (for himself, Mr. CÁRDENAS, Mr. MULLIN, and Ms. SINEMA) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title I of the Patient Protection and Affordable Care Act and title XXVII of the Public Health Service Act to revise the definition of small employer.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Protecting Affordable
5 Coverage for Employees Act”.

1 **SEC. 2. REVISION OF DEFINITION OF SMALL EMPLOYER**
2 **UNDER HEALTH INSURANCE MARKET PROVI-**
3 **SIONS.**

4 (a) PPACA AMENDMENTS.—Section 1304(b) of the
5 Patient Protection and Affordable Care Act (42 U.S.C.
6 18024(b)) is amended—

7 (1) in paragraph (1), by striking “101” and in-
8 serting “51”;

9 (2) in paragraph (2), by striking “100” and in-
10 serting “50”; and

11 (3) by amending paragraph (3) to read as fol-
12 lows:

13 “(3) STATE OPTION TO EXTEND DEFINITION
14 OF SMALL EMPLOYER.—Notwithstanding paragraphs
15 (1) and (2), nothing in this section shall prevent a
16 State from applying this subsection by treating as a
17 small employer, with respect to a calendar year and
18 a plan year, an employer who employed an average
19 of at least 1 but not more than 100 employees on
20 business days during the preceding calendar year
21 and who employs at least 1 employee on the first
22 day of the plan year.”

23 (b) PHSA AMENDMENTS.—Section 2791(e) of the
24 Public Health Service Act (42 U.S.C. 300gg-91(e)) is
25 amended—

1 (1) in paragraph (2), by striking “101” and in-
2 serting “51”;

3 (2) in paragraph (4), by striking “100” and in-
4 serting “50”; and

5 (3) by adding at the end the following new
6 paragraph:

7 “(7) STATE OPTION TO EXTEND DEFINITION
8 OF SMALL EMPLOYER.—Notwithstanding paragraphs
9 (2) and (4), nothing in this section shall prevent a
10 State from applying this subsection by treating as a
11 small employer, with respect to a calendar year and
12 a plan year, an employer who employed an average
13 of at least 1 but not more than 100 employees on
14 business days during the preceding calendar year
15 and who employs at least 1 employee on the first
16 day of the plan year.”.

○

September 2, 2015

The Honorable John Boehner
Speaker
U.S. House of Representatives

The Honorable Mitch McConnell
Majority Leader
United States Senate

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives

The Honorable Harry Reid
Minority Leader
United States Senate

Dear Bipartisan Leaders,

As employer organizations representing the interests of millions of businesses of every size, sector, and region, we write to urge your swift action by mid-September to pass the *Protecting Affordable Coverage for Employers (PACE) Act* (H.R. 1624 / S. 1099). This legislation would allow states to keep the current definition of a small group market as 50 and fewer employees, or expand the group size if the market conditions necessitate the change. Removing the *Affordable Care Act's* mandated expansion and returning to the historical role of state determination will mitigate dramatic premium increases and allow small employers to keep their health plans.

To minimize disruption to small employers, it is imperative the *PACE Act* be enacted this September. Not only will states need time to make and implement decisions regarding the size of the market, but brokers and businesses also need time to communicate information with and enroll employees. Brokers and employers need to have final rates and product information by late September, as about one-third of mid-sized employers renew their coverage in January. To renew or begin new plans in January, businesses traditionally shop for coverage options in September and October to get the best deals. These employers must make their final coverage decisions in October so that they can prepare employee communications and open enrollment materials. They then conduct open enrollment in advance of the effective date so employees can select a health plan – similar to open enrollment for federal employees and other large employers. It is critical to enact this legislation now to allow employers time for this process to unfold.

We are pleased to see that support for the *PACE Act* has grown tremendously since its introduction this spring. The House of Representatives has over 200 bipartisan cosponsors, and the Senate has nearly 30 bipartisan cosponsors. It is clear Members of Congress have recognized that time is of the essence to avoid significant disruption and much higher premiums for the small and mid-size groups.

Thank you for your continued attention to this urgent matter. We look forward to working with you to move the bipartisan *PACE Act* forward by mid-September to protect small and mid-sized employers and their employees.

Sincerely,



America's Health
Insurance Plans

Karen Ignagni
President &
Chief Executive Officer



March 26, 2015

The Honorable Brett Guthrie
United States House of Representatives
2434 Rayburn Building
Washington, D.C. 20515

The Honorable Tony Cardenas
United States House of Representatives
1510 Longworth Building
Washington, D.C. 20515

Dear Representatives Guthrie and Cardenas:

On behalf of America's Health Insurance Plans (AHIP), I am writing to express our support for your bipartisan legislation to amend the Affordable Care Act's definition of the small group market and provide a role for the states in addressing this issue.

Our members appreciate your efforts to address the concerns of employers that have 51 to 100 employees, many of whom potentially could face higher premiums under ACA provisions that re-define employer size. By restoring the traditional definition of a small employer and giving states flexibility in this area, your legislation takes an important step toward promoting market stability and avoiding coverage disruptions for businesses and families. We believe your bill offers a thoughtful solution to addressing the concerns of our employer customers and would take important steps to prevent cost increases.

Thank you for your strong leadership on this important issue. We look forward to continuing to work with you.

Sincerely,



Karen Ignagni
President and CEO

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004
202.778.3200



July 8, 2015

The Honorable Brett Guthrie
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Tony Cardenas
U.S. House of Representatives
1510 Longworth House Office Building
Washington, D.C. 20515

Dear Representatives Guthrie and Cardenas:

On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business advocacy organization, I'm writing in support of H.R. 1624, the *Protecting Affordable Coverage for Employees Act*. This bipartisan legislation would prevent the federally mandated expansion of the small group health insurance market to businesses with up to 100 employees beginning in 2016, as required by the Patient Protection and Affordable Care Act (ACA). Instead, it would maintain existing state small group health insurance market definitions of 1-50 employees, and would permit states to choose whether to expand their small group health insurance market definition.

Beginning on January 1, 2016, the ACA will create a federal definition of the small group health insurance market, replacing existing state small group health insurance markets. In March, NFIB wrote a letter to Health and Human Services (HHS) Secretary Sylvia Mathews Burwell detailing potential health insurance premium increases and benefit flexibility limitations for small businesses resulting from the expansion.

A March 2015 issue brief from the American Academy of Actuaries (AAA) estimates the premium impact on current small group market enrollees (businesses with 1-50 employees) and newly eligible small group market enrollees (businesses with 51-100 employees).¹ The AAA states businesses with 51-100 would face more restrictive rating rules and additional benefit and cost-sharing requirements, which would increase premiums. Many healthy midsize businesses would be incentivized to self-insure, avoiding the new requirements. Costs would likely increase for the current small group market enrollees as less healthy midsize businesses are absorbed into the small group health insurance market outweighing any benefits of increased risk pooling, according to the brief.

Many states are taking advantage of the administration's option to allow non-ACA-compliant plans to continue through 2017, providing temporary relief for businesses with 51-100 employees from the new requirements and costs. Without further action, these businesses would be subject to lose the health insurance plans they currently enjoy in the near future. Small businesses require a more permanent solution.

This pending expansion of the small group health insurance market is tremendously concerning for small business owners and their employees. H.R. 1624 would avert these consequences for many businesses by maintaining the current state small group market definitions (1-50 employees), unless a state chooses to expand the market. We look forward to working with you in the 114th Congress on this important issue.

Sincerely,



Amanda Austin
Vice President
Public Policy

¹ Issue Brief, March 2015. American Academy of Actuaries. http://www.actuary.org/files/Small_group_def_ib_030215.pdf.



April 23, 2015

Dear Representatives Guthrie, Cardenas, Mullin, and Sinema:

On behalf of the National Small Business Association, I would like to thank you for your leadership in crafting the *Protecting Affordable Coverage for Employees Act of 2015 (H.R. 1624)*. As the nation's oldest nonpartisan small business advocacy group, NSBA reaches more than 65,000 small businesses nation-wide, and reducing the high cost of health care on small businesses remains a top priority for NSBA. We are pleased to support this measure's efforts to give flexibility to both states and small-to-medium-sized businesses in managing health care costs.

Under the Patient Protection and Affordable Care Act (PPACA), rules governing small group health insurance plans will begin to cover groups of up to 100 employees in 2016. Previously governed by state law, small group rules have generally applied to employers with fewer than 50 employees. Your legislation wisely gives states back the flexibility to decide whether to increase the small group size from 50 to 100 employees.

We are concerned about the current PPACA requirements, since actuarial studies suggest that many companies will see a significant increase in premiums once the small group size goes to 100 employees, particularly for companies that employ younger, healthier workforces. These premium spikes are likely to cause many of those companies to curtail coverage, drop coverage, or shift to a self-insurance option. Once those younger, healthier lives leave the small group fully-insured pool, premiums will rise further for those that remain.

Thank you for your foresight and commitment to keeping further increases in health premiums to a minimum. We look forward to working with you to help insure the passage of this important legislation.

Yours truly,



Todd McCracken
President and CEO



National Association of Insurance and Financial Advisors

2901 Telestar Court • Falls Church, VA 22042-1205 • (703) 770-8188 • www.naifa.org

March 27, 2015

The Honorable Brett Guthrie
United States House of Representatives
2434 Rayburn Building
Washington, D.C. 20515

The Honorable Tony Cardenas
United States House of Representatives
1510 Longworth Building
Washington, D.C. 20515

Dear Representatives Guthrie and Cardenas:

The National Association of Insurance and Financial Advisors (NAIFA) applauds your efforts to amend the Affordable Care Act's definition of the small group market and provide a role for the states in addressing this issue.

Small businesses often rely on NAIFA members to advise them on appropriate health insurance and employee benefits coverage for their employees. H.R. 1624, the Protecting Affordable Coverage for Employees Act will ensure that small group markets remain defined as 1-50 employees rather than change to 1-100 employees on January 1, 2016. This bipartisan modification to the ACA will help NAIFA members continue to serve their small employer clients and avoid plan disruption for employers with 51-100 employees. Without a modification, employers with 51-100 employees will not be able to keep their current health care plans or purchase or renew plans that do not conform to the new regulations.

We look forward to continuing to work with you to enact H.R. 1624 and put in place meaningful reforms to help Americans meet their growing health insurance needs. Thank you again for your leadership.

Sincerely,



Juli Y. McNeely, LUTCF, CFP, CLU
NAIFA President



August 31, 2015

Senator Tim Scott
United States Senate
Washington, D.C. 20510

Representative Brett Guthrie
U.S. House of Representatives
Washington, D.C. 20515

Dear Senator Scott and Representative Guthrie,

The National Association of Professional Insurance Agents (PIA National) is pleased to support S. 1099/H.R. 1624), the Protecting Affordable Coverage for Employees (PACE) Act.

The PACE Act will reverse a misguided policy that would force employers with between 51 and 100 employees to change health care plans by requiring them to purchase insurance with additional mandates in 2016, ultimately leading to higher premiums. States have traditionally determined the size of the small group market operating in their jurisdiction, and all states currently define the small group market as employers with 1-50 employees.

The ACA expands the definition to include employers up to 100 beginning January 1, 2016. Expanding the small group market definition will subject mid-size employers to ACA small group market rating rules that will force premiums to increase. It will also force mid-size employers to change their plans creating a major disruptions for businesses and consumers.

The PACE Act will give states the flexibility to keep the existing small group market definition. By keeping the small group defined as 50 and fewer, instead of expanding it to include 100 and fewer, businesses and their employees will be able to keep their current health care plans and avoid paying higher premiums.

PIA National greatly appreciates your continued dedication to this issue. We look forward to continuing to work with you on this matter. If PIA National can be of any additional assistance, please contact Jon Gentile, PIA National director of federal affairs, at jonge@pianet.org.

Sincerely,



Mike Becker
Executive Vice President and CEO
PIA National



July 27, 2015

The Honorable Brett Guthrie
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Tony Cárdenas
U.S. House of Representatives
1510 Longworth House Office Building
Washington, D.C. 20515

The Honorable Markwayne Mullin
U.S. House of Representatives
1113 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kyrsten Sinema
U.S. House of Representatives
1530 Longworth House Office Building
Washington, D.C. 20515

Dear Representatives Guthrie, Cárdenas, Mullin, and Sinema:

On behalf of the Council for Affordable Health Coverage (CAHC), I am writing to express my strong support for the Protecting Affordable Coverage for Employees (PACE) Act (H.R. 1624). This bipartisan, common-sense legislation would avoid an unnecessary 18 percent increase in premiums and provide much-needed relief to small businesses.

As you may know, CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests — organizations representing small and large employers, insurers, brokers and agents, and physician and patient organizations.

We are extremely concerned about the technical provision in the Affordable Care Act (ACA) that would change the definition of the small group market to include employers with up to 100 employees beginning in 2016. This change will force many companies that have historically been defined as a "large group," into the "small group market." As a result, these companies will have to comply with new mandates, like benefits, rating rules, and actuarial value requirements that will drive up premiums. According to an Oliver Wyman report, if the small group definition moves to 100, premiums could increase by approximately 18 percent for a majority of those in the re-defined small group market. This is unacceptable.

Although 2016 is several months away, the need to address the small group definition is at a critical point as health insurance companies have already filed their proposed health insurance premium rates for the upcoming year. CAHC strongly supports the PACE Act, which would make a helpful adjustment to the ACA for small businesses by providing states with the flexibility to increase the small group market from 50 to 100 if they choose, but removing the

requirement that forces states to change the small group definition. Protecting and preserving the existing small group market will promote stability and predictability when it comes to health insurance premiums. It will also allow small and mid-sized businesses to keep existing health insurance plans for their employees.

Thank you for your leadership on this important issue. CAHC stands ready to work with you and your staff to advance this important legislation that will lower health care costs for small businesses and their employees.

Sincerely,



Joel C. White
President



March 26, 2015

The Honorable Brett Guthrie
308 Cannon House Office Bldg.
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Tony Cardenas
1508 Longworth House Office Bldg.
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Guthrie and Cardenas:

On behalf of the Blue Cross Blue Shield Association, I would like to commend the introduction of H.R. 1624, the Protecting Affordable Coverage for Employees Act. The 37 independent Blue Cross and Blue Shield companies across the country share your strong commitment to ensuring affordability and stability of health coverage for small employers, their employees and families, and we strongly support this important legislation to allow states to maintain the current small group market definition in order to prevent premium increases and disruption for small and mid-sized businesses.

Starting January 1, 2016, the Affordable Care Act expands the small group market definition to include employers with up to 100 employees. This will subject mid-sized employers with 51-100 employees to ACA small group market rating rules and regulations, increasing premiums for the vast majority of small employers, their employees and their families in the newly expanded small group market.

States have traditionally determined the size of their small group market, with almost all states defining their small group market to include employers with 1-50 employees. H.R. 1624 will ensure states maintain the ability to assess their particular markets and determine the small group definition that best suits their local needs.

Again, we support your commitment to ensuring small employers have access to affordable coverage and appreciate your leadership in introducing this important legislation.

Sincerely,



Alissa Fox
Senior Vice President



September 8, 2015

The Honorable Brett Guthrie
United States House of Representatives
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Tony Cardenas
United State House of Representatives
1510 Longworth Building
Washington, DC 20515

Dear Representatives Guthrie and Cardenas:

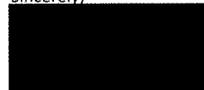
The Delta Dental Plans Association (DDPA) strongly supports HR 1624, the "Protecting Affordable Coverage for Employees Act." Your bipartisan bill protects employee access to dental coverage by amending the Affordable Care Act (ACA) and allowing states the flexibility to define the appropriate size of their small group markets.

Prior to 2016, the ACA allowed states to define their small group market as 50 or fewer employees. As of 2016, groups with up to 100 employees will be defined as part of the small group market. Employers with 51 or more employees will be required to offer coverage as part of the ACA's shared responsibility provisions, and their coverage choices may become more restricted once they fall under the new parameters of the small group market. HR 1624 gives states the flexibility they need to decide whether their small group marketplace should remain at 50 or fewer employees. This flexibility will ensure better choices of health plans and dental plans for constituents and employers in the small group market.

DDPA is the nation's largest, most experienced dental benefits system. Since 1954, DDPA has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups, and individuals. DDPA has traditionally been a strong supporter of the small group marketplace. Our nationwide network of 39 companies and over 150,000 dentists serves more than 68.6 million Americans in over 122,000 groups across the country. Of these, approximately three million enrollees are in the small group market. By providing states the flexibility to appropriately define the small group market within their jurisdictions, your legislation promotes market stability and preserves dental coverage.

DDPA thanks you for your work on this issue and we stand ready to provide any further support of this legislation which is critical to ensuring coverage for America's working families.

Sincerely,



Julia Grant
Vice President Government Relations
Delta Dental Plans Association



Representative Brett Guthrie
2434 Rayburn H.O.B.
Washington, DC 20515

Dear Representative Guthrie:

The Kentucky Chamber of Commerce thanks you for introducing H.R. 1624, which would maintain the current definition of a small group market as 1-50 employees, and would give states the flexibility to expand the group size if the market conditions in their state necessitate the change. It is in the best interest of Kentucky employers and their employees that states determine the definition of their small group market. By repealing the ACA mandated expansion and returning to the state determination model will allow flexibility for employers and ensure a broad array of coverage options and mitigate premium increases.

The Kentucky Chamber feels that expanding the small group market to include groups up to 100 would at this time would reduce choice for this segment of the market. Your legislation will help small businesses keep their current plans because if not implemented, many groups size 51-100 will find they will not be able to keep their current insurer if they are required to buy coverage in the small group market.

Expanding the small group market to include all groups with under 100 employees would have an immediate impact on premiums due to new required Essential Health Benefits, and minimum actuarial value and cost sharing requirements. As the rates increase, mid-sized groups may drop coverage, or self-insure, which would lead to additional rate increases for the small group market. By allowing employees to keep their current coverage, H.R. 1624 will help mitigate premium increases.

We thank you for your leadership on this issue that will greatly help the business community in Kentucky, particularly small business.

We also ask your support on another ACA related bill, the Ax the Tax on Middle Class Americans Health Plan Act (H.R. 879), introduced by Congressman Guinta. H.R. 879 would repeal the 40 percent excise tax that is set to go into effect in 2018 on high-value, employer-sponsored health insurance benefits. Although the implementation of this provision is several years away, Kentucky businesses are already having to restructure their benefits to avoid this costly tax.

The majority of Kentuckians receive their health benefits through their employers, so this 40 percent excise tax will have a major impact on both employers and employees. Because of the structure of this tax, almost half of all large employers are expected to be subject to the tax by 2018 and this number will rise to 82 percent by 2023.

We thank you for your support of these critical pieces of legislation, which will greatly help the business community and employees in Kentucky. If we can be of any assistance to you please let us know.

Sincerely,


Dave Adkisson
President & CEO

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
EXECUTIVE VICE PRESIDENT
GOVERNMENT AFFAIRS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

April 21, 2015

Dear Representatives Guthrie, Cárdenas, Mullin and Sinema,

The U.S. Chamber of Commerce, the world's largest business federation representing the interests of more than three million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations, and dedicated to promoting, protecting, and defending America's free enterprise system, thanks you for introducing H.R. 1624, the "Protecting Affordable Coverage for Employees Act." This legislation would allow states to maintain the current definition of small group market as the relevant insurance market for groups with 50 workers and below. Notably, it would protect small to mid-sized businesses from the significant rate shock that will accompany an expansion of the small group market to include groups with up to 100 employees.

If the small group market expands as current law proposes to include all groups with up to 100 employees, premiums will increase for those employer groups between 51 and 100 workers, making the small group market less stable. This expansion will be subjecting the smallest of the large applicable employers (those between 51-100) required to provide health coverage to all full-time employees to new benefit mandates and rating rules. Additionally, this small group market expansion bifurcates the employer community that is subject to the employer mandate; some "applicable large employers" between 51-100 will be required to provide coverage in the small group market and other "applicable large employers" will be required to provide coverage in the large group market where greater flexibility in rate setting and benefits exists. The change, which is scheduled to begin on January 1, 2016, will also reduce choice since national insurers are only in a portion of small group markets due to a variety of requirements for entry.

Changing the Affordable Care Act (ACA) mandated small group expansion and returning flexibility to the states, to either maintain the existing small group market definition or expand the group size depending on state conditions, is in the best interest of both employers and employees. With this flexibility, states would be able to protect the ability of employers to select from a broad array of coverage options and mitigate the potential for dramatic premium increases. Historically, regulation of the small group health insurance markets has been done at the state level by the state insurance commissioners. Even post-ACA, almost all states elected when they could to keep the small group market defined as serving groups 50 and under. By allowing states to maintain the existing small group market size, this legislation would mitigate premium increases and allow employees to keep their existing plans.

The Chamber thanks you for your leadership in introducing H.R. 1624 and believes this is an important and commonsense approach to protecting small and mid-sized businesses. We look forward to working with you and your colleagues as we find other solutions that improve access to affordable health care coverage and services for both employers and their employees.

Sincerely,



R. Bruce Josten

April 3, 2015

Dear Representatives Guthrie, Cárdenas, Mullin and Sinema,

The undersigned organizations represent the interests of millions of businesses of every size, sector, and region. As employer organizations, we applaud your introduction of legislation (H.R. 1624) maintaining the current definition of a small group market as 1-50 employees, and giving states the flexibility to expand the group size if the market conditions in their state necessitate the change. It is in the best interest of employers and their employees that states determine the definition of their small group market. Repealing the ACA mandated expansion and returning the historical role of state determination will allow flexibility and ensure a broad array of coverage options and mitigate dramatic premium increases.

Expanding the small group market to include groups up to 100 at this time would reduce choice for this segment of the market. While national insurers are in virtually every state's large group market, they are only in a portion of the small group markets – which have numerous administrative requirements for entry. As a result, many groups size 51-100 will find that they cannot keep the insurer they currently have once they are required to buy coverage in the small group market. Your legislation will help these small businesses keep their plans.

Further, expanding the small group market to include all groups with up to 100 employees would have an immediate impact on premiums due to new rating rules, required Essential Health Benefits, and minimum actuarial value and cost sharing requirements. As rates increase, more mid-sized groups may drop coverage or self-insure, resulting in additional rate increases for the small group market – including for those employers with less than 50 employees. Your legislation allowing states to maintain the existing small group market size will mitigate premium increases and allow employees to keep their existing plans.

We thank you for your leadership on this issue. We urge you to continue to work toward its swift passage to give states the flexibility to help protect small employers and their employees.

Sincerely,

American Hotel & Lodging Association
American Rental Association
American Supply Association
Associated Builders and Contractors, Inc.
Auto Care Association
Council for Affordable Health Coverage

Healthcare Leadership Council
International Franchise Association
National Association of Health Underwriters
National Association of Home Builders
National Association of Manufacturers
National Association of Wholesaler-Distributors
National Club Association
National Federation of Independent Business
National Restaurant Association
National Retail Federation
Society of American Florists
The Society for Human Resource Management
U.S. Chamber of Commerce



AMERICAN ACADEMY *of* ACTUARIES

Objective. Independent. Effective.™

**Potential Implications of the Small Group Definition Expanding
to Employers with 51-100 Employees**

Statement of Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

Submitted for the Record

U.S. House of Representatives Energy and Commerce Subcommittee on Health Hearing
Protecting Affordable Coverage for Employees
September 9, 2015

Chairman Pitts, Ranking Member Green, and distinguished Members of the Subcommittee:

On behalf of the American Academy of Actuaries¹ Individual and Small Group Market Committee, I appreciate the opportunity to provide a statement for the record on your subcommittee's hearing on "Protecting Affordable Coverage for Employees" pertaining to the Affordable Care Act (ACA) expansion of the small group definition.

In the current health insurance market, small employers are those employing up to 50 employees. For plan years beginning in 2016, the ACA expands the definition of small employers to include those with up to 100 employees. As groups with 51-100 employees renew or newly purchase coverage, they must abide by the rules and regulations governing the small group market, including those related to benefit coverage, actuarial value, and premium rating restrictions. The small group rules apply to fully insured plans, whether they are purchased through or outside of the Small Business Health Options Program (SHOP) marketplace. Plans covering groups with 100 or fewer employees will be pooled together for premium rating purposes.² Employers that self-insure are not subject to these requirements.

In addition to the expansion of the small employer definition, the ACA's shared-responsibility provisions, which already apply to groups of 100 and above, will begin applying to groups of 50-99 employees in 2016. Under these provisions, employers will face financial penalties if they have employees who obtain subsidized coverage in an exchange and either don't offer coverage

¹ The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² This paper refers to small groups as beginning with groups of one, although many states define small groups as beginning with groups of two.

or offer coverage that doesn't meet minimum value and affordability requirements.³ As a result, beginning in 2016, the small group market will consist of employers with 1-100 employees – those with 1-49 employees will not be subject to the shared-responsibility penalties but those with 50-100 employees will face them.

When considering the small group redefinition, it's important to consider the potential effects, not only on the groups sized 51-100, but also on those sized 1-50. This statement examines how the rules applying to groups sized 51-100 will change and what that means for insurance offerings in the small group market. Specifically, we find that:

- Many employers and employees will be affected by the change in the small group definition. Among employers offering coverage, employees in groups sized 51-100 comprise roughly 30 percent of employees in groups sized 1-100.
- Groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others.
- Groups sized 51-100 will face additional benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums.
- The more restrictive rating and benefit requirements could cause more groups sized 51-100 to self-insure, especially among those whose premiums would increase under the new rules.
- If adverse selection occurs among groups sized 51-100, premiums for groups sized 1-50 could increase.

Many employers and employees will be affected by the new small-group definition

The extent of a potential disruption due to the change in the definition of a small group depends in part on the size of the small group market as well as the relative size of the 51-100 employer group market compared to the 1-50 employer group market.

Data from the Medical Expenditure Panel Survey (MEPS) Insurance Component can be used to gauge the numbers of potentially affected employers and employees, even though the firm size categories of the MEPS differ slightly from the categories affected by the small group definition change. According to the MEPS, there were 159,000 private-sector establishments with a firm size between 50 and 99 that offered only fully insured coverage in 2013.⁴ Upon renewal of their health insurance plan in 2016, any insurance these groups obtain must meet the ACA small group requirements, unless they have grandfathered coverage.⁵ Although establishments with 50-99 employees comprised only 9 percent of all establishments with fewer than 100 employees that offered coverage, there were 3.4 million enrolled employees in these firms – 29 percent of the enrolled employees in firms with fewer than 100 employees.

³ See the Kaiser Family Foundation “Penalties for Employers Not Offering Coverage under the Affordable Care Act During 2015 and 2016,” for more details on the shared responsibility requirements and penalties. Available from: <http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>.

⁴ In the MEPS, the unit of observation is an establishment, but the size categories reflect the entire firm. Establishments reflect a particular workplace or physical location where business is conducted. A firm is a business entity consisting of one or more establishments under common ownership or control. A firm represents the entire organization. In the case of a single-location firm, the firm and establishment are identical.

⁵ Many states have adopted the ACA transition program, which allows small employers renewing coverage prior to Oct. 1, 2016, to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.

Private-Sector Establishments* Offering Coverage and Workers Enrolled, by Firm Size, 2013				
Firm Size	Establishments Offering Only Fully Insured Coverage**		Employees Enrolled in Fully Insured Coverage	
	Number (thousands)	Percent	Number (thousands)	Percent
1-49 Employees	1,592	91%	8,393	71%
50-99 Employees	159	9%	3,413	29%
Total 1-99 Employees	1,752	100%	11,806	100%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/instr/national/series_1/2013/ic13_ia_g.pdf.

* Private-sector establishments include the self-employed with employees and incorporated self-employed with no employees, but exclude the unincorporated, self-employed with no employees.

**Excludes establishments offering coverage that self-insure at least one plan, even if they also fully insure at least one plan.

The Employee Benefit Research Institute (EBRI) found similar results for 2012 when examining the Current Population Survey (CPS).⁶ Among enrolled employees in groups sized 1-99, 30 percent were in groups with 50-99 employees. This figure includes workers in both fully insured and self-insured plans.

Notably, both the MEPS estimates and the EBRI estimates using the CPS focus on coverage of employees by firm size but do not reflect total numbers of members, which not only includes employees but also dependents. Therefore, the total numbers of affected individuals are understated. Also, the relative size of groups 1-50 and groups 51-99 could be different when dependents are included.

Nevertheless, the number of employers and individuals who will be affected by the change in the small group definition is sizeable. How they are affected – in terms of benefit coverage and whether relative premiums would increase or decrease – will vary by group. These issues are discussed in more detail below.

Groups sized 51-100 will face more restrictive rating rules

Currently, issuers have broad flexibility in setting premiums for groups with 51-100 employees. There are no federal limitations in premium-rate development, and at the state level, fewer restrictions are in place for groups sized 51-100 compared to those sized 1-50. When the small group market is expanded, groups sized 51-100 will face significant new rating restrictions. The only allowable characteristics on which the rates may vary from one small group to another are age, geographic area, tobacco use, and family size.⁷ The impact of these more restrictive rules on premiums for groups sized 51-100 will vary across groups.

⁶ Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey." EBRI Issue Brief No. 390. September 2013. Available from: http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13_No390_Sources1.pdf.

⁷ Premium discounts also are available to groups with wellness programs.

Common rating variables for groups sized 51-100 that will be prohibited in 2016 include:

- *Health status/historical group claims experience.* Currently, premiums can reflect the health status or claims experience of the group. Beginning in 2016, premiums cannot vary by health status or claims experience of the group, as premiums must be set based on the experience of the risk pool as a whole, which includes all fully insured, non-grandfathered small groups that are insured by the issuer in the state.
- *Industry.* Industry is commonly used to reflect the differences in risk for blue-collar versus white-collar groups.
- *Group size.* The size of the employer is commonly used as a rating variable to reflect administrative efficiencies and adverse selection.
- *Gender.* Although premiums do not vary by gender within a group, issuers typically use age/gender factors when determining the overall premium of the group. These factors capture not only the impact of age on the cost of coverage, but also the impact of gender which varies by age. Gender rating will no longer be permitted and, as described below, age rating will be limited.
- *Employee participation rates and employer contribution shares.* Issuers often use these factors to reflect adverse selection, since higher participation rates and employer subsidies can be indicative of a better mix of health risks.

Additional federal limitations on the allowable rating variables that begin to apply to the 51-100 market in 2016 include:

- *Age.* Premiums for the group can reflect its age distribution, but the age rating factors are prescribed and may not vary for adults by more than a ratio of 3 to 1. That is, the rate for a 64-year-old cannot be more than three times the rate for a 21-year-old. Currently, issuers' age factors often reflect up to a 5-to-1 ratio or higher.
- *Geography.* Geographic regions within the state are prescribed and may be significantly different than the regions currently used by issuers.
- *Tobacco use.* Premiums may be increased to reflect tobacco use but not by more than 50 percent.
- *Family size.* At most, three children under the age of 21 within a family may be charged a premium. Additional children receive coverage at no additional charge.

These new rules may result in significant premium-rate changes for some groups, depending on the cumulative impact of the elimination or limitation of the various rating factors. These changes could have either a positive or a negative impact on the renewal rates for groups sized 51-100 in 2016. Premium changes will vary based on characteristics of the firm (e.g., firm size, industry, geographic location) and of its insured population, including employees and their dependents (e.g., age, gender, health status). For instance, the compression of premiums due to the age-rating restrictions will increase the relative rates for groups with a younger population and reduce them for groups with an older population. Similarly, the prohibition of health-status rating will increase the relative premiums for groups with a healthy population and reduce them for those with less healthy populations.

In addition to the changes in allowable premium rating factors, groups sized 51-100 could face a change in how issuers bill for group coverage. In the small group market, issuers bill employers by listing the rate applicable to each enrolled employee, based on the age of each member – employee and dependent – enrolled in the plan.⁸ This is referred to as list billing. In contrast, for groups sized 51-100, issuers usually use composite rating, in which the premiums shown on the bill represent the average rate for each family size coverage tier offered. Issuers also may choose to offer its small groups a composite premium option, and the total group premium would be the same as that under list billing. The approach determining the composite premium for the small group market, however, is very different from that currently used for groups sized 51-100. If list billing is extended to the 51-100 group market, it will introduce administrative complexity for that market that does not exist today.

Groups sized 51-100 will face additional benefit and cost-sharing requirements

When the expanded small group definition becomes effective, groups sized 51-100 will for the first time be under ACA plan-design requirements that already apply to groups sized 1-50. First, these groups will be subject to the essential health benefits (EHB) requirement, which defines the set of health care service categories that must be covered by the plan. EHBs include some benefits, such as pediatric dental, that typically are not included in plans in the large group medical market. Second, all plans must satisfy a metallic benefit level ranging from bronze to platinum, reflecting the actuarial value of the plans' cost-sharing features (i.e., the portion of covered benefits paid for by the plan, on average).

When these new requirements were imposed on small groups sized 1-50 beginning in 2014, they did not significantly impede plan-design flexibility, because these groups were already subject to a fairly limited range of benefit-design choices. Compared to groups with 50 or fewer employees, however, groups with more than 50 employees typically have had more flexibility in the benefit options from which they could choose, both from a covered-services perspective as well as for specific cost-sharing features. The ACA required non-grandfathered plans for groups larger than 50 to comply with provisions related to annual out-of-pocket limits, annual benefit limits, and coverage of preventive services with no consumer cost sharing.⁹ But aside from these requirements and the 60 percent minimum value requirement, the ACA allowed large groups a great deal of flexibility regarding covered benefits and other plan-design features.

As a result, the new requirements will impose a greater reduction in benefit and cost-sharing flexibility for groups sized 51-100 than they currently experience. Plans likely will need to be changed to meet benefit coverage and actuarial value requirements. Such changes also could affect premiums. For instance, upward pressure on premiums could result if the EHB and cost-sharing requirements result in more generous coverage.

Younger and healthier groups sized 51-100 may face increased incentives to self-insure

Groups sized 51-100 that will be subject to the small group market rules may have increased incentives to self-insure. A primary reason might be to avoid a higher premium in the fully insured, small group market due to premium-rating limitations and benefit and cost-sharing

⁸ As noted above, a maximum of three children under the age of 21 can be billed as dependents for a specific employee.

⁹ In addition to these provisions, plans were no longer allowed to impose benefit limitations on pre-existing conditions or to charge higher cost-sharing for emergency services provided out of network.

requirements. A self-funded group's health plan costs more directly reflect its own claims experience and demographics. Therefore, groups more likely to see relative premium increases, including those with a younger and healthier population, may have the greatest incentives to self-insure. Offsetting these potential advantages are: a greater fluctuation in cash flow associated with self-funding; potentially greater financial risk, depending on the morbidity of the group; and a greater assumption of administrative responsibilities as well as compliance and reporting requirements, which generally are within the domain of the insurer. Reinsurance mechanisms and third-party administrators can mitigate these disadvantages.

Although self-insurance typically has been more prevalent among larger firms, lower stop-loss attachment points have become more available, making self-insurance with stop-loss coverage a more viable, and less risky, option for small employers. In addition, self-insuring becomes somewhat less risky to plans after the small group definition is extended because it provides these groups the protection of guaranteed issue coverage. Currently, if a member of the self-insured group has a significant continuing claim, the employer's costs will increase. In the underwritten large group market, the employer may have difficulty renewing its stop-loss coverage or finding a fully insured plan with a premium not reflecting the high cost of that continuing claim. As a small group, however, the employer could apply for fully insured, small group coverage at rates that do not reflect health status or claims experience. Once the claim is resolved, it could be possible for the employer to revert back to self-insurance. Notably, an EBRI study found that after Massachusetts implemented health reforms in 2006, self-funding increased for all firm sizes greater than 50.¹⁰

If higher-cost groups sized 51-100 continue to opt for fully insured coverage but more lower-cost groups self-insure, the small group, single risk pool plans would experience adverse selection. Premiums for these plans would increase as a result.

Prevalence of Self-Funding

Employers that offer health insurance benefits can opt to purchase fully insured coverage or they can opt to bear the insurance risks themselves and self-insure. The Employee Retirement Income Security Act (ERISA) exempts self-insured health plans from state health insurance regulations, including issue and rating rules and benefit requirements. As a result, self-insured groups can have more flexibility regarding benefit coverage and plan design, and their costs more directly reflect their actual claims. Self-insured groups are also exempt from state premium taxes and the ACA health insurance fee levied on fully insured plans. Although self-insuring can subject firms to risks of unexpected high claims, this risk can be limited through the purchase of stop-loss coverage.

¹⁰ Paul Fronstin, "Self-Insured Health Plans: State Variation and Recent Trend by Firm Size." EBRI Notes: 33(11). November 2012. Available from: http://www.ebri.org/pdf/notespdf/ebri_notes_11_nov-12.slf-insrd1.pdf

Employer size, in particular, is a primary factor in determining whether it is feasible for an employer to self-insure. In smaller groups, large year-to-year fluctuations in claims can occur, making it more difficult and risky to budget directly for health costs. As group size increases, however, health claims are likely to be more predictable and stable. Indeed, the prevalence of self-funding generally increases by firm size.

Percent of Private-Sector Enrollees that are Enrolled in Self-Insured Plans at Establishments that Offer Health Insurance, by Firm Size, 2013	
Firm Size	Percent of Enrollees in Self-Insured Plans
1-10	13.1%
10-24	9.7%
25-49	11.9%
50-99	14.3%
100-999	33.6%
1,000+	85.6%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from:
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/ic13_ia_g.pdf

An employer's demographic characteristics, which factor into expected health costs, also can influence whether it self-insures. For instance, groups with younger or higher-paid employees may be more likely to self-insure than those with older or lower-paid employees.

Adverse selection among groups sized 51-100 could increase premiums for groups sized 1-50

Current premiums for groups sized 1-50 reflect the average costs for those groups. When the small group definition is extended, premiums in the small group market will change to reflect the influx of groups sized 51-100. If the average costs for groups sized 51-100 that enter the market exceed the current average costs of groups sized 1-50, due to adverse selection or other reasons, small group rates would increase as a result. In response to any higher premiums, groups sized 1-50 may reconsider their decision to offer health insurance, especially because they are not subject to the employer-shared responsibility provisions.

Although it is possible that premiums for groups sized 1-50 would decline if groups sized 51-100 are lower cost on average than smaller groups and they opt to continue to fully insure, factors exerting upward pressure are more likely to dominate.

The premium impact on groups sized 1-50 will depend not only on the average costs of the groups sized 51-100 relative to those of groups sized 1-50, but also the distribution by group size within the 1-100 market. There are more than twice as many covered employees in the 1-50 group size category than in the 51-100 category, which would somewhat moderate the premium impact.

The full impact of the small group definition change on premiums will occur over several years

Many states have adopted the ACA-transition program, which allows small employers to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.¹¹ Groups sized 51-100 that would face higher costs or less attractive benefit plans by moving to an ACA-compliant, small group plan would be more likely to renew their current plans into 2017, after which they would need to move to a small group plan if they want fully insured coverage. This postponement would likely result in higher small group market premiums in 2016. Such an increase could be temporary to the extent that lower-cost groups eventually purchase small group plans in 2017 rather than moving to self-insured plans. Therefore, a new equilibrium may be delayed until 2018, with premium impacts differing in the intervening years.

Conclusion

For plan years beginning in 2016, the definition of small employers will expand from employers with 1-50 workers to also include those with 51-100 workers. Such a change could affect over 150,000 establishments with more than 3 million workers. Groups sized 51-100 will face more restrictive rating rules, which likely would increase relative premiums for some groups, such as those with younger and healthier populations, and reduce relative premiums for others, such as those with older and sicker populations. Additional benefit and cost-sharing requirements could increase the comprehensiveness of coverage, and could also reduce plan-design flexibility and increase premiums. These changes may provide increased incentives for groups sized 51-100 to self-insure in order to avoid these requirements. In particular, the prevalence of self-insurance among lower-cost groups could increase. If such adverse selection were to occur, average premiums could increase not only for fully insured groups sized 51-100 but also for groups sized 1-50, because these two subgroups will be combined for premium rating purposes.

¹¹ The March 4, 2015, CMS Bulletin, "Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016," gives states the option of deferring compliance with the expanded small group definition for groups renewing their policies on or before Oct. 1, 2016. This is a state-by-state decision. Available from: <http://www.cms.gov/CCHO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.



May 18, 2015

The Honorable Brett Guthrie
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Tony Cárdenas
1510 Longworth House Office Building
Washington, D.C. 20515

Dear Representatives Guthrie and Cárdenas :

On behalf of the membership of the National Association of Insurance Commissioners¹, we write today to offer our support and appreciation for the Protecting Affordable Coverage for Employees Act (H.R. 1624/S. 1099). The flexibility afforded to states in this legislation will help ensure stable small group health insurance markets that reflect the unique characteristics and dynamics at play in each of our states. As you know, section 1304(b) of the Patient Protection and Affordable Care Act (ACA) changes the definition of the small group market to include all employers with 1-100 employees. The states, however, are allowed to continue defining the small group market as employers with 1-50 employees until January 1, 2016. Beginning on or after this date, plans sold or renewed for employers with 51-100 employees will be subject to the various small group health plan regulations established by the ACA, such as essential health benefits, rating pools, actuarial value requirements, adjusted community rating rules, medical loss ratio requirements, and others.

The U.S. Department of Health and Human Services has offered a transition option by publishing guidance that they will not enforce certain small group market regulations for existing health plans provided by employers with 51-100 employees if the plan is renewed on or before October 1, 2016, effectively staving off the new regulations until October 1, 2017. The NAIC surveyed the 50 states and the District of Columbia, and most responded they will be utilizing this transition option. Nevertheless, we believe a more comprehensive fix provided by this legislation is necessary.

The NAIC shares your concern that changing the definition of the small group market nationwide to include all employers with 51-100 employees could adversely affect consumers and small business owners. Some employers will lose their current coverage; some will have fewer coverage options; and some will have their health insurance costs increase. The impact will vary by state, which is why defining the small group market should be left to the states.

¹ Founded in 1871, the NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

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With this flexibility in mind, we must note the NAIC is concerned with the limitations imposed on the States in Section 2(b)(7) of this legislation by only allowing them to extend the definition of the small group market to employers with 51-100 employees, as opposed to any number they deem appropriate for their market. We would ask you to consider this additional flexibility, but recognize that even as drafted this legislation represents a significant and important improvement over current law. Thank you again for your leadership on this issue, and we look forward to working with you as this bill moves through the legislative process.

Sincerely,



Monica J. Lindeen
NAIC President
Commissioner
Montana Office of the Commissioner of Securities
and Insurance, State Auditor



John M. Huff
NAIC President-Elect
Director
Missouri Department of Insurance, Financial
Institutions and Professional Registration



Sharon P. Clark
NAIC Vice President
Commissioner
Kentucky Department of Insurance



Ted Nickel
NAIC Secretary-Treasurer
Commissioner
Wisconsin Office of the Commissioner of
Insurance



Senator E. Benjamin Nelson
NAIC Chief Executive Officer



Impact of Small Group Definition on Employers and Their Employees

Employers with 51 to 100 employees will be included in the Affordable Care Act's (ACA) definition of small group market starting in 2016. Instead of providing stability, expanding the definition will force those historically defined "large group plans" into the "small group market," where they will experience higher premiums, less flexibility, and new barriers to coverage.

- **Premium increases:** Premiums would be impacted by benefit package changes, deductible changes, rating changes, limitations and other issues. Sixty-four percent of members in the redefined small group would receive an 18% premium increase on average. Some employers could easily see premium impacts of 35% or more.
- **Reduced competition:** While many national insurers are in almost all states for large group market coverage – they are only in some small group markets. Once groups sized 51-100 become "small groups" – insurers would need to enter the entire small group market in order to continue to sell coverage to this segment. The reality is that most groups sized 51-100 will end up with fewer insurance carrier options once they are "redefined" into the small group market.
- **Negative coverage impacts:** Employers that are faced with significant premium changes could choose to self-fund, drop or downgrade coverage. The U.S. Bureau of Labor Statistics indicates there are around 8.8 million workers in this segment. If even a portion of those workers are negatively impacted, we could see millions of individuals negatively impacted by this group size definition change.
- **Timing issues:** As enacted, the ACA was supposed to have provided this market segment with two full years of experience under the employer mandate and in SHOP exchanges before re-categorizing their plans into the small group market. Because these two very significant building blocks have not occurred as anticipated (both SHOP and the mandate have been delayed), continuing on with a redefinition of small group in 2016 would be particularly harmful and disruptive.

CAHC supports efforts to delay a change in the small group definition and the Protecting Affordable Coverage for Employees (PACE) Act (S. 1099/H.R. 1624).

- Bipartisan, common-sense legislation would provide states with flexibility to increase the small group market from 50 to 100 if they choose, but remove the requirement that forces states to change the small group definition.
- Protecting and preserving the existing small group market will promote stability and predictability when it comes to health insurance premiums.
- Allows small and mid-sized businesses to keep existing health insurance plans for their employees.



Avoiding Health Insurance Rate Shock for Medium-Size Businesses

By Jacqueline Stewart and David Kendall

Despite the ongoing debate over the *Affordable Care Act* (ACA) in Washington, a majority of voters have been very clear about what they want: fix it, not nix it. [Nearly two-thirds of Americans](#) want Congress to improve the law, with only one-third staunchly in the repeal-and-replace camp.

Where to start? One key step is to prevent “rate shock” from hitting medium-size businesses across the United States.

What is happening?

Currently, small employers (up to 50 employees) face different health insurance regulations than medium-size employers (51-100 employees). But, starting in 2016, the insurance regulations for small employers will be extended to medium-size employers. This is because the ACA calls for “blending” the insurance rates by creating one large insurance pool with one set of insurance regulations for employers with up to 100 employees. When that happens, health plans will have to base their insurance rates on those two groups *together*—instead of the way they have done it historically, which was to keep the more volatile small employer market separate from the medium-size employers.

The ACA has improved the stability of coverage for small employers and individuals through provisions such as stopping health plans from charging higher premiums for sicker employees, but the risks of applying the same regulations to medium-size employers may not be worth the trouble, as ACA supporter Sabrina Corlette at the Georgetown University Health Policy Institute has [written](#).

What is the problem?

The problem is twofold: rate shock for medium-size employers and a rate increase for small employers.

Rate shock for medium-size employers

- Currently, many medium-size businesses pay less than they would if they were part of the small group market because they have healthier, younger employees. Small group market rules don't allow premiums to vary health status and also limit the degree to which premiums can vary by the ages of employees. Therefore, many medium-size employers with low premiums would face sharp premium increases, or "rate shock," in 2016 when they pay the rates as small employers. Specifically, nearly two-thirds of medium-size employers could face an average [18% hike](#) in their premiums. While 2016 is more than a half-year away, the problem is urgent, as health plans will start filing their insurance premium rates on May 15, 2015 for the upcoming year. Since the Administration has not yet asserted that it has the authority to grant relief, Congress may need to act before the August recess to allow health plans time to file those rates for new policies and renewals that start on January 1, 2016.
- Once those medium-size employers with healthier employees experienced the rate shock, they could choose to self-insure, which would mean they would avoid having their insurance premiums blended with the larger insurance pool of small employers. The medium-sized employers that chose to purchase health insurance in the new small group market, rather than self-insure, would be on average, older and sicker, and average premiums would rise.
- Wouldn't medium-size employers see a reduction in premiums from being part of a bigger insurance pool that included small employers? No. Any savings from a larger pool would not be enough to offset the rate shock. Moreover, the economies from a larger insurance pool could occur without blending the rates through [private health insurance exchanges](#) that combine the purchasing power of individual employers.

Rate increase for small employers

- After the dust settled from the rate shock, small employers would see their insurance rates go up, too. As the [American Academy of Actuaries](#) points out, the insurance market for small employers would have, on average, more older and sicker employees because of the self-insurance among medium-size employers. As employers with healthier, younger employees pull out of the insurance pool to self-insure, the premiums for everyone else will go up.
- The rates for small employers whose rates were blended with medium-size employers could go up by as much as 5% according to an [Oliver Wyman study](#).

Our recommendation:

First, the Administration should delay the blending of insurance rates for the small and medium-size employers for at least one year. Several Members of Congress [have recently urged](#) the administration to do so, and we support those efforts. The administration has already minimized

disruption to current health care coverage by delaying the implementation of several provisions—including the employer responsibility requirement (also known as the employer mandate) and full operation of the Small Business Health Options Program (SHOP) exchanges, among others.

Second, enact a long-term fix. An important starting point for a legislative fix is a [bipartisan bill](#) (S. 1099/H.R. 1624) introduced by Sens. Tim Scott (R-SC) and Jeanne Shaheen (D-NH) and Reps. Brett Guthrie (R-KY) and Tony Cárdenas (D-CA). The Protecting Affordable Coverage for Employees (PACE) legislation would stop potential health insurance rate shock by allowing states to choose whether to maintain the status-quo small group market or expand the pool to mid-sized employers.

AMERICAN ACADEMY of ACTUARIES

ISSUE BRIEF

MARCH 2015

Key Points

- Many employers and employees will be affected by the change in the small group definition. Among employers offering coverage, employees in groups sized 51-100 comprise roughly 30 percent of employees sized 1-100.
- Groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others.
- Groups sized 51-100 will face additional benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums.
- The more restrictive rating and benefit requirements could cause more groups sized 51-100 to self-insure, especially among those whose premiums would increase under the new rule.
- If adverse selection occurs among groups sized 51-100, premiums for groups sized 1-50 could increase.

Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees

In the health insurance market, small employers are those employing up to 50 employees. For plan years beginning in 2016, the Affordable Care Act (ACA) expands the definition of small employers to include those with up to 100 employees. As groups with 51-100 employees renew or newly purchase coverage, they must abide by the rules and regulations governing the small group market, including those related to benefit coverage, actuarial value, and premium rating restrictions. The small group rules apply to fully insured plans, whether they are purchased through or outside of the Small Business Health Options Program (SHOP) marketplace. Plans covering groups with 100 or fewer employees will be pooled together for premium rating purposes.¹ Employers that self-insure are not subject to these requirements.

In addition to the expansion of the small employer definition, the ACA's shared-responsibility provisions—which already apply to groups of 100 and above—will begin applying to groups of 50-99 employees in 2016. Under these provisions, employers will face financial penalties if they have employees who obtain subsidized coverage in an exchange and either don't offer coverage or offer coverage that doesn't meet minimum value and affordability requirements.² As a result, be-

1. This paper refers to small groups as beginning with groups of one, although many states define small groups as beginning with groups of two.
2. See the Kaiser Family Foundation "Penalties for Employers Not Offering Coverage under the Affordable Care Act During 2015 and 2016," for more details on the shared responsibility requirements and penalties. Available from: <http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>.

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ginning in 2016, the small group market will consist of employers with 1-100 employees - those with 1-49 employees will not be subject to the shared-responsibility penalties but those with 50-100 employees will face them.

As the small group market redefinition takes effect, it's important to consider the potential effects, not only on the groups sized 51-100, but also on those sized 1-50. The American Academy of Actuaries' Individual and Small Group Market Task Force developed this brief to examine how the rules applying to groups sized 51-100 will change and what that means for insurance offerings in the small group market. Specifically, this paper finds that:

- Many employers and employees will be affected by the change in the small group definition. Among employers offering coverage, employees in groups sized 51-100 comprise roughly 30 percent of employees in groups sized 1-100.
- Groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others.
- Groups sized 51-100 will face additional

benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums.

- The more restrictive rating and benefit requirements could cause more groups sized 51-100 to self-insure, especially among those whose premiums would increase under the new rules.
- If adverse selection occurs among groups sized 51-100, premiums for groups sized 1-50 could increase.

Many employers and employees will be affected by the new small-group definition

The extent of a potential disruption due to the change in the definition of a small group depends in part on the size of the small group market as well as the relative size of the 51-100 employer group market compared to the 1-50 employer group market.

Data from the Medical Expenditure Panel Survey (MEPS) Insurance Component can be used to gauge the numbers of potentially affected employers and employees, even though the firm size categories of the MEPS differ slightly from the categories affected by the small group definition change. According to the MEPS, there were 159,000 private-sector establishments with a firm size between 50 and 99 that offered only fully insured coverage in 2013.³ Upon renewal of their health insurance plan in 2016, any insurance these groups obtain must meet the ACA small group

Private-Sector Establishments* Offering Coverage and Workers Enrolled, by Firm Size, 2013				
Firm Size	Establishments Offering Only Fully Insured Coverage**		Employees Enrolled in Fully Insured Coverage	
	Number (thousands)	Percent	Number (thousands)	Percent
1-49 Employees	1,592	91%	8,393	71%
50-99 Employees	159	9%	3,413	29%
Total 1-99 Employees	1,752	100%	11,806	100%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/ic13_ia_g.pdf

*Private-sector establishments include the self-employed with employees and incorporated self-employed with no employees, but exclude the unincorporated, self-employed with no employees.

**Excludes establishments offering coverage that self-insure at least one plan, even if they also fully insure at least one plan.

3. In the MEPS, the unit of observation is an establishment, but the size categories reflect the entire firm. Establishments reflect a particular workplace or physical location where business is conducted. A firm is a business entity consisting of one or more establishments under common ownership or control. A firm represents the entire organization. In the case of a single-location firm, the firm and establishment are identical.

requirements, unless they have grandfathered coverage.⁴ Although establishments with 50-99 employees comprised only 9 percent of all establishments with fewer than 100 employees that offered coverage, there were 3.4 million enrolled employees in these firms—29 percent of the enrolled employees in firms with fewer than 100 employees.

The Employee Benefit Research Institute (EBRI) found similar results for 2012 when examining the Current Population Survey (CPS).⁵ Among enrolled employees in groups sized 1-99, 30 percent were in groups with 50-99 employees. This figure includes workers in both fully insured and self-insured plans.

Notably, both the MEPS estimates and the EBRI estimates using the CPS focus on coverage of employees by firm size but do not reflect total numbers of members, which not only includes employees but also dependents. Therefore, the total numbers of affected individuals are understated. Also, the relative size of groups 1-50 and groups 51-99 could be different when dependents are included.

Nevertheless, the number of employers and individuals who will be affected by the change in the small group definition is sizeable. How they are affected in terms of benefit coverage and whether relative premiums would increase or decrease will vary by group. These issues are discussed in more detail below.

Groups sized 51-100 will face more restrictive rating rules

Currently, issuers have broad flexibility in setting premiums for groups with 51-100 employees. There are no federal limitations in premium-rate development,

and at the state level, fewer restrictions are in place for groups sized 51-100 compared to those sized 1-50. When the small group market is expanded, groups sized 51-100 will face significant new rating restrictions. The only allowable characteristics on which the rates may vary from one small group to another are age, geographic area, tobacco use, and family size.⁶ The impact of these more restrictive rules on premiums for groups sized 51-100 will vary across groups.

Common rating variables for groups sized 51-100 that will be prohibited in 2016 include:

- **Health status/historical group claims experience.** Currently, premiums can reflect the health status or claims experience of the group. Beginning in 2016, premiums cannot vary by health status or claims experience of the group, as premiums must be set based on the experience of the risk pool as a whole, which includes all fully insured, non-grandfathered small groups that are insured by the issuer in the state.
- **Industry.** Industry is commonly used to reflect the differences in risk across groups.
- **Group size.** The size of the employer is commonly used as a rating variable to reflect administrative efficiencies and adverse selection.
- **Gender.** Although premiums do not vary by gender within a group, issuers typically use age/gender factors when determining the overall premium of the group. These factors capture not only the impact of age on the cost of coverage, but also the impact of gender, which varies by age. Gender rating will no longer be permitted and, as described below, age rating will be limited.

4. Many states have adopted the ACA transition program, which allows small employers renewing coverage prior to Oct. 1, 2016, to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.

5. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey," EBRI Issue Brief No. 390, September 2013. Available from: http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13_No390_Sources1.pdf

6. Premium discounts also are available to groups with wellness programs.

Members of the Individual and Small Group Market Task Force include Chairperson, Karen Bender, MAAA, ASA, FCA; Eric Best, MAAA, FSA; Philip Bieluch, MAAA, FSA, FCA; Joyce Bohl, MAAA, ASA; April Choi, MAAA, FSA; Richard Diamond, MAAA, FSA; James Drennan, MAAA, FSA, FCA; Scott Fitzpatrick, MAAA, FSA; Rachel Killian, MAAA, FSA; Kuanhui Lee, MAAA, ASA; Timothy Luedtke, MAAA, FSA; Barbara Niehus, MAAA, FSA; Jason Nowakowski, MAAA, FSA; James O'Connor, MAAA, FSA; Bernie Rabinowitz, MAAA, FSA, FCIA, FIA, CERA; David Shea Jr., MAAA, FSA; Karin Swenson-Moore, MAAA, FSA; Steele Stewart, MAAA, FSA; Martha Stubbs, MAAA, ASA; David Tuomala, MAAA, FSA, FCA; Rod Turner, MAAA, FSA; Cori Uccello, MAAA, FSA, FCA, MPP; Dianna Welch, MAAA, FSA, FCA; and Thomas Wildsmith, MAAA, FSA

- *Employee participation rates and employer contribution shares.* Issuers often use these factors to reflect adverse selection, since higher participation rates and employer subsidies can be indicative of a better mix of health risks.

Additional federal limitations on the allowable rating variables that begin to apply to the 51-100 market in 2016 include:

- *Age.* Premiums for the group can reflect its age distribution, but the age rating factors are prescribed and may not vary for adults by more than a ratio of 3 to 1. That is, the rate for a 64-year-old cannot be more than three times the rate for a 21-year-old. Currently, issuers' age factors often reflect up to a 5-to-1 ratio or higher.
- *Geography.* Geographic regions within the state are prescribed and may be significantly different than the regions currently used by issuers.
- *Tobacco use.* Premiums may be increased to reflect tobacco use but not by more than 50 percent.
- *Family size.* At most, three children under the age of 21 within a family may be charged a premium. Additional children receive coverage at no additional charge.

These new rules may result in significant premium-rate changes for some groups, depending on the cumulative impact of the elimination or limitation of the various rating factors. These changes could have either a positive or a negative impact on the renewal rates for groups sized 51-100 in 2016. Premium changes will vary based on characteristics of the firm (e.g., firm size, industry, geographic location) and of its insured population, including employees and their dependents (e.g., age, gender, health status). For instance, the compression of premiums due to the age-rating restrictions will increase the relative rates for groups with a younger population and reduce them for groups with an older population. Similarly, the prohibition of health-status rating will increase the relative premiums for groups with a healthy population and reduce them for those with less healthy populations.

In addition to the changes in allowable premium rating factors, groups sized 51-100 could face a change in how issuers bill for group coverage. In the small

group market, issuers bill employers by listing the rate applicable to each enrolled employee, based on the age of each member-employee and dependent-enrolled in the plan.⁷ This is referred to as list billing. In contrast, for groups sized 51-100, issuers usually use composite rating, in which the premiums shown on the bill represent the average rate for each family size coverage tier offered. Issuers also may choose to offer its small groups a composite premium option, and the total group premium would be the same as that under list billing. The approach determining the composite premium would be the same as that under list billing. The approach determining the composite premium for the small group market, however, is very different from that currently used for groups sized 51-100. If list billing is extended to the 51-100 group market, it will introduce administrative complexity for that market that does not exist today.

Groups sized 51-100 will face additional benefit and cost-sharing requirements

When the expanded small group definition becomes effective, groups sized 51-100 will for the first time be under ACA plan-design requirements that already apply to groups sized 1-50. First, these groups will be subject to the essential health benefits (EHB) requirement, which defines the set of health care service categories that must be covered by the plan. EHBs include some benefits, such as pediatric dental, that typically are not included in plans in the large group medical market. Second, all plans must satisfy a metallic benefit level ranging from bronze to platinum, reflecting the actuarial value of the plans' cost-sharing features (i.e., the portion of covered benefits paid for by the plan, on average).

When these new requirements were imposed on small groups sized 1-50 beginning in 2014, they did not significantly impede plan-design flexibility, because these groups were already subject to a fairly limited range of benefit-design choices. Compared to groups with 50 or fewer employees, however, groups with more than 50 employees typically have had more flexibility in the benefit options from which they could choose, both from a covered-services perspective as well as for specific cost-sharing features. The ACA requires non-grandfathered plans for groups

7. As noted above, a maximum of three children under the age of 21 can be billed as dependents for a specific employee.

larger than 50 to comply with provisions related to annual out-of-pocket limits, annual benefit limits, and coverage of preventive services with no consumer cost sharing.⁸ But aside from these requirements and the 60 percent minimum value requirement, the ACA allows large groups a great deal of flexibility regarding covered benefits and other limitations on plan-design features.

As a result, the new requirements will impose a greater reduction in benefit and cost-sharing flexibility for groups sized 51-100 than they currently experience. Plans likely will need to be changed to meet benefit coverage and actuarial value requirements. Such

changes also could affect premiums. For instance, upward pressure on premiums could result if the EHB and cost-sharing requirements result in more generous coverage.

Younger and healthier groups sized 51-100 may face increased incentives to self-insure

Groups sized 51-100 that will be subject to the small group market rules may have increased incentives to self-insure. A primary reason might be to avoid a higher premium in the fully insured, small group market due to premium-rating limitations and benefit and cost-sharing requirements. A self-funded

Prevalence of Self-Funding

Employers that offer health insurance benefits can opt to purchase fully insured coverage, or they can opt to bear the insurance risks themselves and self-insure. The Employee Retirement Income Security Act (ERISA) exempts self-insured health plans from state health insurance regulations, including issue and rating rules and benefit requirements. As a result, self-insured groups can have more flexibility regarding benefit coverage and plan design, and their costs more directly reflect their actual claims. Self-insured groups are also exempt from state premium taxes and the ACA health insurance fee levied on fully insured plans. Although self-insuring can subject firms to risks of unexpected high claims, this risk can be limited through the purchase of stop-loss coverage.

Employer size, in particular, is a primary factor in determining whether it is feasible for an employer to self-insure. In smaller groups, large year-to-year fluctuations in claims can occur, making it more difficult and risky to budget directly for health costs. As group size increases, however, health claims are likely to be more predictable and stable. Indeed, the prevalence of self-funding generally increases by firm size.

Firm Size	Percent of Enrollees in Self-Insured Plans
1-10	13.1%
11-24	9.7%
25-49	11.9%
50-99	14.3%
100-999	33.6%
1,000+	85.6%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from: http://mepsaahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/rc13_la_g.pdf

An employer's demographic characteristics, which factor into expected health costs, also can influence whether it self-insures. For instance, groups with younger or higher-paid employees may be more likely to self-insure than those with older or lower-paid employees.

8. In addition to these provisions, plans were no longer allowed to impose benefit limitations on pre-existing conditions or to charge higher cost-sharing for emergency services provided out of network.

group's health plan costs more directly reflect its own claims experience and demographics. Therefore, groups more likely to see relative premium increases, including those with a younger and healthier population, may have the greatest incentives to self-insure. Offsetting these potential advantages are: a greater fluctuation in cash flow associated with self-funding; potentially greater financial risk, depending on the morbidity of the group; and a greater assumption of administrative responsibilities as well as compliance and reporting requirements, which generally are within the domain of the insurer. Reinsurance mechanisms and third-party administrators can mitigate these disadvantages.

Although self-insurance typically has been more prevalent among larger firms, lower stop-loss attachment points have become more available, making self-insurance with stop-loss coverage a more viable, and less risky, option for small employers. In addition, self-insuring becomes somewhat less risky to plans after the small group definition is extended, because it provides these groups the protection of guaranteed issue coverage. Currently, if a member of the self-insured group has a significant continuing claim, the employer's costs will increase. In the underwritten large group market, the employer may have difficulty renewing its stop-loss coverage or finding a fully insured plan with a premium not reflecting the high cost of that continuing claim. As a small group, however, the employer could apply for fully insured, small group coverage at rates that do not reflect health status or claims experience. Once the claim is resolved, it could be possible for the employer to revert back to self-insurance. Notably, an EBRI study found that after Massachusetts implemented health reforms in 2006, self-funding increased for all firm sizes greater than 50.⁹

If higher-cost groups sized 51-100 continue to opt for fully insured coverage but more lower-cost groups self-insure, the small group, single risk pool plans would experience adverse selection. Premiums for these plans would increase as a result.

Adverse selection among groups sized 51-100 could increase premiums for groups sized 1-50

Current premiums for groups sized 1-50 reflect the average costs for these groups. When the small group definition is extended, then premiums in the small group market will change to reflect the influx of groups sized 51-100. If the average costs for groups sized 51-100 that enter the market exceed the current average costs of groups sized 1-50, due to adverse selection or other reasons, small group rates would increase as a result. In response to any higher premiums, groups sized 1-50 may reconsider their decision to offer health insurance, especially because they are not subject to the employer-shared responsibility provisions.

Although it is possible that premiums for groups sized 1-50 would decline if groups sized 51-100 are lower cost on average than smaller groups and they opt to continue to fully insure, factors exerting upward pressure on premiums are more likely to dominate.

The premium impact on groups sized 1-50 will depend not only on the average costs of the groups sized 51-100 relative to those of groups sized 1-50, but also the distribution by group size within the 1-100 market. There are more than twice as many covered employees in the 1-50 group size category than in the 51-100 category, which would somewhat moderate the premium impact.

The full impact of the small group definition change on premiums will occur over several years

Many states have adopted the ACA-transition program, which allows small employers to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.¹⁰ Groups sized 51-100 that would face higher costs or less attractive benefit plans by moving to an ACA-compliant small group plan would be more likely to renew their current plans into 2017, after which they would need to move to a small group plan if they want fully insured coverage. This postponement would likely result in higher small group market premiums in 2016. Such an increase could be

9. Paul Fronstin, "Self-Insured Health Plans: State Variation and Recent Trend by Firm Size," EBRI Notes: 33(11), November 2012. Available from: http://www.ebri.org/pdf/notespdf/ebri_notes_11_nov-12.selfinsrd1.pdf

10. The March 4, 2015, CMS Bulletin, "Insurance Standards Bulletin Series - Extension of Transitional Policy through October 1, 2016," gives states the option of deferring compliance with the expanded small group definition for groups renewing their policies on or before Oct. 1, 2016. This is a state-by-state decision. Available from: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

temporary to the extent that lower-cost groups eventually purchase small group plans in 2017 rather than moving to self-insured plans. Therefore, a new equilibrium may be delayed until 2018, with premium impacts differing in the intervening years.

Conclusion

For plan years beginning in 2016, the definition of small employers will expand from employers with 1-50 workers to also include those with 51-100 workers. Such a change could affect over 150,000 establishments with more than 3 million workers. Groups sized 51-100 will face more restrictive rating rules, which likely would increase relative premiums for some

groups, such as those with younger and healthier populations, and reduce relative premiums for others, such as those with older and sicker populations. Additional benefit and cost-sharing requirements could increase the comprehensiveness of coverage, and could also reduce plan-design flexibility and increase premiums. These changes may provide increased incentives for groups sized 51-100 to self-insure in order to avoid these requirements. In particular, the prevalence of self-insurance among lower-cost groups could increase. If such adverse selection were to occur, average premiums could increase not only for fully insured groups sized 51-100 but also for groups sized 1-50, because these two subgroups will be combined for premium rating purposes.



SMALL BUSINESS HEALTH INSURANCE COVERAGE IN A POST-ACA WORLD

Sabrina Corlette, JD, Senior Research Fellow and Project Director, Center on Health Insurance Reforms, Georgetown University

June 2015

Small business owners have long struggled to provide health insurance to their workers, facing high and often volatile premiums relative to large businesses, a lack of market power for negotiating premiums, and high administrative costs associated with covering a small number of workers. In addition, minimum participation requirements used to safeguard against adverse selection mean that small employers often can offer only one plan and must cover a hefty portion of employees' premiums in order to get enough employees to enroll. These pressures have contributed to a steady decline in the number of small businesses offering coverage and left their employees more likely to be uninsured. Furthermore, even small business workers who received insurance have historically had less generous coverage, with much higher deductibles and lower employer contributions for dependent coverage.¹

THE ACA AND THE SMALL GROUP MARKET

While much of the focus of the Patient Protection and Affordable Care Act (ACA) was on addressing a dysfunctional health insurance market for individuals, policymakers also wanted to help more small businesses offer adequate and affordable coverage. Key pillars included revised insurance rules and new marketplaces to facilitate shopping.

Insurance Reforms. The ACA established a set of national minimum standards that took aim at the most glaring problems in the small group market. Consistent with the changes

effected for the individual market, the small group reforms prohibited health underwriting, required minimum essential health benefits and first-dollar coverage of approved preventive services, ended benefit limits and exclusions based on pre-existing conditions, and capped enrollees' annual out-of-pocket liability. In addition, insurers offering products in the small group market are now required to set rates using a single risk pool that includes all enrollees across their small group plans in the state. Finally, small employers can avoid having to meet minimum participation thresholds if they obtain coverage during a November-to-December open enrollment period.

To date, only firms with 50 or fewer workers have been affected by these provisions. Although the ACA allowed states to expand the small group market to include firms with 51 to 100 workers for 2014 and 2015, no state elected to do so. This expansion is set to be enacted nationwide in 2016, however, newly subjecting these mid-size firms to the ACA's rating and benefit reforms at the same time they must also begin complying with the ACA's employer mandate. Concerns about the potential for premium increases, adverse selection and market destabilization resulting from this expansion have prompted a rare bipartisan effort in Congress to repeal this provision of the ACA and leave the market definition decision to the states.

SHOP Exchanges and Tax Credits. The ACA also created the Small Business Health

Options Program (SHOP) exchanges, or marketplaces, where small businesses can shop for health insurance. Responding to small business owners' concerns about their inability to give employees a choice of plans, SHOPs are designed to provide an "employee choice" option whereby employers can set a contribution level and let each employee select his or her preferred option from a range of plans.

Each state has a SHOP, some run by the state but the majority operated by the federal government. With few exceptions, the SHOPs were slow to get off the ground and enrollment has been low so far. In 2014, only a minority of states offered online enrollment and fewer still prioritized the SHOP in their marketing and outreach campaigns.² In addition, mandatory nationwide implementation of employee choice was delayed until 2016, resulting in uneven rollout of this option across states. As of 2015, 31 states are providing some form of employee choice (Figure 1).

The ACA also provides premium tax credits to help make insurance more affordable for very small employers with moderate-income workers. The credits are available only to businesses enrolling through the SHOP, and then only for two years. Few small businesses have made use of these credits, likely due to narrow and complex eligibility requirements and relatively low credit amounts.^{3,4}

EVERYBODY INTO THE POOL? (MAYBE NOT)

Under the ACA reforms, many small employers — and their employees — will benefit from the new rating and benefit standards and

cost-sharing protections. Others, particularly those with young and healthy workers, may face premium increases as they are brought into a single risk pool that includes older and sicker workers. Several alternative coverage options currently enable such employers to circumvent the single risk pool, leaving the higher-risk people who remain in the pool to face higher premiums and threatening the long-term viability of the small group market.

Non-ACA Compliant Plans. Many small group plans are exempt from the ACA market reforms. Some are considered “grandfathered” because they were in existence before the ACA was passed and have not made significant changes to benefits. Others were granted a reprieve under a transitional rule that allows states to permit small employers (and individuals) to remain in the plans they had before reforms took effect in 2014 – the so-called “grandmothered” plans. The great majority of states have opted to permit renewals of transitional plans until October 2016 (extending coverage into 2017),⁴ and anecdotal evidence suggests that many small employers in these states have remained on their pre-ACA plans.³ Most states have also announced plans to permit mid-size group plans to take advantage of the transitional policy when the small group market is expanded.

Self-Funding. Small and, soon, mid-size employers with healthy groups may also find it tempting to self-fund coverage, meaning that they bear the risk of employees’ medical claims. Such a move exempts them from many of the ACA’s rating and benefit reforms and effectively removes them from the insurance risk pool. Self-funding employers can purchase a reinsurance or stop-loss policy to protect against the significant financial risk of unexpectedly large claims. Increasingly, these policies are incorporating very low thresholds above which claims are covered; such policies can thus mimic traditional health insurance while avoiding health insurance regulations. Researchers have projected that use of low-threshold stop-loss policies can lead to large premium increases for employers remaining in the regulated small group market,⁵ undermining market stability.

While there is limited evidence that current small employers have been transitioning to self-funding in significant numbers at this time, the propensity to self-fund may increase as the small group market expands.⁶ Not only would mid-size employers be somewhat better able to accept the financial risk, those with young or healthy workforces may see self-

FIGURE 1. MOST EXPANSIVE EMPLOYEE CHOICE MODEL AVAILABLE IN 2015

Employee Choice Model:	States Offering Model:	
Single Plan	Employer selects a single plan for employees	20 states: AL, AK, AZ, DE, ID, IL, KS, LA, MA, ME, MI, MT, NH, NJ, NC, OK, PA, SC, SD, WV
Horizontal Employee Choice	Employer selects one metal level and employees may select from available insurers/plans at that level	21 states: AR, CA, FL, GA, HI, IN, IA, MO, MS, NE, ND, NM, NV, OH, OR, TN, TX, VA, WI, WA, WY
Employee Choice Across Metal Levels	Employer permits employees to select from plans at multiple metal levels offered by one or more insurers	4 states: CO, CT, DC, MD
Full Employee Choice	Employer permits employees to select any plan available	6 states: KY, MN, NY, RI, UT, VT

Most states permitting more expansive employee choice also let employers offer less choice. Typology adapted from Dash and Lucia (2014). State status updated to 2015 using data from CCRO (<http://tinyurl.com/inn68fc>) and author correspondence with state-based SHOPs.

funding as a way to avoid premium increases associated with the ACA’s expanded benefits and pricing based on a single risk pool. As more mid-sized firms choose to self-fund, adverse selection could spread across the entire small group market, putting additional upward pressure on premiums. Self-funding is also likely to be attractive to small group employers of all sizes as they move off of transitional plans over the next couple of years, making this a trend to watch.

THE OUTLOOK FOR THE FUTURE

Despite a decade or more of declining offer rates, many small employers still find it important to provide high quality health coverage for their workers. The ACA insurance reforms, SHOP exchanges, and premium tax credits offer them new options for doing so, although the ultimate impact of these policies remains to be seen. With the exception of Vermont and Washington DC, small employers can bypass the SHOP and continue to purchase coverage directly from an insurer, and a growing number of private exchanges are also coming online to serve this market.

But the long-term viability of the small group market needs to be closely monitored. With the continued enrollment in transitional plans, it will be a few more years before the effects of the ACA are fully felt. Additionally, the upcoming expansion of the market to include firms with 51 to 100 workers is likely to have a destabilizing impact.

A second change set for next year whose impact bears monitoring will be the nationwide availability of employee choice within the SHOP exchanges. The exchanges will need to balance the goals of attracting employers to the SHOP and giving small business workers more say in selecting their own health coverage with the risk of adverse selection posed by the more expansive models of employee choice.⁷

It will also be important to watch whether small employers now offering coverage begin to drop coverage and encourage their workers to enroll in the individual health insurance exchanges instead. Employers with 50 or fewer workers face no penalty for doing so and their lower-income workers might be better off accessing premium subsidies in the individual market. There is early anecdotal evidence that some small employers are doing exactly this,⁸ and this trend would be accelerated if the small group market begins to experience significant adverse selection. Additionally, legislation now pending in Congress would permit small employers to contribute to an employee’s health reimbursement account and send the employee to the individual exchange to purchase stand-alone coverage, potentially making this option more attractive.

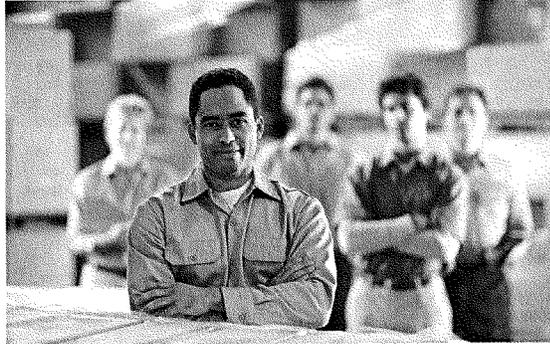
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Washington - Offer rates at firms with less than 50 employees (2010-2014)

Year	Establishments	Employees
	offering HI	offered HI
2010	42.1%	65.8%
2011	32.4%	50.4%
2012	36.1%	55.5%
2013	33.8%	52.6%
2014	31.9%	46.6%

AHIP
ISSUE Brief



Why Maintaining the Current Definition of the Small Group Market is Critical

KEY TAKEAWAYS

3.4 million Enacting bipartisan legislation in Congress can **preserve access to affordable coverage and care for 3.4 million employees and their families**

+ Expanding the definition of the small-group market to include mid-size employers (51-100 employees) could have **far-reaching implications for the affordability and stability of coverage**

2/3 Nearly **two-thirds** of workers in mid-size firms (64%) would **experience premium increases of 18%** as a result of applying the ACA modified community rating rules



Background

Currently, all states define their small-group insurance markets as employers with up to 50 employees. Under the Affordable Care Act, beginning in 2016, the definition for the small-group market will be significantly expanded to include employers with up to 100 employees in all states. Expanding the definition of the small-group market to include mid-size employers (51-100 employees) could have far-reaching implications for the affordability and stability of coverage for millions of employees and their families.

According to the American Academy of Actuaries, 3.4 million employees currently receive health insurance coverage through mid-size firms.¹ And, this segment of the market has been successful in providing access to affordable, high-quality coverage to workers and families. According to research by the Kaiser Family Foundation, over 91% of mid-size firms (with more than 50 employees) offer coverage to their employees² and consumer satisfaction with employer-sponsored coverage remains high.³

Bipartisan legislation has been introduced in the House (H.R. 1624) and Senate (S. 1099) that would enable states to maintain their current definitions for their small employer marketplace—which represents an important step toward promoting market stability and avoiding coverage disruptions for small employers and families.

Failure to maintain the current definition could result in higher premiums for many mid-size businesses and their employees, create instability in the small group market, and may cause coverage disruptions for millions of workers and their families.

Premium increases for the majority of mid-size businesses and their workers

Expanding the definition of the small-group market will impose significant new rating restrictions and benefit requirements on mid-size firms (51-100 employees)—including the ACA's modified community rating requirements, which bars the use of health status or claims experience in establishing premiums and permits only limited variations in premiums on the basis of age (3 to 1), geographic area, family size, and tobacco use. This is a significant departure in how the mid-size marketplace currently works—where premiums are largely set based on the health care costs of the entire group (e.g., experience rating). Moreover, in the medium- and large-employer market, insurers have broad flexibility in setting premiums through

the use of common rating factors such as industry, group size, employee participation, and employer contributions as a way to assure affordable coverage and a broad and stable risk pool.

According to the American Academy of Actuaries, the application of the new ACA rules to mid-size firms would result in “significant rate changes for some groups” and would particularly increase rates for mid-size firms with younger and healthier employees.⁴ Research by Oliver Wyman found that nearly two-thirds of workers in mid-size firms (64%) would experience premium increases of 18% as a result of applying the ACA modified community rating rules.⁵



Applying benefit and cost-sharing requirements will also place upward pressure on premiums—increasing rates an additional 3%-5%, on average. This is the result of imposing a “greater reduction in benefit and cost-sharing flexibility for groups sized 51-100 than they currently experience.”⁶

Instability for the small-employer marketplace

Extending the small-group marketplace to include mid-size firms could result in less stable coverage for the broader marketplace, according to leading actuaries and other experts. Mid-size firms that employ older and less healthy workers would be more likely to purchase coverage in the small-group marketplace—as they would benefit under the ACA’s modified community rating requirements. At the same time, medium-sized firms with younger, healthier workers (faced with increased premiums) may forego coverage entirely—which leads to a less healthy small-employer risk pool and higher premiums. While the potential effects of including mid-size firms in the small-group market are complex and varied, the American Academy of Actuaries has concluded that “factors exerting upward pressure on premiums are more likely to dominate.”⁷ In a separate analysis, Oliver Wyman found that premiums could increase by an additional 6%-18% as a result of adverse selection and related risk pool effects.⁸

Coverage disruptions for many small business employees and their families

While the mid-size employer marketplace for health insurance has been a stable source of coverage for 3.4 million employees and their families, imposing restrictive new requirements could result in unintended coverage disruptions. For example, many mid-size firms will have to select new plans for their employees—as their existing plans no longer meet the ACA’s rating rules and

benefit requirements. Moreover, facing sharp premium increases, some mid-size firms may elect to non-renew or forego coverage for the 2016 plan year—due to concerns around affordability. In both cases, many employees and families could face coverage disruptions due to the combination of escalating premiums and application of new regulatory requirements.

Conclusion

Congress should pass bipartisan legislation (H.R. 1624/S.1099) to provide flexibility to states to retain their current small-employer health insurance definition. This legislation is supported by a broad array of prominent stakeholders—including large and small employer organizations,⁹ health plans, state insurance regulators, and a broad array of health policy experts and consumer organizations. Enactment on this legislation would represent an important step toward maintaining affordability and stability of coverage for millions of employees and their families.



End Notes

- 1 Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees. American Academy of Actuaries, March 2015
- 2 Gary Claxton et al. Employer Health Benefits 2015 Annual Survey. Kaiser Family Foundation and HRET, September 10, 2014. <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>
- 3 Margot Sanger-Katz. How People Feel About Their Employer-Sponsored Plans. New York Times, September 4, 2014. http://www.nytimes.com/2014/09/05/upshot/how-people-feel-about-their-employer-sponsored-health-plans.html?_r=0&abt=0002&abg=1
- 4 Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees. American Academy of Actuaries, March 2015
- 5 Kurt Giesa. "Impact of Including Employers with 51 to 100 Employees in the Small Group Market in 2016. Oliver Wyman—Prepared for BlueCross Blue Shield Association, January 27, 2015.
- 6 See American Academy of Actuaries Issue brief and Oliver Wyman analysis previously cited.
- 7 Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees. American Academy of Actuaries, March 2015
- 8 Kurt Giesa. "Impact of Including Employers with 51 to 100 Employees in the Small Group Market in 2016. Oliver Wyman—Prepared for BlueCross Blue Shield Association, January 27, 2015.
- 9 See Letter to Representatives Guthrie, Cardenas, Mullin, and Sinema from coalition of nearly 20 employer groups. https://www.uschamber.com/sites/default/files/150403_coalition_letter_h_r_1624_protecting_affordable_coverage_for_employees_act_guthrie_cardenas_mullin_sinema.pdf

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Why keeping the current definition of the small-group market is critical to businesses and consumers

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FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
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Minority (202) 225-3841

October 5, 2015

Ms. Monica Lindeen
President
National Association of Insurance
Commissioners
444 North Capitol Street, N.W
Washington, DC 20001

Dear Ms. Lindeen:

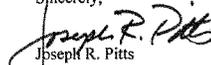
Thank you for appearing before the Subcommittee on Health on September 9, 2015, to testify at the hearing entitled "Protecting Affordable Coverage for Employees."

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.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on October 19, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Responses to Questions Posed by the Honorable Representative Blackburn

As a result of the ACA, small and midsize employers are now prohibited from utilizing employer payment plans, or reimbursing their employees for the purchase of individual market health insurance. Continuing to do so now has a \$36,500 per employee per year penalty. Many smaller businesses pursued this arrangement because they were unable to obtain or afford an expensive small group health insurance plan. In 2016, more businesses will be subject to this expensive marketplace. Ultimately, the ACA had led to fewer choices and costly plans and penalties.

1. **Do you know how many businesses or individuals in your states obtained insurance through employer payment plans (sometimes referred to as health reimbursement accounts)?**

I do not have any information about how many employers paid for individual health insurance premium through Health Reimbursement Accounts (HRAs) or other pre-tax vehicles. Many states, including Montana, did not allow employers to pay for individual health insurance plans with pre-tax dollars, even before the ACA passed. In general, insurance departments do not have a way to track that information.

2. **Does prohibiting employer payment plans and reimbursement for individual plans, like through an HRA, mean more or fewer choices for small businesses and individuals?**

Prohibiting employers from paying for individual health insurance through HRAs did not result in fewer choices for employers in Montana because other laws prohibited this before the IRS clarified its opinion on the legality of this practice. In Montana, 2016 small employer health insurance premiums for a high deductible health plan are more affordable than individual coverage. For instance, a bronze small employer group health plan for a 40 year old costs \$213 per month. A similar bronze individual market plan for a 40 year old costs \$264 per month. Small employers will not save money by paying for individual health insurance premiums in 2016.

3. **Do you believe these businesses will add an expensive group benefit or drop assistance altogether?**

In Montana, we do not have any evidence that would indicate that large employers have dropped coverage. Many large employers operate "self-funded" health plans, and insurance departments do not collect data on self-funded plans. Enrollment in large group commercially insured health plans has not declined; in fact, since 2011, it has increased by 17%.

Enrollment in small employer group health plans has declined slightly since 2013. My staff believes that this is because many small employers are family owned businesses employing only family members and some of them are in fact, better off purchasing

individual health insurance through the marketplace. Also, a significant number of small employers moved to self-funded multiple employer welfare arrangements (MEWAs).

Responses to Questions Posed by the Honorable Representative Brooks

1. **In the National Association’s letter to House leadership, NAIC said “the flexibility afforded to states with immediate passage of H.R. 1624 will help ensure stable small group health insurance markets that reflect the unique characteristics and dynamics at play in each of the states. Without it, a series of market disruptions could occur.” Can you explain why it’s important Congress act quickly on this bill? What happens if we don’t act soon?**

The NAIC encourages Congress to act quickly because most mid-size employers shop for coverage annually to ensure the best price for themselves and their employees, but they need final rates and product information by late September in order to make these decisions and carry on with the preparing of employee communications and open enrollment materials and the actual conducting of open enrollment in advance of the effective date. Those employers who may be new entrants into the market in 2016 also need to know what options will be available to them. Quick action would avoid unnecessary confusion and disruption as we move into 2016.

2. **H.R. 1624 would allow the states to continue defining the small group health insurance market as employers with 1-50 employees. Can you talk about the standard state-level “consumer protections” that would still be in place if current policy is maintained?**

The standard state-level consumer protections are as follows: 1) large group premiums are still subject to state regulatory review and must be actuarially justified, sufficient and nondiscriminatory; 2) large group plans are subject to a higher Medical Loss Ratio (MLR); and 3) large group plans are subject to many state-level consumer protections, such as mandated benefits, grievance and appeals rights, and network adequacy standards.

3. **What do you think are the three most important messages for consumers who are listening today to our hearing to understand the benefits of H.R. 1624?**

The following three scenarios could occur if H.R. 1624 is not signed into law: 1) employers with 51-100 employees would be subject to new rating restrictions, which could result in significant premium increases for some groups; 2) employers with 51-100 employees would face additional benefit requirements and cost-sharing restrictions, which would reduce benefit flexibility and could increase out-of-pocket spending; and 3) expansion of the small group definition could lead some employers with younger and/or healthier employees to self-insure as a way of avoiding higher premiums and limited coverage options, which could result in adverse selection in the small group pool, thus increasing premiums for employers with 1-50 employees.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
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October 5, 2015

Mr. Mike Kreidler
Insurance Commissioner
Washington State
P.O. Box 40255
Olympia, WA 98504

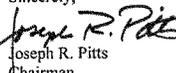
Dear Mr. Kreidler:

Thank you for appearing before the Subcommittee on Health on September 9, 2015, to testify at the hearing entitled "Protecting Affordable Coverage for Employees."

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.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: (360) 725-7000



OFFICE OF
INSURANCE COMMISSIONER

October 19, 2015

The Honorable Joseph R. Pitts
Chairman, U.S. House Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts:

Thank you for the opportunity to testify before the Subcommittee on Health on September 9, 2015 regarding the "Protecting Affordable Coverage for Employees" act. Please accept the following responses to the questions submitted by Representative Marsha Blackburn:

1. Do you know how many businesses or individuals in your state obtained insurance employer payment plans (sometimes referred to as health reimbursement accounts)?

The Washington state Office of Insurance Commissioner estimates that approximately 6,000 employees were enrolled in health reimbursement accounts (HRAs) in Washington state in 2015. I stress that this is an estimate as our office does not track data on HRAs. We base our estimate on the Kaiser Family Foundation 2015 Employer Health Benefits Survey. This national survey indicates that nine percent of employees in businesses sized 3-199 have an HRA. Since employers with fewer than 50 employees are less likely to offer an HRA, due to a higher prevalence of part-time workers, we calculated that for employees of firms under 50 employees, the enrollment would be closer to five percent.

2. Does prohibiting employer payment plans and reimbursement for individual plans, like through an HRA, mean more or fewer choices for small businesses and individuals?

In my testimony to the Subcommittee on Health, I reported that the small group market in Washington state is continuing to increase in the number of employees enrolled and in the number of plans being offered to small groups. We have seen similar increases in the individual market. Rate increases for 2016 averaged only 4.5 percent. This indicates there has been an increase in the number of choices for small businesses and individuals since the implementation of the Affordable Care Act (ACA).

There are still some very small employers that likely cannot afford to purchase insurance for their employees at this time, but still want to assist their employees. Continuing the ability for these employers to participate in HRAs could keep that option available for these employers and help their employees obtain and maintain enrollment in health insurance coverage. However, to

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OFFICE OF INSURANCE COMMISSIONER

The Honorable Joseph R. Pitts
Chairman, U.S. House Subcommittee on Health
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continue to grow and maintain a robust and affordable small group market, the continuation of HRAs should be limited to truly small employer groups (e.g. those with 25 and fewer employees).

3. Do you believe these businesses will add an expensive group benefit or drop assistance altogether?

In Washington state, we have been successful at keeping the cost of health insurance in the small group market down and have continued to see growth in enrollment and in the number of plans offered. The increased number of plans being offered should increase options and also slow premium cost increases for small employers due to the increasing competition in the market. Certainly some employers may find insurance too costly and drop coverage. I cannot predict the number of employers that may choose that route. The option of allowing very small businesses to continue providing an HRA, as discussed previously, could be one method to preserve coverage for some employees and provide an additional option for very small employers to contribute to coverage.

Again, thank you for the opportunity to testify before the Subcommittee on Health and to provide this additional information.

Sincerely,



Mike Kreidler
Insurance Commissioner

